DEPARTMENT OF MENTAL HEALTH

Minimum Standards Guidelines

June 2010

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Mental Health Minimum Standards
CLINICAL CARE AUDIT RECORD

Client involved in Evidence Based Practices programs:	**QUALITY OF CARE: EVALUATION SUMMATION**
SE: _____ **DBT: _____** **IDDT: _____** **IMR: _____** **FPE: _____**	**A. Needs Assessment comprehensive (I-VI)?** **B. Support systems in the IPC (VII)?** **C. Do progress notes indicate that the treatment plan meets identified mental-health needs (VIII)?** **D. Medical and psychiatric care coordinated (IX-X)?** **E. Crisis plan (XI)?** **F. Advance Directives (XII)?** **G. Utilization Review: Do the Monthly Notes provide a good overview of needs and changes (XIII)?**

	ABSENT (0)	PARTIAL (1)	PRESENT (2)	EXCEEDS	Not Applicable (2)	Comments
I. Timeliness and Legibility of Assessment/Reassessment:						
A. Timely (within two-years)?						
B. Legible?						
II. Assessment of Presenting Issues, Symptoms and History:						
A. Presenting issues						
B. Target symptoms						
C. History of presenting issues						
D. Expectations of treatment						
E. Assessment is trauma informed, as evidenced by the following:						
1.						
2.						
3.						
4.						
III. Functional Capacity and Support Systems:						
A. Legal issues						
B. Employment information						
C. Education information						
	ABSENT (0)	**PARTIAL (1)**	**PRESENT (2)**	**EXCEEDS**	**Not Applicable**	**Comments**

D. Information on Activities of Daily Living						
E. Financial and/or benefits information						
F. Description of housing/living situation						
G. Hobbies/leisure interests/community involvement						
H. Support/Value System						
1. Relationships with family & friends, past and present						
2. Cultural & ethnic influences						
3. Spiritual resources						
I. Documentation of screening for substance use/abuse is present						
J. When indicated substance abuse assessment is present						
IV. Current mental status? If partial, note missing areas.						
V. Diagnosis: Axes I-V? If partial, note missing areas.						
VI. Formulation/Interpretive Summary						
A. Consumer strengths and/or treatment preferences considered?						
B. Clinical hypothesis (summary of conclusions)						
C. Treatment recommendations reflect best practices						
D. Clinician's signature, degree, and title?						
VII. Individual Plan of Care (IPC)						
A. Is the plan current?						
B. Goals reflect assessment/evaluations?						
C. Client input?						
D. Client's goals clinically interpreted into mental-health goals?						
E. Are clinical interventions documented?						
F. Do strategies indicate client activities?						
G. Does documentation show who will provide services?						
H. Is frequency range of services given?						
I. Does plan articulate expected outcomes?						
J. Is consumer's signature present?						
K. Is physician's signature on the service prescription?						
VIII. Progress notes						
	ABSENT (0)	**PARTIAL (1)**	**PRESENT (2)**	**EXCEEDS**	**Not Applicable**	**Comments**
A. Do the notes reflect treatment interventions/objectives in IPC?						

B. Do the notes reflect planned range of services as prescribed in IPC?						
C. Are monthly notes a comprehensive review of services provided?						
D. Do the progress notes evaluate the plan's effectiveness or outcomes?						
E. Is there evidence of consultation for complex or treatment-refractory cases?						
F. Is there a reduction or denial of services? Yes/No If yes, consult definitions for entries in this row.						
G. Are changes in Progress Notes reflected/updated in IPC?						
H. Clinician's signature?						
IX. Medical and Psychiatric care						
A. Physical health assessment?						
B. Primary care physician identified?						
C. Documentation of ongoing physical health needs-or, if none, then documentation of no ongoing needs						
D. Documentation of integration or collaboration with primary care?						
E. Chart contains copy of most recent psychiatric evaluation						
X. Medication management						
A. Names of medication(s) given						
B. Documentation about when medication(s) was/were started changed, or ended						
C. Documentation of active medication management/review when needed?						
D. Date of the next med check noted?						
E. Consumer education/understanding of medications?						
F. Allergies/side effects/adverse reactions noted?						
XI. Crisis management plan						
A Is there a crisis management plan?						
B. Does the plan address precursor symptoms?						
C. Does the plan address aspects of wellness?						
D. Does plan address stabilization methods?						
E. Does plan promote consumer illness self-management strategies?						
F. Does plan consider outside social supports?						
G. Does plan offer strategies for crisis intervention?						
	ABSENT (0)	**PARTIAL (1)**	**PRESENT (2)**	**EXCEEDS**	**Not Applicable**	**Comments**
XII. Advance Directives						
A. Does client have an Advance Directive?						
B. If no, is there evidence of some discussion of developing an Advance Directive?						

XIII. Utilization Review						
A. Does the record contain eligibility determination/review of ongoing CRT eligibility?						
B. Are services provided consistent with IPC?						
C. Is there a monthly service summary printout?						
D. Intensity of services matches the documentation of need (right amount)?						

Department of Mental Health
Minimum Standards/Clinical Care Review Definitions

I. Timeliness and Legibility

I.A. Timely
0 = absent or older than two years
2 = within two years

I.B. Legible
0 = Handwriting that cannot be read in whole or in large part
1 = Handwriting that cannot be read in part except with difficulty and occasional assistance from other reviewers
2 = Handwriting that can be read easily by the reviewer
3 = Typed notes, documentation that is well organized and easily referenced

II. Assessment

II.A. Presenting Issues

0 = Documentation not in client's chart
1 = Components are unclear or incomplete (for example, the use of single-word descriptors, yes/no answers when more information is necessary for someone not familiar with the client/situation to understand the client's service needs)
2 = Clear information on presenting issues/problems is present, clearly and completely defined and explained
3 = Additional helpful information is present and/or comes from additional sources (such as information from families and/or other providers, for example)

II.B. Target Symptoms

0 = Documentation not in client's chart
1 = Components are unclear or incomplete (for example, the use of single-word descriptors, yes/no answers when more information is necessary for someone not familiar with the client/situation to understand the client's service needs)
2 = Clear information on target symptoms is present, clearly and completely defined and explained
3 = Additional helpful information is present and/or comes from additional sources/ resources (such as information from families and/or other providers, for example)

II.C. History of Presenting Issues:

0 = Documentation not in client's chart
1 = History of presenting issues is unclear or incomplete (for example, the use of single-word descriptors, yes/no answers when more information is necessary for someone not familiar with the client/situation to understand the client's service needs)
2 = Clear information on history of presenting issues, clearly and completely defined and explained, is in chart
3 = Additional helpful information is present and/or comes from additional sources/ resources (such as information from families and/or other providers, for example)

II.D. Expectations of treatment

0 = Documentation not in client's chart
1 = Expectations of treatment are unclear or incomplete (for example, the use of single-word descriptors, yes/no answers when more information is necessary for someone not familiar with the client/situation to understand the client's service needs)
2 = Clear information on expectations of treatment, clearly and completely defined and

explained, is in chart
3 = Additional helpful information is present and/or comes from additional sources/ resources (such as information from families and/or other providers, for example)

II.E. Documentation of trauma-informed assessment, as evidenced by…..1,2,3,4

III. Functional Capacity & Support Systems

III.A. Legal Issues

0 = Documentation not in client's chart; avoid leaving space blank
1 = Documentation is unclear or incomplete, or noted as not applicable
2 = Clear documentation that legal issues have been explored and none are present—or, if they are present, they are documented so that someone not familiar with the client/situation can easily understand them
3 = Additional information that enhances understanding/insight into current or pending legal issues that may affect client's service needs (for example, guardianship, recent arrest or other trouble with the law, probation, order of nonhospitalization or other legal information relevant to client's situation)

III.B. Employment Information

0 = Documentation not in client's chart; avoid leaving space blank
1 = Documentation is unclear or incomplete, or noted as not applicable
2 = Clear documentation of current status as employed (full-time/part-time) or unemployed (seeking employment or not seeking employment, and why), so that someone not familiar with the client/situation can easily understand
3 = Additional information that enhances understanding/insight into client's aspirations, service needs, and employment interests (type of work or career sought, for example, office work, outdoors, human services, writing, consulting, culinary arts, etc.); and/or information about competing disabilities that prevent employment

III.C. Education Information

0 = Documentation not in client's chart; avoid leaving space blank
1 = Documentation is unclear or incomplete, or noted as not applicable
2 = Clear documentation of current status (student/non-student) and highest grade or degree achieved
3 = Additional information that enhances understanding/insight into client's aspirations and service needs (for example, level of study (full-time, part-time; secondary school or above, vocational training, pursuing General Equivalency Diploma or college degree, taking literacy classes, etc.)

