307.0 Peer, Supervisory and Administrative File Reviews

307.1 Policy Approval Clearance Record

☒ Rural Services Policy ☐ Mental Health Policy ☐ Developmental Services Policy	This policy supersedes: 5.1001 – Peer Reviews (MH)	Number of pages in Policy:
Review by Representative from the Office of the Attorney General: N/A	Date: N/A	Date Policy Effective: 01/01/2012
Rural Services Director Approval Signature: *Barbara Legier*	Date: 01/01/2012	Policy Lead: Barbara Legier

307.2 Statement of Purpose

307.2.1 **Policy Statement:** A peer, supervisory and administrative review process is necessary to evaluate the quality and compliance of the service delivery system.

307.2.2 **Purpose:** To provide a standardized process of review and analysis that will provide information to be utilized in program planning, evaluation and training to ensure compliance with agency standards.

307.3 Authority

NRS 435
NAC 435
Medicaid Waiver Chapter for MR (Ch. 2100)
Medicaid Waiver Chapter on Targeted Case Management (Ch. 2500)

307.4 Unique Definitions and Acronyms

307.4.1 **Quarter** means three months beginning on the state fiscal year:

July 1 – September 30
October 1 – December 31
January 1 – March 31
April 1 – June 30

307.5 Procedures

307.5.1 The peer review process encourages candid educational discussions in a confidential setting among colleagues in order to increase the quality of services provided to individuals served and facilitate compliance with agency standards. The supervisory and administrative review process establishes the opportunity to identify strategic planning ideas and compliance issues and determine training needs of subordinate staff with the goal of targeting planning processes, increasing compliance and addressing quality of services provided. Peer, Supervisory and Administrative File Reviews encompass six levels of analysis as follows:

A. **Peer, Supervisory and Administrative Reviews:** At the beginning of each fiscal year and dependent upon the results of the previous year's quality assurance annual reports, the team for the Management for the Administration of Rural Services (MARS) determines the need to target reviews by focusing on key questions in each review form or utilizes the entire form when conducting reviews. This permits the completion of reviews using the review form in part (targeted review) or in totality (total reviews). The number of reviews required in the following procedures is considered the minimum number of files designated for review. This requirement may be increased as determined by the Agency Director. The review process is as follows:

1. **Clinical Peer Reviews:** Clinical staff (psychologists, clinicians) will review open clinical records to evaluate compliance, the quality and therapeutic outcome of the services provided to the person served using attachment RSCL0307A, Clinical Services Peer Review Form. Reviews will be based upon applicable standards of care. Center Directors will coordinate and oversee the completion of reviews in offices in which there is only one clinician by coordinating with another center to conduct reviews. Reviewers will complete reviews of one clinical/file per month.

2. **Case Management Peer Reviews:** Developmental Specialist IIIs (DS III) and Psychiatric Caseworker IIs (PCW) will review open files to evaluate compliance, quality and efficacy of case management services provided to persons served using attachment RSDS0307B, Developmental Services Case Management Peer Review Form; and RSMH0307C, Mental Health Services Case Management Peer Review Form. Supervisors will coordinate and oversee the completion of reviews in offices in which there is only one DS III or PCW II by coordinating with another office/center to conduct reviews. Reviewers will complete reviews of one file per month.

3. **Nursing Services Peer Review**: RNs will review open files to evaluate compliance, quality and efficacy of nursing services provided to persons served using attachment; RSN0307D, QA Nursing Peer Review Form. The DON and nursing co-supervisor will coordinate and oversee the completion of reviews in offices in which there is only one RN by coordinating with another office/center to conduct reviews. Reviewers will complete reviews of one file per month.

4. **Supervisory Reviews:** Supervisors and managers [Center Directors, Lead Psychologist, Mental Health Counselor IIIs, Developmental Specialist IVs (DS IV)] will review open clinical records/client files to identify strategic planning ideas, compliance issues and determine training needs of subordinate staff with the goal of targeting planning processes, increasing compliance and addressing quality of services provided using attachment RSDS0307E, Developmental Services Supervisory Review Form or RSMH0307F, Mental Health Services Supervisory Review Form. Reviewers will review one file per staff person supervised (Mental Health Counselor II, Licensed Clinical Social Worker, DS III, Psychiatric Caseworker II) per quarter. Adjustments may be negotiated in larger centers when the supervisory span impacts the ability to review the designated number of files.

5. **Medical Staff Peer Review:** Designated contract medical staff will review open files to evaluate compliance, quality and efficacy of psychiatry services provided to persons served using attachment; RSMD0307G, Medical Staff Peer Review Form. The DON will oversee the completion of these reviews. Reviewers will complete reviews of one file per month, or in accordance with contract requirements.

6. **Administrative Reviews:** The Clinical Program Manager (CPM) II, Mental Health Services, shall review open client files to evaluate compliance, quality and therapeutic outcome of the services provided to the person served using attachment RSAD0307H, Administrative Mental Health Review Form. Reviewer will review one clinical record from every center per year. The CPM II, Developmental Services, shall review open files to evaluate compliance, quality and efficacy of the services provided to the person served using attachment RSDS0307J, Administrative Developmental Services Review Form. Reviewer will review two files per office per year.

B. Selection of Files for Review and Reporting Requirements

QA staff will conduct systematic sampling in which a randomly selected starting point is chosen, and every "nth" name is chosen. "Nth" will begin with the 3rd name on the list, and progress numerically as needed to reach the desired sample size for the review period for all reviews.

1. **Clinical Peer Reviews:** Quality assurance (QA) staff will identify files selected for peer review. Files reviewed must include an equal distribution of individuals in service less than 90 days and individuals in service more than 90 days Supervisors (CPM I or CPM II in the absence of a CPM I) and lead psychologist will assign clinical staff (psychologists, clinicians) to review files to evaluate compliance, quality and therapeutic outcome of the services provided to the person served. Identified files must be provided by QA staff to designated program staff in order to meet required timelines.

    - By the 5th working day of each month, the supervisor will assign each clinician one file to review. The review must be completed within 5 working days of assignment. A copy of the completed Clinical Peer Review Form must be emailed to the supervisor immediately upon completion. The clinical staff reviewing the file must meet with the clinical staff whose file was reviewed and discuss the results of the review within 5 working days of completion. The Clinical Peer Review Form must be signed by all parties, a copy provided to the clinical staff person and forwarded to the supervisor immediately for signatory approval. The supervisor will maintain a file of all completed review forms. The supervisor will compile the data from each review form and monitor the review process by completing the RSRT0307K, Review Tracking Form and submitting the document to Quality Assurance staff by the 15th working day of each quarter. The Quality Assurance staff will compile the data into quarterly and annual reports. The CPM II will use this report to identify mentoring, training and policy needs.
    - Upon completion of the review and discussion the clinician has 10 working days to make any identified corrections to the file, document the corrections made on the form, and submit the form to the supervisor.
    - The supervisor has 3 working days to verify that the corrections have been made and document this confirmation on the form
    - Review form documents may be requested by QA staff when conducting compliance audits.
    - Every three months, during regular supervisory meetings with the clinician, the supervisor will review one of the completed Peer Review Forms. The review discussion will be documented in the supervision file.

    Developmental Services (DS) Case Management Peer Review: QA staff will identify files selected for peer review, cross checking those files assigned for waiver review as noted on the FY "Waiver and Non-Waiver Service Review Schedule" to avoid duplication. Both waiver and non waiver files will be reviewed during the course of one year with a one to one ratio (waiver/non waiver) of reviews of each type conducted. DS IVs will assign DS IIIs under their supervision to review files of other DS IIIs to evaluate compliance, quality and efficacy of the services provided to the person

served. The QA DS III will also complete peer reviews as assigned by the QA III, following the procedures outlined below.

- By the 5th working day of each month, the supervisor will assign each DS III (II, I) one file to review. The review must be completed within 5 working days of assignment. A copy of the completed form must be emailed to the DSIV immediately upon completion. The DS III (II, I) reviewing the file must meet with the DS III whose file was reviewed and discuss the results of the review within 5 work days of completion. The form must be signed by all parties, a copy provided to the DS and forwarded to the DSIV immediately for signatory approval. The supervisor will maintain a file of all review forms. The supervisor will compile the data from each review form and monitor the review process by completing the RSRT0307K, Review Tracking Form and submitting the document to QA staff by the 15th work day of each quarter. The QA staff will compile the data into quarterly and annual reports. The CPM II will use this report to identify mentoring, training and policy needs.
- The DS IV will monitor the review process by completing the RSRT0307K, Review Tracking Form and submit this form to the QA Staff at the conclusion of each quarter for compilation and reporting. The CPM II will use this report to identify mentoring, training and policy needs.
- Upon completion of the review and discussion the Developmental Specialist has 10 working days to make any identified corrections to the file, document the corrections made on the Developmental Services Case Management Peer Review Form, and submit the form to the DS IV.
- The DS IV has 3 working days to confirm that the corrections have been made and document this confirmation on the Review Tracking Form. The tracking form will record aggregate data to be submitted to Rural Services QA staff for tracking and data trending purposes quarterly.
- Review form documents may be requested by QA staff when conducting compliance audits.
- Every three months, during regular supervisory meetings with the Developmental Specialist, the DS IV will review one of the completed Developmental Services Case Management Peer Review Forms. The review will be documented in the DS IV's supervision file.

2. **Case Management MH Peer Reviews:** QA staff will identify files selected for peer review. Supervisors will assign staff to review files to evaluate compliance, quality and efficacy of the services provided to the person served. The Clinical Program Planner (CPP) I will also complete peer reviews as assigned by the CPPII, following the procedures outlined below.

- By the 5th work day of each month, the supervisor will assign each PCW one file to review. The review must be completed within 5 working days of assignment. A copy of the completed form must be emailed to the supervisor immediately upon completion. The PCW reviewing the file must meet with the PCW whose file was reviewed and discuss the results of the review within 5 work days of completion. The form must be signed by all parties, a copy provided to the PCW and forwarded to the supervisor immediately for

signatory approval. The supervisor will maintain a file of all review forms. The Supervisor will monitor the review process by completing the RSRT0307K, Review Tracking Form and submit this form to QA Staff for reporting. The supervisor will compile the data from each review form and monitor the review process by completing the RSRT0307K, Review Tracking Form and submitting the document to QA staff by the 15th work day of each quarter. The QA staff will compile the data into quarterly and annual reports. The Clinical Program Manager (CPM) I and II will use this information to identify mentoring, training and policy needs.

