To identify charts to be reviewed, randomly select clients from the "Active Clients by Program of Service". Before starting the review, run the [Client Ledger] to identify services for the review period, [Services Without a Progress Note] to identify if there are any services without a progress note for the client, and the [Services Under the Wrong Episode] to identify if there are any billable services to the wrong episode for the client.

Basic Information:

1. Date of Chart Review: Date the chart review is conducted
2. Type of Review: Identifies when the review is occurring for the client (newly active or upon). Charts should be reviewed when the initial tx plan is due or when the annual tx plan is coming due to ensure requirements are met before being due.
    a. For now: LEAVE BLANK until a report is developed to assist with this
    b. Select "Newly Active Client" for a client who is new to DMH (an LE00019 had to be created) or returning for services (client had been inactivated; there was a discharge progress note)
    c. Select "Annual Treatment Plan Month" for a client who has been in ongoing treatment and the annual treatment plan is coming due
3. Service Area: Service area for the program the review is conducted for
4. Program of Service: The program the review is conducted for
5. Client ID: Enter the client's IBHIS identification number
6. Client Name: Enter the LAST NAME, FIRST NAME of the client
7. Primary Contact: Identifies the primary contact for the program of service for which the review is being conducted; if none is listed, write "N/A" and establish one (if applicable)
    a. Run the **[Client Treatment Team]** report
8. Primary Program of Service: Identifies the Program of Service responsible for coordinating the care of the client; if none listed, write "N/A" and establish one (if applicable)
    a. Run the **[Active Clients by Program of Service] STATS** report
9. Review Period: Identify the period of services for which the chart will be reviewed
    a. For now: Enter THREE MONTHS prior to the review date
    b. For "Newly Active Client", the review period is the date of the first assessment contact to the date of the chart review (should be about 45 days)
    c. For "Annual Treamtent Plan Month", the review period is the three months prior to the Client Treatment Plan End Date
10. Date of Most Recent Billable Service: Identifies the most recent date of service anywhere in DMH
    a. Run the **[Client Ledger]** report

Client Access, Consents and Acknowledgements:

1. Is a Consent for Services on file? Identifies if a valid Consent for Services has been completed (Note: Be sure to also verify if the completed form has been logged)

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   a. Go to the **Chart View/Form View, select Client Consents/Acknowledgements** (be sure to review the Current tab and the History tab)
   b. Go to the **HIPAA Forms/Consents/Acknowledgements** folder under Documents in the Chart View and review the scanned images (Note: This is what determines the "yes" or "no")
2. Is an Advanced Health Care Directive Acknowledgment on file? (NA if client is under 18) Identifies if a valid Advanced Health Care Directive Acknowledgement has been completed (Note: Be sure to also verify if the completed form has been logged)
   a. Go to the **Chart View/Form View, select Client Consents/Acknowledgements** (be sure to review the Current tab and the History tab)
   b. Go to the **HIPAA Forms/Consents/Acknowledgements folder under Documents** in the Chart View and review the scanned images (Note: This is what determines the "yes" or "no")
3. Is a Beneficiary Acknowledgment on file? Identifies if the Medi-Cal Required Informing Materials Beneficiary Acknowledgement was completed which documents offering of the booklet and provider list (Note: Be sure to also verify if the completed form has been logged)
   a. Go to the **Chart View/Form View, select Client Consents/Acknowledgements** (be sure to review the Current tab and the History tab)
   b. Go to the **HIPAA Forms/Consents/Acknowledgements** folder under Documents in the Chart View and review the scanned images (Note: This is what determines the "yes" or "no")
4. Is an Acknowledgement of Receipt on file? Identifies if the Notice of Privacy Practices was provided to the client
   a. Go to the **Chart View/Form View, select Client Consents/Acknowledgements** (be sure to review the Current tab and the History tab)
   b. Go to the **HIPAA Forms/Consents/Acknowledgements** folder under Documents in the Chart View and review the scanned images (Note: This is what determines the "yes" or "no")
5. Does the client/collateral have a primary language other than English? Identifies the primary language of the client (and if applicable the collateral) and whether services should be provided in another language
   a. Go to the **Chart View/Form View, select Update Client Data** and review Primary Language. If it is not there, select **Admission (Outpatient)**
6. Does the client/collateral have any cultural considerations and/or special service needs (eg hearing, visual, transportation accommodations)?
   a. Go to the **Chart View/Form View, select Mental Health Triage** and review "Other Special Service Needs" or review the assessment for any cultural or special needs