III.D. Activities of Daily Living

0 = Documentation not in client's chart; avoid leaving space blank
1 = Documentation is unclear or incomplete, or noted as not applicable
2 = Clear documentation of degree of difficulty client has with ADLs—or, if no, difficulty, clear documentation to that effect so that someone not familiar with client/situation can easily understand service needs
3 = Additional information that enhances understanding/insight into client's service needs (for example, capability in housekeeping, day-to-day chores, money management and shopping, self-care skills, ability to pursue interests independently, and capacity for/ degree of community integration)

III.E. Financial and Benefits Information

0 = Documentation not in client's chart; avoid leaving space blank

1 = Documentation is unclear or incomplete, or noted as not applicable
2 = Clear documentation of source(s) of income such as Supplemental Security Income (SSI), Social Security Disability Income (SSDI), or income from employment, etc., AND Medicaid/Medicare eligibility (current coverage or application in process) or other insurance coverage, housing subsidies, food stamps, other income, entitlements or benefits
3 = Additional information that enhances understanding/insight into client's living conditions, quality of life and service needs (benefit amounts, income amounts)

III.F. Living/Housing Situation

0 = Documentation not in client's chart; avoid leaving space blank
1 = Documentation is unclear or incomplete, or noted as not applicable
2 = Clear documentation of where client lives (for example, owns or rents own home, lives with parents or other relatives, lives independently in apartment, lives in supported apartment, group home, etc.)
3 = Additional information that enhances understanding/insight into client's living situation and met/unmet needs for housing

III.G. Leisure Interests/Involvement

0 = Documentation not in client's chart; avoid leaving space blank
1 = Documentation is unclear or incomplete, or noted as not applicable
2 = Clear documentation about client's interests and involvement in any number of activities that can be undertaken either individually or in groups, including but not limited to reading, sports, outdoor activities, physical fitness, arts, crafts, theatre, public speaking, playing musical instruments or singing, cooking, etc.
3 = Additional information that enhances understanding/insight into client's interests and pursuits and their effect(s) on client's functioning as well as their importance in client's life and recovery

III.H.1. Support/Value System. Family and Friends

0 = Documentation not in client's chart; avoid leaving space blank
1 = Documentation is unclear or incomplete, or noted as not applicable
2 = Clear documentation exploring client's relationships with family and friends, past and present, to include information about any abuse issues and/or significant losses/ recent changes in relationships
3 = Additional information that enhances understanding/insight into client's relationships with family and friends, their participation in treatment, and factors supporting or impeding client's recovery

III.H.2. Support/Value System. Cultural and Ethnic Influences

0 = Documentation not in client's chart; avoid leaving space blank
1 = Documentation is unclear or incomplete, or noted as not applicable
2 = Clear documentation of cultural and ethnic influences and/or interests, to include include information on family roots, social beliefs, and physical or intellectual limitations (for example, deafness or developmental disability)
3 = Additional information that enhances understanding/insight into cultural and ethnic influences and how they affect client's need for services as well as how they help or impede client's recovery

III.H.3. Support/Value System. Spiritual Resources

0 = Documentation not in client's chart; avoid leaving space blank
1 = Documentation is unclear or incomplete, or noted as not applicable
2 = Clear, complete documentation of religious/spiritual beliefs, practices, and values; church membership or other spiritual connections, etc.
3 = Additional information that enhances understanding/insight into client's spiritual resources, how they affect client's need for services and help or impede recovery

III.I. Substance use/abuse documented

0 = Documentation not in client's chart; avoid leaving space blank
1 = Documentation is unclear or incomplete, or noted as not applicable
2 = Clear documentation of use of standardized screening tool

III.J. When indicated, substance-abuse assessment is present

0 =
1 =
2 =
3 =
4 =
NA = No use/abuse of substances for six months or more

IV. CURRENT MENTAL STATUS: If partial, note missing areas.

0 = Documentation not in client's chart
1 = One or more boxes on assessment form are left unchecked
2 = All boxes on assessment form are checked
3 = Additional narrative information is given to enhance components of assessment

V. DIAGNOSIS: If partial, note missing areas.

0 = Documentation not in client's chart; avoid leaving space blank
1 = Some of Axes are left blank
2 = Clear documentation on Axis I (primary and secondary), Axis II (primary and secondary), and Axes III, IV, and V

VI. FORMULATION/INTERPRETIVE SUMMARY

VI.A. Client's strengths and/or treatment preferences

0 = Documentation not in client's chart
1 = Documentation lacks or inconsistently incorporates patient preferences, strengths and needs into interpretive summary
2 = Clear documentation in client's own words
3 = Additional information that enhances understanding/insight into client's treatment preferences, strengths and needs, and contributory information from other substantiating sources

VI.B. Clinical hypothesis (summary of conclusions)

0 = Documentation not in client's chart
1 = Documentation is unclear or incomplete

2 = Clear documentation/summary of conclusions leading into IV.C.
3 = Additional information that enhances understanding/insight into client's needs for treatment and services to meet those needs

VI.C. Treatment recommendations flow from VI.A. and VI.B.

0 = Disconnect between assessment and recommended treatment
1 = Disconnect between treatment recommendations and either IV.A. or IV.B.; or observational versus active treatment intervention (e.g., "monitoring" activity noted in the absence of a structural intervention)
2 = Discussion of client preferences and strengths as they relate to treatment strategy of hypothesis is clear enough to be understandable to an individual unfamiliar with the client
3 = Comprehensive documentation of client preferences and strengths, enhancing understanding of client's needs for treatment and services designed to meet those needs

VI.D. Clinician's signature, degree, and title

0 = All three components are absent
1 = Signature only is present
2 = Signature and degree are present, or complete list of current staff and degrees is made available during chart review

VII. INDIVIDUAL PLAN OF CARE (IPC)

VII.A. Is the plan current?

0 = Service plan is either (a) absent from record or (b) over a year old
2 = Clear indication of the date of the service plan

VII.B. Do the goals stem from the assessment?

0 = No connection between assessment formulation and goals
1 = Unclear connection between assessment formulation and goals
2 = Clear connection between assessment formulation and goals discernible by a person unfamiliar with the client
3 = Additional information that enhances reviewers' understanding/insight into service plan and goals sought

VII.C. Is there evidence of client input into the service plan?

0 = No evidence of client input into service plan
1 = Evidence of client input into service plan, but it is unclear or incomplete
2 = Clear evidence of client input into service plan
3 = Additional information that enhances reviewers' understanding/insight of ways in which client is active participant in the service planning process

VII.D. Clinical interpretation of client's needs into mental-health goals

0 = Clinical interpretation is absent
1 = Unclear clinical interpretation of client's needs into mental-health goals
2 = Clear concise clinical interpretation of client's needs into mental-health goals
3 = Additional information that enhances reviewers' understanding of clinician's insight into client's needs and how they relate to mental-health goals

VII.E. Clinical interventions

0 = Documentation of clinical interventions is absent from service plan
1 = Unclear documentation of clinical interventions (e.g., "meet with client" or "process with client" or "provide community support") or lists clinical service modality only
2 = Clinical intervention strategy is clearly documented in service plan
3 = Documentation indicates use of evidence-based practice(s)

VII.F. Does the plan indicate client activities?

