COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

Edition 2011-03

Program Support Bureau
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April 11, 2011

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CLINICAL RECORDS BULLETIN

Important Reminder

Because the Clinical Forms Inventory is a newly released document and there is a lot of information on it, we are still in the process of ensuring all the information is accurate. If you notice any information that needs to be updated, please email Marilou Joguilon at mjoguilon@dmh.lacounty.gov with the corrections.

NEW CLINICAL RECORDS FORMS INVENTORY

NEW Forms Inventory Available on Internet

(http://dmh.lacounty.gov/ToolsForClinicians/clinical_forms.html - Inventory)

DMH Official Form Usage Policies and Other Resources

DMH Policy 104.8: Clinical Record Guidelines (For Directly-Operated Programs Only)
DMH Policy 104.9: Clinical Documentation
Organizational Providers Manual
(http://dmh.lacounty.gov/ToolsForAdministrators/agency_admin.html)
EHRS Memo - See Attached

To assist both Directly-Operated and Contract agencies, a Clinical Forms Inventory has been created and placed on-line. The Clinical Forms Inventory identifies all DMH Official Clinical Record Forms, both those currently in use and those that are obsolete and should no longer be in use. The Inventory lists the following information:

- MH #
- Official Clinical Form Name
- The Status of the Form (in use, not in use, obsolete)
- The date of the most up-to-date version of the form
- Where the form can be located on-line
- The type of form (for use by Contract Agencies ONLY; see below for additional information)
- Any special program use/designation

Under the direction of the Clinical Records Director, the Quality Assurance Division-Clinical Records is responsible for creating and maintaining all DMH Official Clinical Record Forms.

Form Status and Updating the Clinical Records Forms Inventory:

Clinical Record Forms will be listed with the following status:

- In Use - The form is currently in use and should/may be used in applicable situations
- Not In Use - The form is currently outdated and QA is working on updating the form. If an agency is currently using the form, they may NOT continue doing so.
- Obsolete - The form is no longer in use and if an agency is currently using the form, they should discontinue use as soon as possible.

DO YOU KNOW THE ANSWERS TO THESE QUESTIONS? (DIRECTLY-OPERATED ONLY)

1. When is documentation required to be completed?
2. Am I allowed to save my assessments or progress notes on the computer so I can refer back to them later?

Answers on the next page

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The Clinical Records Forms Inventory will be updated as forms are revised, created, or removed from use. A Clinical Records Bulletins will be issued to alert Providers of any revisions to the Clinical Forms Inventory.

Information for Directly-Operated Programs

Directly-operated programs may ONLY use DMH Official Clinical Record Forms. If a program is currently using a form not on this list, please contact the Quality Assurance Division-Clinical Records regarding the process of making a form into a DMH Official Form. If your program is currently using an out-of-date form, please update the form by located the current version on-line (if available) or contacting the Quality Assurance Division-Clinical Records for the updated form. If your program is currently using an obsolete form, please discontinue its use. If you believe you still have a need for an obsolete form and it has not been replaced by a corresponding form, please contact the Quality Assurance Division-Clinical Records. Contact for these purposes are by e-mail ONLY to Marilou Joguilon at mjoguilon@dmh.lacounty.gov.

Information for Contract Agencies

In some situations contract agencies must use forms of their own making while in other situations they must use the DMH official Clinical Record Form. The Clinical Forms Inventory indicates the appropriate usage under "type of form". The following types of form options are available and defined in Attachment 1 of the attached memo:

- **DMH Required Clinical Record Form**
- **DMH Required Elements Clinical Record Form**
- **DMH Optional Clinical Record Form**
- **DMH Ownership Clinical Record Form**
- **NA -** Forms that are not applicable for Contract Agencies. These Forms were generally created for a very specific type of directly-operated program and there are no requirements regarding the use of these Forms by Contract Agencies.

For contract agencies utilizing an Electronic Health Record System, please refer to the attached Memo describing how to translate DMH Clinical Record Forms into an Electronic Health Record System.

If you have any questions regarding this Bulletin, please contact your Service Area Liaison.

c: Executive Leadership Team
District Chiefs
Department QA Staff
Program Heads
Provider Record Keepers
QA Service Area Liaisons
TJ Hill - ACHSA
Nancy Butram - RMD
Judith Miller - Compliance

I KNOW THE ANSWERS TO THOSE QUESTIONS!

