County of San Diego
Behavioral Health Services

Medical Record Reviews FY 2017-18
Trending Questions Summary
AOA and CYF Programs
Q3 FY 2017-18

		Overall Compliance CYF	Overall Compliance AOA
	Number of charts reviewed	**142**	**70**
Assessment			
1	Demographic form is completed and previous information is reviewed/updated upon admission.	**95%**	**86%**
2	Demographic form is updated if there was a change in client information after admission and at a minimum annually.	**63%**	**85%**
3	Initial BHA was final approved within 30 calendar days of program assignment (date of assignment counts as day one).	**92%**	**97%**
4	In the BHA covering the review period, the BHA was updated as indicated or at a minimum of annually from previous BHA final approval date.	**73%**	**88%**
5	In the BHA covering the review period, presenting problem documents how client meets or continues to meet medical necessity.	**97%**	**93%**
6	In the BHA covering the review period, documentation evidences a cultural formulation which includes an understanding of how or if culture impacts client's mental health.	**79%**	**89%**
7	In the BHA covering the review period, the Sexual Orientation question has been assessed and answered.	**97%**	**95%**
8	In the BHA covering the review period, the Gender Identity question has been assessed and answered.	**97%**	**96%**
9	In the BHA covering the review period, the Domestic Violence questions have been assessed and answered.	**98%**	**93%**
10	In the BHA covering the review period, the Trauma questions have been assessed and answered.	**97%**	**95%**
11	In the BHA covering the review period, past and current substance use and its impact on client functioning is documented and diagnosed, if applicable.	**66%**	**62%**
12	In the BHA covering the review period, if any item on the HRA is marked "yes", the Protective Factors and Self Injury/Suicide/Violence Management Plan fields are completed.	**75%**	**89%**
13	Within the past year (from date of current MRR), when a client has discharged from a 24 hour facility (Hospital or Crisis House) for a mental health suicidal/homicidal crisis, a High Risk Assessment (HRA) is completed.	**100%**	**86%**
14	In the BHA covering the review period, BHA documents client was asked if he/she has a primary care physician (PCP).	**98%**	**97%**
15	In the BHA covering the review period, if client does not have a PCP, client was advised to seek a PCP.	**70%**	**94%**
16	The BHA covering the review period includes a clearly substantiated Title 9 primary diagnosis.	**97%**	**95%**
17	In the BHA covering the review period, the Clinical Formulation documents client's symptom(s), and functional impairment(s).	**89%**	**86%**
18	In the BHA covering the review period, the Clinical Formulation documents proposed plan of care/services to address the client's behavioral health needs.	**88%**	**87%**
	Client Plan		
19	Initial Client Plan was completed and final approved within 30 days of program assignment (date of assignment counts as day one) and contains all required signatures or reason documented why not signed or final approved.	**92%**	**96%**
20	A new and updated Client Plan covering the review period was written and final approved annually or reviewed at UM (CYF only) and contains all required signatures or reason documented why not signed or final approved.	**85%**	**73%**
21	Documentation evidences that the Client Plan was explained to the client or family/legal guardian in his/her primary language.	**100%**	**97%**
22	Documentation evidences that the client or family/legal guardian was offered a copy of the plan or reason why not offered.	**100%**	**99%**
23	The Client Plan covering the review period is completed with all tiers and includes individualized narratives: (Area of Needs, Strenghts, Applied Strengths, Objectives, and Interventions)	**78%**	**80%**

Data from FY 17-18 Medical Record Reviews
Report by: HHSA BHS QI Quality Management Team (TW)