0 = Plan does not indicate client activities
1 = Plan is unclear about client activities
2 = Plan is clear and identifies easily understandable client activities
3 = Additional information enhances reviewers' understanding/insight about client activities and how they relate to achievement of goals

VII.G. Who will provide services

0 = Service plan does not identify provider/staff person
1 = Service plan's identification of provider/staff person is unclear
2 = Service plan clearly identifies provider/staff person

VII.H. Frequency range of services

0 = Frequency range of services is missing from service plan
1 = Frequency range of services is unclear or incomplete
2 = Frequency range of services is clear and complete

VII.I. Expected outcomes

0 = Service plan does not articulate expected outcomes
1 = Expected outcomes are unclear
2 = Expected outcomes are clearly articulated
3 = Additional information enhances reviewers' understanding/insight about expected outcomes

VII.J. Consumer's signature

0 = Consumer's signature absent from service plan
2 = Consumer's signature is present

VII.K. Physician's signature

0 = Physician's signature absent from service prescription
2 = Physician's signature is present on service prescription

VIII. PROGRESS NOTES

VIII.A. Do the notes reflect a connection between the IPC and interventions/interactions?

0 = No connection between progress notes and IPC
1 = Missing or inconsistent documentation, "canned" or photocopied progress notes from month to month, or only partial implementation of treatment plan
2 = Clear reflection of IPC treatment interventions/objectives in progress notes
3 = Additional detail enhances reviewers' understanding/insight into treatment interventions/objectives

VIII.B. Do the notes reflect the planned range (frequency) of services as prescribed in IPC?

0 = Progress notes do not reflect IPC range (frequency) of services
1 = Progress notes only partially reflect IPC range (frequency) of services
2 = Clear reflection of IPC range (frequency) of services in progress notes

VIII.C. Are the monthly notes a comprehensive review of services provided?

0 = No connection between printout and progress notes
1 = Progress notes state modality only, or notes are vague (for example, "processed with client" or "supported client"), or notes address client activity only, or notes fail to explain fluctuations in service pattern
2 = Documentation of services specifies the services provided, explains fluctuations, and identifies clinician's role
3 = Additional detail enhances reviewers' understanding/insight into services provided

VIII.D. Do the progress notes evaluate the plan's effectiveness or outcomes?

0 = Progress notes do not evaluate plan's effectiveness or outcomes
1 = Documentation of plan's effectiveness or outcomes is unclear or incomplete
2 = Documentation clearly evaluates plan's effectiveness or outcomes
3 = Additional detail enhances reviewers' understanding/insight into plan's effectiveness or outcomes

VIII.E. Is there evidence of consultation for complex or treatment-refractory cases?

0 = Evidence of consultation is absent from documentation
2 = Evidence of consultation is present in documentation
3 = Progress notes reflect ongoing consultation and coordination
NA = Documentation does not suggest a need for consultation

VIII.F. Is there a reduction or denial of services?

0 = Documentation of notice to client is absent from record
1 = Documentation of notice is present but reduction or denial is unresolved
2 = Documentation of notice is present and reduction or denial has been negotiated or resolved
NA = Documentation does not reflect denial of service or reduction outside of range of Services prescribed

VIII.G. Are changes in services present in progress notes but not reflected/updated in IPC?

0 = N
2 = Y
NA = No changes in services noted in progress notes

VIII.H. Is the clinician's signature present?

0 = Clinician's signature is absent
2 = Clinician's signature is present

IX. MEDICAL AND PSYCHIATRIC CARE

IX.A. Physical health assessment done by a physician

0 = Physical health assessment not in client's chart

1 = Physical health assessment is unclear or incomplete
2 = Clear physical health assessment present
3 = Additional information that enhances understanding/insight into client's physical health needs

IX.B. Identification of primary care physician

0 = Primary care physician's name not in client's chart
1 = Primary care physician's name incomplete or illegible
2 = Clear identification of primary care physician, with contact information

IX.C. Ongoing physical health needs

0 = No documentation of client's ongoing physical health needs
1 = Unclear documentation of client's ongoing physical health needs
2 = Clear documentation of ongoing physical health needs—or, if none, also clear documentation

IX.D. Documentation of integration or collaboration with primary care

0 = No documentation of integration or collaboration between mental-health services and primary care
1 = Unclear documentation of integration or collaboration with primary care
2 = Clear documentation of integration or collaboration with primary care
3 = Additional information that enhances understanding/insight into integration or collaboration between of mental-health services and primary care

IX.E. Copy of the most recent psychiatric evaluation

0 = Most recent psychiatric evaluation is missing/in a previous file
2 = Most recent psychiatric evaluation is present in chart under review

X. MEDICATION MANAGEMENT

X.A. Names of medication(s)

0 = No documentation of psychiatric medication(s)
1 = Unclear documentation of psychiatric medication(s)
2 = Clear documentation of psychiatric medication(s), including dosages and schedules
3 = Additional information that enhances understanding/insight into client's psychiatric medication(s), dosages and schedules

X.B. When medication(s) was/were started, changed, or ended

0 = No documentation of dosage(s) and schedule(s)
1 = Unclear documentation of dosage(s) and schedule(s)
2 = Clear documentation of dosage(s) and schedule(s)
3 = Additional information that enhances understanding/insight about dosage(s) and schedule(s)

X.C. Medication management review when needed

0 = Documentation of medication review absent
1 = Unclear documentation of medication review and client need

2 = Clear documentation of medication review and client need
3 = Additional information that enhances understanding/insight about client's medication(s)

X.D. Documentation of date of next med check

0 = Date for next med check absent from record
1 = Unclear or inconsistent documentation of date for next med check
2 = Clear, complete documentation of date for next med check

X.E. Documentation of consumer education/understanding of medication(s)

0 = No documentation about consumer education/understanding of medication(s)
1 = Unclear documentation about consumer education/understanding of medication(s)
2 = Clear documentation consumer education/understanding of medication(s)
3 = Additional information that enhances reviewers' understanding/insight about consumer education/understanding of medication(s)

X.F. Documentation of allergies/side effects/adverse reactions

0 = No documentation about allergies/side effects/adverse reactions
1 = Unclear documentation about allergies/side effects/adverse reactions
2 = Clear documentation about allergies/side effects/adverse reactions
3 = Additional information that enhances reviewers' understanding/insight about allergies/side effects/adverse reactions and what is done to control or avoid them

XI. CRISIS MANAGEMENT PLAN

*****NOTE TO OURSELVES:** We need to work out a scoring function for this section; the content is OK. MLM 5/20/05

XI.A. Is there a crisis management plan?

0 = Crisis management plan is not in record
1 = Crisis management plan is present but sections are blank
2 = Crisis management plan is in record
NA = Pattern of service use does not indicate a need for a crisis plan

XI.B. Does the plan identify precursor symptoms?

0 = Precursor symptoms are not identified
2 = Precursor symptoms are identified
3 = Additional information enhances reviewers' understanding/insight about consumer's awareness of precursor symptoms and how to deal with them

XI.C. Does the plan address aspects of wellness?

0 = Crisis management plan does not address aspects of wellness
2 = Crisis management plan addresses aspects of wellness
3 = Additional information enhances reviewers' understanding/insight about consumer's awareness of wellness

XI.D. Does the plan identify stabilization methods?

0 = Crisis management plan does not identify stabilization methods
1 = Documentation of stabilization methods is impractical or unrealistic
2 = Crisis management plan identifies an array of stabilization methods or options

3 = Additional information enhances reviewers' understanding/insight about stabilization methods and their importance to this individual consumer

XI.E. Does the crisis plan promote consumer illness self-management strategies?

0 = Crisis management plan offers no consumer illness self-management strategies or deals only with what others can do
1 = Crisis management plan is impractical or unrealistic, or offers solutions outside the person's control
2 = Crisis management plan promotes consumer illness self-management strategies that are realistic and practical
3 = Additional information enhances reviewers' understanding/insight about consumer's ability to use illness self-management strategies successfully

XI.F. Does the crisis plan consider outside social support?

