APPENDIX ZO

ACT Chart Peer Review Tool

Reviewer:	Date of Review:										
Assigned Clinician/Degree:	Date of 1st Contact:								Date Appt Offered:		
Review Month:	Funding Sources: (Program Name)										
Service/Chart Number:	*Select One*										
Please answer all questions - an incomplete peer review is not useful.	**Co-Occur-ring**		**MH**		**SA**		**High Risk**				

ASSESSMENT	**score 1=meets 0=does not meet**	**NA**	**ACT Specific**	**Comments**
Assessments are updated annually (outpatient only)				***Annual updates must be in record along with original assessment***
Assessments are updated when significant changes occur in the consumer's presentation. (same as #6)				***Assessment update must occur each time consumer presents with a significant change***
Consent for treatment includes the Consumer and/or Guardian signature, witness signature and is in a language understood by the Consumer. (MAD)				*The treatment record should contain a completely filled out consent form for treatment signed by the consumer and/or guardian. Score "0" if any data is missing.*
Presenting problems, along with relevant psychological and social conditions affecting the Consumer's medical and psychiatric status are documented.				*The assessment section of the clinical record includes the clinically significant psychosocial issues impacting the Consumer's presenting signs, symptoms, complaints and documented physical and mental illness*
Special status situations, such as imminent risk of harm (suicidal, homicidal or abuse), medically complex or elopement potential are prominently documented. (same as #8)				*The medical record must indicate and assess the current level of risk. NA applies if no special risk issue is documented*
A psychiatric evaluation has been completed, signed & dated. (same as #8)				*BiPolar seen within 14 days Y or N BiPolar labs in chart Y or N; Schiz seen within 14 days; Maj Dep seen within 30 days of diagnosis.*
A psycho-social assessment and history are documented including: psychiatric/treatment, medical, educational, legal, family, substance abuse, housing, and employment.				*The treatment record must contain a psycho-social assessment signed by the clinician.*
The Mental Status Evaluation (MSE) documents affect, speech, mood, thought, content, judgment, insight, attention or concentration, memory and impulse control. (MAD)				*The chart contains a completed MSE*
The Consumer's strengths are documented in the assessment. (DHI 24.6)				*The chart contains an admission and psychiatric assessment that documents the Consumer's strengths (e.g. family support, social support and housing)*

The Consumer's religious, spiritual and cultural values are documented in the assessment. (MAD)				*The treatment record must contain documentation of religious, spiritual and cultural values Consider single parenthood, dealing with a mental illness, lack of transportation/money/support system, etc.*
Consumer's 12 and older, there is a screening for past and present use of cigarettes, alcohol, illicit, prescribed and OTC drugs. (MAD)				*There is clear indication that drug use, nicotine, alcohol, etc. are documented or there is documentation that the Consumer does not use these substances.* *NA if consumer is under age 12.*
Diagnostic Review includes an SDMI diagnosis and is updated annually.				
LIVING ARRANGEMENTS	**score**	**NA**		**Comments**
The Consumer's living situation is clearly described in the treatment record. (MAD)				*Living situation is clearly documented in treatment record*
DSM-IV DIAGNOSES (ALL FIVE (5) AXES)	**score**	**NA**		**Comments**
DSM-IV diagnoses (Axis I-IV) are documented initially and updated at least annually.				*The treatment record must have all 5 axis completed every year.*
The DSM-IV diagnoses are consistent w/the presenting problems, target symptoms, history, mental status evaluation, and/or other assessment data. (MAD)				*There is documentation that the diagnoses match the presenting symptoms.*
MEDICATION MANAGEMENT	**score**	**NA**	NA if psychotropic meds not prescribed	**Comments**
Psychiatric notes reflect target symptoms, rationale for medications, treatment recommendations and response to medications.				*Abilify, Clozaril, Geodon, Haldol, Mellaril, Moban, Novane, Orap, Prolixin, Risperdal, Seroquel, Stelazine, Thorazine, Trilafon, Zydis, Zyprexa*
Written informed consent for medication (in a language understood by the consumer and/or guardian) is documented.				***AIMS required every 90 days*** *Initial _____Every 90 days_____ _____ _____ _____ _____ Discharge_____*
There is evidence that the consumer and/or guardian received information about the illness or target symptoms for which the medication was prescribed.				***Schizophrenia*** *dx receives AIMS every 90 days_____ _____ _____ _____*
There is evidence of discussion regarding the need to take the medication as prescribed and not stop w/o discussing it w/the physician.				*Based upon documentation, the reviewer can conclude the consumer was told how to take the medication and not to stop w/o doctor approval.*
The record indicates what medications have been prescribed, the dosages of each and the dates of initial prescriptions or refills. (MAD)				*Prescribed medications are documented. Dosages, routes and schedules for medications are documented.*
Allergies, or lack of known allergies and adverse reactions and sensitivities to pharmaceuticals and other substances are prominently noted. (MAD)				*There is documentation that the Consumer was asked about allergic reactions to medications and other substances.*
When medications are prescribed, there is evidence of an evaluation of the Consumer's response to the medication and adjustments are made as needed.				*There is documentation in the prescriber's notes of the consumer's response to the medication prescribed.*

