I. Assessment/Re-Assessment

1. Is there an Assessment present & completed within 60 days of admission date to the program OR, if open for more than 1 year, is there an annual reassessment present?

   ***Compliance:*** (adapted from 2016/2017 DHCS Protocol Section K)
   In accordance with Title 9, there is 60 day timeline for completing assessments. The completion of the assessment/reassessment is necessary as part of the authorization for ALL services past the first 60 days.

2. Is the presenting problem and current level of functional impairment clearly documented on the assessment or reassessment? Reminder: A functional impairment is a dysfunction in social, developmental and/or occupational spheres of life.

   List of Functional Impairments: Occupational/Educational; Activities Of Daily Living (ADLs), Family And Social Relationships; Housing; Health; Symptoms; History Of Psychiatric Hospitalizations; Probability Of Deterioration In An Area Of Life Functioning

   ***Compliance:*** (adapted from 2016/2017 DHCS Protocol Section K)
   The symptoms of the DSM 5 diagnosis need to be clearly documented, the beneficiary's chief complaint, history of the presenting problem, current level of functioning, relevant family history, and current family information, as well as functional impairments as a result of a mental disorder.

3. Is there a complete Mental Health History?

   ***Compliance:*** (adapted from 2016/2017 DHCS Protocol Section K)
   Mental Health History includes: previous treatment, including providers, therapeutic modality (e.g. medications, psychosocial treatments) and response, and inpatient admissions. If possible, include information from other sources of clinical data, such as previous mental health records, and relevant psychological testing or consultation reports.

4. Is there a complete Medical History? (Physical health conditions reported by the clients are identified or updated.)

   ***Compliance:*** (adapted from 2016/2017 DHCS Protocol Section K)
   Medical History includes: relevant physical health conditions reported by the beneficiary or a significant support person. Include name and address of current source of medical treatment.

   For children only, does the Medical History include perinatal and developmental history?

   ***Compliance:*** (adapted from 2016/2017 DHCS Protocol Section K)
   For children and adolescents, the medical history must include perinatal events and relevant/significant developmental history.

5. Is there a completed Medication section with current medications, history of current medications, and include doses?

***Compliance:*** (adapted from 2016/2017 DHCS Protocol Section K)
Information about medication the beneficiary has received, or is receiving, to treat mental health and medical conditions, including duration of medical treatment. The assessment shall include documentation of an informed consent of medications.

6. Was client screened for alcohol/drug/tobacco use?

   ***Compliance:*** (adapted from 2016/2017 DHCS Protocol Section K)
   Assessments must include past and present use of tobacco, alcohol, caffeine, and complementary and alternative medications (CAM), over-the-counter and illicit drugs.

7. Is there a risk assessment (current and historical risk of Danger to Self [DTS] and/or Danger to Others [DTO]) including an assessment of past or current trauma?

   ***Compliance:*** (adapted from 2016/2017 DHCS Protocol Section K)
   Assessments must include assessments of situations that present a risk to the beneficiary or others, including DTS/DTO, a history of presenting problem, relevant family history, and current family information, history of trauma or exposure to trauma.

8. Is there a complete Mental Status Examination?

   ***Compliance:*** (adapted from 2016/2017 DHCS Protocol Section K)

9. If client's primary language was not English, or if the client had other needs related to ability to access/receive services, is there documentation of how these needs were met?

   ***Compliance:*** (adapted from 2016/2017 DHCS Protocol Section B and K (6))
   The county/contractor must provide alternatives and options for cultural services that accommodate individual preference, or cultural and linguistic preferences, including making information available in alternative formats.

10. Are the client's strengths in achieving the client plan goals documented?

    ***Compliance:*** (adapted from 2016/2017 DHCS Protocol Section K)
    Documentation of the beneficiary's strengths in achieving client plan goals related to the beneficiary's mental health needs and functional impairments as a result of the mental health diagnosis.

11. Is it signed by the clinician, and if applicable, with a co-signature of a licensed/waived supervisor?

## II. Medical/Service Necessity

13. Is there a full DSM 5 Diagnosis (including a narrative and code) that is consistent with presenting problem, history, and/or clinical data?

    ***Compliance:*** (adapted from 2016/2017 DHCS Protocol Section K)
    A complete diagnosis from the most current version of the DSM, or a diagnosis from the most current ICD-code shall be documented, consistent with the presenting problems, history, mental status examination and/or other clinical data; and additional clarifying formulation information, as needed.

14. Does the primary diagnosis meet criteria for medical necessity (i.e., is it an included diagnosis)?

15. If the assessment showed evidence of substance use, is there a diagnosis of substance use?

## III. Client Plan

16. Are the client objectives SPECIFIC, OBSERVABLE and/or MEASUREABLE?

    ***Compliance:*** (adapted from 2016/2017 DHCS Protocol Section K)
    The client plan must have objectives that are specific to the client, observable (i.e. staff has documented how he/she and the client will know if the goal is achieved), and measurable. Measurable objectives include counting, percentage, scaling, etc. and may have a baseline so that improvement can be seen.