0 = Crisis management plan does not consider outside social support
1 = Consideration of outside social support relates only to the role of the community mental health center
2 = Crisis management plan considers outside social support other than the CMHC
3 = Additional information enhances reviewers' understanding/insight about a wide array of the consumer's resources in regard to outside social support

XI.G. Does the plan offer strategies for clinical interventions in addition to stabilization methods when the client is in crisis?

0 = Crisis management plan does not offer strategies for clinical intervention
1 = Documentation of strategies for clinical intervention is too narrow (for example, listing medications as the only clinical option available)
2 = Crisis management plan offers a range of options for clinical intervention

XII. DURABLE POWER OF ATTORNEY FOR HEALTH CARE (DPOAHC)/ ADVANCE DIRECTIVES

XII.A. Does the client have a DPOAHC or other advance directive?

N = DPOAHC/other advance directive is absent from client's file
Y = File contains copy of DPOAHC/other advance directive

XII.B. If no, is there evidence of discussion of developing a DPOAHC?

N = Evidence of discussion is absent from client's file
Y = Evidence of discussion is present in client's file

XIII. UTILIZATION REVIEW

XIII.A. Does the record contain eligibility determination/review of ongoing CRT eligibility? Look in assessment or two-year reassessment.

0 = Eligibility determination/review of ongoing CRT eligibility is absent or out of date
1 = Documentation of criteria for enrollment or ongoing enrollment is unclear or incomplete, or criteria are not met
2 = Documentation of eligibility criteria for ongoing CRT eligibility is present

XIII.B. Is the MCIS Encounter Profile consistent with the agency-generated services profile in the

clinical record?

0 = The agency-generated profile is absent from clinical record
1 = Significant inconsistencies appear between the MCIS Encounter Profile and the agency-generated profile in the clinical record, or record-keeping for the time reviewed is incomplete
2 = MCIS Encounter Profile is reasonably consistent with the agency-generated profile in the clinical record

XIII.C. Are services provided consistent with IPC?

0 = There is a void in the documentation evaluating service need in relation to services delivered in month-to-month progress notes
1 = There is some evidence of consideration given to evaluating the IPC services prescribed, the services needed, and the decision to deliver amount of services in month-to-month progress notes
2 = There is documented evidence of evaluation of the client's need for services prescribed and services delivered in month-to-month progress notes
3 = There is clear correlation and process for evaluation of client needs, services delivered, and/or clinical flexibility in determining service levels

Psychiatric Evaluation Medical Notes

Record Review Record #_____ Psychiatrist/APRN _____

	P	A	Pt	Comments:
Does the **psychiatric assessment / evaluation** contain these basic components?				
Identification				
Chief Complaint				
History of present illness				
Past psychiatric history				
Physical health history				
Psychosocial history				
Family history				
Mental status				
Physical Exam, Diagnostic studies				
Diagnosis				
Formulation				
Treatment recommendations				
Is the write-up adequate to reflect and substantiate the diagnosis and support the treatment plan?				
Each **medication note** must contain at least the following information:				
Current problems				
Current meds (physical and psych) including:				
Name of med				
Dose and schedule				
Identification of target symptoms				
Mental status				
Side effects monitored				
Compliance / patient education evident				
Any medication changes and intended benefits of changes				

Pertinent physical health information / lab results				
Physician/APRN's assessment of effectiveness of meds, progress				
Allergies are prominently displayed?				
Date of next visit				

EMERGENCY SERVICES RECORD REVIEW

Record Number	Note Date	Clinician	Do Notes Reflect the Definition of Emergency Services Care?	Presenting Problem documented?	Mental Status Exam documented?	Description of Resources Accessed or Considered	Disposition Reflects Assessed Need	Comments
			Yes [ ] No [ ] PT [ ]	Yes [ ] No [ ] PT [ ]	Yes [ ] No [ ] PT [ ]	Yes [ ] No [ ] PT [ ]	Yes [ ] No [ ] PT [ ]	

Record Number	Note Date	Clinician	Do Notes Reflect the Definition of Emergency Services Care?	Presenting Problem documented?	Mental Status Exam documented?	Description of Resources Accessed or Considered	Disposition Reflects Assessed Need	Comments
			Yes [ ] No [ ] PT [ ]	Yes [ ] No [ ] PT [ ]	Yes [ ] No [ ] PT [ ]	Yes [ ] No [ ] PT [ ]	Yes [ ] No [ ] PT [ ]	

Record Number	Note Date	Clinician	Do Notes Reflect the Definition of Emergency Services Care?	Presenting Problem documented?	Mental Status Exam documented?	Description of Resources Accessed or Considered	Disposition Reflects Assessed Need	Comments
			Yes [ ] No [ ] PT [ ]	Yes [ ] No [ ] PT [ ]	Yes [ ] No [ ] PT [ ]	Yes [ ] No [ ] PT [ ]	Yes [ ] No [ ] PT [ ]	

Record Number	Note Date	Clinician	Do Notes Reflect the Definition of Emergency Services Care?	Presenting Problem documented?	Mental Status Exam documented?	Description of Resources Accessed or Considered	Disposition Reflects Assessed Need	Comments
			Yes [ ] No [ ] PT [ ]	Yes [ ] No [ ] PT [ ]	Yes [ ] No [ ] PT [ ]	Yes [ ] No [ ] PT [ ]	Yes [ ] No [ ] PT [ ]	

CMHC:	Date:	CT Initials:	Age:	Record #:	Reviewer:

Children's Mental Health Minimum Standards
Chart Review Form

Standard	Absent (0)	Partial (1)	Present (2)	Comments/Score
I. General Record:				
A. Release signed yearly?				
B. Record is current, organized and legible?				
C. Permission to treat forms signed by parent/guardian and child (if appropriate)				
D. Financial and benefits eligibility is reviewed with family annually				
Section Total (8 possible):				
II. Clinical Assessment of Presenting Issues, Symptoms and History:				
A. Timely (within 2 years)?				
B. Presenting issues/target symptoms from youth's and family's perspective				
C. Presenting issues/target symptoms from multiple informants				
D. Presenting issues/target symptoms are described in multiple settings (home, community, school)				
E. Assessment includes the child's and family's strengths, abilities, interests, assets, resources, skills, capabilities and natural positives.				
F. The assessment clearly indicates why the family and youth have asked for help and what they hope to accomplish. This includes the liabilities and weaknesses				
G. Assessment is trauma informed as evidenced by the following: a brief trauma screen, if screen yields a positive result a follow up trauma assessment is completed or child is referred for an assessment.				
H. Legal issues				
I. Employment information				

Standard	Absent (0)	Partial (1)	Present (2)	Comments/Score
J. Education information and relationship with school and teachers				
K. Developmental History				
L. Relationships with family & friends, past and present including who currently lives in household.				
M. Hobbies, leisure interests and community/school involvement and community relationships.				

N. Natural supports: who are they and how do the youth and family wish others to be involved in treatment? What can the family rely on?				
O. Significant life events and family history				
P. The assessment explores cultural, ethnic and spiritual resources and influences.				
Q. Documentation of screening for substance use/abuse is present (if applicable)				
R. A full substance use assessment is completed for treatment implications if indicated.				
S. A complete mental status assessment				
T. Special status situations, such as imminent risk of harm, suicidal/homicidal ideation, are actively considered and integrated into the plan of care.				
Section Total (40 possible/36 if Q & R not applicable):				
III. Formulation/Interpretive Summary:				
A. The Axis I-V Diagnosis is consistent with assessment findings				
B. Clear clinical summary that uses the information gathered and is developmentally sensitive				
C. Clear and specific treatment recommendations that address presenting issues and target symptoms				
D. Treatment recommendations reflect best practices				
E. Clinician's printed name, signature, degree, and title present?				
Section Total (10 possible):				
IV. Individual Plan of Care (IPC)				
A. Treatment plan (IPC) is current – no more than 1 year old.				
B. Goals reflect assessment and/or evaluations				
C. Client input				
D. Client's goals clinically interpreted into mental health goals				
E. The objectives have realistic, measurable action steps				
F. Plan articulates expected outcomes				
Standard	Absent (0)	Partial (1)	Present (2)	Comments/Score
G. Type of intervention or service, frequency and time frame are identified				
H. Documentation shows who will provide services				
I. The family's and/or child's signature is present				
J. Signature of appropriately credentialed clinician				
K. Signature of psychiatrist/doctor (initial and updates)				
L. Quarterly reviews/ IPC updates identify progress (or lack) towards achieving goals, and any subsequent changes to goals, services or providers.				
M. The IPC is accessible and easy to understand for the consumer.				
N. Interagency coordination is evident in plan if appropriate				
Section Total (28 possible/26 if N not applicable):				
V. Progress notes and Outcomes				
A. Do the notes have a description of the activity and intervention?				
B. Do the notes reflect the client's response?				