- Upon completion of the review and discussion the PCW has 10 working days to make any identified corrections to the file, document the corrections made on the Mental Health Case Management Peer Review Form, and submit the form to the supervisor.
- The supervisor has 3 working days to confirm that the corrections have been made and document this confirmation on the Review Tracking Form. The tracking form will record aggregate data to be submitted to Rural Services QA staff for tracking and data trending purposes quarterly.
- Review form documents may be requested by QA staff when conducting compliance audits.
- Every three months, during regular supervisory meetings with the PCW, the supervisor will review one of the completed Developmental Services Case Management Peer Review Forms. The review will be documented in the supervision file.

3. **Nursing Peer Reviews:** QA staff will identify files selected for peer review. The Director of Nursing (DON) and nursing co-supervisor will assign nursing staff to review files to evaluate compliance, quality and efficacy of the nursing services provided to the person served.

    - By the 5th working day of each month, the DON and nursing co-supervisor will assign each RN one file to review. The review must be completed within 5 working days of assignment. A copy of the completed form, RSN0307C, QA Nursing Peer Review Form, must be emailed to the DON and nursing co-supervisor immediately upon completion. The RN reviewing the file must meet with the RN whose file was reviewed and discuss the results of the review within 5 working days of completion. The form must be signed by all parties, a copy provided to the RN and forwarded to the DON and nursing co-supervisor immediately for signatory approval. The onsite co-supervisor will maintain a file of all review forms. In the absence of an onsite co-supervisor, the DON will maintain a file of all review forms. The co-supervisor will submit the Review Tracking for to the DON and QA staff for monitoring and tracking purposes. The DON will monitor the review process when there is no onsite supervisor by completing the RSRT0307K, Review Tracking Form and submit this form to QA staff at the conclusion of each quarter. The DON and nursing co-supervisor will use this information to identify mentoring, training and policy needs.
    - Upon completion of the review and discussion the RN has 10 working days to make any identified corrections to the file, document the corrections made on the Nursing Peer File Review Form, and submit the form to the supervisor.

- The DON or co-supervisor has 3 working days to confirm that the corrections have been made and document this confirmation on the Nursing Review Tracking Form.
- Review form documents may be requested by QA staff when conducting compliance audits.
- Every three months, during regular supervisory meetings with the nurse, the DON or nursing co-supervisor will review one of the completed Peer Review Forms. The review will be documented in the DON's or nursing co-supervisor's supervision file.

4. **Medical Staff Peer Reviews:** QA staff will identify files selected for peer review. The DON will assign designated medical staff to review files to evaluate compliance, quality and efficacy of the psychiatry services provided to the person served.

    - By the 5th working day of each month, the Director of Nursing (DON) will provide the list of files to be reviewed to the identified medical staff so that one file per month can be reviewed. The reviewer must be complete form RSMD0307G, Medical Staff Peer Review Form, and email or submit the hard copy to the DON or nursing co-supervisor immediately upon completion. The reviewer or DON may meet with the medical staff whose file was reviewed and discuss the results of the review, as appropriate. The nursing co-supervisor has the responsibility for forwarding all review forms to the DON, who will maintain a file of all review forms. The DON will monitor the review process by completing the RSRT0307K, Review Tracking Form and submit this form to QA staff at the conclusion of each quarter. The DON will use this information to identify trends, training and policy needs.
    - If corrective action is needed, the DON will notify the medical staff via email of the corrections needed and follow up until corrections have been made. This confirmation will be entered into the Review Tracking Form.
    - The DON must maintain a copy of the completed form in their office upon verification of corrections. These documents may be requested by QA staff when conducting compliance audits.

5. **Supervisory Reviews:** QA staff will identify files selected for review. The CPP will assign supervisory staff to review MH files to identify strategic planning ideas and compliance issues and determine training needs of subordinate staff with the goal of targeting planning processes, increasing compliance and addressing quality of services provided. The QA III will assign supervisory staff to review DS files to identify strategic planning ideas and compliance issues and determine training needs of subordinate staff with the goal of targeting planning processes, increasing compliance and addressing quality of services provided.

    - Reviews must be made on open files only, all of which must have been in service for a minimum of 90 days. By the 5th working day of each month, the CPP/QA III will assign each supervisor one file to review. The review must be completed within 5 working days of assignment. A copy of the completed form must be emailed by the supervisor to the CPP/QA III for tracking and CPM II immediately upon completion. The CPP/QA III will maintain a file of all review forms. The supervisor reviewing the file must meet with the staff

person whose file was reviewed and discuss the results of the review within 5 working days of completion. The form must be signed by all parties including the supervisor, who will provide a copy to the staff person, CPP/QA and CPM II staff immediately. QA staff will monitor the review process by completing the RSRT0307K, Review Tracking Form and include these results in the quarterly report. The CPM II will use the report information for identification of mentoring, training and policy needs.

- Upon completion of the review and discussion, staff have 10 working days to make any identified corrections to the file, document the corrections made on the form, and submit the form to the supervisor.
- The supervisor has 3 working days to confirm that the corrections have been made and document this confirmation on the form.
- Every three months, during regular supervisory meetings with the staff person, the supervisor will review one of the completed Supervisory Review Forms. The review will be documented in the supervision file.

6. **Administrative Reviews:** QA staff will identify files selected for review. The CPP will assign the CPM II to review MH and DS files to identify strategic planning ideas and compliance issues and determine training needs of subordinate staff with the goal of targeting planning processes, increasing compliance and addressing quality of services provided.

- Reviews must be made on open files only, all of which must have been in service for a minimum of 90 days. By the 5th working day of each month, the CPP/QA III will assign each manager with files to review. MH files will be selected so that one clinical records from every center per year are reviewed and DS files will be selected so that two files per office per year are reviewed.
- The reviews must be completed within 5 working days of assignment. A copy of the completed form must be emailed to QA staff immediately upon completion. The manager reviewing the file must meet with the supervisor whose subordinate's file was reviewed and discuss the results of the review within 5 working days of completion. The form must be signed by all parties, including the manager. The supervisor will provide a copy to the staff person and the manager will provide a copy to QA staff immediately. The QA staff will monitor the review process by completing the RSMH0307L Review Tracking Form and submit this form to the Agency Director at the conclusion of each quarter.
- Upon completion of the review and discussion with the supervisor, any identified corrections to the file that must be made must occur within 10 working days. The CPM II must ensure the supervisor documents the corrections made on the form and submit the form to the CPP/QA III.
- The manager has 3 working days to confirm that the corrections have been made and document this confirmation on the form.
- Every three months, during MARS meetings, aggregate data will be presented by the CPPII to identify strategic planning goals related to compliance issues, training needs and quality of services provided.

7. **Use of Review Forms:** Supervisory staff may assign staff to conduct reviews using any review form as determined appropriate for the intended purpose.
8. **Annual Report:** QA staff will compile all review information into an annual report of aggregate data for presentation to MARS. The report will identify data trends, training needs and recommendations for policy development or revision for action by the MARS team.

307.5.2 Timelines

Table 307.5.1: Timelines for Peer, Supervisory and Administrative File Reviews

Requirement	Deadline	Starting Date	Responsible Party	Actions to be Taken
MARS Team reviews baseline quality assurance data to determine need for targeted reviews or totality reviews. 307.5 (A) QA staff will identify files selected for review for Clinical Peer Reviews, Case Management Peer Reviews, Nursing Peer Reviews, Medical Staff Peer Reviews, Supervisory Reviews, and Administrative Reviews. 307/5(B)(1-6)	Annual and quarterly Clinical Peer Reviews: By the 5th working day of each month. Case Management Peer Reviews: By the 5th working day of each month. Nursing Peer Reviews: By the 5th working day of each month. Medical Staff Peer Reviews: By the 5th working day of each month. Supervisory Reviews: By the 5th working day of the first month of each quarter. Administrative Reviews: By the 5th working day of the first month of each fiscal year.	First working day of each identified period.	MARS Team QAS III CPP II	Determine type of review. Select files for review and coordinate with designated staff to implement the review processes.
Clinical Peer Reviews will be organized by Center Director monthly. 307/5(A)(1)	By the 5th working day of each month.	Between the 1st and 5th of the month.	Center Director	Coordinate reviews with other centers where indicated.
Clinical Reviewers will complete one clinical review per month. 307/5(A)(1)	Last working day of each month.	Fifth working day of each month.	Reviewers	Review files using appropriate forms.
Case Management Peer reviews organized by the DS IVs monthly. 307/5(A)(2)	By the 5th working day of each month.	Between the 1st and 5th of the month.	DS IV; MH Supervisors	Coordinate reviews with other offices where indicated.
Case Management Reviewers will complete one peer review	Last working day	Fifth working day of each	Reviewers	Review files using

Requirement	Deadline	Starting Date	Responsible Party	Actions to be Taken
per month. 307/5(A)(2)	of each month.	month.		appropriate forms.
Nursing Peer Reviews organized by the DON and nursing co-supervisor monthly. 307/5(A)(2)	By the 5th working day of each month.	Between the 1st and 5th of the month.	DON and nursing co-supervisor	Coordinate reviews with other offices where indicated.
Nursing Reviewers will complete one peer review per month. 307.5(A)(2)	Last working day of each month.	Fifth working day of each month.	Reviewers	Review files using appropriate forms.
Medical Staff Peer Reviews organized by the DON monthly. 307.5.5	By the 5th working day of each month.	Between the 1st and 5th of the month.	DON	Ensure medical staff peer reviews occur.
Medical Staff Peer Reviewers will complete one peer review per month. 307.5.5	Last day of the contract period	Upon receipt	DON	Ensure medical staff peer reviews occur.
Supervisory Reviews will be coordinated by the CPM II. 307/5(A)(3)	By the 5th working day of the first month of each quarter.	Between the 1st and 5th of the first month of each quarter.	CPM II	Coordinate reviews with other centers/offices where indicated.
Supervisors will complete one review per staff person per quarter unless otherwise negotiated. 307/5(A)(3)	Last working day of each quarter.	Fifth working day of each quarter.	Reviewers	Review files using appropriate forms .
Administrative Reviews organized by QA staff. 307/5(A)(2)	By the 5th working day of the first month of each fiscal year.	Between the 1st and 5th of the first month of each fiscal year.	QAS III CPPII	Coordinate reviews with other centers/offices where indicated.
CPM II-MH will complete one review per center per year. 307/5(A)(4)	Last working day of each quarter.	First working day of each quarter.	Reviewers	Review files using appropriate forms.
CPM II-DS will complete two reviews per office per year. 307/5(A)(4)	Last working day of each year.	Fifth working day of each year.	Reviewers	Review files using appropriate forms and submit to the QA staff.
Clinical Peer Review forms, Case Management Peer forms, Nursing Peer Review forms, and Supervisory Review forms will be discussed with the designated staff person, forms completed and forwarded to the designated supervisor by all reviewers. 307/5(B)(1-6)	Immediately upon completion.	Within 5 days of completion of the review.	Reviewers	Discussion of findings and submission of paperwork.
Administrative Review forms will be discussed with the supervisor of the person whose file was reviewed and forms forwarded to QA for compilation. Discussion of Medical Staff Peer Reviews	Quarterly	Upon receipt of the form	DON CPM 2	Discussion of findings in MARS for identification of training and policy needs.