1. Per DMH Policy 104.08 - Clinical Record Guidelines: Contents and General Documentation Requirements, "all direct services must be documented in the Clinical Record by the end of the next scheduled work day following the delivery of service and prior to submission of claims for reimbursement."

2. No. Per DMH Policy 104.08 - Clinical Record Guidelines: Contents and General Documentation Requirements. "all clinical documentation shall not be saved on any disk or any other electronic medium".

COUNTY OF LOS ANGELES

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Reply To: (213) 738-2289
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March 30, 2011

TO: Contract Executive Directors

FROM: Norma Fritsche
MHC District Chief, Quality Assurance Division

Jay Patel
Division Chief, Enterprise Applications

SUBJECT: **CLINICAL INFORMATION IN PAPER CLINICAL RECORDS AND ELECTRONIC HEALTH RECORD SYSTEMS**

PURPOSE

This memo and its attachments apply only to providers contracted with the Los Angeles County Department of Mental Health (DMH) to provide direct services. It has four purposes:

1. to introduce revised language to Contract Providers who currently have paper records regarding the requirements of DMH for the forms in their records and
2. to assist Contract Providers who have or are acquiring Electronic Health Records Systems (EHRS) in crosswalking paper clinical form content required by DMH into Data Elements and e-reports or XML Messages which can be produced from a Contract Provider's EHRS that will be in compliance with DMH standards
3. to identify how Contract agencies will be notified of new/revised forms and/or data elements and implementation expectations
4. to describe expectations for EHRS in clinical audits

SCOPE OF THIS DOCUMENT

This document only applies to Short-Doyle/Medi-Cal Outpatient Programs of Contract Providers.

There are many circumstances under which information regarding a client would need to be transmitted between Contractors and DMH including transferring or sharing treatment of a client, claiming, or opening episodes. This document is **only** in reference to the transmission of information for clinical purposes which is currently done by transmitting paper Clinical Forms from one Provider to another.

DMH is in the process of planning for its own EHRS (called IBHIS-Integrated Behavioral Health Information System) and how it will interface with other EHRS within the DMH System of Care. It is expected that after the implementation of IBHIS, there will only be electronic interfaces within the DMH System of Care and DMH will no longer utilize paper Clinical forms except in those situations in which a contractor has not yet implemented its own electronic record. For this purpose, this document is primarily an intermediary between now and when DMH implements IBHIS.

1. REVISED AND DEFINED TERMS

Clinical Records, Forms, and Electronic Health Record Systems use terms with different meanings or use different terms with the same meaning depending on the perspective, operating system, or agency/individual. For this reason, DMH has chosen terms and defined them to include the range of possible terms and definitions. The definitions that are being implemented by this memo take into account the need to reference "data elements" which are currently found on paper Clinical Forms and "e-reports" or "XML Messages" which can be transmitted from an EHRS to DMH. Attachment 1 provides a list of these terms and their definitions. The first section of Attachment 1 contains revised categories and definitions for the types of clinical forms DMH uses in an effort to bring better clarity to Providers with regard to clinical form usage. The second section of Attachment 1 contains the new EHRS terms.

2. CROSSWALKING PAPER CLINICAL FORM CONTENT INTO THE EHRS

As DMH Contract Providers have begun implementing EHRS, DMH has begun to adopt policies and procedures regarding the use of DMH clinical forms in an EHRS environment that does not use hard-copy forms to compose the paper Clinical Record. Attachment 2 establishes DMH clinical expectations for Contractor's EHRS and provides a visual presentation of these expectations. The type of clinical form (identified in Attachment 1) determines what the requirements are for the data elements, structure, and e-report or XML Message.