C. If progress is not being made, the notes reflect a change in clinical direction				
D. Next steps?				
E. Evidence of consultation for complex cases or clients making little or no progress				
F. Clinician's signature, degree and date.				
G. Progress notes are individualized to the client's service interactions and do not contain excessive repetition over time				
Section Total (14 possible/12 if E not applicable):				
VI. Medical and Psychiatric Care				
A. Medical History is explored with a summary of health issues/events and allergies (including medication allergies and adverse reactions).				
B. Primary care physician identified				
C. Documentation of integration or collaboration with primary care				
D. Chart contains copy of most recent psychiatric evaluation				
E. If the child receives psycho-pharmacologic supports, the medications are documented with dosage, route and schedule. There is a list of medication changes, start dates and refills				
F. Medication use or benefits are reflected as well as medical/psychiatric information changes				
Section Total (12 possible/ 6 if D-F not applicable):				

Standard	Absent (0)	Partial (1)	Present (2)	Comments/Score
VII. Crisis management plan and screenings				
A. If appropriate, there is a proactive crisis plan				
B. Are there any crisis screenings?				
C. Description of the situation.				
D. Identify the participants involved in situation				
E. Safety issues identified if present and a plan to address them				
F. If easily resolved: description of resolution and follow-up plan identified if appropriate.				
G. If full screening appropriate, there is a mental status exam, Consultation w/ MD or psychiatrist; the level of care needed is identified, resources are explored, and resolution described with follow up plan identified.				
H. If client is admitted to hospital or hospital diversion: evidence of discharge planning and participation from the DA/SSA				
Section Total (16 possible/ 0 or 2 if all non-applicable or only A applicable):				
Utilization Review				
A. Intensity of services matches the documentation of need				
B. If client is receiving services through residential care, the client will still need to remain open to the DA. There should also be ongoing DA participation in treatment and discharge planning				
Section Total (4 possible/ 2 if B not applicable):				
Chart Total (Score and Percentage of Total Possible):				

Core Capacities:	Services Provided: (check all that apply)
Outreach	
Prevention	
Clinic Based	
Early Screening	
Supports	
Crisis Services	

Proposed Minimum Standard	What are we trying to accomplish by asking this (Intent) and/or examples of questions to ask	Scoring Key
I. General Record:		
A. Release signed yearly?	Regular review of confidentiality and what other providers are working with the family.	0 = Absent or older than two years 1 = Within 2 years 2 = Yearly
B. Record is current, organized and legible?	Handwriting must be legible. Chart is organized so that someone unfamiliar with the case could find basic information and get a sense of identified needs, goals, services being offered, and progress toward goals.	0 = Few clear sections, difficult to find documents, difficult to read documentation. Handwriting that cannot be read in whole or in large part, documentation is more than 6 months old 1 = Handwriting that cannot be read in part except with difficulty and occasional assistance from other reviewers. Most documents in the same location chart but some in different locations. Documentation is more than 3 months old 2 = Handwriting that can be read easily by the reviewer and all documentation is located consistently chart to chart. Documentation is not more than 3 months old
C. Permission to treat forms signed by parent/guardian and child (if appropriate)	Parent signature necessary Best practice is that child signs if older than 14 Evidence that parent is informed of grievance and appeal rights.	0 = No client signatures 1 = Note signed by clinician with date that verbal permission was given. 2 = One signature, either parent or child over 14 ■ 12 years old if receiving substance abuse treatment ■ If child 12 or older for substance abuse treatment or 14 or older for mental health treatment is seeking treatment without parent's permission it is documented that the child is doing so without parental input.
D. Financial and benefits eligibility is reviewed with family annually		0 = Documentation not in chart 2 = Documentation in chart
II. Clinical Assessment of Presenting Issues, Symptoms and History:		
A. Timely (within 2 years)?	To document developmental changes which can have a significant impact during short periods of time, and the influence of changing family dynamics and their impact on child. A current assessment is crucial as the basis to inform treatment. A reassessment is also be important following significant life or status changes to the person or family served	0 = No assessment in chart or older than 5 years. 1 = Last assessment completed is 5-3 years old. 2 = Assessment less than 2 years old.
B. Presenting issues/target symptoms from youth's and family's perspective	In order to work with a child and family effectively you must be aware of the child and family's thoughts on what the issues are and how they perceive the issues. Does the family and child (if age appropriate) view the situations/target symptoms differently? Do they identify different issues of concern? How do they describe the current challenges? Are the	*For each of the following assessment categories, use the same general criteria and scoring key to evaluate each section. In general, it may be satisfactory if a few categories are not clearly documented, but if there is a pattern of incomplete or insufficient data, then the score should reflect that pattern.*

	child's behaviors a reaction to any stresses in the family? Are there any family dynamics that need to be addressed in order to support the child?	0 = Documentation not in client's chart 1 = Component is unclear or incomplete (for example, the use of single-word descriptors, or yes/no answers when more information is necessary for someone not familiar with the client/situation to understand the client's service needs) 2 = Clear information about the component is present, defined and explained. Sufficient information is gathered. Additional helpful information may be present and/or comes from additional sources/resources.
C. Presenting issues/target symptoms from multiple informants	To understand why a child and family were referred and what other's see as the main issues or symptoms. Best practice includes information from child, family, school and any other service providers involved with family (collateral info.)	
D. Presenting issues/target symptoms are described in multiple settings (home, community, school)	To understand if issues or symptoms are only present in certain environments and to better understand why and how you could address those different settings. Information addresses behaviors, feelings and issues in multiple settings. Be concrete and specific. Are behaviors escalating? Chronic? How long?	
E. Assessment includes the child's and family's strengths, abilities, interests, assets, resources, skills, capabilities and natural positives.	Strengths can be used to address presenting issues -- strengths help everyone recognize that a child or family are more than just their problems. Although the assessment should identify the specific characteristics and skills that the child and family identify as strengths, this standard is also about the general tone of the assessment. Is it written with a non-blaming and strengths' focused attitude? Are the parents willing to be actively involved in the child's treatment?	
F. The assessment clearly indicates why the family and youth have asked for help and what they hope to accomplish. This includes the liabilities and weaknesses	To clearly document why you are serving this child and family and begin to formulate a treatment plan. Family and child's voice is incorporated in assessment. Why is the family accessing services at this time? What do they expect to get out of treatment? What do they understand that treatment will look like? What other intervention have they tried? How did they help? Not help? Have the parents been involved in the child's treatment in the past? How? It is clear what the youth and family would consider a successful outcome – be specific and concrete. Are the expectations of the child and family different? Are they realistic? What issues in the family need to be addressed in order to support the child in changing their behaviors?	
H. Assessment is trauma informed as evidenced by the following: a brief trauma screen, if screen yields a positive result a follow up trauma assessment is completed or child is referred for an assessment.	Trauma is often under-identified as a driver of behavior challenges or internalizing behavior. Trauma has a significant impact on mental health and functioning. Is there information around possible trauma the child may have experienced – including, but not limited to witnessing domestic violence, any history of abuse, neglect, family substance abuse, sexual abuse, deaths in the family, significant traumatic events, etc. Did family identify changes in the child's behavior or functioning after an event? How have they addressed the issue? Etc.	
I. Legal issues	To better understand the family issues and stressors. Should include information about the child and/or significant family members.	
J. Employment information	To better understand poverty issues in the family. For both child (if the child is of working age) and parents. If not employed worker may want to explore desire for employment and work interest.	

