Connecticut BHP
Supporting Health and Recovery

Intensive Outpatient Program Percentage of Charts Met Expectations by IOP Program Type			
	Youth IOP Programs	Adult MH/Dual IOP Programs	Adult Substance Abuse IOP Programs
1. The member's clinical record includes a comprehensive biopsychosocial assessment addressing topics such as the presenting problem, treatment history, current medications, substance use, natural supports, diagnosis, and treatment types and frequencies.	93%	98%	99%
2. All admissions are evaluated using standardized mental health and substance use screening instruments with established psychometric properties for routine screening for psychiatric, substance use and trauma. Screening tools are scored and findings are addressed in treatment and incorporated into treatment plan.	61%	47%	72%
3. Documentation of collateral contact made with former/on-going providers, primary care physician and school, if applicable and information incorporated into clinical case formulation.	93%	77%	63%
4. There is evidence that the member has been assessed on admission for the need for psychotropic medication or medication adjustment.	99%	97%	90%
5. If the assessment identifies the need for psychiatric consultation, the timeliness of the consultation takes into consideration the acuity and risk associated with the assessment.	96%	98%	79%
6. A DSM-IV/ICD9 diagnosis, consistent with the presenting problems, history, mental status examination, and/or other assessment data is documented in the treatment record.	96%	96%	93%
7. Physician certified member's need for care - Certification should include diagnosis and psychiatric reason for IOP.	62%	78%	59%
8. Treatment plans are consistent with diagnoses and have both objectives and measurable goals and estimate time frames for goal attainment or problem resolution. For substance abuse treatment or co-occurring disorder, documentation of the individual's stage of change is incorporated into the treatment plan.	77%	61%	65%
9. There is evidence that the treatment provided and interventions support and address the identified focal issues. The member's mental status is assessed regularly and changes are documented.	73%	60%	30%
10. There is evidence that peer support services were offered for members with co-occurring disorders either on-site or through collaboration (e.g. assertive linkage to 12-step groups that are accepting of people with co-occurring disorders, alumni groups).	31%	71%	78%

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11. Follow-up consultations and medication adjustments are timely and appropriate. The symptoms that the medications are targeting are documented and the member's response to medications are identified. There is also documentation of informed consent.	95%	76%	72%
12. On-going assessment of high risk behaviors (fire setting, elopement, sexual acting out behaviors, running away, arrest) and acute at-risk behaviors (suicidal, homicidal, psychosis, self-injurious behaviors).	90%	90%	59%
13. There is evidence that program is monitoring the member's progress toward goals in order to effectuate a successful and timely discharge. SA programs are monitoring progress with regular drug screenings. There is also evidence that program is working to eliminate discharge barriers.	93%	63%	67%
14. The treatment plan reflects changes in approach or interventions where timeframes for goals have not been met.	58%	43%	57%
15. The treatment record reflects evidence of coordination of care with other behavioral health providers.	96%	81%	68%
16. The treatment record reflects evidence of coordination of care with medical practitioners including a list of any medications prescribed by non-clinic practitioners.	93%	66%	51%
17. The treatment record reflects the active involvement of the family/primary caretakers in the assessment and treatment of the member, unless contraindicated.	92%	24%	4%
18. Evidence of appropriate discharge planning - discharge criteria identified and anticipated discharge date noted.	92%	60%	46%
19. DISCHARGE SUMMARY: A discharge summary is completed within 30 days of discharge and includes a summary of services provided.	92%	80%	87%
20. Discharge summary includes summary of progress or lack thereof relative to treatment goals and objectives.	98%	83%	84%
21. Discharge summary includes current mental status and diagnosis.	68%	53%	1%
22. Discharge summary includes current medications.	92%	55%	85%
23. Discharge summary includes identification of behavioral health needs that remain to be met.	17%	22%	32%
24. Discharge summary includes list of aftercare services in place, and list of recommendations and referrals made.	72%	66%	81%
25. Discharge summary includes discharge date.	98%	91%	99%
26. Discharge summary includes date and signature of licensed clinician.	92%	92%	95%