3. NOTIFICATION AND IMPLEMENTATION OF NEW/REVISED CLINICAL RECORD FORMS AND DATA ELEMENTS

The Clinical Records Bulletin is used for communicating all information regarding new, revised and/or deleted Clinical Record forms. These Bulletins are equally important for Providers with paper clinical records as they are for those with an EHRS since the additions and/or changes may impact the data elements and e-reports/XML Messages in the EHRS as much as they impact paper clinical records. DMH has placed these Bulletins on-line for access on the dmh.lacounty.gov webpage: http://dmh.lacounty.gov/ToolsForAdministrators/agency_admin.html

Revisions to Clinical Record Forms will continue to be made and issued in accord with Federal, State, and Local requirements. Unless the changes are required

mandates in order to ensure compliance, EHRS and, when applicable, e-reports/XML Messages will not need to be modified immediately upon the issuance of the Clinical Records Bulletin. The modifications should be made as soon as possible but will be expected to be

completed either within six months of the Clinical Records Bulletin being issued or within a potentially shorter time period established by the Federal, State, or local mandate. DMH will always include the timeframe of implementation in an EHRS when releasing Clinical Record Bulletins.

4. CLINICAL AUDITS AND EHRS

Contract Providers should keep in mind that auditors should be able to easily access and see all data required for audit (attachment 3 Review Protocols Section J). Determining how much and what of an historical paper clinical record needs to be incorporated into an EHRS will be an agency decision. Contractors are cautioned that at present, State Auditors require a complete paper or a complete EHRS; State auditors have verbally stated that they are not willing to "flip/flop" between two record formats. This means that if a Contractor wishes for State auditors to audit their records electronically it must ensure that all relevant information is incorporated into the EHRS. For example, if the Assessment which documents Medical Necessity for the audit period was completed prior to implementation of the EHRS and a Contractor wishes to have their records audited electronically, then the Assessment would need to be incorporated into the EHRS in some manner. Likewise, if a Contractor wishes State auditors to audit their records through paper format it must ensure that all relevant information is incorporated into the paper clinical record. For example, if Progress Notes for the audit period were completed after the implementation of the EHRS, then the Progress Notes for the audit period would need to be printed out and incorporated into the paper clinical record.

For additional information regarding the DMH Clinical Forms Inventory which includes a listing of all DMH Clinical Record Forms and their associated form types, a Clinical Records Bulletin will be issued shortly and the Clinical Record Forms Inventory will be posted on the DMH Internet. If you have questions regarding this memo, please e-mail Rose Esquibel, DMH Clinical Records Director at resquibel@dmh.lacounty.gov.

c: Executive Management Team
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TJ Hill, ACHSA

CLINICAL RECORD FORMS and ELECTRONIC HEALTH RECORD DEFINITIONS

Paper Clinical Record – A client related record of all information and services relating to an individual stored on paper/hard copy. **The following four definitions are applicable ONLY to Contractors.**

DMH Required Clinical Record Form – Forms in PDF format or hardcopy format which must be used, as applicable to the situation, by all Contract Providers without alteration in content, format, or structure.

DMH Required Elements Clinical Record Form – Forms in PDF format or hardcopy format in which all data elements on these forms are required in the DMH valid format, i.e., the only valid date format is mm/dd/yyyy; however, the layout and presentation of the form is up to Contractors. Contract Providers may choose to use the DMH form, without alteration, or may choose to use a form of their own creation. If Contract Providers choose to use a form of their own creation, they are responsible for ensuring all data elements in the DMH valid format are on the form they create.

DMH Optional Clinical Record Form – Forms in PDF format or hardcopy format in which neither data elements, format, or structure of the form are required to be used by Contract Providers. While the forms and their specific data elements are not specifically required, the concept encompassed by the form's title is. This means that Contractors must have a method of documenting the concept captured by the title of the form. Contract Providers may choose to use the DMH form, without alteration or may choose to use a form of their own creation.

DMH Ownership Clinical Record Form – Forms which are required by state or federal law/code or County/Department policy/procedure but because of their potential legal implications cannot be "DMH Required" forms. These forms require the contractor to be familiar with the relevant authority and design a form based on their agency's understanding/interpretation of the authority and its plan to implement compliance with the law/code. If a Contractor chooses to use the DMH form, they must understand they are agreeing to take on the legal responsibilities associated with the language of the form. A Contractor may use a DMH Ownership Clinical Form in its original format so long as the Contractor removes the "Los Angeles County - Department of Mental Health" name and replaces it with their own which signifies having taken ownership of the content of the form.