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Assessment:

7. Is there a Full Assessment/Initial Assessment on file? For every client there must be a Full Assessment (if completed in IBHIS) or Full Assessment/Initial Assessment (if completed on paper)
    a. Go to the **Chart View/Form View, select Adult/Child Adolescent Full Assessment** or **Age 0-5 ICARE Full Assessment**.
    b. If not in IBHIS, check the paper chart
8. Has client returned for services after services were terminated? Identifies if mental health treatment within Directly Operated programs was terminated per policy 202.30
    a. Go to the **Chart View/Form View and select the Primary Program of Service**. Review both the Current and History tabs to see if the primary program of service was inactivated at any point.

8a. If yes, is there a Returning Client Assessment on file? Identifies if a re-assessment was done when the client returned for services after they were terminated
    a. Go to the **Chart View/Form View and select Child/Adult Assessment Addendum**. Check to see if there is an Assessment Type of “Returning Client Assessment”

9. Has client been in services for 3 continuous years since the last assessment? Identifies if an assessment has been done minimally every three years.
    a. Identify the “Date of First Assessment Contact” or “Date Addendum Started” (whichever is most recent) based on the review of a Full/Initial Assessment and a Returning Client Assessment and, if the client is still in treatment, determine if it is 3 years from that date

    9a. If yes, is there a Continuous Client Assessment on file?
    a. Go to the **Chart View/Form View and select Child/Adult Assessment Addendum**. Check to see if there is an Assessment Type of “Continuous Client (3 year) Assessment”

10. Are all sections of the most recent assessment complete based on the type of most recent assessment? Identifies if all assessment data elements were properly completed
    a. Review the most recent **Child/Adult Full Assessment or Child/Adult Assessment Addendum, Child/Adult Mental Status Exam, and Diagnosis from the Chart View/Form View** for the required elements on the last page of the Chart Review Tool
11. Is the Substance Use/Abuse Assessment complete, if indicated by the Full Assessment? Identifies if a substance use assessment was done
    a. Upon review of the Full Assessment, determine if the substance use/abuse assessment is required. If required, go to the **Chart View/Form View and select Child/Adult Substance Use/Abuse Assessment**.

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12. Is the current diagnosis supported by information in the Assessment? Utilizes clinical judgment to determine if the most recent diagnosis is supported by the symptoms, behaviors, impairments documented in an assessment.
13. Medical Necessity: Does the client have an included diagnosis? Identifies if services are eligible for Medi-Cal reimbursement based on diagnosis.
14. Medical Necessity: Are impairments in life functioning and their relationship to the client's mental health symptoms/ behaviors documented? Identifies if services are eligible for Medi-Cal reimbursement based off of documented impairments.

Consent for Medications:

15. Is the client being prescribed medications? Identifies if medications were prescribed.
    a. From the **Chart View, review the "Physician Prescribing Widget"** to determine which system medications would be prescribed in
    b. Go to the **Chart View/Form and select Medication Service Progress Note**. Review the three most recent medication notes to determine if meds were prescribed Note: May also, go to the **Meds/Labs/Vitals console, Medications History tab** and check to see if meds have been prescribed through OrderConnect

15a. If yes, is there a current Outpatient Medication Review on file?
    a. Go to the **Chart View/Form View and select Outpatient Medication Review**. If there is an Outpatient Medication Review on file for each medication prescribed.