Requirement	Deadline	Starting Date	Responsible Party	Actions to be Taken
will occur between the reviewer or DON and medical staff as determined appropriate and forwarded to QA Staff for data compilation. These are reported on an aggregate basis to MARS. 307.5.5 307.5.4				
Upon completion of the Clinical Peer Review, Case Management Peer Review, Nursing Peer Review, Supervisory Reviews and discussion of the results with the staff person by the reviewer, all corrections must be made, documentation entered into the form, and form submitted to the monitoring supervisor. Administrative Reviews are discussed with the supervisor of staff person whose file was reviewed. Medical Staff Peer Reviews are discussed between the reviewer and the medical staff whose file was reviewed as determined appropriate by the reviewer or Director of nursing. 307/5(B)(1-6)	Correction, completion of the review form and submission of the document to supervision must be made within 10 working days of receipt.	Upon receipt of the form.	Reviewer	Action completed in response to review and feedback loop established.
Confirmation that corrections have been made is required. 307/5(B)(1-6)	3 working days	Upon receipt of the form	Supervisors, Managers, QA Staff	Completion of the appropriate sections of the tracking forms.
Monitoring of all review processes will be conducted by completing the review tracking forms for all review processes and forwarding the forms and monitoring documents to QA staff. 307/5(B)(1-6)	Monthly	Upon receipt	Supervisors, Managers, QA staff	Ensuring reviews are completed as required and documentation exists to monitor compliance. Development of annual aggregate data to MARS for review, identification of training and policy needs.
QA staff will compile the data from all review processes, trend data and write an annual quality assurance report. 307/5(B)(7)	September 1st, annually	Upon receipt	QA Staff	Completion of the feedback loop to the MARS Team

307.5.6 **Supervisory Responsibilities:** Supervisors will provide in-service training to ensure all staff understands the requirements of this policy and its procedures. Supervisors will revisit this policy periodically, but no less than annually to identify recommendations for improvement.

307.6 Policy Cross References

307.6.1 **MHDS 4.030 – Basic Documentation Guidelines for Medical Records**

307.6.2 **MHDS 4.038 – Person Centered Service Planning**

307.6.3 **MHDS 4.050 – Service Coordination in Developmental Services**

307.6.4 **MHDS 4.070 – Authorizations and Utilization for MRRC Waiver Services**

307.7 Attachments

307.7.1 RSCL0307A, Clinical Services Peer Review Form

307.7.2 RSDS0307B, Developmental Services Peer Review Form

307.7.3 RSMH0307C, Mental Health Case Management Peer Review Form

307.7.4 RSN0307D, QA Nursing Peer Review Form

307.7.5 RSDS0307E, Developmental Services Supervisory Review Form

307.7.6 RSMH0307H, Mental Health Supervisory Review Form

307.7.7 RSMD0307G, Medical Staff Peer Review Form

307.7.8 RSAD0307H, Administrative Mental Health Review Form

307.7.9 RSAD0307J, Administrative Developmental Services Review Form

307.7.10 RSRT0307K, Review Tracking Form

ATTACHMENT 307.7.1
RSCL0307A
CLINICAL SERVICES PEER REVIEW FORM

CLINICAL SERVICES PEER REVIEW FORM: TOTAL ☐ TARGETED ☐

Client Name:	Clinician Name:
Date of Review:	Client Number:
Reviewer Name:	Date Entered Service:

ASSESSMENT	YES	NO	N/A
1. Is the Intake Assessment present?	☐	☐	
2. Is the Intake Assessment complete and useful?	☐	☐	
3. Does the Intake assessment support diagnoses and functional impairments?	☐	☐	
4. Does case formulation demonstrate justification for the diagnoses and level of care 5. recommendation?	☐	☐	
6. In case formulation, is the SMI/SED determination justified as to the functional impairments specified?	☐	☐	
PROGRESS NOTES	YES	NO	N/A
7. Are notes organized appropriately in DAP format?	☐	☐	
8. Do notes reflect interventions as specified on the treatment plan?	☐	☐	
9. Does the GAF accurately reflect the clinical presentation?	☐	☐	
10. Is suicidal or homicidal ideation assessed and documented?	☐	☐	
11. Are efforts to contact the client reflected in the notes when no-shows occur?	☐	☐	
12. Are consultations and/or referrals to outside providers documented?	☐	☐	☐
13. Do the notes specify adequate plans relevant to progress and barriers?	☐	☐	
TREATMENT HISTORY	YES	NO	N/A
14. Is the frequency of treatment adequate?	☐	☐	
15. Is the course of treatment following the plan that was developed?	☐	☐	
16. Do services provided have a corresponding note?	☐	☐	
17. If a collaboratively served individual, is there information present summarizing developmental services needs in a note?	☐	☐	☐
18. If a collaboratively served individual, is there evidence of collaboration with developmental services staff in note(s)?	☐	☐	☐
TREATMENT PLAN	YES	NO	N/A
19. Was the treatment plan timely written?	☐	☐	
20. Does the treatment plan address high risk problems form Intake/Screening or dimension ratings of “3” or higher on the LOCUS/CASII?	☐	☐	
21. If a collaboratively served individual, does the treatment plan address developmental services needs?	☐	☐	☐
22. Are goals and objectives clinically appropriate?	☐	☐	☐
23. Are goals and objectives measureable?	☐	☐	☐
24. Are goals and objectives time specific?	☐	☐	☐
25. Are goals and objectives attainable?	☐	☐	☐
26. Are interventions reflective of an identifiable, accepted professional modality?	☐	☐	☐
27. If receiving rehabilitation services, do the goals address specific behaviors?	☐	☐	☐
28. If receiving rehabilitation services, are the goals progressive in nature?	☐	☐	☐
29. Is there evidence of useful discharge criteria specified at treatment planning sessions?	☐	☐	☐

CHART REVIEW	YES	NO	N/A
30. Diagnosis present, complete, and supported by information from the review:	☐	☐	
31. LOCUS/CASII complete and timely?	☐	☐	
32. LOCUS/CASII ratings correlate with information from Intake and progress notes?	☐	☐	
33. Makes appropriate program referrals?	☐	☐	
34. Appropriate documentation is present for other episodes such as service coordination, medication clinic, etc.	☐	☐	
OVERALL REVIEW	YES	NO	N/A
35. Documentation provides enough information for another clinician to assume the case with adequate knowledge of the client?	☐	☐	
36. Is there continuity between intake, treatment planning and progress note documentation?	☐	☐	
37. Services appear to be provided in accordance with Agency and Division Policy, and applicable professional regulations?	☐	☐	
38. Course of treatment is appropriate?	☐	☐	
39. Course of treatment reflects evidence-based or widely accepted professional practice?	☐	☐	
COMPLIANCE FORM REVIEW	☐	☐	
40. Is financial information present?	☐	☐	
41. Is the confidentiality statement present and signed by both client and clinician?	☐	☐	
42. Is the confidentiality statement up to date?	☐	☐	

REVIEWER COMMENTS AND FOLLOW UP ACTION PLAN
What action needs to be taken?
Who will do it?
What is the timeline for completing the action needed?
Who will follow up to see that the action has been completed?
Quality Comments
Overall case documentation clearly included rationale for key decision points and gave the reader an understanding of the level of challenge the case circumstances presented:
Key decision points were thoughtfully assessed and based upon sound reasoning:
Proactive clinical decision making resulted in the minimization of crises:
Therapeutic response to treatment is a direct result of the clinical skills and their delivery:
Other:

I have reviewed the findings, comments and action plan for correction of identified areas noted above:

Clinician Signature:_____ Date:_____

Peer Signature: _____ Date:_____

Supervisor Signature:_____ Date:_____

ACTION PLAN FOLLOW UP
Date Corrections were made to file:
Person reviewing corrections:
Other follow-up needed:
Date Follow-up due:

ATTACHMENT 307.7.2
RSDS0307B
DEVELOPMENTAL SERVICES
PEER REVIEW FORM

DEVELOPMENTAL SERVICES PEER REVIEW FORM **TOTAL** ☐ **TARGETED** ☐

Darkened boxes indicate an inappropriate response for the question.

Individual:	Service Coordinator:
Date of Record Review:	Supervisor:
Reviewer:	

Funding Program: ☐ Waiver ☐ Title XX ☐ TANF ☐ TCM	YES	NO	N/A
Identity			
1. Is ISP current (within year/including signature page)	☐	☐	
2. Goals are identified & teaching plans present to address specific, measurable objectives.	☐	☐	
3. All risks were identified.	☐	☐	☐
4. Health, safety and welfare are addressed in the ISP.	☐	☐	
5. Medications and their side effects are addressed.	☐	☐	☐
6. Back up plans are in place for emergency situations.	☐	☐	☐
7. Referrals to clinical services were completed when necessary.	☐	☐	
8. ELCID information is up-to-date.	☐	☐	

Attainment	YES	NO	N/A
9. Data to support progress with ISP is documented.	☐	☐	
10. Current Level of Care in file.	☐	☐	☐
11. Current and annual statement of choice in file.	☐	☐	☐
12. Quarterly contacts are documented. (face to face for Waiver)	☐	☐	
13. Monthly contacts are documented and address person's condition, satisfaction, changes needed, and goals. (Number of contacts divided by months reviewed=)	☐	☐	☐
14. Environmental Checklist is completed within last year.	☐	☐	☐
15. SLA contracts are current & representative of the ISP. (signed by guardian if applicable)	☐	☐	☐
16. CTC contracts are current & representative of the ISP. (signed by guardian if applicable)	☐	☐	☐
17. FPP documentation is on file and up to date.	☐	☐	☐

Rights	YES	NO	N/A
18. There is identification/assessment of and discussion of right restrictions.	☐	☐	
19. There is evidence of due process (HRC/BIC review).	☐	☐	☐
20. Notice of Privacy Practices (HIPPA) form has been completed and is on file.	☐	☐	

Autonomy	YES	NO	N/A
21. There is a current psychological assessment on file.	☐	☐	☐
22. If not, it has been waived & rationale documented.	☐	☐	☐
23. There is an annual, current social update on file.	☐	☐	
24. Unusual disclosure form is located in file.	☐	☐	

DS PEER CHART REVIEW FORM (cont.)

