MSHN
Mid-State Health Network

2023 SUDSP Clinical Chart Review Tool

#	Standard/Elements	Source/Basis	Evidence May Include	Review Guidelines	**Provider to complete:** List evidence provided and where to locate such as page number or highlighted text in document
Screen/Admission/Assessment					
1.1	At point of initial contact, the following information is accurately documented in the REMI Level of Care Determination • Date of initial contact • Presenting Issue • Priority Population Status • Eligibility Determination • ASAM Level of Care Determination • MDOC referred individuals provided assessment regardless of screening documentation	PIHP Contract; Access System Standards	Consumer Chart REMI Brief Screening and Level of Care Determination	Priority Population includes MDOC Brief Screening and LOC Determination are complete in client chart in REMI; Date of First Request in REMI is accurate according to when client called for service NOT the date client was admitted; Provider is not using their own "homegrown" screening tool and entering REMI data after the client is admitted	
1.2	For individuals who do not have Medicaid/Healthy Michigan Plan the Financial Information (Block Grant Only) • Verification of Income • Evidence the provider has offered to assist the consumer in applying for Medicaid/Healthy Michigan Plan	MSHN Contract	Consumer Chart. Signed MSHN SUD Income Verification & Fee Agreement; Case Management Notes/Referrals	*Block Grant Financial Eligibility Form is complete, and a copy saved in client chart and/or REMI if client is using BG funding	

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1.3	Evidence of screening for: • HIV/AIDS • STD/Is • TB • Hepatitis and • Trauma	MSHN Contract PREVENTION POLICY # 02	Provider Intake/Assessment Forms	Provider is utilizing additional screening tools for communicable disease and trauma OR these items are embedded in assessment. Clinical documentation should indicate what follow-up is recommended (and occurs) as a result of positive screening. If communicable disease screening occurs and a referral is indicated and not made, standard is partially met.	
1.4	Evidence consumer has received information regarding: • General nature and objectives of the program • Notice of Privacy • Consent to Treatment • Advanced Directives • Member Handbook • SUD Recipient Rights	R 325.14701. R 325.14305(3) 42 CFR § 438(g)(1). MSHN Contract 42 CFR 438.6 Admin. Rule R325.1397(4)	Consumer chart Recipient Rights understanding form (required) Handbook receipt/offer form (chart note)	This can include separate signed documents or a checklist of the documents the person received.	
1.5	The ASAM Continuum (adults) GAIN I-Core (adolescents) is the only assessment tool used. Initial assessment and/or timely reassessment contains required elements: • ASAM Level of Care-Determination is justified and meets the needs of consumer. • Provisional DSM Diagnosis • Clinical Summary • Recommendations for Care	BSAAS Policy #09, Outpatient Treatment Continuum of Services Access System Standards PIHP Contract	Consumer Chart	Re-assessment should be completed annually	

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Individual Treatment/Recovery Planning and Documentation					
2.1	The amount, scope, and duration for all authorized services are identified in the treatment/recovery plan and appropriate for consumer's needs, objectives, and goals.	BSAAS Policy #06 p.4 Medicaid Manual	Treatment plan & REMI Authorization(s)	Amount, scope, and duration should align with what is being requested in authorizations.	
2.2	Initial treatment plan is developed before consumer is engaged in extensive therapeutic activities: • Outpatient – during/before 3rd session • Residential – within 72-hours of admission • Detoxification – within 72-hours of admission	MSHN Provider Manual, Individualized Treatment Planning section	Initial Treatment Plan with Date & Signatures _ Corresponding Progress Note(s)		
2.3	Plan(s) address needs/issues identified in assessment(s) (or clear documentation of why issue is not being addressed) including but not limited to: • Substance Use Disorder(s) • Medical/Physical Wellness • Co-Occurring D/O • History/Risk/Present Trauma • Gambling	BSAAS Policy #06 p.2, #1; MSHN SUD Provider Manual	Treatment plan Assessment Needs Assessment Screen(s) – Trauma, Co-Occurring (did results indicate a need for action on a treatment plan)		