Electronic Health Record System (EHRS) – A client related record of all information and services relating to an individual stored in an electronic database such as an electronic health record (aka EMRS, EMR, ECR);. **The following three definitions are applicable ONLY to Contract Providers who collect and store, or are preparing to store, health information and services in an electronic format.** Historical information that may be incorporated into an EHRS using scanning or OCR technology of paper records are available as part of an EHRS but are not data elements that can be imbedded in the data of the EHRS and therefore unavailable for incorporation into an e-Report.

Data Elements – content, e.g. first name, last name, diagnosis, etc., of DMH forms that have been identified as data elements and that are entered into fields in an electronic database table (either by manual data entry or an electronic data interface). A data element has a name, a description or definition, and a format (e.g. 10 characters, alphanumeric).

e-Report– an electronic data presentation tool that can be printed out; format examples include: Crystal Reports, MS Excel, MS Access, PDF, HTML, and proprietary EHRS vendor specific formats. This terminology is not being used to always represent a 'report' created using a report writer, it is intended to simply signify a method/format for presentation of data from an electronic database. It may also include e-forms or other methods of capturing data from an electronic record.

XML Message - A set of data that is formatted using the extensible Markup Language (XML). XML is an industry standard set of rules for electronically structuring a document.

CROSSWALK BETWEEN CLINICAL FORMS and DATA ELEMENTS/XML MESSAGES/e-reports in an EHRS

DMH Required Clinical Forms

- *LAC-DMH does not require that any DMH Required Clinical Record Forms be reproduced "as is" in a Contract Providers EHRS, that is, the EHRS may have any structure or use any appropriate collection tools or methods for the input of information into the EHRS.*

- *LAC-DMH does require Contract Providers with an EHRS to have all data elements on DMH Required Clinical Forms in their EHRS AND requires them to be able to produce a printable e-report (hard or soft copy) that replicates the existing DMH Required Clinical Forms in data elements and sequence **OR** XML Message.*

All information on the DMH Required Clinical Forms must be converted to data elements which must be present in an EHRS. In addition, these data elements must be able to be printed in an e-report that matches the sequence of the DMH Required Clinical Form or must be able to be transmitted via XML Message. If there is no information related to a data element, the e-report/XML Message must have some indication regarding the lack of information (i.e. N/A, not able to be obtained).

These standards will facilitate the assurance of coordination and continuity of client care between providers by facilitating the capacity to fulfill record requests when clients move through the LA County System of Care. It also facilitates effective and efficient data/chart reviews. If desired, Providers may reproduce or include any DMH PDF form in their EHRS; that is, there are no copyright restrictions on DMH forms.

DMH Required Data Elements Clinical Forms

- *LAC-DMH does require Contract Providers with an EHRS to have all data elements on DMH Required Elements Clinical Forms.*

All data elements on these forms are considered to be required data elements in an EHRS. Information on the DMH Required Data Elements Clinical Forms must be converted to data elements which must be present in an EHRS.

