Dear ABA Network Applicant:

Congratulations on your decision to join the Optum ABA Network.

The purpose of this document is to provide you with information that we hope you will find helpful to successfully pass the initial ABA audit. Please review this entire document to ensure you are ready for the audit.

Optum conducts program reviews of all agencies providing intensive services for individuals with an Autism diagnosis wishing to contract with Optum as part of our effort to ensure quality care for members. The review is also a forum for education on maintaining records based on National Committee for Quality Assurance (NCQA), the Joint Commission, and Optum standards for treatment record documentation.

A score of 80% or above on the ABA Agency and ABA Record tools are required to pass. A passing score between of 80% - 84% will require a corrective action plan. This review will need to be completed before your agency can be contracted with Optum. Scores of 79% or lower are not passing scores and will require your agency to reapply to the network once the deficiency identified have been corrected.

Attached you will find several items. The first is a checklist. This is for your use as you prepare for the audit. Next you will find a summary of each of the two scoring tools used during the audit process. This summary will assist you in understanding each section of the audit and what your auditor will be looking for as we evaluate your program. We have also included the scoring tools referenced in each summary.

As part of the audit process, you will need to provide select policy and procedures, Human Resources information for direct care staff, and clinical records. We recognize that as an out-of-network provider, you may not have clients that are covered by Optum. For this reason mock charts may be submitted for review. If you choose to submit a mock chart for review, please be advised that a mock chart is considered to be a chart that has been completed as if it were an actual clinical record. This is your opportunity to show your documentation standards in practice. While we do not need a long and complicated mock chart, we are not able to review blank forms. Mock charts that have blank documents will not be accepted for review.

The preferred method of document delivery is through the secure electronic portal, Electronic Communication Gateway (ECG). This allows for electronic access to documents and is HIPAA compliant.

Due to the large number of files sent through ECG, we ask that the file name clearly describe the contents of the file. To ensure that each file is appropriately identified to your submission, please ensure that each follows this naming convention:

[Provider Name] [File Content] [Number]

So, if your agency name was "ABA Services", the Policy and Procedure Manual file would be named:

ABA Services Provider Manual 1

The second HR file submitted would be named:

ABA Services HR File 2

We look forward to the opportunity to work with you through this review process. If you have any questions related to this review, please do not hesitate to ask your Clinical Audit Support Specialist or the Auditor assigned to you.

Regards,
Provider Performance

ABA Audit Checklist

For Each Treatment Record Submitted:

- [ ] All intake documents including:
  - [ ] Consent to treat
  - [ ] Parent/client handouts or handbook
  - [ ] Initial intake questionnaire
- [ ] Diagnostic Assessment with ASD diagnosis
- [ ] Functional Behavior Assessment
- [ ] Initial Service Plan and most recent update
- [ ] Progress notes
  - [ ] Five most recent daily notes with corresponding data tracking
  - [ ] Five most recent parent training notes
  - [ ] Five most recent notes documenting session observation and supervision by BCBA
  - [ ] All notes documenting coordination of care with outside providers including, but not limited to, PCP, medical specialists, OT, PT, mental health providers, etc…
  - [ ] All notes regarding response to safety risks
- [ ] Safety plan
- [ ] Discharge planning
- [ ] Discharge summary

For Each HR File Submitted:

- [ ] Resume
- [ ] Results of background check
- [ ] Reference check
- [ ] Job description
- [ ] License/certification

- [ ] Annual evaluations
- [ ] CPR certification
- [ ] Evidence of ongoing staff training
- [ ] Documentation that staff receive training **prior** to meeting with clients
- [ ] Supervision documentation
- [ ] BCBA providing supervision possess the Supervisor Certification from the BACB
- [ ] Supervision policy
- [ ] Background check policy
- [ ] Policy and Procedure Manual

The ABA Agency tool provides a detailed list of the policies that are Optum expectations. If you do not have a policy that corresponds to an item, you need to write one to add to your policy and procedure manual, employee handbook, and/or client handbook.

The ABA Record tool provides a detailed list of the items Optum expects to find in a treatment record. If there are items you do not currently include in your client records, please create new documents that will capture the requested information.

Summary of the ABA Agency Tool

Introduction:

The ABA Agency Tool evaluates policies and procedures, physical environment (when applicable), processes for assessment and service delivery, hiring practices, and operating procedures. References to client in this document refer to both the child and their family members. The summary below highlights key points to consider when preparing for the review.

