Behavioral Health Hospital Survey Corrective Action Plan (CAP) Notification

Date of Review:

Health Plan Performing Evaluation	**IEHP**	
Facility/Hospital Name:	Provider Name(s):	# of Provider(s) Reviewed: # of Charts Reviewed:
Address:	Contact Person and Title:	
Telephone:	Fax:	☐ Exempted Pass– No CAP Due
BH Hospital Survey Score:	**Date Critical Element CAP Due:** Date BH Hospital Survey CAP Due:	**CAP Follow-up:** ☐ Mail/Fax ☐ Schedule Follow-up visit ☐ Critical Element ☐ BH Hospital Survey ☐ Follow-up visit scheduled date/time: ___________________
		CAP Closed Date:
Reviewer's Name/Title (Print):	**Reviewer's signature/Title:**	

CAP Completion and Submission Requirements

Disclosure and Release

I have received and reviewed copies of the above listed site's evaluations and CAPs for the BH Hospital Survey. I agree to correct each identified deficiency by implementing any corrective action that may be required. **I understand that failure to correct any of the noted Critical Element deficiencies within the required 10 calendar days and any other noted deficiencies within the 30-day time period from the review date,** may result in the exclusion of this facility and the associated provider(s) from IEHP's network. **The completed CAP must include evidence of correction** {e.g. education sign sheets, forms used} **and dates completed.**

For assistance in completing the CAP, please call______________________, RN, CSR at 909- ____________________.

I hereby authorize the above-mentioned health plan and any government agencies that have authority over the health plans, and authorized county entities in the State of California, to furnish to each other these reviews and CAPs of this facility.

______________________________	______________________________	______________
Facility Administrator/Designee Signature	**Printed Name and Title**	**Date**

Please Return Completed CAP via U.S. Mail or FAX to: **Attention: QM Coordinator** **Fax: 909-890-5545**	**Inland Empire Health Plan** **P.O. Box 1800,** **Rancho Cucamonga, CA** **91729-1800**	**Facilities wishing to appeal the results of a BH Hospital Survey must do so in writing to the IEHP Chief Medical Officer or Designee, within 14 working days of the date of the notification letter.**	**P.O. Box listed to the left.** **CMO Fax: (909) 890-2019**

INSTRUCTIONS FOR USE

1st Column: (Health Plan Use Only) Health Plan verification and date – The Health Plans Certified Site Reviewer (CSR) will initial and date the deficiency that the site has addressed/corrected. The Facility's Corrective Action Plan will be verified by the CSR through a desk review by the Health Plan and/or a follow-up on site visit.
2nd Column: (Health Plan Use Only) Criteria – The Health Plan's CSR will check the criteria(s) that were found deficient during the site review and/or medical record review processes. The criteria(s) checked should be addressed/corrected by the hospital. A CAP for all critical element deficiencies, which are **bolded and underlined**, should be submitted to the Health Plan within 10 calendar days. A CAP for other criteria found deficient is due to the Health Plan within 30 days from the date of survey.
3rd Column: (Health Plan Use Only) Deficiency Cited/Reviewer Comments – This column is for the purpose of notifying the Facility and/or designated staff of the deficiency found and/or the CSR findings/comments.
4th Column: (Health Plan and Facility/Hospital Use) Recommended Corrective Action – The Health Plan's CSR will check and/or write comments for the facility/hospital in order to notify the facility and/or designated staff the documents and/or evidence needed in order to fulfill a deficiency.
5th Column: (Facility/Hospital Use Only) Correction Date – The facility/hospital will document the date that a deficiency has been addressed and/or corrected.
6th Column: (Facility/Hospital Use Only) Facility's Comments – The facility/hospital will document corrective actions taken to address/correct a deficiency, as well as provide appropriate documents to support corrective actions taken. If facility/hospital agrees with items checked in the 4th Column (Recommended Corrective Action) then the facility/hospital would write "agree with recommended corrective action," as well as submit supporting documents.
7th Column: (Facility/Hospital Use Only) Signature and Title of Facility Administrator or Designee – The facility/hospital staff who is responsible for maintaining compliance with a deficiency found during a site audit would put their name, title, and initial in this column.
NOTE: The Health Plan's Certified Site Reviewer (CSR) may conduct a follow-up on site review to verify corrective action within 30 days from the date of audit and/or request the CAP to be submitted to the Health Plan via mail and/or fax.