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2.4	Treatment/Recovery Plan is individualized and includes the following: 1. Goals are expressed in the client's words and are unique to the client- No standard or routine goals that are used by all clients. 2. Intervention strategies – the specific types of strategies that will be used in treatment – group therapy, individual therapy, cognitive behavioral therapy, didactic groups, etc. 3. Signatures – client, counselor, and involved individuals, or documentation as to why no signature.	BSAAS Policy #06, p. 2of 5	Treatment plan	Treatment plans should cover all dates of services being requested. Goals & Objectives should not have all the same target & completion dates. No standard or routine goals that are used by all clients.	
2.5	Goals and objectives are written using SMART criteria. (S- Specific, M- Measurable, A- Attainable, R- Relevant, T- Time-bound)	Treatment Policy #06, Individualized Treatment Planning Treatment Plan	Treatment Plan		
2.6	Frequency of periodic reviews of the plan are based on the time frame in treatment and any adjustments to the plan. Outpatient – minimal 90-day Residential 14-day Residential - 30 day	MSHN Provider Manual BSAAS Policy #06	Treatment plan reflects timely review.	Withdrawal Management (if applicable) – if medically necessary submit updated plan based on medical necessity.	

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2.7	The treatment and recovery plan progress review includes: 1. Progress note information matching what is in review. 2. Rationale for continuation/discontinuation of goals/objectives. 3. New goals and objectives developed with client input. 4. Client participation/feedback present in the review. 5. Signatures, i.e., client, counselor, and involved individuals, or documentation as to why no signature	BSAAS Policy #06, p 5.	Treatment plan(s) & reviews include consumer signature with date, consumer feedback (specifically the reviews), etc.	Ensure "as evidenced by" is utilized for justification of changes / no changes to services. Simply writing "doing good" is not enough justification.	
2.8	Case management services shall be guided by each client's individualized treatment plan. Treatment plan review(s) will incorporate case management goals and outcomes with targeted completion dates that are consistent with the treatment plan and are reflected and/or modified in treatment plan review(s).	Treatment Policy #08	Policy/ procedures Progress Notes Treatment Plan	Providers may use different formats of plans (i.e., CM Service Plan, CM Plan, etc.). These are acceptable for review if the service is documented and developed with the person served. If requesting case management, a needs assessment should be uploaded to REMI as well.	
2.9	An evidence-based practice was used and documented in the record for trauma.	MSHN Provider Manual	Assessment Progress notes Other documentation in the record Screening tools	Only include evidence-based practices for trauma. Other EBPs are included in a separate standard. Please identify the evidence-based practice in the comment box that was used in the record. Mark yes if an evidence-based practice was present. Mark no if there was not an evidence-based practice in the record.	

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2.10	An evidence-based practice was used and documented in the record.	MSHN Provider Manual	Assessment Progress notes Other documentation in the record Screening tools	Do not include evidence-based practices for trauma as it is included in a separate standard. Please identify the evidence-based practice in the comment box that was used in the record. Mark yes if an evidence-based practice was present. Mark no if there was not an evidence-based practice in the record.	
Record Documentation and Progress Notes					
3.1	Progress notes reflect information in treatment plan(s): • Identify what goal/objective(s) were addressed during a treatment session • Individual and group sessions that the person participates in must address or be related to the goals and objectives in the plan Document progress/lack of progress toward meeting goals.	BSAAS Treatment Policy #06, 4/2/12, p. 3 of 5.	Documented progress notes reflect relationship to goals and objectives in the treatment plan.	For occasions in which goals were not addressed i.e., crisis), document reason.	
3.2	Services are provided as specified in the plan(s).	Medicaid Provider Manual 2.2 Substance Abuse Services	Progress notes demonstrate the services are provided, as indicated on the consumer's Individual plan of service.	Notes are reflective of authorized services and match plan. No shows and cancellations are documented. Amount, scope, and duration of services provided is commensurate with plan or there is documentation if services are provided differently than specified in plan.	

