Optum TERM						
On-Site Group Monitoring Tool						
Clinician/Facility Name:			Date of Review:			
Reviewer Name:	Client Initials:		Client Gender:	Client Age:		
Rating Scale: Y = Yes N = No NA = Not Applicable			**Y**	**N**	**NA**	
Intake and Assessment Documentation						
	1	The reasons for admission to group are clearly documented. If individual treatment is recommended instead of, or in addition to group treatment, reasons for recommendation are clearly documented.				
Comments:						
	2	Client's mental health history, substance abuse history, and medical history are documented.				
Comments:						
	3	The record documents the presence or absence of suicidal or homicidal risk.				
Comments:						
	4	The mental health history is documented, including: previous treatment dates and providers therapeutic interventions and responses, and relevant family history information.				
Comments:						

Rating Scale: Y = Yes N = No NA = Not Applicable			Y	N	NA
	5	If the screening indicates an active alcohol or substance use problem, there is documentation that the PSW was notified of the appropriateness for an intervention for substance abuse/dependence.			
Comments:					
	6	The substance abuse screening includes documentation of past and present use of nicotine, caffeine, illicit/prescribed and over the counter drug use (if indicated).			
Comments:					
	7	The psychosocial assessment documents the cultural variables/diversity factors that require special attention and that may influence treatment.			
Comments:					
	8	The record documents the presence or absence of relevant legal issues of the client and/or family.			
Comments:					
	9	The record includes TERM required assessments: MAST, DAST, and Mental Status/Psychiatric Symptoms.			
Comments:					
	10	A clear summary of presenting problems and relevant conditions affecting the client's physical health and mental health status is documented.			
Comments:					

Rating Scale: Y = Yes N = No NA = Not Applicable			Y	N	NA
Intake Assessment Form					
	11	A completed Intake Assessment is in the record.			
Comments:					
	12	A complete mental status exam is recorded, documenting the patient's affect, speech, mood, thought content, judgment, insight, attention or concentration, memory, and impulse control.			
Comments:					
	13	Intake Assessment includes the client's strengths that can be leveraged in promoting acts of protection by the client.			
Comments:					
	14	ICD-10 diagnostic Code and corresponding DSM-IV diagnosis are documented, consistent with presenting protective issues and concerns, case history, and mental health assessment.			
Comments:					
	15	The treatment record documents the Safety Plan and addresses its adequacy in preventing future child abuse, including sexual abuse.			
Comments:					
	16	The treatment plan is consistent with the protective issues and Levenson & Morin (2001) criteria, as documented in the Initial Assessment.			
Comments:					

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	17	There is evidence that the TERM required assessment measurements are used in developing the treatment plan and goals.			
Comments:					
Group Quarterly Progress Report					
	18	The Group Quarterly Progress Report indicates the client's participation and involvement in group.			
Comments:					
	19	The Group Quarterly Progress Report reflects ongoing risk assessments (suicide and homicide) and monitoring of at-risk situations.			
Comments:					
	20	The Group Quarterly Progress Report describes/lists client strengths and limitations in achieving treatment plan goals and objectives.			
Comments:					
	21	A Discharge Summary is submitted upon completion of treatment.			
Comments:					
Client Record					
	22	Client has a separate treatment record and the client's name or identification number is on each page of the record.			
Comments:					

Rating Scale:		Y = Yes N = No NA = Not Applicable	Y	N	NA
	23	The record includes the client's address, employer or school, home and work telephone numbers (including emergency contacts), marital or legal status, and appropriate releases of information.			
Comments:					
	24	All entries in the treatment record include the responsible clinician's name, professional degree, licensure, and relevant identification number, if applicable, and dated and signed where appropriate.			
Comments:					
	25	Client record includes a progress note for each group session including specific and observable treatment goals with a proposed intervention for each goal consistent with the protective issue and client's specific case circumstance.			
Comments:					
	26	The progress notes document any referrals recommended to the PSW regarding additional services or resources.			
Comments:					
	27	Provider utilizes interventions that are evidence based and are consistent with professional standards.			
Comments:					

Rating Scale:		Y = Yes N = No NA = Not Applicable	Y	N	NA
	28	All entries include the date and duration of service.			
Comments:					
	29	The client record is legible.			
Comments:					
	30	Missed appointments (client “no shows”) have not been claimed.			
Comments:					
	31	Clear and uniform modifications; any error is lined through so that it can still be read, then dated and initialed by the person making the change.			
Comments:					
	32	Time spent face to face with client must match CPT code on the contracted rate schedule.			
Comments:					
	33	The clinician uses Consent for Treatment and Informed Consent forms that describe limits of confidentiality, to whom information will be released, the role of the provider in CWS cases, mandated reporting requirements, and TERM site monitoring visits.			
Comments:					

Rating Scale: Y = Yes N = No NA = Not Applicable			Y	N	NA
	34	Documentation of continuity and coordination of care with other professionals involved in the client's case. If client refuses, documentation of client refusal to allow such communication and the client's reason for refusal.			
Comments:					
On-Site Group Monitoring					
	35	Facilitator demonstrates cultural sensitivity.			
Comments:					
	36	Group size is between 3-12 participants.			
Comments:					
	37	Facilitator addresses off-topic behaviors (i.e. disruptions, inappropriate comments, blaming, denial, etc.).			
Comments:					
	38	Facilitator uses appropriate curriculum topics consistent with Levenson & Morin (2001) curriculum.			
Comments:					
	39	Facilitator refrains from engaging in multiple relationships or conflicts of interest regarding acceptance of clients into group.			
Comments:					

Rating Scale: Y = Yes N = No NA = Not Applicable			Y	N	NA
	40	Facilitator appropriately reports any high-risk behavior and makes mandated reports as needed.			
Comments:					
	41	Facilitator demonstrates use of evidence-supported treatment approaches.			
Comments:					
	42	Supervisory log reflects licensing board rules and guidelines for the practice of interns.			
Comments:					
TOTAL Audit Score:					