CAP COMPLETION SIGNATURE PAGE

I have completed the CAPs for the facility and medical record reviews performed on ________________________________. I affirm each
(Enter Date of Review)

corrective action has been implemented as indicated on the attached Corrective Action Plan. I hereby authorize the reviewing health plan to furnish to all collaborative partner, any government agencies that have authority over the health plans, and authorized county entities in the State of California, the CAPs and related review tools for this facility.

________________________________	________________________________	______________
Facility Administrator/Designee Signature	**Printed Name and Title**	**Date**

Please Return Completed Corrective Action Plan and this signature sheet via U.S. Mail or FAX to:

Inland Empire Health Plan
P.O. Box 1800
Rancho Cucamonga, CA 91729-1800
Attention: QM Coordinator
Fax: 909-890-5545

Behavioral Health Hospital Survey

I. Policies and Procedures Criteria

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
	IA ☐	No evidence that staff competence was assessed initially and/or again once every three years.	☐ A copy of the staff competence assessment documentation ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	IB ☐	No evidence that the hospital has/follows a written policy addressing the control of medication between receipt by an individual health care provider and administration of the medication, including safe storage, handling, wasting, security, disposition, and return to storage.	☐ A copy of a policy addressing the control of medication between receipt by an individual health care provider and administration of the medication, including safe storage, handling, wasting, security, disposition, and return to storage ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	IC ☐	No evidence that the hospital has/follows a written policy for as needed (PRN) orders: orders acted on based on the occurrence of a specific indication or symptom.	☐ A copy of policy for as needed (PRN) orders: orders acted on based on the occurrence of a specific indication or symptom ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	ID ☐	No evidence that the hospital has/follows a written policy for standing orders: A prewritten medication order and specific instructions from the licensed independent practitioner to administer a medication to a person in clearly defined circumstances.	☐ A copy of policy for standing orders: A prewritten medication order and specific instructions from the licensed independent practitioner to administer a medication to a person in clearly defined circumstances. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			

I. Policies and Procedures Criteria

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	IE ☐	No evidence that the hospital has/follows a written policy for titrating orders: orders in which the dose is either progressively increased or decreased in response to the patient's status.	☐ A copy of policy for titrating orders: orders in which the dose is either progressively increased or decreased in response to the patient's status ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	IF ☐	No evidence that the hospital has/follows a written policy for taper orders: orders in which the dose is decreased by a particular amount with each dosing interval.	☐ A copy of policy for taper orders: orders in which the dose is decreased by a particular amount with each dosing interval. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	IG ☐	No evidence that the hospital has/follows a written policy for orders for medications at discharge or transfer.	☐ A copy of policy for orders for medications at discharge or transfer. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	IH ☐	No evidence that the hospital has/follows a written policy that defines actions to take when medication orders are incomplete, illegible, or unclear.	☐ A copy of policy that defines actions to take when medication orders are incomplete, illegible, or unclear. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	II ☐	No evidence that the hospital has/follows a written policy that defines actions to take and report for a sentinel event.	☐ A copy of policy that defines actions to take and report for a sentinel event. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			

II. Format Criteria

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
	II A ☐	Each Member did not have a separate record.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	II B ☐	Each record did not have the Members address, employer or school, home and work telephone numbers documented.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	II C ☐	Emergency "contact" was not identified.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the form is attached. ☐ Other:			
	II D ☐	Guardianship information was not identified.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the form is attached. ☐ Other:			
	II E ☐	Medical records were not maintained and organized.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	II F ☐	Member's attending physician and/or rendering physician (PCP) was not identified.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the form is attached. ☐ Other:			

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	II G ☐	Primary language and interpreter service needs of non-or limited-English proficient (LEP) or hearing-impaired persons were not prominently noted.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	II H ☐	Person or entity providing medical interpretation was not identified, as necessary.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	II I ☐	No evidence of Signed Copy of the Notice of Privacy.	☐ A copy of the policy and procedure regarding Notice of Privacy is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			