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3.3	Consumer strengths are identified within the record and used to drive the person-centered planning process.	BSAAS Policy #06 p 2 of 5; MSHN SUD Manual	Assessment, Treatment Plan		
3.4	FASD Children are screened for FASD, and a referral is made when applicable.	MDHHS Treatment Policy 11, p 3 of 5 MSHN Contract	Consumer Chart Intake Packet/Forms Individual/Group Progress Note Assessment	Standard applies to all individuals (men/women) who have care of a minor child. Standard is not specific to only women with minor children. The following circumstances should prompt a clinician to complete a screen to determine if there is a need for a diagnostic referral: When prenatal alcohol exposure is known and other FAS characteristics are present, a child should be referred for a full FASD evaluation when substantial prenatal alcohol use by the mother (i.e., seven or more drinks per week, three or more drinks on multiple occasions, or both) has been confirmed. When substantial prenatal alcohol exposure is known, in the absence of any other positive criteria (i.e., small size, facial abnormalities, or central nervous system problems), the client will be referred to the primary care physician for further assessment. When information regarding prenatal exposure is unknown, a child should be referred for a full FASD evaluation.	Moved to documentation section.
Coordination of Care					

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4.1	There is evidence of primary care physician coordination efforts. If the client does not have a primary care provider, there is documentation that they were offered information and referral to a provider of their choice.	PIHP Contract; MSHN Provider Manual, MSHN Treatment Contract	Consumer file, documented communication/coordination	Evidence must include a signed release of information for the primary care provider, including name and contact information, or documentation of the client's refusal to provide consent. Must use required release form ONLY release is required – must have contact info. Must have evidence of coordination/attempted coordination	
4.2	There is evidence of coordination of care with external entities including, but not limited to, legal system, child welfare system, behavioral healthcare system. Documentation of coordination of care may include phone calls, non-billable progress notes, letters, emails, etc. A signed release of information is not sufficient to document coordination of care. • MDOC referred individuals have evidence of at least monthly coordination (sent by the 5th day of the following month) between agency and supervising agent	PIHP Contract;	Consumer file, MDOC Monthly Progress Report	Ensure provider is documenting coordination of care efforts. This should include phone calls, emails, meetings, etc. There should be coordination with all relevant parties as is needed for support of consumer's treatment/ engagement/recovery.	

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4.3	There is evidence of effective coordination between transitions from one provider or level of care to another. Evidence should include sharing of any ASAM Continuum/Gain I-Core assessments and may also include treatment plans and discharge information that improves care and reduces redundancy for the person served.	SUD Directors Consensus Statement reg MAT MSHN SUD Provider Manual	Consumer file	Required for consumers entering services from another provider or level of care. Providers should send/request assessments, discharge(s), treatment plans and any other documents relevant to care that would reduce redundant work.	
4.4	There is evidence that provider makes appropriate referrals and documents follow-up and outcomes, as is applicable to meet the consumer/family needs.	LARA SUD Administrative Rules R 325.1359 R325.1363 (c)	Consumer Chart	When needs are identified there should be services provided to meet the needs. If the provider does not offer the services, a referral to an agency that offers the services should be made.	
Discharge/Continuity in Care					
5.1	Discharge Summary includes all Continuum of Care Detail(s) including next provider contact information, date/time of intake appointment, relevant information etc.	MSHN SUD Provider Manual	Discharge Summary		