The tool has 6 sections:

Environment of Care:

The items are related to the physical environment and are not applicable if you do not provide services in your office. The questions in this section will be scored as NA if provide only home-based services.

Policies and Procedures

- Safety and security issues: While your agency should consider local issues that may be particular to your region, some areas of general safety should include:
    - How your staff responds if there is a safety concern in the client's home
    - Expectations for reporting suspected child abuse/neglect
    - Protocols for staff if they feel threatened in a client's home
    - Protocols for communication of cancelled appointments
    - Guidelines for transporting the clients in staff vehicles
    - Guidelines related to parental/guardian presence while services are rendered in the home
    - Guidelines for transporting the clients in staff vehicles
    - Guidelines related to parental/guardian presence while services are rendered in the home
- Management of hazardous materials and bodily fluids:
    - Protocols for diaper or pull-up changing
    - Protocols for management of wounds (to the client or to the staff member)
- Disaster plan:

   - Protocols for addressing natural disasters
   - Protocols for the suspension of services due to a disaster, including communication of cancellations and the process for rescheduling/resuming services
   - Protocols for protection/recovery of documentation, including reporting the loss of any documentation

- Rights, Responsibilities and Ethics --These items review how you establish a safe and open practice with your clients. You are expected to:

   - Communicate rights and responsibilities to the client at the time services are initiated
   - Communicate the importance of the child and the family being involved in the treatment process
   - Obtain an informed consent from a parent or guardian prior to starting services
   - Comply with standards set forth by the Health Insurance Portability and Accountability Act (HIPAA) related to confidentiality
   - Provide reasonable access to care within the limits of ethical practice, the laws, and your agency's capabilities and mission.

- Assessment --Policies and procedures should describe your process for initial and ongoing assessments, treatment planning, coordination of care, and documentation of client response to treatment throughout the course of care. The following elements should be clearly documented in the record:
  - A diagnostic assessment including evaluation of learning needs and barriers to learning
  - A functional behavioral or skills-based assessment
  - Additional assessment(s) that may be required at the outset of treatment
  - Presenting problems noting the reason(s) the child is entering your program and the psychological and social conditions affecting the child's current status.
  - Medical and treatment history for the child including:
    - Childhood illnesses, including the ages any illnesses occurred
    - Previous attempts to address the child's Autism Spectrum Disorder (ASD) presentation
    - Current medical conditions which may directly impact treatment or require a staff member to intervene
    - Presence or absence of infectious diseases
    - Presence of absence of allergies (medications, foods, etc)
    - Family history of medical and behavioral health issues

    - A risk assessment noting maladaptive behavioral issues such as biting, head-banging, tantrums, and scratching
    - Identification of community-based resources currently or previously used by the family
    - A summary of each family members' participation in the child's life, including the extent of their support for treatment
    - Identification of sources of, support, barriers, and influences impacting the child and family, such as:
        - Vocational
        - Spiritual
        - Cultural
        - Educational
        - Legal
    - Identification of and referral to additional needed services
    - For any child over the age of 12, a substance abuse screening should be completed; if substance use is present or risk factors for use are identified, the child should be referred for a complete substance abuse assessment; findings should be included in treatment planning
- Infection Control -- The nature of ABA services necessitates that providers are aware of illnesses in the homes that they visit. Policies and procedures should address staff response to a potential infectious disease. The policies should include:
    - Identification of any chronic infectious disease issues at the outset of treatment
    - Protocols outlining staff response if the child or other family member appears to be ill during treatment
    - Education provided to the parent/guardian regarding their responsibility to notify staff when there is an infectious illness in the home
    - How staff are trained in Standard Precautions
    - Reporting requirements regarding identification of infectious diseases consistent with your local health department
- You should have a standard policy addressing the handling of complaints and how parents and/or guardians are notified of the process for submitting a complaint.
- Policies and procedures should include a description of how you evaluate the effectiveness of the services you provide and how improvements are implemented.
- Management of Information -- Providing an organized program of services to any size client base requires the specific management of a wide range of information, and it is important to have a standardized plan of operations for maintaining this information. This includes:

    - Service/treatment records should be safely maintained in an organized fashion that ensures the confidentiality of the client
    - Clinical staff should have access to service record information as needed to provide services to their clients
    - A protocol to maintain the confidentiality and safety of the record if the record is transported outside of the office
- A sentinel events process which defines a standard approach to reviewing these incidents; a sentinel event is defined as an unexpected occurrence involving death or serious physical or psychological injury that occurs in the course of a client receiving treatment; this process should include the following:
    - The nature of the issue
    - Precipitants to the event
    - Opportunities for improvement, including timelines for implementation of changes (for example, updates to policies and procedures or training of staff)
    - Reporting requirements

Continuum of Care:

The following items should be present:

- A program description that describes the goals of treatment and identifies criteria for transitioning a child to other services
- A list of any criteria that would exclude an individual from your services (e.g., age, secondary diagnoses, and/or medical conditions)
- Written criteria for the transition of the child to other service providers. This includes but is not limited to the following:
    - Identification of who has oversight of this process
    - Coordination of care with other service providers
    - Rationale for the transition of care
    - Development of a written discharge plan that is reviewed with and signed by the parent/guardian

Care and Treatment:

Policies and procedures should clearly define your expectations for completion of the service/treatment plan and transitioning to other levels of care.

Education and Communication:

- A policy and procedure should clearly define your responsibilities to provide education to the parents and/or guardians of the child on an ongoing basis.
- A policy and procedure should clearly define use and limitation of the use of electronic means (cell phone, tablet, etc.) to communicate with clients and their family by direct service staff. This should include any expected protections to be followed to ensure HIPAA compliance.

Human Resources:

There are standard expectations for hiring, training, and evaluating your clinical staff. which include:

- A process for evaluating staff competency and performance
- Provision or support of ongoing training
- A personnel file maintained with a copy of resume, completed references and criminal background checks, job descriptions, verification of license/certification (when applicable), and annual evaluations
- A job description identifying essential knowledge and skills consistent with the work to be completed
- A policy defining the process for conducting and documenting supervision of staff

Please note, four personnel records will be evaluated during the review process.

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Optum - Behavioral Network Services

ABA AGENCY AUDIT TOOL

Facility Name:

Reviewer Name:

Date of Facility Review:

	Rating Scale: NA = Not Applicable Y = Yes N = No	Y	N	NA
Environment of Care (Section scored as N/A for agencies providing services in Home or Community)				
1	The facility location is easily identifiable from the street.			
2	The furnishings and décor are appropriately professional, and reasonably neat and clean.			
3	The exits are well marked and free of obstruction.			
4	There are fire extinguishers in the facility or there is a fire suppression system.			
5	The facility has parking for handicapped vehicles.			
6	The facility has a ramp allowing entrance into the building.			
7	The facility has wide doorways for wheelchair access.			

8	The facility has handicap accessible restroom(s).			
9	If the facility is not handicap accessible, does the program staff screen for handicap needs prior to the first session and refer patients out as needed?			
10	There is a fire safety plan.			
11	There is evidence of compliance with fire safety procedures/regulations, including inspection by the fire department/marshall.			

Policies and Procedures

12	There is a policy addressing safety and security appropriate to where services are rendered.			
13	There is a policy and/or procedure for dealing with life threatening emergencies.			
14	There is a comprehensive disaster plan , including plans for continuation of care when services are disrupted.			
15	There is a policy and procedure about patient rights, responsibilities and ethics.			
16	Patient rights, responsibilities and involvement in care are posted in waiting areas and patient care areas.			

17	There is a policy and procedure about patient involvement in care and services.			
18	There is a policy and procedure about reasonable access to care.			
	Individuals shall have reasonable access to treatment or accommodations regardless of race, age, creed, sex, national origin, handicap or sources of payment for care.			
19	There is a policy and procedure about family involvement in patient care.			
20	There is a policy addressing control of hazardous materials, cleaning supplies/chemicals, and wastes, including management of any spills of bodily fluids (This question applies to all facilities).			
21	There is a policy and procedure regarding infection control at the facility which includes written protocols for communication with local public health authorities.			
22	There is a process in place for screening for infectious diseases.			
23	There are written protocols how the agency safely works with individuals with infectious diseases.			
24	There is a policy and procedure about confidentiality.			
25	There is a policy and procedure about the limits, use, and protections related to the use of portable electronic media to communicate with patients, including cellular phone calls, text messages and email.			
26	There is a Quality Improvement Process in place for the program.			

27	There is a policy/written criteria addressing sentinel events to include identifying opportunities for improvement and implementing corrective action when indicated.			
	Sentinel events are defined as a serious, unexpected occurrence involving a member that is believed to represent a possible quality of care issue on the part of the practitioner/facility providing services, which has, or may have, deleterious effects on the member, including death or serious disability, that occurs during the course of a Member receiving behavioral health treatment.			
28	There is a policy and procedure about informed consent for patients.			
29	All services are provided under the supervision of a Board Certified Behavior Analyst (BCBA) **or** a licensed mental health professional with training/experience in the treatment of Autism Spectrum Disorders (ASD).			
30	Each client/family will be assigned to a treatment team (BCBA and paraprofessionals or licensed mental health professional and paraprofessionals).			
31	There is policy/written criteria that agency obtains a copy of the assessment from the provider who completed it. The assessment will be placed in the treatment record so it is accessible to all staff working with the client and family.			
32	The BCBA or licensed mental health professional will complete an assessment of the client that will be used to develop the treatment/behavioral plan.			
33	The BCBA or licensed mental health professional will develop the treatment/behavior plan and make any updates/changes to that plan.			
34	The treatment/behavior plan will include objective and measurable goals.			

35	The treatment/behavior plan will include baseline and mastery criteria for all goals.			
36	The direct (one to one) services to the clients and families are provided by paraprofessionals or tutors who are supervised by the BCBA or licensed mental health professional. Score as NA for providers who do not employ paraprofessionals or tutors.			
37	The paraprofessional or tutor will carry out the treatment/behavior plan. Score as NA for providers who do not employ paraprofessionals or tutors.			
38	There is a protocol in place describing family involvement in care; it is clear to the clients and families that family involvement must occur as part of treatment.			
39	There is a policy/written protocol regarding how the agency will make referrals for any services they do not provide. This includes how they will identify the services that are needed and how referrals will be facilitated.			
40	For all services that are rendered, there is written criteria for admission and discharge to services.			
41	There is criteria for transitioning members to a different level of care or different intensity of services.			
42	For clinic-based services: There is a policy/written criteria on the administer and/or monitoring of medications.			
Continuum of Care				
43	There is a policy/written criteria about expectations for treatment at each level of care, including criteria for transitioning to another level of care, or at the time of their discharge.			

#	Item			
44	There is a policy/written criteria about expectations for coordinating care with medical and other behavioral health treating providers.			
Direct Observation and Supervision				
45	There is a policy addressing both direct clinical observation and supervision.			
46	There is evidence that the BCBA(s) completing supervision possesses the Supervisor Certification from BACB.			
47	The clinical supervisor is easily accessible (either in person or by phone) for any concerns or consultations during sessions.			
48	For BCaBA's and paraprofessionals: A minimum of 1 hour of supervision per month for each case the BCaBA or Paraprofessional is involved. The maximum hours approved are based on the direct number of hours the member is receiving: 1 hour for every 10 hours of direct paraprofessional hours being provided, ordinarily not to exceed 8 hours per month.			
49	Direct clinical observation can be completed 1:1, in groups, or both.			
	Direct Clinical Observation completed as a group occurs when multiple paraprofessionals serve one family.			
50	Direct clinical observation is documented either in the client's file or a supervision log.			
Treatment Records				
51	The facility/agency has a process in place to ensure the availability of treatment records to the treating clinicians and the patient.			

No.	Standard			
52	For facilities/agencies with Electronic Health Records Only: The facility/agency has an established procedure to maintain a backup copy of all electronic health records.			
53	If records need to be transported to another service location, there is a protocol in place to maintain confidentiality of records throughout the transportation process.			
Complaints				
54	There is a protocol dealing with complaints			
55	The facility documents that patients/families are informed of methods of resolving complaints.			
Human Resources				
56	Personnel files include: resume, background checks, reference check, job description, license, and annual evaluations.			
57	There is evidence of on-going assessment of staff competency through performance evaluations and training.			
58	Job Descriptions list essential knowledge and skills consistent with the work to be completed.			
59	The facility has a written process in place regarding the pre-screening of direct care staff background prior to hiring.			
60	A sample of the practitioners' employee/credentialing files were reviewed and the files contained documentation of credentialing consistent with facility policy.			

61	There is evidence of a criminal background check for each staff member.			
62	When applicable, there is evidence of verification of any licensure or certification the staff member holds.			
63	There are distinct job descriptions for the different types of providers at the agency.			
64	Competency criteria are defined for each job category.			
65	There is evidence of on-going training for staff to support competency (initial training as well as annual trainings).			
66	All new staff complete required trainings and orientations **prior** to providing any services.			
67	There is evidence that all new staff complete CPR training.			

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Summary of the Treatment Record Tool

Introduction

The ABA Record Tool evaluates the overall documentation including the assessment, treatment plan, progress notes, and coordination of care. It is understood that in many cases, part of the documentation may be kept in the family home since this is where the services are most often provided. It will be important to have a significant representation of this documentation accessible for the review. The summary below highlights key points to consider when preparing for the review.

The tool has 6 sections

General Documentation Standards

These are the general elements of any record:

- They are individual
- They include the general contact information
- The record is legible
- There is evidence of consents for treatment
- There is evidence that education is provided to family/guardians
- There is evidence that parents/guardians are educated on risks of non-compliance of services

Assessment

These items review documentation standards, including how you obtain information at the outset of treatment. You are expected to maintain a unique treatment record for each client. Documentation expectations include:

- Basic client contact information
- All record entries are signed by the person making the entry
- An appropriate diagnosis for the treatment being received
- A clear explanation of the reason for seeking treatment
- A history of any previous behavioral health or ABA treatment the client has received
- Identification of basic medical information and any co-occurring medical issues

- A complete copy of the initial diagnostic assessment
- A history of any previous medical treatment the client has received
- A family history of behavioral health or medical issues
- An assessment of any risk behaviors exhibited by the client
- History of abuse the client has experienced
- History of sexualized behavior
- A comprehensive developmental history
- A screening of alcohol, nicotine, or other substance use/abuse
- A screening for exposure to alcohol, nicotine, or other substances
- A screening of family spiritual and cultural values which may impact treatment
- An educational assessment, including information about Individualized Education Plans (IEPs) if applicable
- Assessment of family legal issues, including divorce, child custody, or orders of protection
- Identification of community support services the family is using
- History of allergies
- A consent for treatment signed by the parent(s)/guardian prior to beginning services

Service Plan

You are expected to develop a treatment plan for each client. The treatment plan should:

- Be based on the assessments and address the identified needs of the client
- Include long term and short term goals
- Include goals that are measurable and time-limited
- Include new goals as identified
- Document completion of goals
- Be reviewed with the parent(s)/guardian

Document involvement of the client and the parent(s)/guardians in the treatment process

Progress Notes

Progress notes should include the following:

- Documentation of Start and Stop time of direct services being delivered
- Ongoing re-assessment
- Documentation of the monitoring of risk and targeted maladaptive behaviors
- Documentation of the client’s strengths and limitations
- Documentation of progress or lack of progress towards treatment goals
- Documentation of referrals to outside agencies or providers

Coordination of Care

The treatment record should document efforts to coordinate care with other treating providers including:

- Identification of and contact information for all other treating providers i.e. the Pediatrician/Primary Care Physician, other behavioral health treating professionals, school social worker, neurologist, occupational or physical therapists, or others
- A signed release of information for each provider or documentation that the parent(s)/guardian refused to sign a release of information
- When a signed release of information is obtained, there will be documentation of initial and subsequent contacts with the provider

Discharge Planning

At the time of discharge or transfer to another program, the following should be documented:

- Identification of the next services the client will be receiving
- Coordination of care with the new provider to facilitate transition
- A discharge summary (completed within 30 days of discharge or transfer) including
    - A summary of the treatment
    - Progress towards treatment goals
    - Identification of follow-up activities

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Optum - Behavioral Network Services

ABA RECORD AUDIT TOOL

Facility Name:

Reviewer Name:

Date of Facility Review:

Rating Scale: NA = Not Applicable Y = Yes N = No		Y	N	NA
General Documentation Standards				
1	Each client has a separate record.			
2	Each record includes the client's address, employer or school, home and work telephone numbers including emergency contacts, relationship or legal status, and guardianship information if relevant.			
3	All entries in the record include the responsible service provider's name, professional degree and relevant identification number, if applicable, and dated and signed where appropriate.			
4	The record is clearly legible to someone other than the writer.			
5	There is evidence of a Consent for Treatment or Informed Consent in the record that is signed by the client and/or legal guardian.			
6	There is documentation that the service provider provides education to client/family about service planning, discharge planning, supportive community services, behavioral health problems, and care options.			
7	There is documentation that the risks of noncompliance with treatment recommendations are discussed with the client and/or family or legal guardian.			