Medical	YES	NO	N/A
25. Current Annual Physical is on file.	☐	☐	☐
26. If not, it has been waived & rationale documented.	☐	☐	☐
27. Current Annual nursing assessment on file.	☐	☐	☐
28. If not, it has been waived & rationale for documented.	☐	☐	☐
29. Are any other medical issues documented and addressed?	☐	☐	☐
30. If Nursing services are required there is evidence of service request being made to agency providing State Plan nursing services.	☐	☐	☐

Fiscal	YES	NO	N/A
31. Two months of billing summaries and invoices were sampled and evaluated using the fiscal audit form. Hours on summary were added up, and match the hours approved by the SC for payment. Months reviewed	☐	☐	
32. If summary does not match amount approved by SC for payment, what month(s) did errors occur?			☐
33. Monthly SLA billing shows evidence of service coordinator review/approval. (SLA billing checklist)	☐	☐	☐
34. Provider case management notes reflect monthly home visits to assess for health and safety issues.	☐	☐	☐
35. Monthly SLA billing includes documentation from direct support staff.	☐	☐	☐

Comments
1. What action needs to be done? 2. Who will do it? 3. Timeline for getting it done.
Action Plan

I have reviewed the findings, comments and action plan for correction of issues noted above:

Service Coordinator Signature:_____ Date:_____

Peer Signature: _____ Date:_____

Supervisor Signature:_____ Date:_____

Quality Comments
Overall case documentation clearly included rationale for key decision points and gave the reader an understanding of the level of challenge the case circumstances presented:
Key decision points were thoughtfully assessed and based upon sound reasoning:
The treatment plan goals and objectives were well thought out, comprehensive, and achievable:
Creativity was evident with the identification of and referral to community resources:
Follow up on service coordination activities was thorough, timely and documentation included key information to understand the status of referred services:
Follow Up
Date Corrections were made to file:
Person reviewing corrections:
Other follow-up needed:
Date Follow-up due:

ATTACHMENT 307.7.3
RSMH0307C
MENTAL HEALTH CASE MANAGEMENT
PEER REVIEW FORM

Mental Health Case Management Peer Review Form TOTAL ☐ TARGETED ☐

Reviewer:	Site:	Date:
Last Name & Record #:	**Age/DOB:**	**Date Entered Service:**

Criteria for admission (Medicaid 2502.7 & Division policy #3.002)			
1. Documentation that the individual needs assistance in gaining access to medical, social, education, & other support services, including housing & transportation.	YES	NO	N/A
Comments:			
2. Documentation of needs is initially noted by QMHP and further assessed by Service Coordinator & services are planned. **NOTE:** This does not include rehabilitation.	YES	NO	N/A
Comments:			
Services meet criteria (Medicaid 2502.10 & Division policy #3.002)			
3. A thorough assessment of service needs was completed.	YES	NO	N/A
Comments:			
4. Planning meetings occurred with the client's input and involvement that addressed client's expressed needs.	YES	NO	N/A
Comments:			
5. Referrals were appropriately made to meet service needs.	YES	NO	N/A
Comments			
6. Monitoring and follow up was conducted as necessary to provide mediation and advocacy of services needed.	YES	NO	N/A
Comments:			
7. When coordination with other SCs is needed, this collaboration is evident.	YES	NO	N/A
Comments:			
8. Services being provided in accordance with needs & ongoing assessments denote need for services at level being provided.	YES	NO	N/A
Comments:			
Appropriate SC documentation			
9. Notes are in accordance with DAP format.	YES	NO	N/A
Comments:			

10. Notes clearly contain content of services provided.	YES	NO	N/A
Comment:			
11. Notes clearly identify status towards completion of planned goals.	YES	NO	N/A
Comments:			
12. Progress notes are signed and dated. (Incidental (non-billable) notes do not need to be in DAP format).	YES	NO	N/A
Comments:			
13. Rehabilitative services are not documented as Service Coordination.	YES	NO	N/A
Comments:			
Continuing Stay Criteria (Medicaid 2503.1A & Division policy #3.00/#4.035)			
14. The treatment/service plan indicates all service needs of person. Discharge/exclusionary criteria must be documented in the file.	YES	NO	N/A
Comments:			
15. Ongoing monitoring notes indicate person continues to meet admission criteria.	YES	NO	N/A
Comments:			
16. 90 day plan review indicates the person continues to meet admission criteria.	YES	NO	N/A
Comments:			
17. Discharge planning is evident.	YES	NO	N/A
Comments:			
18. Discharge/exclusionary criteria is documented in the file.	YES	NO	N/A
Comments:			
Comments			
1. What action needs to be done? 2. Who will do it? 3. Timeline for getting it done.			
Action Plan			

I have reviewed the findings, comments and action plan for correction of issues noted above:	
Service Coordinator Signature:	Date:
Peer Reviewer Signature:	Date:
Supervisor Signature:	Date:

Quality Comments
Overall case documentation clearly included rationale for key decision points and gave the reader an understanding of the level of challenge the case circumstances presented:
Key decision points were thoughtfully assessed and based upon sound reasoning:
The treatment plan goals and objectives were well thought out, comprehensive, and achievable:
Creativity was evident with the identification of and referral to community resources:
Follow up on service coordination activities was thorough, timely and documentation included key information to understand the status of referred services:

Follow Up
Date Corrections were made to file:
Person reviewing corrections:
Other follow-up needed:
Date Follow-up due:

ATTACHMENT 307.7.4
RSN0307D
QA NURSING
PEER REVIEW FORM

QA NURSING PEER REVIEW FORM TOTAL ☐ TARGETED ☐

Name of RN:	Reviewer name:	Date:
Client name:	Client #:	Date entered service:

ASSESSMENT SECTION		
1. Scheduling in AVATAR at intake	☐ YES ☐ NO ☐ NA	Clarification:
2. Nursing Assessment done at intake and annually/complete and useful per policy #1103	☐ YES ☐ NO ☐ NA	Clarification:
3. Health Review done every 90 days	☐ YES ☐ NO ☐ NA	Clarification:
4. LOCUS/ CASSI complete and timely (at admission and every 90 days)	☐ YES ☐ NO ☐ NA	Clarification:
5. Progress Notes done at each contact (DAP Format)	☐ YES ☐ NO ☐ NA	Clarification:
6. AIMS done every 6 months	☐ YES ☐ NO ☐ NA	Clarification:
7. Treatment Plan (Med Clinic only) initial and review/update signatures every 90 days	☐ YES ☐ NO ☐ NA	Clarification:
8. Treatment Plan Notation by center	☐ YES ☐ NO ☐ NA	Clarification:
9. Treatment Plan (Not Med Clinic only)(Medication Maintenance section)	☐ YES ☐ NO ☐ NA	Clarification:
10. Medication Assessment upon arrival and updated PRN/ then annual	☐ YES ☐ NO ☐ NA	Clarification:
11. Child, Adolescent, Young Adult, (to age 24) Follow up documented per policy #3.2005	☐ YES ☐ NO ☐ NA	Clarification:
11A. Once a week for the first four (4) weeks	☐ YES ☐ NO ☐ NA	Clarification:
11B. Every two (2) weeks for the next (4) weeks	☐ YES ☐ NO ☐ NA	Clarification:

11C. After taking the anti antidepressant for twelve (12) weeks	☐ YES ☐ NO ☐ NA	Clarification:
11D. After Twelve (12) weeks follow your healthcare provider's advice about how often to come back or whether they should come more often if problems or questions arise	☐ YES ☐ NO ☐ NA	Clarification:
12. Suicidal or Homicidal ideation is assessed & documented	☐ YES ☐ NO ☐ NA	Clarification:
13. Notes indicate communication with client when no-show/missed appointments occur	☐ YES ☐ NO ☐ NA	Clarification:
14. Consultation and/or referrals to other providers is documented	☐ YES ☐ NO ☐ NA	Clarification:
15. Notes specify adequate plans relevant to progress and barriers	☐ YES ☐ NO ☐ NA	Clarification:
GOALS/OBJECTIVES/INTERVENTIONS(G,O,I) SECTION		
16. G,O,I address specific behaviors or skills problems related to rehab & are evolutionary/progressive in nature	☐ YES ☐ NO ☐ NA	Clarification:
LEVEL OF CARE SECTION		
17. LOCUS/CASII ratings correlate with information from Intake and Progress Notes	☐ YES ☐ NO ☐ NA	Clarification:
18. Based on Intensity of Needs, appropriate program referrals are made (e.g., rehab, SC/CM)	☐ YES ☐ NO ☐ NA	Clarification:
OVERALL		
19. Documentation provides information for another clinician to assume the case	☐ YES ☐ NO ☐ NA	Clarification:
20. Continuity exists between Intake, Treatment Plan and Progress Notes	☐ YES ☐ NO ☐ NA	Clarification:
21. Services are provided in accordance with Agency/Division policy, state law, and applicable professional regulations	☐ YES ☐ NO ☐ NA	Clarification:
22. Course of treatment appropriate; reflects evidence-based or widely accepted professional practice	☐ YES ☐ NO ☐ NA	Clarification:

23. Financial Information completed initially & updated annually or when a change could impact service provision	☐ YES ☐ NO ☐ NA	Clarification:
24. Confidentiality and privacy forms are signed by both client and clinician initially and annually	☐ YES ☐ NO ☐ NA	Clarification:
25. Authorization for services form signed and up-to-date	☐ YES ☐ NO ☐ NA	Clarification:

Quality Comments
Overall case documentation clearly included rationale for key decision points and gave the reader an understanding of the level of challenge the case circumstances presented:
Key decision points were thoughtfully assessed and based upon sound reasoning:
The Medication Clinic treatment plan goals and objectives were well thought out, comprehensive, and achievable:
Proactive approach to medical health needs of the client were well thought out, clearly communicated to the client and resulted in strategic follow up:
Follow up on Medication Clinic nursing coordination was thorough, timely and documentation included key information to understand the status of coordinated or referred services (labs, pharmacy, PCP, etc.):
RESPONSE BY RN:
RN signature/date:
REVIEW BY SUPERVISOR:
I have reviewed any proposed corrections with the RN.
Supervisor Signature/date:

ATTACHMENT 307.7.5
RSDS0307E
DEVELOPMENTAL SERVICES SUPERVISORY REVIEW FORM

DEVELOPMENTAL SERVICES SUPERVISORY REVIEW FORM TOTAL ☐ ☐
TARGETED

Individual:	Service Coordinator:
Date of Record Review:	Supervisor:
Reviewer:	ID#:

Identity	YES	NO	N/A
1. The ISP is current, thorough and appropriately signed.	☐	☐	
2. Goals are identified, reasonable, and achievable & teaching plans are present to address specific, measurable objectives.	☐	☐	
3. Risks were identified. If refusing services risks associated with service refusal were discussed with the client and appropriately documented.	☐	☐	☐
4. Health, safety and welfare are adequately addressed in the ISP.	☐	☐	
5. An assessment of ability to self administer medications was completed and side effects addressed.	☐	☐	☐
6. Emergency back up plans are thorough.	☐	☐	☐
7. Consultation and referrals to clinical services are appropriate, ongoing, as necessary and clearly articulated.	☐	☐	

Attainment	YES	NO	N/A
8. Data to support ISP progress has been analyzed by the DS III and action taken as appropriate.	☐	☐	☐
9. Level of care is appropriate.	☐	☐	☐
10. Documentation regarding choice is evident in file.	☐	☐	☐
11. Quarterly contacts are concisely documented, include required information and reflect quality interaction with the individual.	☐	☐	
12. Monthly contacts are concisely documented, include required information and reflect quality interaction with the individual, guardian or provider, as appropriate.	☐	☐	☐
13. Environmental Checklist has been completed accurately and thoroughly.	☐	☐	☐
14. SLA contracts are appropriately written to address health and safety needs, clear and concise, (no guesswork is required to understand the document), representative of the ISP and contain appropriate signatures.	☐	☐	☐
15. SLA contracts are submitted timely.			
16. JDT contracts are appropriately written to address health and safety needs, clear and concise, representative of the ISP and contain appropriate signatures.	☐	☐	☐
17. JDT contracts are submitted timely.	☐	☐	☐
Rights	YES	NO	N/A
18. There is clear, concise identification, assessment of and discussion of rights restrictions.	☐	☐	
19. There is evidence of due process (HRC/BIC review).	☐	☐	☐
20. There is evidence of coordination between the provider and the DSIII regarding BIC and HRC reviews, information gathering and response to the committees.	☐	☐	

Autonomy	YES	NO	N/A
21. There is evidence that the psychological assessment has been reviewed and recommendations acted upon.	☐	☐	☐
22. If there is no current psychological evaluation, it has been waived & rationale clearly and concisely documented.	☐	☐	☐
23. The social assessment is thorough, concise and updated as required.	☐	☐	
24. The ISP reflects social assessment information.	☐	☐	
25. There is an assessment of ADL capability clearly and concisely documented.	☐	☐	
Medical	YES	NO	N/A
26. Current Annual Physical is on file and evidence exists that recommendations have been acted upon.	☐	☐	☐
27. If no annual physical is on file, and it has been waived, the rationale documented makes sense.	☐	☐	☐
28. Current Annual nursing assessment on file and evidence exists that recommendations have been acted upon.	☐	☐	☐
29. If no annual nursing assessment is on file, and it has been waived, the rationale documented makes sense.	☐	☐	☐
30. Are any other medical issues documented and addressed?	☐	☐	☐
31. When nursing services are required there is evidence of a service request being made.	☐	☐	☐
Fiscal	YES	NO	N/A
32. There is evidence in the file that demonstrates DS III audits of all SLA and JDT provider billings and corrective action taken to ensure appropriate billing has occurred.	☐	☐	☐
Provider Contact	YES	NO	N/A
33. There is evidence in the file that demonstrates collaboration with the provider is ongoing and appropriate.	☐	☐	☐
34. There is evidence in the file that demonstrates provider participation in support team meetings.	☐	☐	☐
Support Team Meetings	YES	NO	N/A
35. Team meetings are regularly held utilizing a formal agenda that is outcome driven.	☐	☐	
36. Team meetings consist of appropriate participants.	☐	☐	
37. Team meeting decisions are evident and acted upon.	☐	☐	

Quality Comments

Overall case documentation clearly included rationale for key decision points and gave the reader an understanding of the level of challenge the case circumstances presented:

Key decision points were thoughtfully assessed and based upon sound reasoning:

The treatment plan goals and objectives were well thought out, comprehensive, and achievable:

Creativity was evident with the identification of and referral to community resources:
Follow up on service coordination activities was thorough, timely and documentation included key information to understand the status of referred services:

Action:
1. What action needs to be done? 2. Who will do it? 3. Timeline for getting it done.
Action Plan

I have reviewed the findings, comments and action plan for correction of issues noted above:

Service Coordinator Signature:_____ Date:_____

Peer Signature: _____ Date:_____

Supervisor Signature:_____ Date:_____

Follow Up
Date Corrections were made to file:
Person reviewing corrections:
Other follow-up needed:
Date Follow-up due:

ATTACHMENT 307.7.6
RSMH0307F
MENTAL HEALTH
SUPERVISORY REVIEW FORM

MENTAL HEALTH SUPERVISORY REVIEW FORM TOTAL ☐ TARGETED ☐

Clinician name:	Reviewer name:	Date:
Client name:	Client #:	Date entered service:

ASSESSMENT SECTION		
1. The Assessment is present, complete & useful	☐ YES ☐ NO	Clarification:
2. The Assessment supports diagnoses & functional impairments	☐ YES ☐ NO	Clarification:
3. The case formulation provides justification for the diagnoses and level of care recommendations	☐ YES ☐ NO	Clarification:
4. If a collaboratively served individual (CSI), evidence exists demonstrating coordination of service provision between Developmental Services (DS) and Mental Health (MH.	☐ YES ☐ NO	Clarification:
5. SMI/SED determination justifies the functional impairments within the case formulation	☐ YES ☐ NO	Clarification:
6. Are past and current risk factors addressed?	☐ YES ☐ NO	Clarification:
7. Diagnosis present, complete, and supported by information from the review	☐ YES ☐ NO	Clarification:
PROGRESS NOTES SECTION		
8. Notes are in DAP format & organized appropriately	☐ YES ☐ NO	Clarification:
9. Notes reflect interventions as specified on the treatment plan	☐ YES ☐ NO	Clarification:
10. GAF is congruent with current clinical presentation.	☐ YES ☐ NO	Clarification:
11. Suicidal or Homicidal ideation is assessed & documented	☐ YES ☐ NO	Clarification:

12. Notes indicate communication with client when no-show/missed appointments occur	☐ YES ☐ NO	Clarification:
13. Consultation and/or referrals to other providers is documented	☐ YES ☐ NO	Clarification:
14. Progress toward goals and objectives are reflected in the notes.	☐ YES ☐ NO	Clarification:
15. If high risk, coordination of care is documented.	☐ YES ☐ NO	Clarification:
TREATMENT HISTORY SECTION		
16. The frequency of treatment is adequate – amount, scope, and duration is identified for each service.	☐ YES ☐ NO	Clarification:
17. The course of treatment follows the plan as formulated	☐ YES ☐ NO	Clarification:
18. Services provided have corresponding notes	☐ YES ☐ NO	Clarification:
19. Treatment Plans completed timely (initially 30-45 days & every 90 days thereafter)	☐ YES ☐ NO	Clarification:
20. Treatment plan addresses high risk problems from intake/screening & dimension ratings of "3" or higher on the LOCUS/CASII	☐ YES ☐ NO	Clarification:
21. If a CSI, treatment plan reflects DS service needs.	☐ YES ☐ NO	Clarification:
22. If a CSI, evidence exists demonstrating participation in team and support meetings by both MH and DS staff.	☐ YES ☐ NO	Clarification:
GOALS/OBJECTIVES/INTERVENTIONS(G,O,I) SECTION		
23. G,O,I are clinically appropriate (e.g., MDT involvement where indicated, standard of care services)	☐ YES ☐ NO	Clarification:
24. G,O are measurable, attainable, and time specific	☐ YES ☒ NO	Clarification:.

25. I reflect an identifiable, accepted professional modality	☐ YES ☐ NO	Clarification:
26. G,O,I address specific behaviors or skills problems.	☐ YES ☐ NO	Clarification:
27. G,O,I specify meaningful/useful discharge criteria	☐ YES ☐ NO	Clarification:
28. Are strengths adequately identified?	☐ YES ☐ NO	Clarification:
LEVEL OF CARE SECTION		
29. SMI/SED determination within the last year and appropriate	☐ YES ☐ NO	Clarification:
30. LOCUS/CASII complete and timely (at admission & every 90 days)	☐ YES ☐ NO	Clarification:
31. LOCUS/CASII ratings correlate with information from Intake and Progress Notes	☐ YES ☐ NO	Clarification:
32. Based on Intensity of Needs, appropriate program referrals are made (e.g., rehab, SC/CM)	☐ YES ☐ NO	Clarification:
OVERALL		
33. Is the chart clinically comprehensive and assumable by another clinician?	☐ YES ☐ NO	Clarification:
34. Documentation exists for other episodes (e.g., SC/CM, rehab, Med Clinic, etc.)	☐ YES ☐ NO	Clarification:
35. Continuity exists between Intake, Treatment Plan and Progress Notes	☐ YES ☐ NO	Clarification:
36. Services are provided in accordance with Agency/Division policy, state law, and applicable professional standards of practice.	☐ YES ☐ NO	Clarification:
37. Course of treatment appropriate; reflects evidence-based and/or widely accepted professional practice	☐ YES ☐ NO	Clarification:
38. Financial Information completed initially & updated annually or when a change could impact service provision	☐ YES ☐ NO	Clarification:

39. Confidentiality and privacy forms are signed by both client and clinician initially and annually	☐ YES ☐ NO	Clarification:
40. Authorization and consent for treatment present	☐ YES ☐ NO	Clarification:

Qualitative Comments
Overall case documentation clearly included rationale for key decision points and gave the reader an understanding of the level of challenge the case circumstances presented:
Key decision points were thoughtfully assessed and based upon sound reasoning:
Proactive clinical decision making resulted in the minimization of crises:
Therapeutic response to treatment is a direct result of the clinical skills and their delivery:
Other:
Clinician signature/date:
REVIEW BY CLINICAL SUPERVISOR:
I have reviewed any proposed corrections with the clinician.