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5.2	MDOC referred individuals have evidence of the following (with appropriate release): • Provider will ensure a recovery plan is completed and sent to the supervising agent within five (5) business days of discharge- plan must include individual's knowledge of plan and any aftercare services • Provider will ensure documentation of informing the client's supervising agent prior to any discharge due to violation of program rules/regulations except in extreme circumstances. • Provider will collaborate with the supervising agent for any non-emergency discharge of the referred individual and allow the MDOC time to develop a transportation plan and/or a supervision plan prior to removal.	PHIP Contract, MSHN Contract	Consumer file, progress notes, discharge summary	Evidence that recovery plan was sent to supervising agent (i.e.: email/fax confirmation, communication notes in consumer chart, etc.)	
5.3	Consumer's treatment episode is summarized including: • Status at time of d/c (Status may include prognosis, stage of change, met & unmet needs/goals/objectives, referrals &/or follow-up information) • Summary of received services/ participation • Discharge rationale is clearly & accurately documented	MSHN SUD Provider Manual	Consumer file includes discharge summary with required status and condition described. Discharge summary clearly indicates rationale.		

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Residential					
6.1	**Residential detoxification** At the time of admission and prior to any medications being prescribed or services offered, the medical director, a physician, physician's assistant, or advanced practice registered nurse shall complete and document the medical and drug history, as well as a physical examination, of the recipient. **Residential** The recipient record for residential service categories shall also include medical history and physical examination	R 325.1387(8) R 325.1361(3)(a) R 325.1361 (2)(a)	Copy of medical exam is included in the client chart.	Verify the date of medical history and examination are prior to the first date of medication being dispensed for new medications. Withdrawal Management- Verify date of medical history and examination are prior to services being provided.	
6.2	**Residential Treatment** PROVIDER must assure all consumers entering residential treatment will be tested for TB upon admission and the test result is known within five (5) days of admission	MSHN Provider Contract, Attachment A: Statement of Work	Copy of TB testing & results is included in the client chart.	Verify TB test is included in the record.	

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6.3	MDOC Referred Individuals ONLY (with proper release): • Individual referred does not appear or is deemed to not meet residential medical necessity the provider will notify the supervising agent within one (1) business day • Referred individual may not be given unsupervised day passes, furloughs, etc. without consultation with the supervising agent. • Leaves for any non-emergent medical procedures should be reviewed/coordinated with the supervising agent • If a MDOC referred individual leaves an off-site supervised therapeutic activity without proper leave to do so, the provider must notify the supervising agent by the day on which the event occurred. • The PIHP/designated provider may require individuals participating in residential treatment to submit to drug testing when returning from off property activities and any other time there is a suspicion of use. Positive drug test results and drug test refusals must be reported to the Supervising Agent.	PIHP Contract, MSHN Contract	Client Chart documentation	If none of the conditions exist, then it should be N/A. The contract does not specify how these items are documents just that they are so evidence could be anything in the chart.	

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6.4	MDOC-Additional reporting notifications for individuals receiving residential care include: • Death of an individual under supervision. • Relocation of an individual's placement for more than 24 hours. • The PIHP/designated provider must immediately and no more than one hour from awareness of the occurrence, notify the MDOC Supervising Agent any serious sentinel event by or upon an individual under MDOC supervision while on the treatment premises or while on authorized leaves. • The PIHP/designated provider must notify the MDOC Supervising Agent of any criminal activity involving an MDOC supervised individual within one hour of learning of the activity.	PIHP Contract, MSHN Contract	Client Chart documentation	If none of the conditions exist, then it should be N/A. The contract does not specify how these items are documents just that they are so evidence could be anything in the chart.	
Medication Assisted Treatment					
7.1	Documentation that a medical evaluation, including a medical history and physical examination, has been performed before the patient receives the initial methadone or Suboxone dose. (However, in an emergency situation the initial dose of methadone may be given before the physical examination).	Admin. Rule R325.14404/2(b), MSHN SUDSP Manual	Copy of medical exam is included in the client's chart.	Include Vivitrol. Copies of med exam in record. TX History Meds IV Use Pregnancy/Childbearing Age STI's	