K. Education information and relationship with school and teachers	To better understand how the child's educational needs my be effecting mental health, behavior or how to better treat. Is child on grade level? Receiving special educational supports? Learning disabilities? Cognitive or developmental disabilities? What type of educational program is the child in? (Mainstream? Alternative? Etc.) How does the child and family feel about school and education? What is the child's cognitive functioning? Will this impact their ability to engage, or the type of treatment offered?	
L. Developmental History	Understanding a child's developmental history can provide insight into when the child began to struggle with particular issues, as well as the parents' understanding of typical child development and how they respond to challenges. Also, a child's development can be interrupted or derailed by sickness, trauma, neglect etc. – especially during certain developmental periods, and it can have a significant impact on the child's ability to learn particular skills or build on the skills they missed. So, when did the child meet common developmental milestones? Where there any particular struggles? At what point? How did the parent cope with these problems or encourage development?	
M. Relationships with family & friends, past and present including who currently lives in household.	Relationships can give insight into issues and strengths. Other members of the household can impact all other members. What are the types and quality of the relationships the child has with family and friends? How have they changed over the years? What relationships are important to them? What activities does the family enjoy together?	
N. Hobbies, leisure interests and community/school involvement and community relationships.	Additional activities can be very instrumental in helping children develop other strengths and give them opportunities to practice skills or have positive outlets. What activities does the child enjoy participating in? Does the family do activities/hobbies together? Do the activities and hobbies help the child interact with other children? Do they provide opportunities to work on social skills? Are any of the child's hobbies things that a provider might support or use as a activity to help build a therapeutic relationship?	
O. Natural supports: who are they and how do the youth and family wish others to be involved in treatment? What can the family rely on?	Developing natural supports is a crucial to maintaining progress and can be key in supporting treatment plans. Who else does the child or parent know outside of immediate family that can support them? How can they help or be involved in the child's treatment? Who will be there for the child and family when treatment ends?	
P. Significant life events and family history	Past events can have an impact on current functioning. What events and experiences have formed this family? Where have they come from? Have they lived in the same house all their lives? Moved around a lot? Any changes in significant family relationships? Substance abuse during pregnancy?	
Q. The assessment explores cultural, ethnic and spiritual	These can be positive resources and areas of strengths and natural supports. Are any of these	

resources and influences.	issues important to the family members, either as part of their identity, or as an internal coping support, or by having access to external supports (ie. churches, spiritual organizations, cultural clubs, etc)?	
R. Documentation of screening for substance use/abuse is present (if applicable)	Each DA should have the ability to provide a SA screening.	0 = No screening – or screening not applicable. 1 = Screening present, but incomplete or results unclear. 2 = Screening is present using one of the screens identified by ADAP for any child 12 or older.
S. A full substance use assessment is completed for treatment implications if indicated.	SA and MH should be addressed in a co-occurring model if possible. Both issues can have an impact on each other and it is best to identify and make sure the treatment plan addresses both. If not possible within the agency, then there is documentation that the child or parent was referred for a full assessment and treatment? If assessment was completed, is there evidence of it in the file?	0 = Screening indicated SA concerns, but no indication that a full substance abused assessment complete or referral made for full assessement – or SA assessment not indicated. 1 = Referral for full substance abuse assessment made, but no indication it was followed through. 2 = Substance abuse assessment is completed and information that can be shared is incorporated into chart and treatment plan.
T. A complete mental status assessment	Complete mini mental status exam with all elements or full mental status if indicated.	0 = Documentation not in client's chart 1 = One or more boxes on assessment form are left unchecked 2 = All boxes on assessment form are checked
U. Special status situations, such as imminent risk of harm, suicidal/homicidal ideation, are actively considered and integrated into the plan of care.	This can have an impact on current functioning and treatment planning. Has the child been screened by emergency services before? What has been the severity/potential lethality of the behaviors? Is there a current crisis plan in place? Do they need one?	0 = Documentation not in client's chart 1 = Component is unclear or incomplete (for example, the use of single-word descriptors, yes/no answers when more information is necessary for someone not familiar with the client/situation to understand the client's service needs) 2 = Clear information about the component is present, defined and explained. Additional helpful information may be present and/or comes from additional sources/resources.
III. Formulation/Interpretive Summary:		
A. The Axis I-V Diagnosis is consistent with assessment findings	An accurate understanding of any mental health issues is important in order to develop appropriate treatment plan. Does it make sense? Reflect the symptoms and exhibited behaviors? Meet criteria? Not superficial or just a holdover from previous assessments? (e.g., not Adjustment D/O for five years, etc.). Is it age-appropriate? Significant diagnosis needs additional documentation to support.	0 = Documentation not in client's chart; or diagnosis space blank 1 = Some of Axes are left blank or inappropriate diagnosis are listed 2 = Clear and appropriate documentation on Axis I (primary and secondary), Axis II (primary and secondary), and Axes III, IV, and V = GAF
B. Clear clinical summary that uses the information gathered and is developmentally sensitive	In order to tie all the information together to be able to develop a clear treatment plan. The central theme is apparent. This should be a brief, but thorough summary of the presenting issues for the child and family, the severity of the issues, their strengths, willingness and ability to participate in treatment, any potential barriers to treatment or co-occurring disabilities, and the diagnosis.	0 = Documentation not in client's chart 1 = Documentation is unclear or incomplete 2 = Clear documentation/summary of conclusions, including the clients' strengths and resources that provide understanding/insight into client's needs for treatment
C. Clear and specific treatment recommendations that address presenting issues and target	Recommendations should be thoughtful, logical, address the presenting issues and reflect both the identified child's issues, as well as any family	0 = Disconnect between assessment and recommended treatment 1 = Unclear or incomplete treatment

symptoms	issues or dynamics that should be addressed in order to support the child. The child and family's perception of their needs, strengths, limitations and problems should be outlined. The clinical judgement regarding both positive and negative factors likely to affect the course of treatment and clinical outcomes is documented.	recommendations, or recommendations that only address partial issues presented in assessment and/or only addresses child's treatment needs and not relevant family issues. 2 = Discussion of client preferences and strengths as they relate to treatment strategy and comprehensive recommendations of the types of services and supports necessary to meet the child's and family's treatment needs
D. Treatment recommendations reflect best practices	Treatment recommendations for type of treatment, as well as frequency, should reflect best practice standards, as well as the child's and family's ability to realistically engage or complete treatment (e.g., intensive psychotherapy should not be recommended for a child with cognitive limitations, etc). Family participation should be strongly encouraged. Recommendations should include any special assessments or tests and routine procedures. Also includes general discussion of anticipated level of care, length and intensity of treatment and expected focus.	0 = No recommendations, or no connection between summary and best practice treatment recommendations. 1 = Unclear or recommendations inconsistent with best practice philosophy, methodology or frequency of service. 2 = Recommendations reflect best practice for type and frequency of services/supports, and, if appropriate, include recommendations for family involvement/treatment.
E. Clinician's printed name, signature, degree, and title present?	Medicaid requirement to document who wrote assessment and their qualifications	0 = All three components are absent 1 = Signature only is present 2 = Signature and degree are present, or signature is present and a complete list of current staff and degrees is made available during chart review
IV. Individual Plan of Care (IPC)		
A. Treatment plan (IPC) is current – no more than 1 year old.	Treatment Plans should be dated from beginning of services or by fourth billable hit. Updated yearly or more frequently if there are significant sustained changes in services	0 = No IPC in chart 1 = IPC more than 1 year old or services out of range of IPC for sustained amount of time 2 = IPC in chart and completed within 1 year and changed as needed
B. Goals reflect assessment and/or evaluations	Goals should be tied directly to the assessment. Do goals reflect the treatment recommendations of the most recent assessment, or is there documentation in progress notes to show that the child's issues/challenges have shifted or developed?	0 = No connection between assessment formulation and goals 1 = Unclear connection between assessment formulation and goals 2 = Clear connection between assessment formulation and goals discernible by a person unfamiliar with the client
C. Client input	Clients will feel more ownership of goals if they are in their language. Are the goals stated in the client's words with interpretation by the clinician? Do they seem to reflect the issues identified in the assessment? Are the objectives concrete and reasonable for the client to work toward? Was the plan developed with the active participation of the person served?	0 = No indication that was client involved in identifying and setting goals. 1 = Documentation unclear or incomplete, but indicates client was involved with identifying and setting goals. 2 = Clear indication that client was involved in identifying and prioritizing goals (e.g., space for goals in client's words, as well as clinical interpretation)
D. Client's goals clinically interpreted into mental health goals	Goals must reflect mental health treatment needs. If necessary or appropriate, are the client's words, needs, desires and/or goals translated into mental health oriented goals that identify and target a mental health issue?	0 = Clinical interpretation is absent 1 = Unclear clinical interpretation of client's needs into mental-health goals 2 = Specific, concise clinical interpretation of client's needs into mental health goals
E. The objectives have realistic, measurable action steps	The action steps to complete a goal are laid out with objectives that are appropriate (to age and developmental level) concrete, measurable, reflect the ability and commitment level of the client, understandable to the client, and	0 = Action steps are missing from service plan and goals. 1 = Action steps are listed, but do not seem realistic or measurable. 2 = Action steps are clear, realistic and