III. Documentation Criteria

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
	III A ☐	Allergies were not prominently noted.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	III B ☐	Chronic problems and/or significant conditions were not listed.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the chronic problem(s) and/or significant conditions form is attached. ☐ Other:			
	III C ☐	Current *continuous* medications were not listed.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the current continuous medications form is attached. ☐ Other:			
	III D ☐	No evidence that a Consent for Treatment or Informed Consent in the record was signed by the Member and/or legal guardian. For minors, the Consent for Treatment must be -signed by the Member's parent/caregiver/court officer (CFS worker or Probation Officer).	☐ A copy of the policy and procedure regarding Consent for Treatment or Informed Consent is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the Consent for Treatment/ Informed Consent form(s) is attached. ☐ Other:			

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	III E ☐	No evidence that the patient was given information to create psychiatric Advance Directives.	☐ A copy of the information is available regarding psychiatric Advanced Directive is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the psychiatric Advanced Directive is attached. ☐ Other:			
	III F ☐	No evidence that the patient was provided with referrals to peer support services.	☐ A copy of the policy and procedure regarding referrals to peer support services is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	III G ☐	No evidence that all entries in the record included the responsible service provider's name, professional degree and/or relevant identification number, if applicable, and were signed and dated (including electronic signature for EMR systems) where appropriate.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	III H ☐	No evidence that the service provider provided education to Member/family about service planning, discharge planning, supportive community services, behavioral health problems, and care options.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			

III. Documentation Criteria

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	III I ☐	No evidence that the risks of noncompliance with treatment recommendations were discussed with the Member and/or family or legal guardian. For minors, discussions may also be made with the Member's parent/caregiver/ court officer (CFS worker or probation officer if appropriate)	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	III J ☐	No evidence that there was information that documents the course and result(s) of patient's care, treatment, and services.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	III K ☐	The record was not clearly legible.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			
	III L ☐	Errors were not corrected according to legal medical documentation standards.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ Other:			

IV. Initial Assessment Criteria

Health Plan verification and date	**CRITERI**	**Deficiency Cited / Reviewer Comments**	**Recommended Corrective Action**	**CORRECTION DATE**	**PRACTITIONERS COMMENTS**	**SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE**
	IV A ☐	No evidence of a complete clinical case formulation documented in the record (e.g. primary diagnosis, medical conditions, psychosocial and environmental factors and functional impairments).	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	IV B ☐	No psychiatric evaluation completed within 24 hours of admission.	☐ A copy of the policy and procedure regarding psychiatric evaluation is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	IV C ☐	No evidence that a medical history and/or physical exam (appropriate to level of care) was in the record.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	IV D ☐	Current medical condition not identified.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			

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	IV D1 ☐	No evidence of documentation of communication/collaboration with the treating medical clinician for medical condition occurred.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	IV D2 ☐	No evidence of documentation that the patient/legal guardian refused consent for the release of information to the treating medical clinician. For minors, release of information may also be refused by the Member's parent/caregiver/court officer (CFS worker or Probation Officer).	☐ A copy of the policy and procedure regarding consent for the release of information is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	IV D3 ☐	No evidence of documentation that medical treatment history included the following information: known medical conditions, dates and providers of previous treatment, current treating clinicians, and current therapeutic interventions and responses.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	IV E ☐	No evidence of documentation of a complete mental status exam was in the record (patient's affect, speech, mood, thought content, judgement, insight, attention or concentration, memory, and impulse control) nor the frequency in which the mental status exam is completed.	☐ A copy of the policy and procedure regarding mental status exam/assessment is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the mental status exam form is attached. ☐ Other:			

IV. Initial Assessment Criteria

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	IV F ☐	No evidence of documentation of patients' overall level of risk for suicidal/homicidal tendencies and/or the plan to mitigate the risk for suicide/homicide.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	IV G ☐	Behavioral health treatment history did not include the following information: dates and providers of previous treatment, and therapeutic interventions and responses.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	IV H ☐	No evidence of documentation of previous behavioral health hospitalization(s) were assessed and/or documented.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	IV I ☐	**No evidence of documentation of previous suicidal or homicidal/violent behaviors and risk, including dates, method, and lethality.**	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	IV J ☐	**No evidence of documentation of behavioral health history which includes an assessment of any abuse or psychological trauma the member has experienced or if the member has been the perpetrator of abuse.**	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			