DMH Optional Clinical Forms

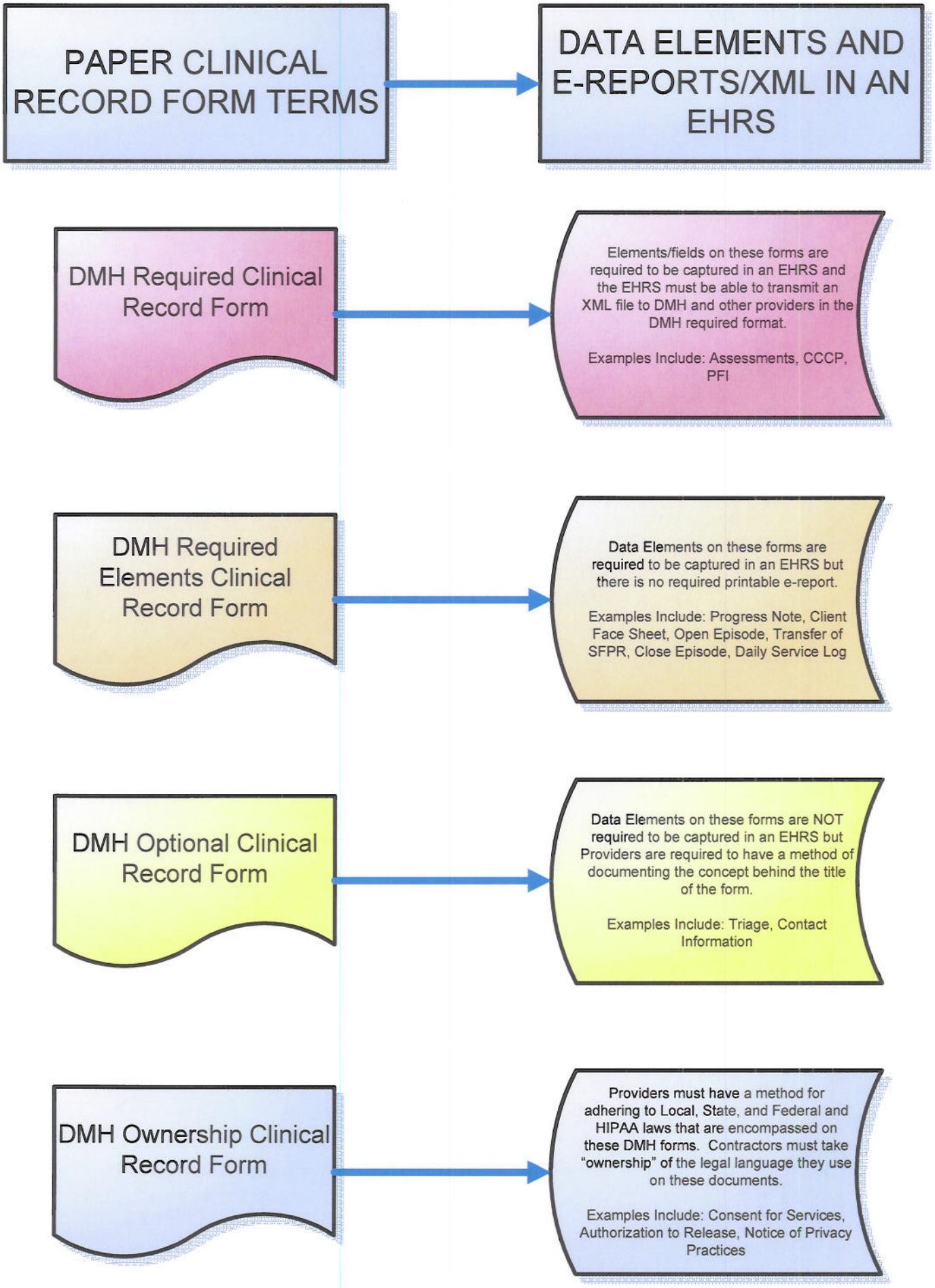
- *LAC-DMH does NOT require providers with an EHRS to have the data elements on DMH Optional Clinical Forms in their EHRS.*

Contract agencies may incorporate the data elements on these forms into their EHRS or they may identify their own data elements. If Contractors do not use the data elements on the DMH forms, they must have data elements in their EHRS which capture the concept of the title of the form.

DMH Ownership Clinical Record Forms

- *LAC-DMH does require providers with an EHRS to have a method for adhering to State and Federal laws, including HIPAA laws, and LAC-DMH Policy and Procedure contained within DMH Ownership Clinical Record Forms, that is, the concept of the form is required but for risk management reasons each legal entity must assume responsibility for establishing its own form content.*

Contract Providers may utilize any method or collect any information in any manner in their EHRS which they believe complies with State and Federal laws, including HIPAA laws, and LAC-DMH Policy and Procedure. This may include replicating DMH Ownership Forms so long as they remove the "Los Angeles County Department of Mental Health" name and replace it with their own name and in so doing assume full responsibility for the content of the form.


PAPER CLINICAL RECORD FORM TERMS
DATA ELEMENTS AND E-REPORTS/XML IN AN EHRS
DMH Required Clinical Record Form
Elements/fields on these forms are required to be captured in an EHRS and the EHRS must be able to transmit an XML file to DMH and other providers in the DMH required format.
Examples Include: Assessments, CCCP, PFI
DMH Required Elements Clinical Record Form
Data Elements on these forms are required to be captured in an EHRS but there is no required printable e-report.
Examples Include: Progress Note, Client Face Sheet, Open Episode, Transfer of SFPR, Close Episode, Daily Service Log
DMH Optional Clinical Record Form
Data Elements on these forms are NOT required to be captured in an EHRS but Providers are required to have a method of documenting the concept behind the title of the form.
Examples Include: Triage, Contact Information
DMH Ownership Clinical Record Form
Providers must have a method for adhering to Local, State, and Federal and HIPAA laws that are encompassed on these DMH forms. Contractors must take "ownership" of the legal language they use on these documents.
Examples Include: Consent for Services, Authorization to Release, Notice of Privacy Practices