	achievable.	measurable.
F. Plan articulates expected outcomes	Could a client or reader understand what would indicate a successful completion of the goal? For examples, not just that a behavior disappears, but what other behavior, situation or relationship would take it's place, or what level of change in behavior is being worked on.	0 = Service plan does not articulate expected outcomes 1 = Expected outcomes are unclear 2 = Expected outcomes are clearly articulated
G. Type of intervention or service, frequency and time frame are identified	Must be clear about what is being provided to help client obtain goals. Specific supports that are needed, and the frequency of that service without having PRN incorporated into the plan. Plan should also identify a realistic time frame for accomplishing the goal. See attached chart for descriptions of acceptable ranges of care for frequency of services.	0 = Type of clinical intervention, frequency or time frame of services is missing from IPC 1 = Type of intervention, frequency and/or time frame of services is unclear or incomplete 2 = Clincial intervention strategy, frequency and time frame of services is clear and complete
H. Documentation shows who will provide services	Best practice would have the name of the clinician or provider listed, but at least the program name should be indicated that is providing the service.	0 = Service plan does not identify provider/staff person 1 = Service plan's identification of provider/staff person is unclear 2 = Service plan clearly identifies provider/staff person
I. The family's and/or child's signature is present	Parent signature necessary, unless child is over 18. Best practice is that child signs if older than 14 ■ 12 years or older if receiving substance abuse treatment without parent permission ■ 14 years or older if receiving mental health treatment without parent permission	0 – No client signatures 1 =Note signed & dated by clinician that verbal agreement was given 2 – One signature, either parent or child over 12
J. Signature of appropriately credentialed clinician	Medicaid requirement	0 = No signature present 1 = Signature only is present 2 = Signature and degree are present, or signature is present and complete list of current staff and degrees is made available during chart review

K. Signature of psychiatrist/doctor (initial and updates)	An IPC for a Medicaid recipient is considered a prescription of "medically necessary" treatment and requires an appropriate doctor's signature.	0 = Physician's signature absent from service prescription 1 = Physician's signature is present on service prescription but not on all updates or quarterly reviews. 2 = Physician's signature is present on service prescription and on all updates or quarterly reviews.
L. Quarterly reviews/ IPC updates identify progress (or lack) towards achieving goals, and any subsequent changes to goals, services or providers.	Explain the progress made or limits to progress. Explains why the IPC's goals or service strategies will or will not change to assure the stated goals are achieved as soon as possible.	0 = Documentation not in client's chart 1 = Review is unclear or incomplete (for example, the use of single-word descriptors, simple number score only or yes/no answers when more information is necessary for someone not familiar with the client/situation to understand the client's service needs) 2 = Clear information about the component is present, clearly and completely defined and explained. Additional helpful information may be present and/or comes from additional sources/resources.
M. The IPC is accessible and easy to understand for the consumer.	The IPC does not use excessive jargon or only mental health terminology. The organization of the form is logical and understandable, and it is obvious that the client's abilities and goals have	0 = Documentation not in client's chart 1 = Component is unclear, incomplete, or uses some jargon, without goals being stated in client's words or IPC is confusing to follow.

	been incorporated into the plan.	2 = Goals are stated clearly in both client's words and with mental health interpretation, or there is clear indication that client was involved in setting goals; the form is logical and easy to understand and follow.
N. Interagency coordination is evident in plan if appropriate	Interagency coordination is the cornerstone of the system of care. Often children and families present with multiply issues and it's important for the other providers to work together with mental health and make sure services are coordinated and not duplicated. If another agency referred the child and is looking for a specific outcome, is that reflected in the goals? Are they involved in the interventions? Does the plan of services reflect the supports and services the child and family are receiving in the community?	0 = Documentation not in client's chart 1 = Component is unclear or incomplete 2 = Clear information about the component is present, clearly and completely defined and explained.
V. Progress notes and Outcomes		
A. Do the notes have a description of the activity and intervention?	Is the activity defined? Is the therapeutic goal of the activity stated? Is there appropriate content in the description to ensure that there is not excessive repetition over time? For instance, if the activity is a discussion, is there enough content in the note to show there was a quality interaction and progress toward goals? Or, if the intervention is more activity-based, is there a description of how the activity has a therapeutic component and will help the client make progress toward a goal? Indicate what the clinician is doing to support the client in meeting his/her goals	0 = Documentation not in client's chart 1 = Notes lack sufficient or relevant detail to explain the provider's mental health intent in the activity (e.g., use of the service modality as description of the activity, or use day-to-day repetition) 2 = Clear information about the component is present, defined and explained. Additional helpful information may be present and/or comes from additional sources/resources.
B. Do the notes reflect the client's response?	Is there a description of the client's affect, engagement in the activity, and general response to the intervention?	0 = Documentation not in client's chart. 1 = Documentation is vague, incomplete, or off topic (e.g., relies on single word descriptors, or is excessively brief or repetitive) 2 = Documentation is clear, informative, individualized, and describes the client's response to the intervention.
C. If progress is not being made, the notes reflect a change in clinical direction	Is there thoughtful assessment of the progress (or lack of progress) the client is making, and how the interventions are helping them achieve their goals? If they are not making progress, is a change in direction, alternate intervention, or change in service frequency identified?	0 = Documentation not in client's chart. 1 = Documentation unclear or incomplete (e.g., relies on single word descriptors, or is excessively brief or repetitive) 2 = Documentation is clear, informative, individualized and describes the client's progress toward their treatment goals or any changes in therapeutic direction.
D. Next steps?	It is not acceptable to simply say – "meet next week." What is the next step in treatment – continue to practice the current skill? Address the same issue in more depth? Move to the next step? Etc.	0 = Next steps not discussed 1= Documentation alludes to next steps but is not discussed 2 = Documentation clearly indicates next steps and why
E. Evidence of consultation for complex cases or clients making little or no progress	For clients who exhibit challenging boundary issues, have extremely complex presentations, or are making little or no progress, is there documentation that the clinician or provider is accessing regular supervision to support them in addressing the client's needs?	0 = Evidence of regular and clear treatment issues, but no documentation of consultation or supervision around how to address – or Section not applicable. . 1 = Evidence of attempt to change therapeutic direction, but no change in client outcomes, and no documentation of consultation. 2 = Clear documentation of consultation and supervision and its impact on treatment outcomes.
F. Clinician's signature, degree and	For Medicaid billing. Needs to be legible. –	0 = All three components are absent