ATTACHMENT 307.7.7
RSMD03097G
MEDICAL STAFF
PEER REVIEW FORM

RURAL SERVICES MENTAL HEALTH

Medical Staff Peer Review (AVATAR only) TOTAL ☐ TARGETED ☐

Chart No:_____Admit Date:_____Discharge Date:_____Attending: Dr.:_____

	PSYCHIATRIC INTAKE	**YES**	**NO**	**NA**
1	Intake Assessment contains criteria to justify primary diagnosis and planned treatment			
2	Information on Assessments tabs is adequate and clinically useful			
3	Mental status exam includes descriptions of the client's presentation during examination that is relevant to the diagnosis and planned treatment			
4	Presence or absence of Tardive Dyskenisia is documented for clients with past or current neuroleptic medication use			
5	Lab tests are ordered and clinically relevant			
	PROGRESS NOTES	**YES**	**NO**	**NA**
6	Progress notes do not contain un-approved abbreviations			
7	There is a progress note every at a minimum of 90 days			
8	Progress notes describe what has happened to the client since the last visit			
9	The psychiatrist assesses risk (e.g., suicidal, homicidal, self-harm, etc.) within each progress note			
10	Psychiatric diagnoses listed on each progress note			
11	Medication regime consistent with current psychiatric diagnosis			
12	Current psych meds listed on each progress note			
13	If medication exceeds standard dosing levels, the psychiatrist documents adequately			
14	Medication side effects are adequately documented and addressed, and include statement of "denies TD, EPS or akathisia" (for patients on anti-psychotics).			
15	Progress notes describe whether medications effective in reducing signs & symptoms or, if not effective, medications changed/explanation given			
16	If lab tests were ordered progress notes provide evidence that labs were used in treatment planning			
17	Evidence of medical follow-up as necessary or evidence that the client was referred for medical follow-up			
18	Discharge progress note includes discharge diagnoses, medications and/or notation of client referral to another psychiatrist or clinic after discharge			
19	Progress notes contain appropriate electronic signature and credential information			

Additional Comments:_____

_____

_____

_____

_____ _____

Reviewing Psychiatrist Signature **Date**

Approved: 01/01/2012

ATTACHMENT 307.7.8
RSAD0307H
ADMINISTRATIVE MENTAL HEALTH REVIEW FORM

RSAD0307H Administrative Mental Health Review Form TOTAL ☐ TARGETED ☐

Reviewer:	**Site:**	**Date:**
Last Name & Record #:	**Age/DOB:**	**Date Entered Service:**

IDENTIFICATION SECTION (left-hand side of hard-copy chart & top right side)			
1. **Request for Services (NRS 433A 120-140)** – Completed to determine eligibility for services (no blanks) & signed/dated by the consumer (or guardian/designee) and staff. If a break in service exceeds 1 year, a new form is completed. Copy of page 2 is filed in the assessment section.	YES	NO	N/A
Comments:			
2. **Guardianship papers (NRS 433.484)** – Copies of custody and/or guardianship papers are on file for minors living with a single parent, or an adult found not competent and updated when changes in custody/guardianship occur.	YES	NO	N/A
Comments:			
3. **Financial Agreement form (RC policy #4.1002)** – Completed & signed by the consumer, with the application portion also signed by staff. If insured, a copy of the insurance card must also be on file (or TANF info). If employed, verification of income must also be on file. If indigent/homeless, an affidavit of support.	YES	NO	N/A
Comments:			
4. **Privacy Rule Consent (Division policies #6.003 & #6.006)** – Concepts of HIPAA/privacy are discussed with all persons at orientation & annually – signing this form at orientation & annually is an acknowledgement of their understanding of HIPAA regulations as it pertains to their records & service provision. Form has no blanks.	YES	NO	N/A
Comments:			
5. **Acknowledgement of Information (RC policy #2.1002)** – Confidentiality, rights & responsibilities are reviewed with, and the form signed (both printed names and signatures) by, each person served at orientation. Minors (ages 13-17) can sign the form in addition to the parent/guardian signature. These concepts are reviewed annually and the form signed. Form has no blanks.	YES	NO	N/A
Comments:			
6. **Information Update (RC policy #4.1002)** – Completed (no blanks) and signed by the consumer and staff on an annual basis to note any changes. Changes from the form should be reflected in AVATAR.	YES	NO	N/A
Comment:			
7. **Program Movement (RC policy #3.1001)** – Each chart tracks Wait List, Admission & Terminations (Discharge) for every service, including start and end dates	YES	NO	N/A
Comment:			

TREATMENT/SERVICE PLANS AND REVIEWS (AVATAR)			
8. **Presenting Problems (Division policy #4.031)** – Reasons from assessment and Request are noted on the treatment plan (30 days) & individualized to the person (not canned) and include diagnosis, other problems & descriptors. Problems not addressed should have sufficient documentation as to the status. When alcohol, drugs, suicide or homicide is noted on the assessment, it is clinically addressed on the plan. The plan includes Axis I diagnosis.	YES	NO	N/A
Comments:			
9. **Outcome Measures (Long & short-term goals (Division policy #4.031)** – Plans include maximum or optimal treatment outcome (long-term goals & discharge criteria) relational to each problem & objective and include anticipated duration of overall services. The plan also includes specific, behavioral, measurable, achievable, realistic, time-limited steps (short-term objectives) to address the identified problem(s) and demonstrate the reduction/elimination of the problem(s) and evolve with functional progress.	YES	NO	N/A
Comments:			
10. **Services/Interventions (Division policy #4.031, Medicaid 402.39)** –Services, including specific interventions & models/modules, must be provided in the least restrictive/most normative beneficial setting (NRS 433.494). Services are clinically appropriate, consistent with standards of good practice, measurable, behavioral, contribute to progress toward treatment goals & objectives and include amount, scope, duration & name of staff. When needed, persons are referred for other services/interventions & high-risk consumers have coordinated care.	YES	NO	N/A
Comments:			
11. **90-day Review (NRS 433.494)** –Review progress toward treatment objectives/goals and sign plan (QMHP, QMHA, QBA/MHT staff, consumer and other applicable people).	YES	NO	N/A
Comments:			
12. **Plan requirements (Division policy #4.031 & Medicaid 402.34)** – Every plan flows from Assessment data & documents joint planning with the consumer/legal representative & contains signatures of all participants (e.g., clinician, RN, Psychiatrist, etc.). If another clinician starts the process, the incoming clinician must sign next to the previous clinician (if there are no changes) or develop a new plan. The plan includes the extent to which services may be available by alternate providers and any referrals.	YES	NO	N/A
Comments:			
Progress Notes (AVATAR)			
13. **Notes reflect plan/needs (Division policy #4.030 & Medicaid 402.31)** – Reflective of treatment plan (including those provided by contract providers), such that no problem tracked via progress notes is not indicated on the plan (unless emergency/crisis) and there is concordance between documents, including frequency of services based upon clinical need.	YES	NO	N/A
Comments:			
14. **Services/Interventions (Medicaid requirement?)** – Service notes include scope/nature, duration, intervention used and provider name and date/time. Applicable portions of the treatment plan are appended.	YES	NO	N/A
Comments:			
15. **Appropriate Charting (Division policy #4.030)** – Data/Description, Assessment & Plan (DAP) specific to the next steps and meeting date/time. Notes should be in chronological order and follow guidelines when making corrections to notes. There must be a note for each session. There are no blank forms or spaces on notes.	YES	NO	N/A
Comments:			

Progress Notes (AVATAR)			
16. **Review reflected in notes (Division policy #4.031)** – Each 90-day review is recorded, with a note including date/time of review, review of diagnoses (all axes or note "no change") – when initial diagnoses have been determined as "deferred", each active problem, progress toward tx goals & objs., and any changes/revisions to the plan of treatment. A note is written if the review cannot occur at the 90-day interval.	YES	NO	N/A
Comments:			
17. **Emergency Services Progress Note (Division policy #4.030)** – For every emergency/crisis situation in which services were needed to reduce psychiatric & personal distress, & specific reference to crisis/emergency contact and description of how the person met the criteria for this service. What was the end result & how did intervention/session end (plan of action). FH11As, as applicable, are completed.	YES	NO	N/A
Comments:			
18. **No-Show/Cancellation note (Division policy #4.025)** – When scheduled appointments are missed follow-up must occur and be noted in the file (DAP format is not required), to phone call, letter 2nd time, & discharge.	YES	NO	N/A
Comments:			
INTAKE ASSESSMENT INFORMATION (AVATAR)			
19. **Identifying data (Medicaid 403.4)** – Age, sex, race, living situation, marital status (adults), grade level & other pertinent identifying data (e.g., culture, language assistance needs, divorce pending/parental problems, etc.) is noted in the assessment (information is complete)	YES	NO	N/A
Comments:			
20. **Presenting Problem(s) (Medicaid 403.4)** – Reason(s) for seeking assistance clearly documented, including precipitating factors & stressors. Information can be obtained from the person seeking services, significant others, outside referral sources, or staff. Reasons should not be vague or ill defined but indicate who, what, where, when, and why the person is seeking services. Information is complete.	YES	NO	N/A
Comments:			
21. **Presenting Symptoms (Medicaid 403.4)** – Documentation of onset, frequency, antecedents, intensity, & duration of each symptom, noting increase/persistence of symptoms to warrant the medical necessity of services, including risk of harm, functional impairments & symptoms clarify the presenting problem(s) & include relevant cultural issues. Information is complete	YES	NO	N/A
Comments:			
22. **Social/Family History (Medicaid 403.4)** – Birthplace, family, social and environmental issues related to family, relationships, job, military history, financial problems, education, housing (living situation), friends, other relationships, legal issues, hobbies/recreation, religious affiliation, cultural/ethnic issues, and support systems. Information is complete.	YES	NO	N/A
Comments:			
23. **Trauma/Abuse history (Medicaid 403.4)** – History of trauma, violence, abuse/neglect, & related sequelae, which includes: type (childhood/adult rape, domestic violence, sexual, physical, emotional, exposure to disaster, etc.), age (when abuse occurred), who (perpetrator or victim), & assessment of symptoms (disorientation, flashbacks, hyper-vigilance, self-injury, anxiety, depression, etc.) and used to determine additional planning (crisis plan, safety plan, etc.). Information about homicidal ideation, if applicable, and includes items noted above (type, age, who, and assessment). Information is complete.	YES	NO	N/A
Comments:			