When medications are prescribed that require serum level monitoring and/or other laboratory tests, those tests are done and the results are documented.				*There is documentation that appropriate labs were ordered and the results are in the treatment records. NA if the consumer is not on meds requiring monitoring and/or lab testing.*
RESPONSE TO TREATMENT/PROGRESS NOTES	**score**	**NA**		**Comments**
Progress notes reflect the response to treatment and the progress toward goals.				*There are progress notes reflecting consumer's response to treatment.*
Progress notes reflect documentation regarding the Consumer's status in treatment (missed and/or kept appointments).				*There is documentation in progress notes of missed and/or kept appointments.*
The record reflects continuity and coordination of care (i.e. consents for contact) w/health care institutions, consultants, ancillary and other non-behavioral health providers.				*There is documentation of signed releases when indicated. NA applies if consumer is not involved w/other services.*
The record reflects the active involvement of the family/primary caregivers in the assessment and treatment of the consumer, unless contraindicated.				*There is documentation of involvement of family or caregivers in the treatment process. NA if consumer is an adult w/o caretaker or the evaluation determined the involvement of family would be detrimental to recovery.*
The record documents preventive/recovery services as appropriate (e.g. relapse prevention, stress management, peer directed programs, wellness programs, lifestyle changes and referrals to community resources.				*There is documentation of recovery/prevention services as needed.*
The record reflects continuity and coordination of care w/ PCP.				*There is documentation of communication w/the PCP unless the consumer does have a PCP. NA applies if documentation states the consumer does not have a PCP.*
Progress note content supports the objective(s) identified from the tx plan that are addressed during that appointment.				
Program Director countersigns all Crisis related notes.				
Progress note identifies place of service				
Progress note justifies a billable service.				
ACCESS TO CARE	**score**	**NA**		**Comments**
For Inpatient: Follow-up appointments are offered within 7 or 30 days of discharge. (MAD)				***Pt readmitted to IP within 30 days Y or N*** *. NA applies if treatment record does not indicate consumer was an inpatient.*
Outpatient: Appointments are offered within 14 business days of initial contact for Medicaid funding and 10 business days for DOH funding.				*Routine=14 or 10 days Urgent=24 HRS Emergent = 30min/phone 8hr/Face*
The record reflects provider follow-up activities related to consumers who miss or reschedule appointments. (MAD)				*There is documentation that appointments were missed and that follow-up was done as a result.*
DISCHARGE	**score**	**NA**		**Comments**
The intake assessment and/or initial treatment plan indicate discharge planning was initiated upon admission.				*Preliminary discharge plans should be noted in the initial intake assessment.*

The discharge summary describes the presenting problem, course of treatment, treatment gains made, and specific (who, what and where) aftercare plans. (Same as #41)				*The record has a comprehensive discharge summary. NA applies if consumer is still in care.*
SUBSTANCE ABUSE	**score**	**NA**		**Comments**
The treatment record documents an Addiction Severity Index (ASI).				*SA DX, ASI required: Admission_____, 90 day F/U_____, every 120 days_____, Discharge_____*
The treatment record documents a substance abuse assessment/screen (e.g. SASSI, MAST, MIDAS) (MAD)				*The record has a substance abuse assessment /screen*
The record documents a substance abuse DSM IV diagnosis. (MAD)				*Substance abuse diagnosis is documented. NA applies if there is no substance diagnosis.*
The treatment record documents provision of SA tx by ACT or coordination of care including external referral to a substance abuse provider. (MAD)				*There is documentation of coordination of care. NA applies if no coordination of care is needed.*
Treatment strategies include group modalities.				
TREATMENT PLAN & RECOMMENDATIONS	**score**	**NA**		**Comments**
A treatment plan is present in the clinicial record.				*There is documentation that the treatment plan is relevant to primary diagnosis and Consumer agreed with goals.*
A master/comprehensive treatment plan was completed within 30 days or the third session of outpatient services.				*There is documentation of a completed master treatment plan signed and dated, within 30 days or the third session form the initial intake date.*
A treatment plan review was completed at least every 90 days for Outpatient Services				*Documentation of a completed treatment plan review at least every 90 days for adults & 30 days for children, signed and dated.*
Treatment plans are consistent with diagnoses and Consumer's agreed upon goals. (MAD)				*There is documentaiton that the treatment plan revelant to primary diagnosis and Consumer agreed with goals.*
Goals/Objectives are measurable				*There is documentation of measurable goals and objectives.*
Goals/Objectives are **individualized.** (MAD)				*There is documentation the goals and objectives are based on the individual's assessment/needs.*
There is a time frame for goal attainment/problem resolution. (Same as #54)				*There is documentation of time frames.*
Treatment interventions are consistent w/the treatment plan.				*There is documentation of treatment modalities and interventions related to the goals of treatment.*
The treatment plan is written in a language the consumer can understand. (MAD)				*There is documentation that the consumer participated in the treatment plan development and has understanding of the plan, with a consumer signature.*
Documentation includes the signature of appropriate parties.				*The treatment plan is signed by th treatment team.*

Treatment plan reflects utilization of Consumer's strengths. (MAD)					*Consumer strengths are incorporated in treatment plan.*
	TOTAL				

Documents that require signatures and an update review at least once a year. The only exception is the DOH form, which is completed once. ***Check all that apply***

[ ]	Clients Rights, Responsibilities, Grievance	[ ]	DOH Release (1 time requirement)
[ ]	Consent For Treatment	[ ]	Division of Vocational Rehabilitation (DVR)
[ ]	Medication Informed Consent	[ ]	School Release
[ ]	HIPAA Privacy Notice	[ ]	PO Release
[ ]	HIPAA Privacy Notice/ Substance Abuse C.F.R.	[ ]	SSI Release Form
[ ]	EPSDT Health Questionaire	[ ]	Form
[ ]	PCP Notification		
[ ]	PCP Release		