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7.2	Informed consent for pregnant women and all women admitted to methadone or Suboxone assisted treatment that may become pregnant, stating they would not knowingly put themselves and their fetus in jeopardy by leaving treatment against medical advice.	MDHHS Policy #05, page 6 of 11, 10/1/12, MSHN SUDSP Manual	Signed Consent Form		
7.3	Documented random toxicology testing. SUBOXONE ONLY: toxicology screens must be done at intake and then randomly, at least weekly, until 3 consecutive screens are negative. Methadone ONLY: consumer screened weekly. Monthly only occurs after 6-months of consecutive negative screens. Any positive screen results in new 6-month cycle of weekly screens.	R325.14406, MSHN SUDSP Manual	Clinical documentation in client's chart	All UDS results must be uploaded into REMI within 24 hours. (Needed for auth/re-auth purposes.) THC without medical marijuana card is considered illicit use of substance.	
7.4	Copies of the prescription label, pharmacy receipt, or pharmacy print out, must be included in the individual's chart, or kept in a "prescribed medication log" that must be easily accessible for review.	BSAAS Treatment Policy #05, 10/1/12, p. 5 of 11, MSHN SUDSP Manual	Clinical documentation in client's chart	MAPS conducted at intake. Look for counter-reactive meds. Phase change also should result in MAPs. Physical – include MAPs. Be aware of over-the-counter meds and document in case of disputed test results (meds causing false negatives can be easily checked sometimes)	

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7.5	Documented review of Michigan Automated Prescription System (MAPS) is included in the client file at admission, a prior to any off-site dosing, and prior to any reauthorization requests. Note: Per MDHHS guidance, the MAPS report cannot be placed in the individual's chart. Information can be documented in the chart.	MDHHS Policy #05, page 5 of 11, 10/1/12, MSHN SUDSP Manual	Clinical documentation in client's chart	Documentation of MAPS report outcomes in chart.	
7.6	Documentation that there is coordination of care with prescribing physician when there are prescriptions for controlled substances.	MSHN SUDSP Manual	Signed release of information, clinical and medical documentation in client's chart.	Get the release, call the doctor, send mutual patient letter, etc. Very important for Benzo's etc. Be cautious of counter-reactive substances.	
7.7	All alcohol use and illicit drug use during treatment is addressed in treatment and documented in Progress Notes.	BSAAS Treatment Policy #05, p. 7, MSHN SUDSP Manual	Clinical documentation in client's chart. Drug screen outcomes, indicating illicit use, are addressed immediately and communication is documented.		
7.8	**METHADONE ONLY:** Documentation that the physical examination includes medical assessment to confirm the current DSM Diagnosis of Opioid **dependency of at least one year** as was identified during screening process	MDHHS/CA Contract Treatment Policy #05	Clinical documentation in client's chart		

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7.9	**METHADONE ONLY:** Documentation that the OTP, as part of the informed consent process, has ensured that individuals are aware of the benefits and hazards of methadone treatment.	BSAAS Treatment Policy #05, 10/1/12, p. 4 of 11.	Clinical documentation in client's chart	Should be signed and in consumer record. Generally found as part of the intake paperwork. Checklist w/ initials also acceptable.	
7.10	**METHADONE ONLY:** Documentation that the client is informed of emergency procedures to be followed when there is an adverse reaction, overdose, or withdrawal. (Client is given emergency numbers to contact in case of emergency with medications that occur outside regular business hours).	R 325.14422(7)(h)	Clinical documentation in client's chart	Verified via checklist/signed acknowledgement. Should complete during intake.	
7.11	**METHADONE ONLY:** Documentation of a client-signed consent to contact other OTPs within 200 miles to monitor for enrollments in other methadone programs.	BSAAS Treatment Policy #05, 10/1/12, p. 4 of 11).	Clinical documentation in client's chart	Documented during intake paperwork, accompanied by release form allowing the enrollment check.	
7.12	**METHADONE ONLY:** Evidence that daily attendance at the clinic is occurring for methadone dosing, including Sundays and holidays if criteria for take home medication are not met.	BSAAS Treatment Policy #05, 10/1/12, p. 4 of 11	Clinical documentation in client's chart	EMR can generally track dosing info. Consumers sign for dosing, etc. Records should flag consumer's meeting take home criteria requirements.	
7.13	**METHADONE ONLY:** OTP is following Medicaid Provider Manual guidelines for administrative discharge	Medicaid Provider Manual, MSHN SUD Provider Manual – Appendix C		NOTE: Extra chart pulled in sample to review for an administrative discharge or review from ABD Case selection.	

