

**Provider Report for ALL providers**

	<u>Yes</u>	<u>No</u>	<u>N/A</u>	<u>Percentage</u>
<b>Core</b>				
1. Each page in the tx record contains the patients name or ID number?	139	5	0	97%
2. Each tx record includes the patients address, employer or school name, home phone number, work phone number, emergency contacts, marital status or legal status, appropriate consent forms, and guardianship information if relevant?	138	6	0	96%
3. All entries in the tx record include the treating clinicians name, professional degree, and relevant identification number, if applicable?	106	38	0	74%
4. All entries in the tx record are dated?	143	1	0	99%
5. The tx record is legible to someone other than the writer?	144	0	0	100%
6. Relevant medical conditions are listed, prominently identified, and revised as appropriate in the tx record?	136	8	0	94%
7. Presenting problems, along with relevant psychological and social conditions affecting the patients medical and psychiatric status, are documented in the tx record?	143	1	0	99%
8. Special status situations, such as imminent risk of harm, suicidal ideation, or elopement potential, are prominently noted, documented and revised in the tx record in compliance with ValueOptions written protocols?	140	4	0	97%
9. Each tx record indicates what medications have been prescribed, the dosages of each, and the dates of initial prescription or refills? N/A if medications are not prescribed. For non-prescribing practitioners, each tx record indicates what medications have	41	1	102	98%
10. Allergies and adverse reactions are clearly documented in the tx record?	43	101	0	30%
11. A lack of known allergies and sensitivities to pharmaceuticals and other substances is prominently noted in the tx record?	42	102	0	29%
12. A medical and psychiatric history is documented in the tx treatment record, including previous tx dates, provider identification, therapeutic interventions and responses, sources of clinical data, relevant family information, results of laboratory tests	139	5	0	97%
13. For children and adolescents, prenatal and perinatal events, along with a complete developmental history including physical, psychological, social, intellectual, and academic are documented in the tx record? N/A if the patient is over the age of 18.	22	18	104	55%
14. For patients 12 and older, documentation in the tx record includes past and present use of cigarettes and alcohol, as well as illicit, prescribed, and over-the-counter drugs? N/A if the patient is under the age of 12.	114	3	27	97%
15. A mental status evaluation that includes the patients affect, speech, mood, thought content, judgment, insight, attention, concentration, memory, and impulse control is documented in the tx record?	129	15	0	90%
16. A DSM-IV diagnosis, consistent with the presenting problems, history, mental status examination, and/or other assessment data is documented in the tx record?	141	3	0	98%
17. Tx plans are consistent with diagnoses and have both objective measurable goals and estimated time frames for goal attainment or problem resolution?	125	19	0	87%
18. The focus of tx interventions is consistent with the tx plan goals and objectives?	131	13	0	91%
19. Informed consent for medication and the patients level of understanding is documented? N/A if medication is not prescribed or the practitioner being reviewed is not a prescriber.	17	1	126	94%
20. Progress notes describe patient strengths and limitations in achieving tx plan goals and objectives?	133	11	0	92%
21. The tx record documents patient strengths and limitations in achieving tx plan goals and objectives?	36	1	107	97%