17. Are staff interventions specific to the client's mental health functional impairments or diagnostic criteria for his/her primary diagnosis?

    ***Compliance:*** (adapted from 2016/2017 DHCS Protocol Section K)
    Interventions need to have the frequency and duration, focus on the functional impairments which result from the mental health disorder and be consistent with the diagnosis, goal, and objectives.

18. Is the Client Plan signed by the client, or the client's legal representative?

    ***Compliance:*** (adapted from 2016/2017 DHCS Protocol Section K and County procedures)
    The signature of the client or client's representative is required on client plans.

    a. If not, is there a reason given on the client plan or a corresponding progress note, as to why no signature is present?

       ***Compliance:*** (adapted from 2014-15 DHCS Protocol Section K, p.65 and County procedures)
       If the client refuses to sign the client plan, there needs to be documentation that the client refuses or was unavailable to sign. The documentation must include the reason why the client refused/was unavailable to sign the client plan.

19. Is the client plan signed by a licensed or waived clinician?

    ***Compliance:*** (adapted from 2016/2017 DHCS Protocol Section K)

20. Is the client plan legible?

    ***Compliance:*** (adapted from 2016/2017 DHCS Protocol Section K)

## IV. Charting Documentation

21. Has a consent for treatment been signed?

    ***Compliance:*** (adapted from DHCS Protocol and County procedures)
    Staff must obtain consent for treatment. There should be a signed consent for treatment form in the chart. If the client refused to sign the consent form, there should be a note documenting the client's refusal to sign.

22. Is there a current release of information (ROI) in the chart?

    ***Compliance:*** (adapted from HIPAA regulations)
    Staff must obtain a release of information to exchange information with others outside of BHRS, except as allowed in HIPAA or in mandated reporter situations.

23. Is there a note for every billed service?

24. Overall, do the notes include objective(s) that are consistent with client plan objectives?

    ***Compliance:*** (adapted from 2016/2017 DHCS Protocol Section K)
    Progress notes are connected to the client plan and the objectives are the steps the client will take to achieve the client's goals. Services should assist client in achieving objectives (and, ultimately, his/her goals) by improving the clients' symptoms and areas of functioning which have been outlined in the client plan.

25. If client was at risk of harm to self or others, is there documentation of follow up and appropriate intervention?

    ***Compliance:*** (adapted from 2016/2017 DHCS Protocol Section K)
    As part of continuity of care and risk management, documentation needs to include: client's risk, interventions made to manage risk and help assure welfare, as well as follow-up or referrals.

26. If service was provided in a language other than English, does the documentation clearly state the language the service was provided in?

    ***Compliance:*** (adapted from 2016/2017 DHCS Protocol and County policy)
    Consumers have a right to receive services in the language of their choice. If services were provided in a language other than English, the language of the service needs to be documented in each note.

27. If client receives medications, is there evidence in the notes of collaboration/consultation with medical staff?

    Collaboration with a client's support system helps ensure good care. Staff need to document collaboration with prescribing professionals. Collaboration should occur on at least a quarterly basis.

28. Is there documentation of follow-up care or a discharge summary, if applicable?

29. Does the note state the date, location, and duration of service?

30. Does the note provide a clear picture of the client's mental health impairments and how those impairments effect their current daily functioning?

    ***Compliance:*** (adapted from 2016/2017 DHCS Protocol Section K)
    Progress notes need to document the mental health symptoms and how the symptoms are affecting the client's level of daily functioning (i.e. functional impairments). Notes need to describe how services reduce impairment, restore functioning or prevent significant life deterioration.

31. Does the note clearly document the intervention provided by staff?

    ***Compliance:*** (adapted from 2016/2017 DHCS Protocol Section K)

Notes must include relevant clinical decisions and interventions applied during the service.

32. Does the note include the client's observed behavioral and verbal responses to applied intervention(s)?

    ***Compliance:*** (adapted from 2016/2017 DHCS Protocol Section K)
    Notes must include the client's response to the interventions.

33. Does the note document a plan for continued care (i.e., relevant clinical decisions)?

    ***Compliance:*** (adapted from 2016/2017 DHCS Protocol Section K)

    Notes must include the plan for ongoing treatment.

34. If group notes are present, do the notes clearly document the individual's participation and response to group interventions?

    The same rationale for interventions for individual notes applies to group notes. Notes must include relevant clinical decisions, interventions applied during the service, as well as the individual client's response.

35. Should this client be closed to the program being reviewed?

    Part of the purpose of a Utilization Review is to review whether or not a client continues to need her/his current level of care. If the client no longer meets criteria for Specialty Mental Health Services, he/she should be considered for a lower level of care. If the client no longer meets criteria for Medical Necessity a discharge plan or transition plan should be evident in the documentation. If the client met his/her treatment objectives, documentation of the client's transition to natural supports should be evident.

36. Does this chart require further review by QA?