Initial Assessment				
8	An initial primary treatment diagnosis is present in the record, including who gave the diagnosis, and any diagnostic report leading up to the ASD diagnosis.			
9	There is evidence of a functional behavioral or skills-based assessment, as appropriate, is in the record.			
10	Prenatal and perinatal events, along with a complete developmental history (physical, psychological, social, intellectual and academic), are documented.			
11	The initial assessment screens for any current behavioral health conditions.			
12	The behavioral health treatment history includes the following information: dates and providers of previous treatment, and therapeutic interventions and responses.			
13	The initial assessment screens for any current medical conditions.			
14	The medical treatment history includes the following information: known medical conditions, dates and providers of previous treatment, current treating clinicians, and current therapeutic interventions and responses.			
15	The presence or absence of drug allergies and food allergies, including adverse reactions, is clearly documented.			
16	The record includes a thorough assessment of targeted risk behaviors which includes harm to self or others.			

17	The record includes a history of any previous services received, for behavioral health or other intensive autism related services, including dates of service.			
18	The behavioral health treatment history includes family history information.			
19	The medical treatment history includes family history information.			
20	When appropriate, there is evidence of an IEP in the record, or documentation of other school-based interventions.			
21	The assessment documents the spiritual variables that may impact treatment			
22	The assessment documents the cultural variables that may impact treatment			
23	An educational assessment appropriate to the age and level of care is documented.			
24	The record documents the presence or absence of relevant legal issues of the client and/or family.			
25	There is documentation that the client and/or family was asked about community resources (support groups, social services, school based services, other social supports) that they are currently utilizing.			

Service Planning

26	The service plan is consistent with diagnosis and has objective and measurable short and long term goals.			
27	The service plan is reviewed and updated with the patient at regular intervals.			
28	The service plan shows evidence of moving toward discharge.			
29	There is evidence that the service plan is reviewed on a regular basis.			

Progress Notes

30	Daily notes measure patient response to intervention in specific programs.			
31	There is evidence of patient response to interventions related to targeted behaviors.			
32	Documentation of the place of service is in the service note.			
33	It is clear in the daily notes who rendered the services.			
34	The length of time of service is clearly documented in the service note.			
35	The service notes clearly document that targeted risk behaviors are monitored and addressed.			

36	There is evidence of notes documenting communication with parents/guardians.			
37	There is documentation of parent/caregiver training at regular intervals and on an ongoing basis.			
38	There is documentation of who is in attendance at the session (parents, other children, BCBA, etc).			
39	The record, including the service plan, reflects discharge planning.			
40	There is evidence of regular direct observation/supervision.			
41	There is evidence of specific service notes of supervision/direct observation in the record.			

Coodination of Care

42	Does the client have a medical physician (PCP)? **This is a non-scored question.**			
43	The record documents that the client was asked whether they have a PCP. **Y or N Only**			
44	If the client has a PCP there is documentation that communication/collaboration occurred.			

45	If the client has a PCP, there is documentation that the client/guardian refused consent for the release of information to the PCP.			
46	Is the client being seen by another behavioral health clinician (e.g. psychiatrist and social worker, psychologist and substance abuse counselor). **This is a non-scored question.**			
47	The record documents that the client was asked whether they are being seen by another behavioral health clinician. **Y or N Only**			
48	If the client is being seen by another behavioral health clinician, there is documentation that communication/collaboration occurred.			
49	If the client is being seen by another behavioral health clinician, there is documentation that the client/guardian refused consent for the release of information to the behavioral health clinician.			
Discharge and Transfer				
50	Was the client transferred/discharged to another clinician or program? **This is a non-scored question.**			
51	If the client was transferred/discharged to another clinician or program, there is documentation that communication/collaboration occurred with the receiving clinician/program.			
52	If the client was transferred/discharged to another clinician or program, there is documentation that the client/guardian refused consent for release of information to the receiving clinician/program.			
53	Prompt referrals to the appropriate level of care are documented when client cannot be safely treated at their current level of care secondary to homicidal or suicidal risk or an inability to conduct activities of daily living.			

54	The discharge plan summarizes the reason(s) for treatment and the extent to which treatment goals were met.			
55	The discharge/aftercare/safety plan describes specific follow up activities.			
56	Clinical records are completed within 30 days following discharge.			