ALAMEDA COUNTY Behavioral Health Care Services

ADULT MENTAL HEALTH SERVICES CLINICAL/QUALITY REVIEW

Date: ____

Client Name:
Client PSP#:
Provider Name:
Reporting Unit:
Clinician:
Admission Date:
Review Period: *from* *to*

Request for (check all that apply):

Mental Health Services:
- ☐ Individual/Family Treatment/MHS
- ☐ Group Treatment/MHS
- ☐ Rehabilitation Services/MHS
- ☐ Case Management/Brokerage Services/MHS
- ☐ Medication Services/MHS

Day Treatment Services (check all that apply):

INTENSIVE: ☐ 5 Days/Week or Less ☐ Exceeds 5 Days/Week ☐ Initial ☐ 90 Days (3 months)

REHABILITATIVE: ☐ 5 Days/Week or less ☐ Exceeds 5 Days/Week ☐ Initial ☐ 180 Days (6 months) ☐ OTHER: ____

Service Necessity (current or within past six months):
- ☐ Psychiatric hospitalizations
- ☐ Suicidal/homicidal ideation or acts
- ☐ Psychotic symptoms
- ☐ Other: ____

Tentative Discharge Date and Aftercare Plan:
____

Medical Necessity- including 5-Axis covered diagnosis; support for primary diagnosis, impairments to functioning:
____

Outcomes Desired/Expected with Continued Services:
____

Interventions & timeframes:
____

Agency Clinician _____ **Recommended Approval:** ☐ Yes ☐ No
Signature/License

Agency Supervisor: _____ **Recommended Approval:** ☐ Yes ☐ No
Signature/License

CQRT Reviewer: _____ **Recommended Approval:** ☐ Yes ☐ No (30 Day Return)
Signature/License

Committee Chair

Rationale for Continuation of Services:
- ☐ At risk for psychiatric hospitalizations: ____
- ☐ Suicidal/homicidal ideation or acts: ____
- ☐ Severe or psychotic symptoms: ____
- ☐ Other: ____

Return Chart (6 months): ☐ Yes ☐ No
Return Chart (30-days): ☐ Yes ☐ No
☐ No Authorization (30 Day Return)

Start Date:		End Date:	

Committee Chair:		
	Signature & Credential	Staff#

Returns Only

Committee Chair

Rationale for Continuation of Services:
- ☐ At risk for psychiatric hospitalizations: ____
- ☐ Suicidal/homicidal ideation or acts: ____
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- ☐ Other: ____

Return Chart (6 months): ☐ Yes ☐ No
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Start Date:		End Date:	

Committee Chair:		
	Signature & Credential	Staff#

Regulatory Compliance

Provider Name:

Chart Review	
1. Chart ID	
2. Clinician 1	
3. Clincian 2	
4. MD	
5. Reviewer	

Medical Necessity	Yes	No	N/A
6. 5-axis diagnosis from current DSM & primary diagnosis is "included."	☐	☐	☐
7. Documentation supports primary diagnosis(es) for tx.	☐	☐	☐
8. Impairment Criteria: *Must have one of the following as a result of dx*			
8A. Signif. impairment in important area of life functioning, or	☐	☐	☐
8B. Probable significant deterioration in an important area of life functioning, or	☐	☐	☐
8C. Probable the child won't progress developmentally, as appropriate, or	☐	☐	☐
8D. If EPSDT: MH condition can be corrected or ameliorated.	☐	☐	☐

9. Intervention Criteria: Must have: 9A and 9B, or 9C, or 9D			
9A. Focus of proposed intervention: Address condition above, and	☐	☐	☐
9B. Proposed intervention will diminish impairment/prevent signif. deterioration in important area of life functioning, and/or	☐	☐	☐
9C. Allow child to progress developmentally as appropriate, or	☐	☐	☐
9D. If EPSDT, condition can be corrected or ameliorated.	☐	☐	☐

Service Necessity: Must have both 10 and 11			
10. The mental health condition could not be treated by a lower level of care? (true = yes)	☐	☐	☐
11. The mental health condition would not be responsive to physical health care treatment? (true=yes)	☐	☐	☐

Informing Materials:			
12. Informing Materials signature page is signed annually (Tx Consent, Free.Choice, Conf/Priv., BenefProblemRes., HIPAA/HiTech, AdvDir.)	☐	☐	☐
13. Releases of information, when applicable.	☐	☐	☐
14. Informed Consent for Medication(s), when applicable.	☐	☐	☐

Special Needs:			
15. Client's cultural/comm. needs noted	☐	☐	☐
16. Client's cultural/comm. needs addressed	☐	☐	☐
17. Client's physical limitations are noted	☐	☐	☐
18. Client's physical limitations are addressed	☐	☐	☐

Chart Maintenance			
19. Writing and signatures are legible.	☐	☐	☐
20. Admission date is noted.	☐	☐	☐
21. Clinical record filing is appropriate.	☐	☐	☐
22. Client identification on each page in clinical record.	☐	☐	☐
23. Discharge/termination date noted, when applicable.	☐	☐	☐
24. Face Sheet info, esp. emergency contact info prominent.	☐	☐	☐

