Information requested mirrors what you already collect and report. We are changing the way we gather information standardizing your experience across Care Advocacy Centers to increase efficiency with predictable question sets. Live review combined with a standardized clinical format will reduce phone time and the need to follow up on items not covered in a voice-mail review.

Content Category	What is included?	Highlights
Admission Four sections, all of which must be completed before moving into other clinical content areas	Provider Demographics	Requested Level of Care must be noted before moving to another content area
	Member Demographics	1) We will routinely ask whether the member has a Psychiatric Advance Directive (PAD) and if yes, noting the relevant details (e.g., no ECT) 2) We will require legal guardian name when applicable
	Diagnosis	1) We will ask whether there are any abnormal labs and if so, whether they have been medically addressed 2) If Axis III is endorsed and medications for condition are indicated we will request medication information
	Precipitant	1) We have established an extensive checklist to capture current status and "why now?" information rather than narrative reporting 2) More consistent capture of specific risk areas related to treatment history, symptoms, legal & other psychosocial factors
Assessment Ten standard categories and two contingent categories * *** EDO & Geriatric questions are limited to cases meeting diagnostic or age criteria**	Suicidal Ideation	New system standardizes reviews of SI/HI risk and substance use & treatment history
	Homicidal Ideation	
	Substances	
	Mental Status	Checklist feature supports quick collection and documentation of relevant information
	Biopsychosocial	
	Psychiatric Medications	We will consistently request date medication information was reported and by whom (e.g., patient, family member)
	Eating Disorder *	Standardizes notations related to this condition - BP, fluids, WT, HT - increasing efficiency
	Geriatric *	Questions asked for all patients 65 and older to consistently address potential age-associated risks
	Coordination of Care	We will consistently ask about coordination with treatment providers (medical and behavioral) and will note whether contact has been made
	Discharge	Discharge planning discussion will occur routinely
	Treatment Goals	System will populate key problem areas to be addressed such as primary precipitant, substance use issues, etc
	Request	Level of Care and Estimated Length of Stay routinely reviewed and updated as needed
Conclusion	Attestation	Documents that information provided is reflected in medical record

Concurrent Review – Recovery Planning Questions
Did the member participate in creating their plan of care? (Y/N)
Is the member actively engaged in their plan of care? (Y/N)
Have the member's strengths been identified and incorporated into their plan of care? (Y/N)
Is the family or other significant support involved in the member's recovery/discharge planning? (Y/N)
Has a family therapy session occurred since the last review? (Y/N)
Have empowerment tools been discussed with the member? (Y/N)