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| BHCS LogoADULT MENTAL HEALTH SERVICESCLINICAL/QUALITY REVIEWDate: | | | | | | 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:** | | | | | | | | |
|  | | | | | | | | |
| **Clinician** | |  | | | | | **Recommended Approval:  Yes  No  Needs Discussion** | |
|  | | **Signature/License** | | | | |  | |
| **Clinical Supervisor:** | |  | | | | | **Recommended Approval:  Yes  No  Needs Discussion** | |
|  | | **Signature/License** | | | | |  | |
| **CQRT Reviewer:** | |  | | | | | **Recommended Approval:  Yes  No  Needs Discussion** | |
|  | | **Signature/License** | | | | |  | |
| **Rationale for Continuation of Services:**  **At risk for psychiatric hospitalizations:**  **Suicidal/homicidal ideation or acts:**  **Severe or psychotic symptoms:**  **Other:** | | | | | | | **Provisional Authorization (6 months):  Yes  No**  **Provisional Authorization (30-days):**  **Yes**  **No**  **Attach the previous CQRT form on return.** | |
| **COMMITTEE COMMENTS:** | | | | | | | | |
| **Start Date:** |  | | **End Date:** | |  | | **Quality Review:  Approved  Return to Supervisor** | |
|  | | | | | | | ***(See back page)*** | |
| **Committee Chair:** | |  | | | | | **Reviewer:** | |
|  | | **Signature** | | **Staff #** | | | **Signature** | |
| **Approval Date:** | |  | | | | | **Review Date:** |  |
|  | | | | | | | | |

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| **Regulatory Compliance** | | |
| **Provider Name:** |  |  |

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| **Chart Review** |  |
| 1. Chart ID |  |
| 1. Clinician 1 |  |
| 1. Clincian 2 |  |
| 1. MD |  |
| 1. Reviewer |  |

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| **Medical Necessity** | Yes | No | N/A |
| 1. 5-axis diagnosis from current DSM & primary diagnosis is "included." |  |  |  |
| 1. Documentation supports primary diagnosis(es) for tx. |  |  |  |
| 1. **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. |  |  |  |

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| 1. **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. |  |  |  |

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| **Service Necessity: Must have both 10 and 11** | | | |
| 1. The mental health condition could not be treated by a lower level of care? (true = yes) |  |  |  |
| 1. The mental health condition would not be responsive to physical health care treatment? (true=yes) |  |  |  |

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| **Informing Materials:** | | | |
| 1. Informing Materials signature page is signed annually (Tx Consent, Free.Choice, Conf/Priv., BenefProblemRes., HIPAA/HiTech, AdvDir.) |  |  |  |
| 1. Releases of information, when applicable. |  |  |  |
| 1. Informed Consent for Medication(s), when applicable. |  |  |  |

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| **Special Needs:** | | | |
| 1. Client's cultural/comm. needs noted |  |  |  |
| 1. Client’s cultural/comm. needs addressed |  |  |  |
| 1. Client’s physical limitations are noted |  |  |  |
| 1. Client’s physical limitations are addressed |  |  |  |

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| **Chart Maintenance** | | | |
| 1. Writing and signatures are legible. |  |  |  |
| 1. Admission date is noted. |  |  |  |
| 1. Clinical record filing is appropriate. |  |  |  |
| 1. Client identification on each page in clinical record. |  |  |  |
| 1. Discharge/termination date noted, when applicable. |  |  |  |
| 1. Face Sheet info, esp. emergency contact info prominent. |  |  |  |

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| **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) |  |  |  |
| 1. Date |  |  |  |
| 1. Drug name |  |  |  |
| 1. Drug Strength/Size |  |  |  |
| 1. Instructions/ Frequency |  |  |  |
| 1. Signatures/Initials |  |  |  |