STATE DEPARTMENT OF MENTAL HEALTH
MEDI-CAL OVERSIGHT

ANNUAL REVIEW PROTOCOL FOR CONSOLIDATED SPECIALTY MENTAL HEALTH SERVICES AND OTHER FUNDED SERVICES

FISCAL YEAR (FY) 2010-2011

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SECTION J CHART REVIEW—NON-HOSPITAL SERVICES

		IN COMPLIANCE		*INSTRUCTIONS TO REVIEWERS*
	CRITERIA	**Y**	**N**	**COMMENTS**
RE: MEDICAL NECESSITY				
1. 1a.	Does the beneficiary meet all three of the following reimbursement criteria (1a, 1b, and 1c. below)? The beneficiary has a DSM IV diagnosis contained in the CCR, title 9, section 1830.205(b)(1)(A)-(R).			**NOTE:** Review assessment(s), evaluation(s), and/or other documentation to support a-c. • Is the beneficiary's diagnosis among the list of diagnoses in CCR, title 9, section 1830.205(b)(1)(A)-(R).
1b.	The beneficiary, as a result of a mental disorder listed in 1a, must have, at least, one of the following criteria (1-4 below): 1) A significant impairment in an important area of life functioning. 2) A probability of significant deterioration in an important area of life functioning. 3) A probability that the child will not progress developmentally as individually appropriate. 4) For full-scope MC beneficiaries under the age of 21 years, a condition as a result of the mental disorder that SMHS can correct or ameliorate.			**NOTE:** Refer to CCR, title 9, sections 1830.205 (b)(2)(A-C) and 1830.210 (a)(b)(c).

SECTION J CHART REVIEW—NON-HOSPITAL SERVICES

	CRITERIA	IN COMPLIANCE Y	N	*INSTRUCTIONS TO REVIEWERS* COMMENTS
1c.	Must meet each of the intervention criteria listed below (1 and 2): 1) The focus of the proposed intervention is to address the condition identified in No. 1b. (1-3) above, or for full-scope MC beneficiaries under the age of 21 years, a condition as a result of the mental disorder that SMHS can correct or ameliorate per No. 1b. (4)? 2) The expectation is that the proposed intervention will do, at least, one of the following (A, B, C, or D): A) Significantly diminish the impairment. B) Prevent significant deterioration in an important area of life functioning. C) Allow the child to progress developmentally as individually appropriate. D) For full-scope MC beneficiaries under the age of 21 years, correct or ameliorate the condition.			**NOTE:** Does the proposed intervention(s) focus on the condition(s) identified in 1b. (1-3) or, for full-scope MC beneficiaries under the age of 21 years, on a condition that SMHS can correct or ameliorate No. 1b. (4)? • Can a connection be identified between the proposed intervention and the following: A) Diminishing the impairment? B) Preventing a significant deterioration? C) Allowing a child to progress developmentally as individually appropriate? D) Correcting or ameliorating the condition?

		IN COMPLIANCE		*INSTRUCTIONS TO REVIEWERS*
	CRITERIA	**Y**	**N**	**COMMENTS**
• *CCR, title 9, sections 1830.205(b) , 1830.210(a)*				**OUT OF COMPLIANCE:** • Criteria a-b not supported by documentation. • Criteria "c" not established. • No connection can be made between the diagnosis and the service(s) provided. • No evidence that the intervention(s) will correct or ameliorate a defect, mental illness, or condition.
Documentation: (List document(s) reviewed that demonstrates compliance and provides specific explanation of reason(s) for in compliance or out of compliance.)				
RE: ASSESSMENT				
2.	Regarding the Assessment, are the following conditions met:			**NOTE:** Assessment information need not be in specific document or section of the chart.
2a	Has an assessment been completed and, as appropriate, does it contain areas addressed in the MHP Contract with the DMH?			• Review assessment(s), evaluation(s), and/or other documentation to support 1a, 1b, and 1c.

