

Substance Use Disorder/Suicide Management Clinical Practice Guideline Audit Checklist

REVIEWER INFORMATION
Reviewer Name _____ Date of Review _____ CMC ID _____ Health Plan Code _____
PATIENT INFORMATION
Patient ID _____ Date of Birth _____
PROVIDER INFORMATION
Provider Name (Last, First)/Group Name /Credentials _____ Provider ID (MIS Number) _____ Date of Initial Assessment _____

DOMAIN 1: DIAGNOSTIC ASSESSMENT

The provider assessed for and found sufficient evidence to support the diagnosis of substance use disorder, and determined if complicating medical/psychiatric conditions were present. The initial evaluation included assessment for:

1a. HISTORY AND SYMPTOM PRESENCE AND DURATION that meet DSM-IV criteria for substance use disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
1b. A CO-MORBID SUBSTANCE-INDUCED DISORDER	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
1c. OTHER PSYCHIATRIC DISORDERS that could account for the symptoms or complicate treatment	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
1d. PSYCHOSOCIAL STRESSORS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
1e. MEDICAL CONDITIONS that may cause symptoms and/or complicate treatment	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
1f. PAST AND CURRENT MEDICATIONS (abstinence aids) AND RESPONSE (including side effects)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
1g. TREATMENT PARTICIPATION	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
1h. DANGEROUSNESS TO OTHERS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
1i. RISK FACTORS FOR RELAPSE AND READINESS TO CHANGE	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
2. PSYCHIATRIC REFERRAL: (If provider is a non-M.D., and there is no evidence of a recent psychiatric evaluation, there is documentation of a referral for a psychiatric evaluation)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
DOMAIN 1 SUBSCORE: _____ # of items missed (number of "No's") _____			

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DOMAIN 2: SUICIDE RISK ASSESSMENT AND MANAGEMENT

During the initial evaluation, the provider conducted a thorough suicide risk assessment that, at a minimum, included assessment for:

3a. CURRENT SUICIDAL IDEATION AND PLANS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
3b. HISTORY OF SUICIDAL IDEATION AND ATTEMPTS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
3c. PRESENCE OF HIGH RISK FACTORS, such as significant behavior change in teens, advanced age/debilitating illness/male senior citizens, insomnia, substance use/abuse, anxiety, recent inpatient discharge, history of violence, and/or gender identity disorder in teens	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If suicidal risk was found, the provider implemented a plan to manage the risk, which included:			
3d. Assessment of LETHAL INTENT. Documentation shows interventions to address this with patient and response to measures	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
3e. Assessment for access to any weapons or LETHAL MEANS, if suicidal	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
4a. Developed plan to DIMINISH ACCESS TO WEAPONS/LETHAL MEANS, if suicidal	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
4b. Developed PLAN FOR MAINTAINING SOBRIETY and discussed the role of substance use in increasing suicide risk	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
4c. Attempted to INVOLVE FAMILY AND OTHER SUPPORT SYSTEM MEMBERS in suicide management plans, or documented why not appropriate	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
4d. Documented ACTUAL FAMILY/SUPPORT SYSTEM INVOLVEMENT in suicide management plan	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
DOMAIN 2 SUBSCORE: _____			
# of items missed (number of "No's") _____			

DOMAIN 3: SUBSTANCE USE DISORDER THERAPEUTIC INTERVENTIONS

The provider documents in the treatment plan the following:

5a. Treatment plan includes appropriate FAMILY/SUPPORT PERSON INVOLVEMENT	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
5b. Treatment plan includes MEASURABLE TARGETS for each intervention	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
5c. Treatment plan includes addressing co-morbid psychiatric disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
5d. Treatment plan includes referral to self-help groups	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
6. Delivered education about substance use disorder and its treatment to the member and to the family	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
7. If a medical or psychiatric referral was made, the provider documented the results of that evaluation and any relevant adjustments to the treatment plan	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA

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8a. If provider is a physician, there is evidence of considering abstinence-aiding medication	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
8b. If provider is prescribing buprenorphine, there is evidence of periodic urine testing for illicit opiates	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
9. There is evidence of attempting to collaborate with any physician prescribing pain medication in a patient abusing analgesics	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
10. If provider finds evidence of potential relapse, provider plans interventions to address relapse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
11. There is evidence at every visit of assessment of progress toward goals	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
DOMAIN 3 SUBSCORE: _____			
# of items missed (number of "No's") _____			
TOTAL SCORE: _____			
TOTAL # of items missed (number of "No's") _____			

Instructions

1. Treatment Record Selection

Select medical records with a diagnosis of substance use disorder.

2. Audit Process

Using this audit tool, review the minimum necessary sections of the medical record, including the medication sheet, initial evaluation, progress notes and treatment plans.

3. Scoring and Intervention Guidelines

After auditing multiple records per provider, calculate the average total scores of items missed, and then apply the table below.

	Quantitative (Average score from all records reviewed)			Qualitative (if found on any record reviewed)
	0 - 3 average total score	3.1 - 6 average total score	> 6 average total score	
Actions	Essentially compliant, send letter A (unless qualitative applies)	Improvement opportunity, send letter B (unless qualitative applies)	Requires RNCC or designee review and letter C or individualized alternative to letter C (unless qualitative applies)	If item missed is 4a, or if both 4b and 4c are missed, then should go to RNCC or designee review and letter C, or alternative to letter C