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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
 | [ ]  | [ ]  | [ ]  |
|
| 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:** |