Optum

Optum TERM					
IPV Psychotherapy Group Monitoring Tool					
Clinician/Facility Name:			Date of Review:		
Reviewer Name:	Provider Name:		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 indicated.			
Comments:					
	2	A mental health history, substance abuse history and medical history is documented.			
Comments:					
	3	The record documents the presence or absence of suicidal or homicidal risk.			
Comments:					
	4	The mental health treatment history includes the following information: dates and providers of previous treatment (including therapeutic interventions and responses) and relevant family history information.			
Comments:					
	5	If the screening indicates an active alcohol or substance use problem, there is documentation that an intervention for substance abuse/dependence occurred.			
Comments:					

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	6	The record documents a risk assessment with considerations for physical, emotional, and technological safety.			
Comments:					
	7	The psychosocial assessment documents the cultural variables that may impact treatment.			
Comments:					
	8	The record documents the presence or absence of relevant legal issues of the patient and/or family.			
Comments:					
	9	Client records include TERM required assessment instruments.			
Comments:					
Intake Assessment Form					
	10	A completed Intake Assessment is in the record.			
Comments:					
	11	A complete mental status exam recorded, documenting the patient's affect, speech, mood, thought content, judgment, insight, attention or concentration, memory, and impulse control.			
Comments:					

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	12	Intake Assessment includes the client's strengths, including treatment interventions that are consistent with goals.			
Comments:					
	13	A DSM diagnosis is documented, consistent with presenting problems, history, and mental health assessment.			
Comments:					
	14	Most recent DSM is used for diagnoses and signed by a licensed clinician.			
Comments:					
	15	The treatment record documents and addresses the adequacy of safety network and safety plan.			
Comments:					
	16	The treatment goals are consistent with diagnosis and are objective and measureable.			
Comments:					
	17	There is evidence that 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:					

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	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 patient strengths and limitations in achieving treatment plan goals and objectives.			
Comments:					
	21	The Group Quarterly Progress report documents any referrals made to other clinicians, agencies, and/or therapeutic services.			
Comments:					
	22	A Discharge Summary is submitted upon completion of treatment.			
Comments:					
Client Record					
	23	Each client has a separate treatment record.			
Comments:					
	24	Each record includes the client's address, employer or school, home and work telephone numbers (including emergency contacts), marital or legal status, appropriate consent forms and guardianship information if relevant.			
Comments:					

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	25	All entries and in the treatment record include the responsible clinician's name, professional degree and relevant license/registration number, and dated and signed where appropriate.			
Comments:					
	26	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 diagnosis and results of assessment.			
Comments:					
	27	Provider utilizes interventions that are consistent with those recommended in Optum TERM standards.			
Comments:					
	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:					

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	31	There is documentation that communication/collaboration with CFWB occurred.			
Comments:					
	32	The clinician uses Consent for Treatment or Informed Consent forms with all clients. Informed consent includes TERM site monitoring visit			
Comments:					
	33	If the client in being seen by another mental health clinician, there is documentation that communication/collaboration occurred.			
Comments:					
On-Site Group Monitoring					
	34	Facilitator demonstrates cultural sensitivity.			
Comments:					
	35	Group size is between 3-12 participants.			
Comments:					
	36	Participants attend group session free of substances.			
Comments:					
	37	Facilitator addresses off-topic behaviors (i.e. disruptions, inappropriate comments, blaming, denial, etc.).			
Comments:					

Rating Scale: Y = Yes N = No NA = Not Applicable			Y	N	NA
	38	Facilitator uses appropriate curriculum topics consistent with Optum TERM standards.			
Comments:					
	39	Group members appropriate for group (no signs of dual relationships or inability to participate).			
Comments:					
	40	Facilitator appropriately reports any high-risk behavior and makes mandated reports as needed.			
Comments:					
	41	Facilitator demonstrates use of psychotherapy best-practice-informed interventions.			
Comments:					
	42	Facilitator presents evidence-informed psychoeducation.			
Comments:					
	43	Supervisory log reflects licensing board rules and guidelines for the practice of interns			
Comments:					
TOTAL Audit Score:					