		IN COMPLIANCE		*INSTRUCTIONS TO REVIEWERS*
	CRITERIA	**Y**	**N**	**COMMENTS**
				• Does the assessment(s) include the appropriate elements? These elements may include the following: a) Physical health conditions reported by the beneficiary are prominently identified and updated; b) Presenting problems and relevant conditions affecting physical and mental health status (e.g. living situation, daily activities, and social support); c) Beneficiary strengths in achieving client plan goals. d) Special status situations and risks to beneficiary or others; e) Medications, dosages, dates of initial prescription and refills, and informed consent(s); f) Allergies and adverse reactions, or lack of allergies/sensitivities; g) Mental health history, previous treatments dates, providers, therapeutic interventions and responses, sources of clinical data, relevant family information, lab tests, and consultation reports; and h) Past and present use of tobacco, alcohol, and caffeine, as well as, illicit, prescribed, and over-the-counter drugs. i) For children and adolescents, pre-natal and perinatal events, and complete developmental history

	CRITERIA	IN COMPLIANCE Y	N	*INSTRUCTIONS TO REVIEWERS* COMMENTS
2b.	Documentation that is legible.			
• *CCR, title 9, section 1810.204*		**OUT OF COMPLIANCE:** • NFP. • No assessment has been completed. • The assessment does not contain the elements, as appropriate.		
Documentation: (List document(s) reviewed that demonstrates compliance and provides specific explanation of reason(s) for in compliance or out of compliance.)				
RE: CLIENT PLAN				
3.	Does the client's plan contain the following elements?			
3a.	Specific, observable, or quantifiable goals.			
3b.	The proposed type(s) of intervention(s).			
3c.	The proposed duration of the intervention(s).			
3d.	Documentation that is legible.			

	CRITERIA	IN COMPLIANCE Y	N	*INSTRUCTIONS TO REVIEWERS* COMMENTS
3e.	A signature (or electronic equivalent) of, at least, one of the following (1, 2, or 3): 1) A person providing the service(s). 2) A person representing the MHP providing the service(s). 3) When the plan is used to establish that services are provided under the direction of an approved category of staff, and if the above staff are not of the approved categories, one of the following must sign: A) A Physician. B) A Licensed/Waivered Psychologist. C) A Licensed/Registered/ Social Worker. D) A Licensed/Registered/ Marriage and Family Therapist. E) A Registered Nurse.			**NOTE:** It is good clinical practice to include the date with every signature. • If necessary, ask for a list of staff, staff signatures, and staff licenses.

	CRITERIA	IN COMPLIANCE Y	N	*INSTRUCTIONS TO REVIEWERS* COMMENTS
3f.	Is the documentation of the beneficiary's degree of participation and agreement with the client plan as evidenced by one of the following? 1) When the beneficiary is a long-term client, as defined by the MHP, and the client is receiving more than one type of service, the client's signature, or an explanation of why the signature could not be obtained, is documented on the plan. 2) When the beneficiary is not a long-term beneficiary, examples of documentation include, but are not limited to, reference to the client's participation and agreement in the body of the plan, the client's signature on the plan, or a description of the client's participation and agreement in the progress notes.			**NOTE:** Does the chart contain documentation of the beneficiary degree of participation and agreement with the plan? • Describe how the MHP defines "long-term beneficiary." • Is the beneficiary a long-term client beneficiary? • Is the beneficiary receiving more than one type of service? • Is there a beneficiary signature or documentation of why the signature could not be obtained and documented on the plan? • Is there reference to the beneficiary's participation and agreement in the body of the plan, beneficiary's signature on the plan or, is there a description of the beneficiary's participation and agreement in the progress notes?
• *CCR, title 9, sections 1840.314 and 1810.440(c)*				**OUT OF COMPLIANCE:** • NFP. • No client plan has been completed. • Requirements not met in a-c. • Writing that is illegible. • Absence of signature for e-f.
Documentation: (List document(s) reviewed that demonstrates compliance and provides specific explanation of reason(s) for in compliance or out of compliance.)				