Med Order Sheet ("pink sheet")			
Med Log updated at each visit, and with: (i.e. 4/8/10; Seroquel; 200mg; 1 po QHS; Marvin Gardens, MD)	☐	☐	☐
25. Date	☐	☐	☐
26. Drug name	☐	☐	☐
27. Drug Strength/Size	☐	☐	☐
28. Instructions/ Frequency	☐	☐	☐
29. Signatures/Initials	☐	☐	☐

Assessment:			
30. Initial Assessment done by 30 days of episode opening date. (FSP/Brief Service by 60 days; Level 3 by 4th visit.)	☐	☐	☐
31. Psychosocial history.	☐	☐	☐
32. Presenting problems & relevant conditions.	☐	☐	☐
33. Risk(s) to client and/or others assessed.	☐	☐	☐
34. Client strengths/supports.	☐	☐	☐
35. MHP MD Rx's: Doses, initial Rx dates.	☐	☐	☐
Allergies/adverse reactions/sensitivities or lack thereof 36. Noted in chart	☐	☐	☐
Allergies/adverse reactions/sensitivities or lack thereof 37. Noted prominently on chart's cover.	☐	☐	☐
38. Relevant medical conditions/hx noted & updated.	☐	☐	☐
39. Mental health history.	☐	☐	☐
40. Relevant mental status exam (MSE).	☐	☐	☐
41. Past/present use: Tobacco, alcohol, caffeine, illicit/Rx/OTC drugs.	☐	☐	☐
42. Youth: Pre/perinatal events & complete dev. hx.	☐	☐	☐
43. Annual Community Functioning Evaluation (ACFE) N/A for FSP/Brief Service Programs & Level 3)	☐	☐	☐

Client Plan:	Yes	No	N/A
44. Initial Client Plan done by 60 days of episode opening date. (Level 3 by 4th visit)	☐	☐	☐
45. Plan reviewed every 6 months from opening episode date. (N/A=FSP/Brief Svcs.) (Level 3 from first f-to-f)	☐	☐	☐
46. Client Plan revised/rewritten annually.	☐	☐	☐
47. Plan revised when significant change (e.g., in service, diagnosis, focus of treatment, etc.)	☐	☐	☐
48. Client Plan is consistent with diagnosis.	☐	☐	☐
49. Goals/Objectives are observable or measureable with timeframes.	☐	☐	☐
50. Plan identifies proposed interventions & their frequency to address identified impairments.	☐	☐	☐
51. Updates Ct. strengths, Dx & special needs, if applicable.	☐	☐	☐
52. Risk(s) to client/others have plan for containment.	☐	☐	☐
53. Plan signed/dated by LPHA (if licensed, use desig.).	☐	☐	☐
54. Plan signed/dated by MD, if provider prescribes MH Rx.	☐	☐	☐
55. Coordination of care is evident, when applicable.	☐	☐	☐
56. Plan signed/dated by client, or documentation of client refusal or unavailability.	☐	☐	☐
57. Plan signed/dated by legal rep., when appropriate.	☐	☐	☐
58. Plan indicates client was offered copy of Plan or client may obtain copy on request (may be in informing materials).	☐	☐	☐
59. Plan contains Tentative Discharge Plan	☐	☐	☐

Progress Notes:			
60. There is a progress note for every service contact.	☐	☐	☐
61. Correct service/code,	☐	☐	☐
62. Date of service	☐	☐	☐
63. Location	☐	☐	☐
64. Amount of time. *(Level 3 n/a - Location & Time)*	☐	☐	☐
65. Notes for Ct encounters incl. that day's eval/ behavioral presentation	☐	☐	☐
66. Notes for Ct. encounters incl.that day's Staff Intervention	☐	☐	☐
67. Notes for Ct. encounters incl. that day's Ct. response to Intervention.	☐	☐	☐
68. Notes for Ct. encounters incl. Ct &/or Staff f/u plan	☐	☐	☐
69. Group service notes include # clients served/on behalf.	☐	☐	☐
70. Services are related to Client Plan's goals/objectives.	☐	☐	☐
71. Unresolved issues from prior services addressed, if app.	☐	☐	☐
72. Signed/dated + title/degree/lic. (if lic., use designation).	☐	☐	☐
73. Completion line at signature (n/a for electronic notes).	☐	☐	☐
74. Service provided while Ct. was Not in lock-out setting, IMD, or Jail.	☐	☐	☐
75. Service provided was NOT SOLELY transportation, supervision, academic, vocational, or social group	☐	☐	☐
76. The activity was NOT SOLELY clerical, payee related, or voicemail	☐	☐	☐
77. Progress note was written within one working day of the date of service, and if needed, finalized within 5.	☐	☐	☐
78. Progress note documents the language that the service is provided in, as needed	☐	☐	☐
79. Progress note indicates interpreter services were used, and relationship to client is indicated, as needed	☐	☐	☐

Reviewer:	Date: