Minimum Standards for Children's Mental Health
Definitions and Intent
November 2017

	Compliance Section		
	Proposed Minimum Standard	**What are we trying to accomplish by asking this (Intent) and/or examples of questions to ask**	**Scoring Key**
Source	**I. General Information:**		
AR 4.9.5	1. Signed authorization by parent/guardian to release information	Ensuring that parent/guardian consents to release information	0 = No signature 1 = Signature present
AR 4.9.2	2. Consent to evaluation and treatment/services signed by client/guardian	Parent signature necessary Best practice is that the youth signs if 14 or older Evidence that parent is informed of grievance and appeal rights.	0 = No signature 1 = Signature present, parent or youth if 14 or older • 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.
AR 4.9.10 and 4.9.11 EPSDT/Medicaid	3. Medical home/PCP identified or evidence thereof	Ensuring that the child/youth has a PCP to promote physical wellness during crucial developmental phases, with the intent of collaboration with the DA/SSA	0 = No medical home/PCP identified 1 = Medical home/PCP identified
AR 4.9.10 and 4.9.11 EPSDT/Medicaid	4. Dental home identified or evidence thereof	Encourage healthy oral hygiene and overall wellness during crucial developmental phases, as well as collaboration with DA/SSA, if applicable	0 = No dental home identified 1 = Dental home identified
	II. Clinical Evaluation, Assessment, and/or Screening:		

FFS Manual	1. Assessment is completed within 45 days of intake or within 2 years for a reevaluation (CIS One Plan is acceptable for children aged 0-3 years old).	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 2 years. 1 = Assessment less than 2 years old (and completed within 45 days of intake).
FFS Manual	2. Qualified provider's name and credentials are present	Medicaid requirement to document who wrote assessment and their qualifications. **All evaluations must be written or reviewed by a licensed, masters-level clinician.**	0 = All components are absent, or signature is present, but it is not clear if clinician has appropriate credential. 1 = Signature and appropriate credential are present.

	III. Individual Plan of Care (IPC):		
FFS Manual	1. If the initial IPC fell under the period under review, it was completed within 45 days of client initiating services. For prenatal to age 6, the plan must be completed within 45 days of referral	Initial IPCs must be completed within 45 days	0 = Initial plan **not** completed within 45 days. 1 = Initial plan completed within 45 days N/A = Most recent plan is an update.
FFS Manual	2. If the plan is an update, it was completed within the last year	IPCs must be updated annually or after an applicable life event	0 = Plan not updated within the last year or a major event has occurred and the plan has not been updated to reflect changes in client's life (e.g. parental divorce, loss of housing, significant medical diagnosis) 1 = Plan has been updated within the last year or after a major event
FFS Manual	3. Signature of psychiatrist/psychiatric nurse practitioner (initial and updates)	An IPC for a Medicaid recipient is considered a service prescription of "medically necessary" treatment and requires an appropriate clinical signature. Signature of psychiatrist/psychiatric nurse practitioner is required initial plans only if any of the following conditions are present: • med management is a service on the plan • the client is discharging from psychiatric hospitalization	0 = Physician's signature required, but absent 1 = If required, physician's signature is present

		• the supervising clinician feels the client's treatment issues warrant psychiatric review or consult.	N/A = Physician's signature not required.
AR 4.9.2	4. The family's and/or child's signature is present.	Parent signature necessary, unless child is 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 = Signature is present, either parent or child over 12 or note signed and dated by clinician that verbal agreement was given or documentation of attempts made to get signatures (more than one attempt must be made).
FFS Manual	5. Signature and credential of appropriately credentialed clinician	Medicaid requirement -- at least a licensed master's level clinician operating within the scope of their licensure or an advanced practice psychiatric nurse practitioner operating within the scope of their licensure	0 = No signature present, or signature is present, but lacking credentials (no staff list provided) 1 = Signature and credential are present, or signature is present and complete list of current staff and degrees is made available during chart review
	IV. Crisis Management and Screenings:		
AR 4.9.9 HCBS	1. 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.	0 = Indications of engagement with crisis or hospital emergency services, but no proactive crisis plan present 1 = Formalized proactive crisis plan present N/A = Documentation does not indicate the need for a crisis plan
	Compliance and Quality Section		

	I. Clinical Evaluation, Assessment, and/or Screening:		
FFS Manual	1. History of presenting issues, needs or deficits, target symptoms from multiple informants, where appropriate, and described in multiple settings (home, community, school etc.)	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 child's behaviors a reaction to any stresses in the family? Are there any family dynamics that need to be addressed to support the child? Best practice includes information from child, family, school and any other service providers involved with family (collateral info.)	*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.* <u>Compliance:</u> 0 = Documentation not found in chart 1 = Documentation is present in chart <u>Quality:</u> 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. 3 = Additional, helpful information is present and/or comes from additional sources/resources.
FFS Manual	2. The evaluation 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 now? 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 to support the child in changing their behaviors?	
FFS Manual	3. Education information and relationship with school and teachers	To better understand how the child's educational needs may 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 do 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?	
FFS Manual	4. Clear indication of client's strengths, abilities, interests, and resources	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?	
FFS Manual	5. Developmental history and needs	Understanding a child's developmental history can provide insight into when the child began to struggle, 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 specific skills or build on the skills they missed. So, when did the child meet common developmental milestones? Where there any specific struggles? At what point? How did the parent cope with these problems or encourage development?	
FFS Manual	6. Medical history	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.	
FFS Manual	7. Psychosocial history: • Significant life events and family history • Relationships with family & friends, past and present including who currently lives in household. • Natural supports: who are they and how do the youth and family wish others to be involved in treatment? • Family stressors (income/housing/food insecurity/legal issues) • Education information • Cultural, ethnic and spiritual resources and influences	To better understand the child/youth and their family, the evaluation and assessment should include information about the child/youth and/or significant family members. 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? 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?	
FFS Manual	8. Complete mental status exam	Complete mini mental status exam with all elements or full mental status if indicated.	
FFS Manual	9. At least one standardized screening/assessment tool is used to assess client's functioning and/or care/treatment needs	Standardized tools may include, but are not limited to: CANS, ASEBA, and CBCL	
FFS Manual	10. Evaluation 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 and can have 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?	
FFS Manual	11. Documentation of screening for substance use/abuse is present (if applicable)	Each DA should have the ability to provide a SA screening using one of the screens identified by ADAP for any child 12 or older.	
FFS Manual	12. 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?	
FFS Manual	13. The DSM or ICD Diagnosis is consistent with evaluation 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.	
FFS Manual	14. Clinical formulation or interpretive summary that uses the information gathered, is developmentally sensitive, and identifies strengths and needs	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.	
FFS Manual	15. Clear and specific treatment recommendations that address presenting issues and target symptoms	Recommendations should be thoughtful, logical, address the presenting issues and reflect the identified child's issues, as well as any family 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 judgment regarding both positive and negative factors likely to affect the course of treatment and clinical outcomes is documented.	
FFS Manual	16. 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.	
	II. Individual Plan of Care (IPC)		
AR 4.9.3 and FFS Manual	1. Goals/outcomes are meaningful to and have been developed in partnership with client and family, as evidenced by documented input from client/family	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?	<u>Compliance</u>: 0 = Documentation not found in chart 1 = Documentation is present in chart <u>Quality</u>: 1 = Documentation is unclear or no indication that was client involved in identifying and setting goals. 2 = Documentation is clear and indicates client was involved with identifying and setting

			goals. 3 = 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
FFS Manual	2. Goals reflect evaluation and/or other assessments	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?	Compliance: 0 = Documentation not found in chart 1 = Documentation is present in chart Quality: 1 = No connection or unclear connection between assessment formulation and goals 2 = Clear connection between assessment formulation and goals 3 = Connection between assessment formulation and goals discernible by a person unfamiliar with the client, very thorough
FFS Manual	3. Plan includes at least one goal that has a clear mental health focus	At least one goal 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?	Compliance: 0 = Documentation not found in chart 1 = Documentation is present in chart Quality: 1 = Mental health goal is absent or unclear 2 = Adequate clinical interpretation of client's needs into mental-health goals 3 = Specific, concise clinical interpretation of client's needs into mental health goals

FFS Manual	4. The objectives have realistic, measurable action steps that clearly define the work and expectations between service provider and family	• 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 achievable. Could a client or reader understand what would indicate a successful completion of the goal? For example, not just that a behavior disappears, but what other behavior, situation or relationship would take its place, or what level of change in behavior is being worked on. • Must be clear about what is being provided to help client attain 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.	<u>Compliance</u>: 0 = Documentation not found in chart 1 = Documentation is present in chart <u>Quality</u>: 1 = Action steps are missing from service plan and/or goals do not seem realistic or measurable. 2 = Objectives are clear and action steps are listed 3 = Objectives are clear and action steps are clear, realistic, and measurable.
AR 4.9.1	5. 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 been incorporated into the plan.	<u>Compliance</u>: 0 = Documentation not found in chart 1 = Documentation is present in chart <u>Quality</u>: 1 = Documentation not in client's chart 2 = Components and language are clear, complete, and easy to understand 3 = 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.
AR 4.9.9 HCBS	6. Special status situations, such as imminent risk of harm, suicidal/homicidal ideation, are actively considered and	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?	<u>Compliance</u>: 0 = Documentation not found in chart

	integrated into the plan of care.		1 = Documentation is present in chart Quality: 1 = Special situation indicated, but not documented in client's IPC 2 = Documentation is clear and complete (someone not familiar with the client/situation is able to understand the client's service needs) 3 = Clear information about the component is present, defined and explained. Additional helpful information may be present and/or comes from additional sources/resources.
FFS Manual	7. 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.	Compliance: 0 = Documentation not found in chart 1 = Documentation is present in chart Quality: 1 = Type of clinical intervention, frequency or time frame of services is missing from IPC 2 = Type of intervention, frequency and/or time frame of services is present 3 = Clinical intervention strategy, frequency and time frame of services is clear and complete
AR 4.9.1 and FFS Manual	8. Plan articulates expected outcomes	Could a client or reader understand what would indicate a successful completion of the goal? For example, not just that a behavior disappears, but what other behavior, situation or relationship would take its place, or what level of change in behavior is being worked on.	Compliance: 0 = Documentation not found in chart 1 = Documentation is present in chart Quality:

			1 = Service plan does not articulate expected outcomes 2 = Expected outcomes are present 3 = Expected outcomes are clearly articulated
FFS Manual	9. 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.	Compliance: 0 = Documentation not found in chart 1 = Documentation is present in chart Quality: 1 = Service plan does not identify provider/staff person 2 = Service plan's identification of provider/staff person is mostly clear 3 = Service plan clearly identifies provider/staff person, title, and credentials
FFS Manual	10. Signature of qualified provider on treatment plan	Medicaid requirement to document who wrote the plan and their qualifications. All plans must be written or reviewed by a licensed, masters-level clinician.	Compliance: 0 = Documentation not found in chart 1 = Documentation is present in chart Quality: 1 = All components are absent, or signature is present, but it is not clear if clinician has appropriate credential. 2 = Signature(s) and appropriate credential are present. 3 = Signature(s) and appropriate credential are present and a staff list has been provided
	III. Service Delivery and Documentation		

FFS Manual	1. Progress notes document service modality and describe contact, purpose, intervention used, observations, and client's response	Is the therapeutic goal of the activity stated and how it will help the client meet his/her goals? 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	Compliance: 0 = Documentation not found in chart 1 = Documentation is present in chart Quality: 1 = Notes do not include all elements listed 2 = Notes include all elements 3 = Notes include all elements in detail and provide a thorough description
FFS Manual	2. Intervention content is consistent with client's IPC goals	Is the therapeutic goal of the activity stated and how it will help the client meet his/her goals? 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	Compliance: 0 = Documentation not found in chart 1 = Documentation is present in chart Quality: 1 = Notes lack sufficient or relevant detail to explain the provider's mental health intent in the activity 2 = Clear information about the component is present, defined and explained. 3 = Additional helpful information is present and/or comes from additional sources/resources
FFS Manual	3. Progress notes document the positive interventions and supports used; • If a safety need warrants a restriction or modification to the client-focused IPC, it is supported by a specific assessed need and the positive interventions and supports that were	There should be clear evidence in the progress notes that positive interventions and supports are utilized, are tied into the treatment goals, and any restrictions related to safety concerns are well documented and used only after attempting positive interventions and supports.	Compliance: 0 = Documentation not found in chart 1 = Documentation is present in chart Quality: 1 = Notes lack sufficient or relevant detail to explain the provider's mental health intent in the activity

	attempted prior to the modification are well documented.		2 = Clear information about the component is present, defined and explained. 3 = Additional helpful information is present and/or comes from additional sources/resources
FFS Manual	4. Interagency coordination is evident, 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?	Compliance: 0 = Documentation not found in chart 1 = Documentation is present in chart Quality: 1 = Coordination is unclear or lacking 2 = Clear information about the component is present, clearly and completely defined and explained. 3 = Additional helpful information is present and/or comes from additional sources/resources
FFS Manual	5. 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?	Compliance: 0 = Documentation not found in chart 1 = Documentation is present in chart Quality: 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.

			3 = Additional helpful information is present and/or comes from additional sources/resources
FFS Manual	6. Service is delivered by or supervised by a qualified provider as noted by clinician signature, degree, and date	For Medicaid billing. Needs to be legible. – Needs to be dated for CARF	Compliance: 0 = Documentation not found in chart 1 = Documentation is present in chart Quality: 1 = All three components are absent or only signature is present 2 = Signature, degree, and date are present 3 = Signature, degree, and date are present and a complete list of current staff and credentials is made available during chart review
FFS Manual	7. If progress is not being made on goals, the reasons are clearly articulated and revisions, if appropriate, to the IPC are made	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?	Compliance: 0 = Documentation not found in chart 1 = Documentation is present in chart Quality: 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. 3 = Additional helpful information is

			present and/or comes from additional sources/resources
FFS Manual	8. 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.	Compliance: 0 = Documentation not found in chart 1 = Documentation is present in chart Quality: 1 = Excessive repetition throughout the case notes or photocopied or "cut and paste" descriptions. 2 = Individualized notes, little to no repetition 3 = Documentation consistently individualized to the specific interaction and client response.
	IV. Medical Care		
FFS Manual	1. Medical History is explored with a summary of health issues/events and allergies	This section is reviewed by the CAFU Child Psychiatrist and is written up in a separate, narrative format that is integrated into the final report.	
FFS Manual	2. If appropriate, there is documentation of integration or collaboration with primary care		
FFS Manual	3. If seeing a psychiatrist outside of the organization, the chart must contain a psychiatric evaluation		
FFS Manual	4. If the child receives psychopharmacological supports from the DA, the medications are documented with dosage, route, and schedule. There is a list of medication changes, start dates, and refills		
FFS Manual	5. Medication use or benefits are reflected as well as		

	medical/psychiatric information changes		
FFS Manual	6. If medication management is provided by private provider, there is evidence of coordination and input in treatment planning		
	V. Crisis Management Plan and Screenings		
FFS Manual	1. If there are crisis screenings, does the screening form include the following: a. A clear description the situation b. Safety issues are identified if present and a plan to address them c. If the situation is easily resolved, is there a description of resolution and a follow up plan identified, if appropriate	**If there are no crisis screenings, record N/As for this section and move to the next section.** -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? 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). - 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.	Compliance: 0 = Documentation not found in chart 1 = Documentation is present in chart Quality: 1 = Inadequate information about why crisis was called, safety issues, resolution, or follow up planning 2 = Clear documentation about the situation, resolution, and follow up plan 3 = Information provided is clear and thorough, additional helpful information is present and/or comes from additional sources/resources
FFS Manual	2. If a full screening is appropriate: there is a mental status exam, consultation w/ MD or psychiatrist, level of care needed identified, resources explored, and resolution described with follow up plan identified.	If clinically indicated, there is a mental status exam that includes consultation with a psychiatrist or MD, the level of care needed must be specified, as well as resources/supports, and a plan for managing the current crisis including a plan for follow up.	Compliance: 0 = Documentation not found in chart 1 = Documentation is present in chart Quality: 1 = Some information but lack of detail 2 = Adequate detail is present and follow up Identified

			3 = Documentation is detailed and additional helpful information is present and/or comes from additional sources/resources
FFS Manual	3. 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).	Compliance: 0 = Documentation not found in chart 1 = Documentation is present in chart Quality: 1 = No indication of follow up or case information being communicated? to case manager 2 = Information clearly communicated and discharge planning considered 3 = Clear documentation of discharge planning, additional helpful information is present and/or comes from additional sources/resources
	VI. Periodic Review and Assessment of Progress		
FFS Manual	1. A standardized screening or assessment tool is used to periodically assess progress on goals	Check for periodic use of screening/assessment tools (i.e. CANS, CBCL, or family stress index)	Compliance: 0 = Documentation not found in chart 1 = Documentation is present in chart Quality: 1 = No periodic use of standardized tools 2 = Standardized tools are used to assess progress toward goals 3 = Standardized tools are used to assess progress toward goals, additional helpful

			information is present and/or comes from additional sources/resources
FFS Manual	2. Information from this screening/assessment tool and progress notes are used to inform client's IPC goals and service delivery as appropriate	Goals should be tied directly to the screenings/assessments. 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?	Compliance: 0 = Documentation not found in chart 1 = Documentation is present in chart Quality: 1 = Little to no connection between screening/assessment formulation, progress notes and goals 2 = Clear connection between assessments/screenings, progress notes and goals discernible by a person unfamiliar with the client 3 = Clear connections are made and additional helpful information is present and/or comes from additional sources/resources
FFS Manual	3. Documentation of ongoing need for continuing intervention (with any description of change in approach if necessary)	What intervention have they tried? How did they help? Not help? What issues in the family need to be addressed in order to support the child in changing their behaviors?	Compliance: 0 = Documentation not found in chart 1 = Documentation is present in chart Quality: 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

			need or any changes in therapeutic direction. 3 = Additional helpful information is present and/or comes from additional sources/resources
FFS Manual	4. Intensity of services match 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?	Compliance: 0 = Documentation not found in chart 1 = Documentation is present in chart Quality: 1 = Level of service does not match intensity (either too much service or too little) or it's unclear if they match 2 = Need and service amount/type match and it's clear that the team has a mechanism to do utilization reviews 3 = Additional helpful information is present and/or comes from additional sources/resources
	VII. Transition and Discharge Planning		
FFS Manual	1. Evidence of proper transition/exit planning documentation and notifications	Planning for a transition to or from a residential setting or discharge from services is critical for the youth and their family. When applicable, all members of the treatment team should be aware of the transition/exit plan and understand their role. There should be evidence of communication with the treatment team, as well as a clear understanding of what the family needs to support a successful transition.	Compliance: 0 = Documentation not found in chart 1 = Documentation is present in chart Quality: 1 = Little or no evidence of transition or discharge planning 2 = Clear evidence of transition or discharge Planning 3 = Additional helpful information is

			present and/or comes from additional sources/resources
FFS Manual	2. 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.	Compliance: 0 = Documentation not found in chart 1 = Documentation is present in chart Quality: 1 = Little interaction between program and DA or client no longer open to agency 2 = Active participation by DA and interaction with residential program on progress, useful treatment strategies, and discharge planning 3 = Additional helpful information is present and/or comes from additional sources/resources

Qualitative Information
Strengths were noted in the following areas: Please record strengths and examples of consistent or exemplary work
Careful consideration needs to be paid to the following areas of this file: Note areas that don't meet standard or patterns that have emerged (i.e. an employee who needs more training on note writing or more consultation on complex cases is needed).
The following needs immediate attention: These are patterns that have emerged or issues that have been uncovered during the review that the agency needs to be notified about during or at the end of the review (i.e. clinicians have consistently not signed off on IPCs, critical documentation is missing, or there is a concern for the level of care a client is/is not getting). These issues often result in a plan of corrective action for the DA.