ALAMEDA COUNTY
Behavioral Health Care Services

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

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

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

**Tentative Discharge Date and Aftercare Plan:**

**Supporting Comments/Outcomes Desired with Continued Services:**

**Clinical Supervisor:** _____ **Recommended Approval:** ☐ Yes ☐ No ☐ Needs Discussion
Signature

**CRT Reviewer:** _____ **Recommended Approval:** ☐ Yes ☐ No ☐ Needs Discussion
Signature

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

**Committee Comments:**

**Provisional Authorization:** ☐ Yes ☐ No
**Start Date:** **End Date:**

**Committee Chair:**
Signature Staff #

**Approval Date:**

**Quality Review:** ☐ Approved ☐ Return to Supervisor
*(See back page)*

**Reviewer:**
Signature

**Review Date:**

**Quality Management Review**
**Regulatory Compliance Checklist**
**Level I Adult Outpatient Services**

| Medical Necessity: | Yes | No | N/A |
|---|---|---|---|
| 1) Five Axes DSM-IV included diagnosis for Specialty Mental Health Services. | | | |
| 2) Documentation supports diagnosis. | | | |
| 3) A significant impairment in an important area of life functioning, or | | | |
| 4) Probability of significant deterioration in an important area of life functioning. | | | |
| **Intervention Criteria:** Must have all, 1, 2, and 3 | | | |
| 1) The focus of proposed intervention is to address the condition identified above and | | | |
| 2) Client is expected to benefit from the proposed intervention by diminishing the impairment or preventing significant deterioration in an important area of life functioning and/or | | | |
| 3) The condition would not be responsive to physical healthcare based treatment alone. | | | |
| **Service Necessity:** | | | |
| 1) Can a different type/level of Specialty Mental Health Services meet this client's need for services reasonably well? | | | |
| 2) Can the client's needs be met through less frequent services? | | | |
| 3) Can a primary care physician or private practitioner/therapist meet this client's need for services (lower level of care) reasonably well? | | | |
| 4) Is the client benefiting or likely to benefit from the intended service? | | | |
| **Evaluation and Consent:** | | | |
| 1) Annual Community Functioning Evaluation or Adult Performance Outcomes are present? | | | |
| 2) Freedom of Choice is documented? | | | |
| 3) HIPAA Privacy Notice Provided. | | | |
| 4) Signed Consumer Grievance form is in chart (or Note of Signature Refusal/Incapacity) is present. | | | |

| Treatment Plan: | Yes | No | N/A |
|---|---|---|---|
| 1) Treatment or Service Plan is completed by 30 days of opening? | | | |
| 2) Treatment Plan is reviewed every 6 months from opening episode date, revised, and re-written annually. | | | |
| 3) Treatment Plan is revised when a significant change occurs in service, problem, or focus. | | | |
| 4) Clinical risks are noted and assessed. | | | |
| 5) Client strengths are noted and assessed. | | | |
| 6) Adequate plan established to contain any identified Clinical Risk. | | | |
| 7) Treatment Plan includes measurable objectives and planned interventions that address identified impairment(s). | | | |
| 8) Treatment Plan signed by client or notation made why client did not sign. | | | |
| 9) Family participation and agreement with client plan is documented, if family is involved. | | | |
| 10) Treatment Plan Review or Service Plan is signed and dated by LPHA. | | | |
| 11) Treatment Plan is signed by MD if the provider prescribes the client's medications. | | | |
| **Progress Notes:** | | | |
| 1) Progress Notes relate to the TPR/SP's goals, objectives, and interventions. | | | |
| 2) All Progress Notes are signed with the practitioner's title. | | | |
| 3) Procedure, location, date, and time are documented for each service. | | | |
| **Special Needs:** | | | |
| 1) Client's cultural and linguistic needs are documented. | | | |
| 2) Information provided to clients with visual and hearing impairments, if applicable. | | | |
| **Legibility:** | | | |
| 1) Writing and signatures are legible. | | | |

**Reviewer:**

**Signature:**

**Results:** ☐ **Meets Standards**
☐ **Corrections Needed**
**> 10% Error Rate**

**Date:**