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7.14	METHADONE ONLY: Documentation that individuals requesting methadone were presented with all appropriate options for substance use disorder treatment, such as: Medical Detoxification. Sub-acute Detoxification. Residential Care. Buprenorphine/Naloxone. Non-Medication-Assisted Outpatient.	BSAAS Treatment Policy #5, 10/1/12 page 4 of 11.	Clinical documentation in client's chart	Clinical documentation will be found in intake paperwork and/or progress notes	
7.15	MDOC Referred Individuals ONLY (with appropriate release): provider informs the Supervising Agent when Medication Assisted Treatment (MAT) is being used, including medication type. If the medication type changes, the Supervising Agent was informed.	PIHP Contract, MSHN Contract	Client chart, progress notes, MDOC release of information		
Women's Designated					
8.1	There is an assessment of needs completed on consumer & each dependent child.	BSAAS Treatment Policy #12	Assessment Needs Assessment(s) for all Children in Care		

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8.2	There is evidence of gender-specific service provision(s)	BSAAS Treatment Policy #12	Progress Notes and Individualized treatment plans in client files. Gender-Specific Service Provisions may include: *Relational Considerations Empowerment utilization in treatment & recovery planning *Employment Skill-building & other Survival Skills	Reviewer will see this in Accessibility, Assessment, Psychological Development, Abuse/Violence/Trauma, Family Orientation, Mental Health Issues, Physical Health Issues, Legal Issues, Sexuality/Intimacy/Exploitation, Survival Skills, Continuing Care/Recovery Support	
Recovery Housing					
9.1	Eligibility is confirmed via outpatient treatment engagement/attendance (no less than 1 time every 30-days).	MSHN Technical Advisory on Housing, Treatment TA #11, NARR guidelines	Consumer charts Outpatient provider verification of admission (OPT provider REMI admission),	Recovery housing provider must ~~t~~verify attendance & engagement w/ outpatient provider.	
9.2	Resident chart includes the following information: Standard demographic information Releases of Information (MSHN, Medical, Treatment Provider, Emergency Contact) Signed Acknowledgement of Rules	Treatment TA #11, NARR guidelines MSHN SUD Provider Manual	Consumer charts	Consents must be on the State approved template & clearly completed. MUST have consents for SUD treatment provider, emergency contact, PCP Rules signed/dated in chart.	

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9.3	Chart includes completed screen and application.	MSHN SUD Provider Manual Treatment TA #11	Consumer charts	Resident initial screen & application should be in the record. Screens must: • Health & Safety (Self-Harm, Homicidal, Harm to Others) • Co-Occurring – asking about current mental health & meds Application Must: • Be used to assist with current resident input. • Be completed by the consumer (via phone or submission) • Be used for decision-making purposes regarding consumer's fit for provider housing programming	
9.4	Service Plan includes the following: Service amount, scope, duration Efforts to achieve independent living arrangements. Evidence of Consumer involvement (individualized plan, 1st person language) Signature/Date by Professional & Resident	MSHN SUD Recovery Housing Technical Requirement 2016, Treatment TA #11, NARR guidelines	Consumer charts	Must include the plan/steps for independent housing (pertaining to consumer). Why does consumer not have housing and what is plan? Amount/scope/duration – what services, when & for how long. Must match authorization & reauthorization in REMI.	