SECTION J ***CHART REVIEW—NON-HOSPITAL SERVICES***

		IN COMPLIANCE		*INSTRUCTIONS TO REVIEWERS*
	CRITERIA	**Y**	**N**	**COMMENTS**
RE:	PROGRESS NOTES			
4. 4a.	Do progress notes document the following? The date services were provided.			**The following information applies to items a-e:**
4b.	Beneficiary encounters, including clinical decisions and interventions.			
4c.	A signature (or electronic equivalent) of the staff providing the service, with professional degree, license, or job title.			
4d.	Documentation that is legible.			

	CRITERIA	IN COMPLIANCE Y	N	*INSTRUCTIONS TO REVIEWERS* COMMENTS
4e.	Timeliness/frequency as following: 1) Every service contact for: A) Mental health services. B) Medication support services. C) Crisis intervention. 2) Daily for: A) Crisis residential. B) Crisis stabilization (one per 23/hour period). C) Day treatment intensive. 3) Weekly for: A) Day treatment intensive. B) Day rehabilitation. C) Adult residential. 4) Other notes as following: A) Psychiatric health facility services: each shift. B) Targeted case management: every service contact, daily, or weekly summary.			**NOTE:** Effective September 1, 2003, day treatment intensive weekly note must be signed by one of the following: - Physician - Licensed/Waivered Psychologist - Licensed/Registered Social Worker - Licensed/Registered Marriage and Family Therapist - Registered Nurse
• *CCR, title 9, section 1810.440(c)*		**OUT OF COMPLIANCE:** • NFP. • Progress notes within the review period do not contain these elements.		
Documentation: (List document(s) reviewed that demonstrates compliance and provides specific explanation of reason(s) for in compliance or out of compliance.)				

		IN COMPLIANCE		*INSTRUCTIONS TO REVIEWERS*
	CRITERIA	**Y**	**N**	**COMMENTS**
RE:	OTHER CHART DOCUMENTATION			
5.	Is there a process to notify the beneficiary that a copy of the client's plan is available upon request?			**NOTE:** Describe the procedure for obtaining the client's plan.
• *DMH Letter 02-01, Enclosure A*		**OUT OF COMPLIANCE:** • There is no evidence of a process in place.		
Documentation: (List document(s) reviewed that demonstrates compliance and provides specific explanation of reason(s) for in compliance or out of compliance.)				
6.	When applicable, was information provided to beneficiaries in an alternative format?			**NOTE:** When applicable, review evidence that beneficiaries were provided with information in an alternative format.
• *CFR, title 42, section 438.10(d)(2)* • *CCR, title 9, section 1810.410(a)* • *DMH Information Notice No. 97-06, D, 5*		**OUT OF COMPLIANCE:** • There is no evidence that beneficiaries were provided with information in an alternative format based on the MHP's IP or policy.		
Documentation: (List document(s) reviewed that demonstrates compliance and provides specific explanation of reason(s) for in compliance or out of compliance.)				

SECTION J CHART REVIEW—NON-HOSPITAL SERVICES

	CRITERIA	IN COMPLIANCE Y	N	*INSTRUCTIONS TO REVIEWERS* COMMENTS
7. 7a.	Regarding cultural/linguistic services: Is there any evidence that mental health interpreter services are offered?			**The following information applies to items a-c:** **NOTE:** Coordinate findings with DMH system review process. • Review CCPR and charts • If beneficiary is LEP, review for interpretive services offered. • Is there evidence beneficiaries are made aware of services available in their primary language? • When families provide interpreter services, is there documentation that other linguistic services were offered first, but the beneficiary preferred to provide a family interpreter?
7b.	When applicable, is there documentation of linking beneficiaries to culture-specific and/or linguistic services as described in the MHP's CCPR?			
7c.	Is service-related personal correspondence provided in the beneficiary's preferred language?			

• *CFR, title 42, section 438.10(c)(4),(5)* • *CCR, title 9, section 1810.410(a),(d)* • *DMH Information Notice No. 02-03, Enclosures, Pages 17-18 and DMH Information Notice No. 10-02, Enclosure, Page 22 and 23*	**OUT OF COMPLIANCE:** • No evidence of a-c.

Documentation: (List document(s) reviewed that demonstrates compliance and provides specific explanation of reason(s) for in compliance or out of compliance.)