IV. Initial Assessment Criteria

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	IV K ☐	**If abuse was reported, there is no evidence that a report was completed to the appropriate authorities.**	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	IV L ☐	**No evidence of documentation of the patient's substance use history.**	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	IV M ☐	No evidence of documentation of spiritual and cultural variables that may impact treatment.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	IV N ☐	**No evidence of documentation of the patient's strengths**	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	IV O ☐	**No evidence of documentation of screening for metabolic disorders**	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			

IV. Initial Assessment Criteria

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	IV P ☐	No evidence of documentation of presence or absence of relevant legal issues of the patient and/or family.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	IV Q ☐	No evidence of documentation that the patient was asked about community resources (support groups, social services, school based services, other social supports) that they are currently utilizing.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	IV R ☐	No evidence that the hospital obtained information on the medications the patient is currently taking when he/she is admitted to the hospital. This information was not documented in a list format that is useful to those who manage medications.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			

V. Treatment Planning Criteria

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
	V A ☐	No evidence of documentation (a signed form) that the patient or legal guardian (based on each state's age of consent) had agreed to the treatment plan. For minors, the parent/caregiver/court officer (CFS worker or Probation Officer) may agree to the treatment plan.	☐ A copy of the policy and procedure regarding treatment plan is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	V B ☐	No evidence that the hospital involved the patient in making decisions about his or her care, treatment, and services.	☐ A copy of the policy and procedure regarding treatment plan is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	V C ☐	The treatment record did not indicate the family's involvement in the treatment process, including care decisions, when appropriate.	☐ A copy of the policy and procedure regarding treatment plan is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	V D ☐	No evidence that services provided were under an individualized treatment or diagnostic plan.	☐ A copy of the policy and procedure regarding treatment plan is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			

V. Treatment Planning Criteria						
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	V E ☐	Services provided did not reasonably improve the patient's condition or were not for the purpose of diagnosis.	☐ A copy of the policy and procedure regarding services provided is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	V F ☐	The treatment plan was not consistent with diagnosis and had no objective and no measurable short and long term goals.	☐ A copy of the policy and procedure regarding treatment plan is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	V G ☐	Documentation was not adequate to justify the diagnosis and the treatment and rehabilitation activities carried out.	☐ A copy of the policy and procedure regarding treatment plan is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	V H ☐	Based on the goals established in the patient's plan of care, staff did not evaluate the patient's needs. The frequency of evaluation was not documented.	☐ A copy of the policy and procedure regarding patient's plan of care/treatment plan is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			

V. Treatment Planning Criteria

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
	V I ☐	The treatment plan did not include a safety plan when active risk issues were identified.	☐ A copy of the policy and procedure regarding treatment plan is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	V J ☐	The treatment plan and goals for care were not revised based on the patient's needs.	☐ A copy of the policy and procedure regarding treatment plan is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	V K ☐	The plan of care did not include the responsibilities of each member of the treatment team.	☐ A copy of the policy and procedure regarding plan of care is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	V L ☐	No evidence that there was clear documentation of medication dispensing, as appropriate and necessary. For DETOX Services, there was no evidence of consistent documentation of vital signs throughout treatment in the record.	☐ A copy of the policy and procedure regarding medication dispensing is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			

V. Treatment Planning Criteria

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
	V M ☐	No evidence of documentation of vital signs throughout treatment or inpatient stay.	☐ A copy of the policy and procedure regarding treatment plan is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	V N ☐	**No evidence that tobacco use treatment was provided or offered.**	☐ A copy of the policy and procedure regarding providing or offering tobacco use treatment is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	V O ☐	**No evidence that there was clear documentation of physical restraint and/or seclusion and hours (if used).**	☐ A copy of the policy and procedure regarding documentation of physical restraint and/or seclusion and hours (if used is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	V P ☐	No evidence that the hospital began the discharge planning process early in the patient's episode of care, treatment, and services.	☐ A copy of the policy and procedure regarding discharge planning process is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			

VI. Progress Notes Criteria

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
	VI A ☐	No evidence progress notes reflected reassessments when necessary.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	VI B ☐	On-going risk assessments are not documented in the progress notes (including but not limited to suicide and homicide) and monitoring of any at risk situations.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	VI C ☐	Progress notes do not indicate treatment given to the patient and do not indicate their reaction to it.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	VI D ☐	Progress notes written by Physicians do not document medical necessity and do not confirm patient is receiving treatment at the appropriate level of care.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	VI E ☐	No documentation of the dates of follow up appointments with their specialists, medical and/or behavioral health provider(s), as appropriate.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			