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| **Assessment:** | | | |
| 1. Initial Assessment done by 30 days of episode opening date. (FSP/Brief Service by 60 days; Level 3 by 4th visit.) |  |  |  |
| 1. Psychosocial history. |  |  |  |
| 1. Presenting problems & relevant conditions. |  |  |  |
| 1. Risk(s) to client and/or others assessed. |  |  |  |
| 1. Client strengths/supports. |  |  |  |
| 1. MHP MD Rx’s: Doses, initial Rx dates. |  |  |  |
| **Allergies/adverse reactions/sensitivities or lack thereof**   1. Noted in chart |  |  |  |
| **Allergies/adverse reactions/sensitivities or lack thereof**   1. Noted prominently on chart’s cover. |  |  |  |
| 1. Relevant medical conditions/hx noted & updated. |  |  |  |
| 1. Mental health history. |  |  |  |
| 1. Relevant mental status exam (MSE). |  |  |  |
| 1. Past/present use: Tobacco, alcohol, caffeine, illicit/Rx/OTC drugs. |  |  |  |
| 1. Youth: Pre/perinatal events & complete dev. hx. |  |  |  |
| 1. Annual Community Functioning Evaluation (ACFE)   N/A for FSP/Brief Service Programs & Level 3) |  |  |  |

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| **Client Plan:** | | Yes | | No | N/A | |
| 1. Initial Client Plan done by 60 days of episode opening date. (Level 3 by 4th visit) |  | |  | | |  |
| 1. Plan reviewed every 6 months from opening episode date. (N/A=FSP/Brief Svcs.) (Level 3 from first f-to-f) |  | |  | | |  |
| 1. Client Plan revised/rewritten annually. |  | |  | | |  |
| 1. Plan revised when significant change (e.g., in service, diagnosis, focus of treatment, etc.) |  | |  | | |  |
| 1. Client Plan is consistent with diagnosis. |  | |  | | |  |
| 1. Goals/Objectives are observable or measureable with timeframes. |  | |  | | |  |
| 1. Plan identifies proposed interventions & their frequency to address identified impairments. |  | |  | | |  |
| 1. Updates Ct. strengths, Dx & special needs, if applicable. |  | |  | | |  |
| 1. Risk(s) to client/others have plan for containment. |  | |  | | |  |
| 1. Plan signed/dated by LPHA (if licensed, use desig.). |  | |  | | |  |
| 1. Plan signed/dated by MD, if provider prescribes MH Rx. |  | |  | | |  |
| 1. Coordination of care is evident, when applicable. |  | |  | | |  |
| 1. Plan signed/dated by client, or documentation of client refusal or unavailability. |  | |  | | |  |
| 1. Plan signed/dated by legal rep., when appropriate. |  | |  | | |  |
| 1. Plan indicates client was offered copy of Plan or client may obtain copy on request (may be in informing materials). |  | |  | | |  |
| 1. Plan contains Tentative Discharge Plan |  | |  | | |  |

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| **Progress Notes:** | | | | |
| 1. There is a progress note for every service contact. |  |  |  | |
| 1. Correct service/code, |  |  |  | |
| 1. Date of service |  |  |  | |
| 1. Location |  |  |  | |
| 1. Amount of time. *(Level 3 n/a - Location & Time)* |  |  |  | |
| 1. Notes for Ct encounters incl. that day’s eval/ behavioral presentation |  |  |  | |
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| 1. Notes for Ct. encounters incl.that day’s Staff Intervention |  |  |  | |
| 1. Notes for Ct. encounters incl. that day’s Ct. response to Intervention. |  |  |  | |
| 1. Notes for Ct. encounters incl. Ct &/or Staff f/u plan |  |  |  | |
| 1. Group service notes include # clients served/on behalf. |  |  |  | |
| 1. Services are related to Client Plan’s goals/objectives. |  |  | |  |
| 1. Unresolved issues from prior services addressed, if app. |  |  | |  |
| 1. Signed/dated + title/degree/lic. (if lic., use designation). |  |  | |  |
| 1. Completion line at signature (n/a for electronic notes). |  |  | |  |
| 1. Service provided while Ct. was Not in lock-out setting, IMD, or Jail. |  |  | |  |
| 1. Service provided was NOT SOLELY transportation, supervision, academic, vocational, or social group |  |  | |  |
| 1. The activity was NOT SOLELY clerical, payee related, or voicemail |  |  | |  |
| 1. Progress note was written within one working day of the date of service, and if needed, finalized within 5. |  |  | |  |
| 1. Progress note documents the language that the service is provided in, as needed |  |  | |  |
| 1. Progress note indicates interpreter services were used, and relationship to client is indicated, as needed |  |  | |  |

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| **Reviewer:** | **Date:** |