Client Treatment Plan: For this section, go to the **Chart View/Form View and select DMH Client Treatment Plan**

16. If treatment services have been provided, is there a current/active Client Treatment Plan on file? Per policy 104.09, treatment services are any services that are NOT for the purpose of assessment, plan development, crisis intervention and, within the first 60 days, linkage to another mental health provider.
    a. Review the **[Client Ledger]** to determine if any treatment services have been provided (look for medication support services, therapy, rehab or TCM procedure codes). If no, leave blank and move on to the next question
    b. Go to the **Chart View/Form View and select DMH Client Treatment Plan**
17. Are the objectives in the Client Treatment Plan related to the symptoms/behaviors or impairments that are identified in the Assessment?
    a. Compare the **Objectives** to the information gathered from reviewing the assessment
18. Is there a SMART (specific, measureable, attainable, realistic, and time bound) objective associated with each type of service (e.g. MHS, TCM, MSS) provided or expected to be provided?
    a. Compare the types of services against the procedure codes from the **[Client Ledger]**

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19. Are there specific interventions and modality (e.g. individual therapy, group rehab) identified for the types of services checked?
    a. Review the **Interventions** to see if they have specific interventions

19a. Is the frequency of each type of service documented?
    a. Review the **Interventions** to see if they have an identified frequency

20. Is there an AMHD signature present for all objectives?
    a. Review the **Participation** to see if a staff member who is an AMHD is present
    b. Check to see if the staff submitting the treatment plan is an AMHD
    c. If the staff submitting the treatment plan is not an AMHD, check to see if the document was routed to a staff who is an AMHD

21. For medication support interventions related to prescriptions, is there an MD, DO, and/or NP signature present?
    a. Review to see if **Interventions** involve prescribing medications. If no, leave blank and move on to the next question
    b. Review the **Participation** to see if a staff member who is an MD, DO, NP is present
    c. Check to see if the staff submitting the treatment plan is an MD, DO, NP
    d. If the staff submitting the treatment plan is not an MD, DO, NP, check to see if the document was routed to a staff who is an MD, DO, NP

22. Has the client/representative signed the DMH Client Treatment Plan?
    a. Review the **Participation** to see if a client role is present
    b. Check to see if there is an electronic signature of the client or identification that a signature is on file

22a. If not, is there a documented reason for the lack of signature?

    a. If applicable, is there a justifiable reason listed that the client did not sign in the **Participation**

23. Was the client offered a copy of the DMH Client Treatment Plan?
    a. Review the **Participation** to see if the client was offered a copy of the plan

24. Was the Client Treatment Plan interpreted in the client's preferred language? (See #5 for preferred language)

Progress Notes: Run the **[Progress Notes Report (IBHIS)]** for the review period

25. Is there a Final Progress Note for each claimed service for the review period?
    a. Run the **[Services Without a Progress Note]** to determine if there are any missing notes

26. Was each service provided in the client/collateral's preferred language?
    a. Based on the response to #5, review progress notes to see what language the services were provided in

27. Was there documentation that any cultural considerations/special needs were addressed?

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   a. Based on the response to #6, review progress notes to see if any cultural/special needs were addressed. If the answer to #6 was no, leave this blank and move to the next question

28. Is the Procedure Code accurate for the service documented?
29. Are all data element fields appropriately completed? (e.g. date of service, program of service, face-to-face/other time, total duration)
30. Is there a staff intervention noted that is a Service Component for the type of service?
31. For treatment services, does the service relate back to the Client Treatment Plan?
32. For any service involving multiple staff, is the intervention of each staff identified?

Signature(s) of Reviewer(s)

1. Reviewer's Signature/Discipline/Title, Printed Name, Date
2. Reviewer's Signature/Discipline/Title, Printed Name, Date

Correction Action Plan (if applicable)

1. Reviewed CAP with Primary Contact/other responsible party:
2. Verified completed/resolved CAP:
3. Supervisor's Signature/Discipline/Title, Printed Name, Date
4. Comments

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