VI. Progress Notes Criteria

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
	VI F ☐	No documentation of any referrals made to other clinicians, agencies, and/or therapeutic services when indicated.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			

VII. Medication Management Criteria

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
	VII A ☐	No evidence of medication monitoring in the treatment record (physicians and nurses) for patients on medication	☐ A copy of the policy and procedure regarding medication management is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	VII B ☐	No evidence that the lab results were received and reviewed by the clinician, when lab work was ordered.	☐ A copy of the policy and procedure regarding medication management/ practitioner review of lab results is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	VII C ☐	No evidence of documentation that the prescribing clinician provided the patient with education about the risks, benefits, side effects, and alternatives of each medication.	☐ A copy of the policy and procedure regarding medication management is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	VII D ☐	No evidence that the prescriber coordinated care within 14 calendar days after initiation of a new medication upon discharge.	☐ A copy of the policy and procedure regarding medication management is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			

VII. Medication Management Criteria

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
	VII E ☐	No documentation that any referrals were made to other clinicians, agencies, and/or therapeutic services when indicated for medication management.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			

VIII. Coordination of Care Criteria

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
	VIII A ☐	No evidence that the patient was asked whether they are being seen by a medical physician (PCP).	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	VIII A1 ☐	Medical physician (PCP) was not documented.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	VIII A2 ☐	No evidence of documentation that communication/collaboration occurrence(s).	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	VIII B ☐	No documentation that the patient was asked whether they are being seen by multiple behavioral health clinician(s) - (e.g. psychiatrist and social worker, psychologist and substance/OTP/MAT counselors).	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			

VIII. Coordination of Care Criteria

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
	VIII B1 ☐	Behavioral health clinician(s) were not documented.	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	VIII B2 ☐	No documentation of communication/collaboration occurrence(s) by other behavioral clinician(s).	☐ A copy of the policy and procedure regarding medical records is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			

IX. Discharge and/or Transfer Criteria

Health Plan verification and date	CRITERIA	Deficiency Cited / Reviewer Comments	Recommended Corrective Action	CORRECTION DATE	PRACTITIONERS COMMENTS	SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE
	IX A ☐	No evidence that the patient was transferred/ discharged to another program or hospital.	☐ A copy of the policy and procedure regarding transfer and/or discharge is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	IX B ☐	No evidence that the patient was provided with written information on the medications that the patient should be taking when he or she is discharged from the hospital.	☐ A copy of the policy and procedure regarding transfer and/or discharge is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	IX C ☐	No documentation of communication/collaboration occurred with receiving clinician/program when patient was transferred/discharge to another program or hospital.	☐ A copy of the policy and procedure regarding transfer and/or discharge is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	IX D ☐	**No evidence that there was communication /collaboration with patient's aftercare providers if patient was discharged home.**	☐ A copy of the policy and procedure regarding transfer and/or discharge is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			

IX. Discharge and/or Transfer Criteria						
Health Plan verification and date	**CRITERIA**	**Deficiency Cited / Reviewer Comments**	**Recommended Corrective Action**	**CORRECTION DATE**	**PRACTITIONERS COMMENTS**	**SIGNATURE AND TITLE OF RESPONSIBLE PHYSICIAN OR DESIGNEE**
	IX E ☐	**No evidence that patients discharged on multiple antipsychotic medications have appropriate justification documented.**	☐ A copy of the policy and procedure regarding transfer and/or discharge is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	IX F ☐	No evidence that the hospital arranged or assisted prior to discharge in arranging the services required by the patient after discharge in order to meet his or ongoing needs for care and services.	☐ A copy of the policy and procedure regarding transfer and/or discharge is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	IX G ☐	**No evidence that tobacco use treatment is provided or offered at discharge**	☐ A copy of the policy and procedure regarding transfer and/or discharge is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			
	IX H ☐	Clinical records were not completed within 30 days following discharge.	☐ A copy of the policy and procedure regarding transfer and/or discharge is attached. ☐ A copy of the in-service outline (agenda) and sign-in sheet are attached. ☐ A copy of the facility/hospital form is attached. ☐ Other:			