INTAKE ASSESSMENT INFORMATION (AVATAR)			
24. <u>Psychiatric History (Medicaid 403.4)</u> – If previous psychological problems (or lack thereof) & treatment provided to include includes provider, location, duration and outcome (gains/setbacks from treatment) of services provided. Also include any treatment history of family members. Lack of previous treatment must be noted. Information is complete.	YES	NO	N/A
Comments:			
25. <u>Psychotropic Medications (Medicaid 403.4)</u> – A list of all psychotropic medications currently being taken and indication of efficacy.	YES	NO	N/A
Comments:			
26. <u>Medical History/Problems (Medicaid 403.4)</u> – Complete past & current physical needs (including oral health & nutrition), family health, exam/labs, etc. Results from other providers are on file. Minors – motor development & functioning, sensorimotor functioning, visual functioning, and immunizations should be included.	YES	NO	N/A
Comments:			
27. <u>Substance Use/Abuse (Medicaid 403.4)</u> – Complete history of use to (caffeine, nicotine, alcohol, drugs, gambling, etc.) to include substance used, age first started, frequency, choice, periods of abstinence, participation in AA/NA, problems/legal issues, etc. This includes minors. If the person has no history, that should be clearly noted. If the person is referred to an outside entity, the referral is documented.	YES	NO	N/A
Comments:			
28. <u>Legal History Status (Medicaid 403.4)</u> – Complete list of current/past legal issues, impact on service provision, and status, impact & stressors related to the legal issue. If not applicable, this is clearly indicated.	YES	NO	N/A
Comments:			
29. <u>Education/Vocation (Medicaid 403.4)</u> – Strengths/supports or stressors/problems regarding employment/vocation. If the person is and/or was in the military, assess for related stressors/problems.	YES	NO	N/A
Comments:			
30. <u>Strengths/Resources (Medicaid 403.4)</u> – Complete list of resources (e.g., Social Security, Welfare, Section 8, etc.) & personal strengths/factors (i.e., knowledge, interests, skills, aptitudes, personal experiences, education, talents, employment, etc.) which are useful in therapy.	YES	NO	N/A
Comments:			
31. <u>Mental Status Exam (Medicaid 403.4 & Division policy #4.029)</u> – Person's current state of mind, under the domains of appearance, attitude, behavior, mood and affect, speech, thought process, thought content, perception, cognition, insight & judgment, including: suicidal & homicidal ideation, auditory/visual hallucinations, affect, appearance, eye contact, mood, behavior, approach, thought content, memory, orientation, insight, judgment, speech, language, etc.	YES	NO	N/A
Comments:			

INTAKE ASSESSMENT INFORMATION (AVATAR)			
32. Diagnoses (Medicaid 403.4) – Complete information on all 5 axes documented, including code & descriptor (no blanks) & accurately reflects the clinical presentation. Diagnoses are updated annually for people under the age of 18. Axis II may be deferred for 6 months. Axis III is reported by the person but include known allergies. Axis IV issues are comprehensive enough to indicate need for support services. Axis V (GAF) is based on clinical judgment & measures the overall level of functioning & disturbances. Discrepancies between clinical and psychiatric diagnoses must be clarified.	YES	NO	N/A
Comments:			
33. SED/SMI Determination (Medicaid 403.4) –Initially, annually, and/or any time there is a significant change in functioning, clinical staff is to determine person's eligibility for services & note functional impairment. Information is complete.	YES	NO	N/A
Comments:			
34. Case Formulation (Medicaid 403.4) – Complete integrated explanation of the clinical assessment to include info about the cause & nature of the presenting problems (not just diagnosis), & justification of SED/SMI, & provide framework for developing the treatment plan/approach (level of need, including referral services). If applicable, formulation must include any relevant cultural context in the expression and evaluation of psychiatric symptoms and dysfunction.	YES	NO	N/A
Comments:			
35. LOCUS/CASII (Medicaid 403.4) – Determination of services (level of care) and/or intensity of needs based upon severity of person's condition is completed at admission (no blanks) and every 90 days. If M/C only (or when clinician not involved), clinical do initially with other disciplines following up.	YES	NO	N/A
Comments:			
36. Mental Health Screening (NRS 433A 120-140 & RC policy #3.1027) – A behavioral health screen (no blanks) to determine eligibility must be complete and on file. Items noted on the screen should be more thoroughly assessed by the use of other assessments.	YES	NO	N/A
Comments:			
MEDICATION CLINIC SERVICES (AVATAR)			
37. Psychiatric Intake (APA & RC policy 1102) – Psychological and emotional disorders require a psychiatric assessment to accurately diagnose and delineate treatment in a comprehensive, bio-psychosocial manner. The assessment is completed in AVATAR within the psychiatric assessment tab at time of appt or end of day.	YES	NO	N/A
Comments:			
38. Medication consent (NRS 433.484) – Consumers prescribed psychopharmacological treatment must consent (sign) for every type of medication prescribed & update every time medication is changed (only when change in type). If the person is not competent, form & updates are signed by legal representative (guardian). Information is complete.	YES	NO	N/A
Comments:			
39. Telemed Consent and Survey (RC policy 1102) - Upon referral to Telemed, the risks and benefits of Telemed are reviewed with the client and written consent is obtained and a Client Satisfaction Survey is completed by the consumer at the end of the first three sessions.	YES	NO	N/A
Comments:			

MEDICATION CLINIC SERVICES (AVATAR)			
40. Nursing Assessments & Medication Documentation (RC policy #3.2001 – in RN assessment episode) – Done upon first mtg w/RN (optimal), routine or walk-in nursing appointments and include: Medical History, Treatment & Health Habits, General Physical Condition (includes quarterly vital signs & weight) & Medication assessment. Assessments are done annually. If needed, a Nutritional Screening (e.g., Diabetes, recent weight gain/loss, Renal Disease, or other major nutritional problems) is done quarterly; AIMS (people on psychotropic/neuroleptic medications) is done every 6 months, & Nursing Disposition is done as needs warrant referral to medical provider. A complete assessment is done annually and includes a progress note. When Med Clinic only this is to include treatment planning.	YES	NO	N/A
Comments:			
41. Medication education by psychiatrist (RC policy 1102) - As new people come into Med Clinic, the psychiatrist is responsible for providing medication education to all persons to include: reason for medication, benefits, side effects, alternatives, etc. in progress notes. Med education will occur any time there is a new/change of meds.	YES	NO	N/A
Comments:			
42. Medication education by nursing staff (RC policy 1102) - When there are any changes to medications or when the need for additional medication education occurs, the nurse must document provision of medication education. Med education will occur any time there is a new/change of meds.	YES	NO	N/A
Comments:			
43. Physician progress note (Division policy #4.030) – Notes to track med-related problems and plans must be signed, dated, include credentials, be in DAP format and other clinical documentation (MSE, S/H ideation, etc.) and be completed at time of appt or end of day. When there are changes to medication, the reason is noted. Any changes or updates are also noted.	YES	NO	N/A
Comments:			
44. Nursing progress note (Division policy #4.030) – Notes for tracking medication-related problems and plan must be signed, dated, include credentials, and be in DAP format. Quarterly nursing notes are required. Face-to-face encounters require a nursing progress note.	YES	NO	N/A
Comments:			
45. Annual Psychiatric Assessment (APA & RC policy 1102) – Persons annually reassessment for their condition, diagnosis and treatment needs for continued accurate diagnose and delineation of treatment needs in a comprehensive, bio-psychosocial manner. This must be done in AVATAR,	YES	NO	N/A
Comments:			
46. MARS (RC policy 1102) - Completed at each session by the contracted Psychiatrist or Psychiatric Nurse. If a MAR is completed by the Psychiatric Nurse, the contracted Psychiatrist must initial each entry at the next visit.	YES	NO	N/A
Comments:			
47. Lab (Division policies #4.032 & #4.033) – Lithium, carbamazepine, valproic acid (VA), clozaril lab procedures as noted in MHDS policy #4.032 are followed before, during & after medications are prescribed or taken. Minimal requirements include: EKG (within the last 6 months & for persons over 40), chemistry panel (US), CBC with differential, thyroid panel, lithium level (after initiation of medication), VA level, etc. Documentation that this has been ordered and results discussed in progress note to include date of lab, results, next date, etc.	YES	NO	N/A
Comments:			

MEDICATION CLINIC SERVICES (AVATAR)			
48. <u>Prescriptions (RC policy 1109)</u> – Prescriptions include: date prescription written, full name of consumer, medication & dose, route of administration, directions for use, quantity dispensed, refills – if applicable, & signature of prescriber.	YES	NO	N/A
Comments:			
RECORD STANDARDS (both sources)			
49. <u>Clinically Assumable (Medicaid 402.7)</u> – Documentation within the clinical record and within the AVATAR system must be accurate (or corrected appropriately) and complete (no blank forms/spaces) – containing all applicable information in such a way the record can be transferred to another clinician or can be provided to another center/agency if the person is transferred and/or discharged.	YES	NO	N/A
Comments:			
50. <u>Release of information (RC policy #3.1019)</u> – Complete (no blanks) for each entity to which information is requested from or sent to. Appropriate timelines should be individualized to the information to be released. Forms are updated annually.	YES	NO	N/A
Comments:			
51. <u>Coordination of care (Medicaid 402.5, Division policy #4.005 & RC policy #3.1019)</u> – Any time a person is under the care of, or has recently obtained, medical/psychological services, a Release of Information is completed & documents obtained to coordinate care (as clinically necessary).	YES	NO	N/A
Comments:			
SERVICE COORDINATION – SC (both sources – work toward AVATAR)			
52. <u>Criteria for admission (Medicaid 2502.7 & Division policy #3.002)</u> – Documentation that the individual needs assistance in gaining access to medical, social, education, & other support services, including housing & transportation. Documentation of needs is initially noted by QMHP and further assessed by Service Coordinator & services are planned. **NOTE:** This does not include rehabilitation.	YES	NO	N/A
Comments:			
53. <u>Services meet criteria (Medicaid 2502.10 & Division policy #3.002)</u> – Services include: assessment, planning, referral/related activities, and monitoring & follow-up. When coordination with other SCs is needed, this is documented and tracked via progress notes. Services being provided in accordance with needs & ongoing assessments (evaluation) denote need for services at level being provided.	YES	NO	N/A
Comments:			
54. <u>Appropriate SC documentation</u> – Notes must be in accordance with criteria noted above, be in DAP format, content of services provided, the status toward the goals on the plan, and signed/dated. Incidental (non-billable) notes do not need to be in DAP format. No rehabilitative services should be documented as Service Coordination.	YES	NO	N/A
Comments:			
55. <u>Continuing Stay Criteria (Medicaid 2503.1A & Division policy #3.00/#4.035)</u> – The treatment/service plan indicates all service needs of person and ongoing monitoring notes and 90-day plan review indicate the person continues to meet admission criteria. Discharge/exclusionary criteria must be documented in the file.	YES	NO	N/A
Comments:			