	<u>Yes</u>	<u>No</u>	<u>N/A</u>	<u>Percentage</u>
22. The tx record documents preventive services, as appropriate? (e.g. relapse prevention, stress management, wellness programs, lifestyle changes, and referrals to community resources)	134	10	0	93%
23. The tx record reflects continuity and coordination of care between the primary clinician, consultants, ancillary providers, health care institutions, behavioral health clinicians and the PCP or other non-behavioral health providers?	109	35	0	76%
24. The tx record documents dates of follow-up appointments or, as appropriate, a discharge plan?	143	1	0	99%
<b>VO</b>				
25. Evidence of coordination with the PCP or declination of this by the patient?	80	64	0	56%
26. When medication is prescribed, there is evidence of consistency among the signs and symptoms, diagnosis, and medication prescribed? N/A if medication is not prescribed or the practitioner being reviewed is not a prescriber.	5	0	139	100%
27. The assessment is culturally relevant? (addresses issues relevant to the patients race, religion, ethnicity, age, gender, sexual orientation, level of education, socio-economic level, etc.)	88	0	56	100%
28. The tx plan is culturally relevant? (addresses issues relevant to the patients race, religion, ethnicity, age, gender, sexual orientation, level of education, socio-economic level, etc.)	84	0	60	100%
29. The record reflects evidence of coordination with other outpatient behavioral health practitioners?	82	14	48	85%
30. The record reflects evidence of coordination with behavioral healthcare institutions/ALOC?	25	1	118	96%
31. The record reflects evidence of coordination with EAP/employer?	1	0	143	100%
<b>CA</b>				
32. The record indicates an assessment of school functioning?	30	0	5	100%
33. Prenatal and perinatal events, along with a complete developmental history (physical, psychological, social intellectual, and academic) are documented?	16	19	0	46%
34. The record reflects the active involvement of the family/primary guardian in the assessment and tx of the patient, unless contraindicated?	34	0	1	100%
35. The record indicates the parent(s) or guardian(s) have given signed consent for the various tx provided?	34	0	1	100%
36. The record indicates evidence of coordination with the youths school to achieve related tx goals?	18	1	16	95%
<b>MDDX</b>				
37. Mood symptoms and suicidality are assessed at every visit?	54	5	0	92%
38. Co-morbid problems are assessed upon initial evaluation and at least annually?	55	4	0	93%
39. When medication is prescribed, there is evidence of consistency among the signs and symptoms, diagnosis, and medication prescribed? N/A if medication is not prescribed or the practitioner being reviewed is not a prescriber	1	0	58	100%
<b>SCHIZ</b>				
40. Evidence of assessment of positive signs of psychosis, e.g., delusions and/or hallucinations?	9	1	0	90%
41. Co-morbid problems are assessed upon initial evaluation and at least annually?	10	0	0	100%
42. When medication is prescribed, there is evidence of consistency among the signs and symptoms, diagnosis, and medication prescribed. N/A if medication is not prescribed or the practitioner being reviewed is not a prescriber.	0	0	10	0%
43. When anti-psychotic medications are prescribed, there is evidence of observation for side effects including EPS such as dystonic reactions, akathisia(cant sit still), or akinesia? (This applies to all discipline levels;NA may not be checked)	9	1	0	90%

	<u>Yes</u>	<u>No</u>	<u>N/A</u>	<u>Percentage</u>
<b>ADHD</b>				
44. The record reflects the active involvement of the family/primary caretakers in the assessment and tx of the patient, unless contraindicated? (see also #30) NA if contraindicated.	7	0	0	100%
45. Co-morbid problems are assessed upon initial evaluation and at least semi-annually?	7	0	0	100%
46. The record reflects education about ADHD and parent training in behavioral management?	1	6	0	14%
47. When medication is prescribed, there is evidence of consistency among the signs and symptoms, diagnosis, and medication prescribed? N/A if medication is not prescribed or the practitioner being reviewed is not a prescriber (see also #26)	5	0	2	100%
48. When medication is prescribed, there is evidence of an evaluation of the patients response to medication and adjustments as needed?	5	0	2	100%

**BIPOLAR**

49. Mood symptoms and suicidality are assessed at every visit?	22	1	0	96%
50. Co-morbid problems are assessed upon initial evaluation and at least annually?	22	1	0	96%
51. When medication is prescribed, there is evidence of consistency among the signs and symptoms, diagnosis, and medication prescribed? N/A if medication is not prescribed or the practitioner being reviewed is not a prescriber (see also #26)	0	0	23	0%
52. When medications are prescribed that require serum level monitoring and/or laboratory tests for medication side effects, those tests are measured as recommended by the drug manufacturer? N/A for non-prescribing practitioners.	0	0	23	0%

**Grand Total Yes**  
3,292

**Grand Total No**  
520

**Grand Total N/A**  
1,171

**Grand Total Percentage**  
86 %