date.	Needs to be dated for CARF	1 = Signature only is present 2 = Signature, degree and date are present, or signature is present and a complete list of current staff and degrees is made available during chart review
G. Progress notes are individualized to the client's service interactions and do not contain excessive repetition over time	Are the notes individualized? Excessive repetition in notes is unacceptable. Photocopied or "cut and paste" descriptions of the activity and/or client response that are used repeatedly are unacceptable.	0 = Excessive and repetition throughout the case notes or photocopied or "cut and paste" descriptions. 1 = Some repetition, but some individualized notes, as well. 2 = Documentation consistently individualized to the specific interaction and client response.
VI. Medical and Psychiatric care	If DA is prescribing	
A. Medical History is explored with a summary of health issues/events and allergies (including medication allergies and adverse reactions).	Need to have a full understanding of health issues as they relate to mental health and this level of care. Also need any relevant allergy information for staff planning activities.	0 = Documentation not in client's chart 1 = Component is unclear or incomplete (for example, the use of single-word descriptors, yes/no answers when more information is necessary for someone not familiar with the client/situation to understand the client's service needs) 2 = Clear information about the component is present, clearly and completely defined and explained. Additional helpful information may be present and/or comes from additional sources/resources.
B. Primary care physician identified	Is there evidence that the child and his/her family have a Medical Home?	0 = No documentation in file 2 = PCP clearly identified
C. Documentation of integration or collaboration with primary care	Is there evidence of coordination of care with the child's primary care physician, especially if the physician is prescribing psychotropic medicines for the child?	0 = Documentation not in client's chart 1 = Component is unclear or incomplete 2 = Clear information about the component is present, clearly and completely defined and explained.
D. Chart contains copy of most recent psychiatric evaluation		0 = Evidence that evaluation took place, but documentation not in file – or not applicable as no psychiatric evaluation completed. 2 = Documentation in file.
E. If the child receives psycho-pharmacologic supports, the medications are documented with dosage, route and schedule. There is a list of medication changes, start dates and refills	The medication is documented in the psychiatric note and/or copy of prescription. If the child receives psychiatric services from a private provider, at least the type of medication and dosage are recorded in the chart.	0 = Documentation not in client's chart – or not applicable 1 = Component is unclear or incomplete 2 = Clear information about the component is present, clearly and completely defined and explained.
F. Medication use or benefits are reflected as well as medical/psychiatric information changes	The medication note should contain information indicating the effectiveness of the medication and documenting any side effects. If side effects are found, then it should document a discussion with the person about how to deal with the side effect.	0 = Documentation not in client's chart – or not applicable. 1 = Component is unclear or incomplete 2 = Clear information about the component is present, completely defined and explained.
VII. Crisis management plan and screenings		
A. If appropriate, there is a proactive crisis plan	The best way to avoid crisis is to plan how to respond. If the child has a history of multiple crisis calls and/or screenings or a significant self-harming or aggressive episode, then a pro-active crisis plan is appropriate. DMH provides an example of a crisis plan form or the DA could create their own template that includes the same or similar elements.	0 = No documentation indicating need for plan 0 = Several crisis calls but no proactive crisis plan present 1 = Several crisis calls and some documentation related to crisis plan but no formalized plan 2 = Formalized proactive crisis plan

B. Are there any crisis screenings?	Yes or no If yes, proceed to next question (VII C). If no, proceed to Section VIII.	If no, score rest of section with 0's and section not included in final percentage.
C. Description of the situation.	To better understand why a call is being placed to the crisis team is there a concise description of the situation that prompted the crisis call?	0 = No information about why crisis was called 1 = Some information but it is not clear why crisis was called 2 = Clearly documents what precipitated the crisis call
D. Identify the participants involved in situation	Sometimes different people involved in a situation see the precipitating factors and clients reaction differently. Are there descriptions of the situation from more than one reporter?	0 = No description of situation or who is involved 1 = Some information is present but not clear what the situation is that requires crisis 2 = It's clear who is involved and why
E. Safety issues identified if present and a plan to address them	To avoid further crisis and injurious behavior (to self or others) safety planning is a must. Any potential safety issues are identified and the level of threat is assessed and the rationale behind the rating is listed (e.g., if there's a history of threats, but no follow-through, then that is identified).	0 = No discussion of safety issues documented 1 = Safety issues identified but no description of severity or planning 2 = Specific safety issues identified with a plan to address
F. If easily resolved: description of resolution and follow-up plan identified if appropriate.	There is a concise description of the resolution, and if necessary a detailed safety plan is laid out. Any follow-up plan identifies who is responsible for completing each action step.	0 = No crisis resolution document – interaction simply ends with crisis 1 = Indication of a plan but no real description of plan 2 = It's clear how the crisis was resolved and next steps
G. If full screening appropriate: mental status exam Consultation w/ MD or psychiatrist; level of care needed identified; resources explored; and resolution described with follow up plan identified.		0 = Information not present 1 = Some information but lack of detail 2 = Adequate detail is present and follow up identified
H. If client is admitted to hospital or hospital diversion: evidence of discharge planning and participation from the DA/SSA	If resolution of crisis is for client to be admitted to a hospital or E-bed, then there is detailed evidence of the plan to get client to the facility, plan identifies who will be informed of the placement, and who is responsible for connecting with the facility to participate in discharge planning. (Note: Although the crisis screener is not responsible for on-going discharge planning, there should be corresponding documentation of the primary clinician/case manager's participation in discharge planning in the regular progress notes).	0 = No indication of follow up or case information being passed on to case manager 2 = Information clearly passed on and discharge planning considered
VIII. Utilization Review		
A. Intensity of services matches the documentation of need	The system does not want to provide more service than needed or not enough services. Does the frequency and type of services match the documented need? Does the level of service provided match the level of services prescribed? If it doesn't, is there documentation of the process to reconsider and adjust?	0 = Level of service does not match intensity (either too much service or too little) 1 = It's unclear if the need and service amount/type match 2 =Need and service amount/type match and it's clear that the team has a mechanism to do utilization reviews
B. If client is receiving services through residential care, the client will still need to remain open to the DA. There should also be ongoing DA participation in treatment and discharge planning	It is best practice to begin discharge planning prior to admission. Residential care is only a piece of a plan not the plan. Ongoing participation in treatment planning and discussions is crucial to understanding the challenges the child will face when returning to the community, as well as what interventions were most (and least) effective. Please refer to the DMH Residential Criteria document.	0 = Client no longer open to agency – or not applicable 1 = Client open but little interaction between program and DA 2 = Active participation by DA and interaction with residential program on progress, useful treatment strategies, and discharge planning

TABLE: Examples of Ranges for Services

Type of Service:	**Examples of Ranges:**
Service Planning and Coordination	*Range should not span greater than 5 hours* Weekly (e.g., 1-3 hours per week) Monthly (e.g., 8-12 hours per month) Quarterly (e.g., 2 hrs 2-3 times per quarter)
Community Support (Individual, Group)	*Range should not span greater than 5 hours* Daily (e.g., 3-6 hours per week) Weekly (e.g., 15-20 hours per month) Monthly (e.g., 2 hrs 3-5 times per month)
Clinical Interventions (individual/ family/ group therapy)	*Range should not span greater than 2 sessions* Weekly (e.g., 1hr 1-2 times per week) Monthly (e.g., 1½ hrs 3-4 times per month)
Medication Evaluation, Management, and Consultation Services	*Range should not span greater than 2 sessions* Weekly (e.g., 30-60 min 1 time per week) Monthly (e.g., 30 min 1-2 times per month) Quarterly (e.g., 15 min 2-3 times per quarter)
Medication/Psychotherapy	*Range should not span greater than 2 sessions* Monthly (e.g., 1hr 1-2 times per month) Quarterly (e.g., 1hr 3-4 times per quarter)
Concurrent to Education Rehabilitation & Treatment (C.E.R.T.)	Weekly (e.g., 6 hrs 5 times per week during school year)
Consultation, Education, Advocacy	*Range should not span greater than 2 sessions* Weekly to Monthly (e.g., 1hr 1-2 times per month) Monthly to Quarterly (e.g., 2hrs 1-2 times per quarter)
Crisis Service	*Range not required as nature of crisis services precludes planned services.