REHABILITATION (both sources – work toward AVATAR)			
56. **Criteria for Admission (Medicaid 403.6B)** – When rehabilitation is prescribed, there is sufficient information to indicate the person meets clinical criteria and/or functional impairment – to include LOCUS/CASII, and/or other assessment documents and clinical notes. Services prescribed by the QMHP must include amount, scope, duration and provider and be approved before provided. **NOTE:** Services must be provided by qualified staff who must meet QBA/QMHA criteria.	YES	NO	N/A
Comments:			
57. **Planning (Division policy #4.031)** – The plan includes clinically appropriate intervention, discharge criteria specific for each goal, duration of services, and coordinated care with those people who need a higher intensity of needs/level of service. Planning includes the person and appropriate others.	YES	NO	N/A
Comments:			
58. **Appropriate documentation (Division policy #4.031)** – Rehab notes must be in accordance with criteria noted above, must be in DAP format, progress toward functional improvement, type of module(s) used, and signed/dated. **NOTE:** Services should not be provided unless staff is competent.	YES	NO	N/A
Comments:			
Prior Authorization of Services (hard-copy)			
59. **FA11A (Medicaid 403.5)** – prior to therapy (individual, group or family), Medication Management, and Rehabilitation services being provided, the QMHP will complete (no blanks) and submit this form to Medicaid for approval of services. Ongoing FH11As must be completed timely so as not to disrupt service provision and maximize billable services. Staff must meld service needs with service limitations. NOTE: An FH11A does is NOT completed for Service Coordination (Provider Type 54) as it has a service cap of 30 hours per month.	YES	NO	N/A
Comments:			
DISCHARGE/TRANSFER PLANNING (AVATAR)			
60. **Discharge/Transfer Summary (Medicaid 402.14)** – A summary is completed within 30 days of a planned discharge & 45 days of an unplanned discharge. The discharge summary will note the last contact date with the person and the reason for discharge (including transfer/exclusionary criteria). Summary information includes presenting problems, treatment provided, and reason for discharge.	YES	NO	N/A
Comments:			
61. **Continuity of Care (Medicaid 402.14)** – To ensure communication between levels of care, the discharge summary notes need to also include the diagnosis at admission and discharge, level of functioning (as last known), and a summation of the effectiveness of treatment and any recommendations for further treatment/services and a plan for accessing those services.	YES	NO	N/A
Comments:			
62. **Transfer of Care – when a person remains open to services (RS MH policy 3.1024)** – When persons are transferred to another level of care (e.g., inpatient) or are referred to another center/agency, a verbal summary is given at the time of transfer, with a written summary provided within 7 calendar days.	YES	NO	N/A
Comments:			

DISCHARGE/TRANSFER PLANNING (AVATAR)			
63. <u>Discharge Transfer of Care – when person will be closed to services (Medicaid 402.14)</u> – When persons are transferred to another level of care, and will no longer be open at the discharging center, documentation is sufficient and timely so as not to disrupt service provision. A verification form is completed by the originating center. Verification of fax to transferring center as well as peer review completed before transfer must be in the file.	YES	NO	N/A

Quality Comments
Overall case documentation clearly included rationale for key decision points and gave the reader an understanding of the level of challenge the case circumstances presented:
Key decision points were thoughtfully assessed and based upon sound reasoning:
Proactive clinical decision making resulted in the minimization of crises:
Therapeutic response to treatment is a direct result of the clinical skills and their delivery:
Other:

I have reviewed the findings, comments and action plan for correction of issues noted above:

Service Coordinator Signature:_____ Date:_____

Peer Signature: _____ Date:_____

Supervisor Signature:_____ Date:_____

Follow Up
Date Corrections were made to file:
Person reviewing corrections:
Other follow-up needed:
Date Follow-up due:

ATTACHMENT 307.7.9
RSAD0307J
DEVELOPMENTAL SERVICES ADMINISTRATIVE REVIEW FORM

DEVELOPMENTAL SERVICES ADMINISTRATIVE REVIEW FORM

Individual:	ID #:
Date of Record Review:	DS III:
Reviewer:	DSIV:

IDENTITY			
1. Is the information current and thorough?	**YES**	**NO**	**N/A**
Comments:			
2. Is ELCID current?	**YES**	**NO**	**N/A**
Comments:			
ISP			
3. Is there evidence of sufficient ISP team meetings to develop the person-centered ISP?	**YES**	**NO**	**N/A**
Comments:			
4. Are goals clearly identified?	**YES**	**NO**	**N/A**
Comments:			
5. Are there specific timeframes for achievement of goals?	**YES**	**NO**	**N/A**
Comments:			
6. Are the goals appropriate including number of goals, for the person served?	**YES**	**NO**	**N/A**
Comments:			
7. Are the goals attainable and measurable within a reasonable period of time?	**YES**	**NO**	**N/A**
Comments:			
8. Are health and safety addressed in the ISP?	**YES**	**NO**	**N/A**
Comments:			
9. As applicable, are medications and their side effects addressed in the ISP?	**YES**	**NO**	**N/A**
Comments:			
10. Are there contingency plans for emergency situations?	**YES**	**NO**	**N/A**
Comments:			

11. Is the language in the plan clear, concise and easily understood?	**YES**	**NO**	**N/A**
Comments:			
12. Is there date to support progress with the ISP?	**YES**	**NO**	**N/A**
Comments:			
13. If this is a collaboratively served individual is there evidence of regular collaboration with the mental health provider?	**YES**	**NO**	**N/A**
Comments:			
14. If a collaboratively served individual, are mental health needs reflected in the ISP?	**YES**	**NO**	**N/A**
Comments:			
Team Meetings			
15. Are support team meetings held as necessary, inclusive, and agendized?	**YES**	**NO**	**N/A**
Comments:			
16. Are support team meetings outcome driven and decisions reflected in the ISP?	**YES**	**NO**	**N/A**
Comments:			
Medical			
17. Appropriate nursing consultation is evident.	**YES**	**NO**	**N/A**
Comments:			
18. Nursing recommendations are appropriately acted upon.	**YES**	**NO**	**N/A**
Comments:			
19. Physical exams are thorough or the DS III/Provider has requested additional information for clarity.	**YES**	**NO**	**N/A**
Comments:			
20. Doctor recommendations are appropriately acted upon.	**YES**	**NO**	**N/A**
Comments:			

OVERALL			
21. The reader is able to understand the flow of the case upon reading case notes and other documentation in the file.	**YES**	**NO**	**N/A**
Comments:			
22. Collaboration with all appropriate parties is timely, appropriate and consistent.	**YES**	**NO**	**N/A**
Comments:			
23. DS III responsiveness to the health and safety needs of the person served is evident.	**YES**	**NO**	**N/A**
Comments:			
24. DSIII addresses billing issues promptly while maintaining a collaborative relationship with the provider.	**YES**	**NO**	**N/A**
Comments:			
25. Person centered planning is evident in the file documentation.	**YES**	**NO**	**N/A**
Comments:			
26. Collaboration and follow through with recommendations made by the DS Clinical and DS Nursing staff is evident.	**YES**	**NO**	**N/A**
Comments:			
Quality Comments			
Overall case documentation clearly included rationale for key decision points and gave the reader an understanding of the level of challenge the case circumstances presented:			
Key decision points were thoughtfully assessed and based upon sound reasoning:			
The treatment plan goals and objectives were well thought out, comprehensive, and achievable:			
Creativity was evident with the identification of and referral to community resources:			
Follow up on service coordination activities was thorough, timely and documentation included key information to understand the status of referred services:			

I have reviewed the findings, comments and action plan for correction of issues noted above:

Service Coordinator Signature:_____ Date:_____

Peer Signature: _____ Date:_____

Supervisor Signature:_____ Date:_____

Follow Up
Date Corrections were made to file:
Person reviewing corrections:
Other follow-up needed:
Date Follow-up due:

ATTACHMENT 307.7.10
RSRT0307K
REVIEW TRACKING FORM

RSRT0307K REVIEW TRACKING FORM

CENTER/OFFICE: ☐ DS ☐ MH Date Range of Quarter Summary:

Supervisor: TOTAL☐ TARGETED☐ Date of Quarterly Submission:

Review Month	Target Questions	Person ID #	Question #	Response: Yes	Response: No	Response: N/A	Clarification Comments:
			1				
			2				
			3				
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			7				
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			14				
			15				

SAMPLE

		CONTINUED – Page 2 CENTER/OFFICE: ☐ DS ☐ MH Submission Date:					
Review Month	**Target Questions**	**Person ID #**	**Question #**	**Response: Yes**	**Response: No**	**Response: N/A**	**Clarification Comments:**
			16				
			17				
			18				
			19				
			20				
			21				
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			32				

SAMPLE

		CONTINUED – Page 3 CENTER/OFFICE: ☐ DS ☐ MH Submission Date:					
Review Month	**Target Questions**	**Person ID #**	**Question #**	**Response: Yes**	**Response: No**	**Response: N/A**	**Clarification Comments:**
			33				
			34				
			35				
			36				
			37				
			38				
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			49				

SAMPLE

		CONTINUED – Page 4 CENTER/OFFICE: ☐ DS ☐ MH Submission Date:					
Review Month	**Target Questions**	**Person ID #**	**Question #**	**Response: Yes**	**Response: No**	**Response: N/A**	**Clarification Comments:**
			50				
			51				
			52				
			53				
			54				
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			64				

SAMPLE