4/10/2018

		Overall Compliance CYF	Overall Compliance AOA
24	The Client Plan covering the review period documents that Area of Need(s) is linked to symptoms/behaviors and level of impairment affecting functioning that were identified in BHA and linked to the diagnosis for the focus of treatment.	90%	92%
25	The Client Plan covering the review period includes objectives that are specific, observable and measurable.	89%	82%
26	The Client Plan covering the review period documents frequency for all Interventions.	87%	91%
27	The Client Plan covering the review period documents duration for all Interventions.	81%	91%
28	The Client Plan covering the review period documents how all Interventions: (a) Will significantly diminish the impairment, or (b) If client is stabilized, will prevent significant deterioration, or (c) For children, will allow developmental progress.	85%	78%
29	For the Client Plan covering the review period, if risk factors of harm to self or others have been identified, there is evidence that the issues are addressed on the Client Plan.	94%	95%
30	For the Client Plan covering the review period, if a Substance Use Disorder has been identified and diagnosed as an ongoing problem for client's mental health, there is evidence that the issues are addressed on the Client Plan.	97%	94%
31	For the Client Plan covering the review period, if physical health needs that affect the client's mental health have been identified, there is evidence that the needs are addressed on the Client Plan.	92%	71%
	Progress Notes		
32	Progress notes document client's impairment(s) in functioning as a result of a mental health diagnosis.	98%	98%
33	Progress notes document specialty mental health intervention(s) utilized to address the impairment(s) and supports the client plan objective(s).	95%	92%
34	Progress notes document recipient's response to the specialty mental health intervention(s).	99%	100%
35	For clients identified at risk, progress notes document ongoing risk assessment, clinical monitoring, and intervention(s) that relate to the level of risk.	100%	96%
36	For clients diagnosed with a co-occurring substance use disorder that is included on the client plan, progress notes document specific integrated treatment approaches.	88%	84%
37	For clients with physical health needs related to their mental health treatment, progress notes document that physical health care (education, resources, referrals, managing health symptoms) is integrated into treatment.	94%	86%
38	Documentation evidences that client was seen or why not seen by a mental health professional within 72 hours of discharge from an inpatient/crisis residential facility, if applicable.	100%	90%
39	Documentation evidences coordination of care (communication, Tx updates, and/or referrals) between the program and client's other service providers (community therapist, FFS psychiatrist, primary care physician, day treatment, case management, school, child welfare, foster care, family/caregivers, or other agencies).	97%	100%
40	Coordination with Primary Care Physicians and Behavioral Health Form is completed and evidences coordination with, or documented reason why not completed.	80%	81%
41	For clients prescribed psychotropic medication by the program, there is an "Informed Consent for the Use of Psychotropic Medication" form signed by both client or family/legal guardian and psychiatrist. (Current JV220 form is an acceptable consent form for court dependents in the CYF SOC.)	90%	96%
42	If applicable, all prompts and check-boxes on the "Informed Consent for the Use of Psychotropic Medication" have been completed.	66%	79%
	Billing		
43	Paper Progress Note includes service code, date of service, service time, date of documentation, signatures, job title/degree, and printed name.	93%	100%
44	Service Code billed matches service code on Paper Progress Note.	97%	100%
45	Time billed is equal to time documented on Paper Progress Note.	100%	100%
46	Service Code is correct for service documented.	72%	65%
47	Time billed is substantiated in documentation. (Time claimed should be reasonably evident in the progress note including face to face, travel and documentation time.)	67%	69%

		Overall Compliance CYF	Overall Compliance AOA
48	Service time is claimed accurately to the minute as there is no trend or pattern of services being rounded or "same time" claimed for face to face, travel and documentation time across progress notes.	88%	81%
49	Selection for Service indicator "Provided at" is correct (especially when client is in a lock-out setting, e.g., correctional facility, hospital).	92%	85%
50	Progress Notes are final approved within 14 calendar days from date of service. (Date of service counts as "day one".)	89%	86%
51	Services provided involving more than one server, document the clinically compelling or medically necessary reason for more than one server. (applies to group and individual services)	69%	0%
52	Services provided involving more than one server, document the clinical therapeutic intervention of each server. (applies to group and individual services)	83%	0%
53	Documentation for all services provided in the review period evidences service was provided within the scope of practice of the server.	99%	94%
54	Services are billable according to Title 9 (e.g., no progress note, no-shows, lock-outs, non-billable activities, medical necessity, etc.).	63%	40%
	UM/UR		
55	During the review period, UM/UR requirements are completed as required.	85%	100%
56	Outcome measures are completed within timeline and entered into database or CCBH (for CFARS) if applicable. (Program will be asked for evidence of entry into database.)	87%	60%
	Day Treatment		
57	Authorization for Day Program Request (DPR) is completed and approved for services entered within required timelines with accurate dates verified in CCBH.	100%	na
58	Documentation in BHA covering the review period supports the level of care for Day Treatment, indicating a lack of progress or stabilization in a lower level of care.	100%	na
59	Daily documentation is present describing Day Treatment Intensive services.	#DIV/0!	na
60	Weekly summary notes include appropriate boxes marked and dates (M/D/YR) of each day attended with services provided.	100%	na
61	Weekly summary notes reflect detailed information regarding client impairment, intervention, responses, and progress towards goals which justify billed time throughout the week.	80%	na
62	Weekly summary notes have been signed/co-signed by licensed/registered/waivered staff.	100%	na
63	Documentation of at least one psychotherapy contact per week for a Day Treatment Intensive program.	100%	na
64	Documentation of at least one contact a month with family and/or significant support person.	100%	na
65	Day program has a system in place to ensure that beneficiaries with "unavoidable absences" have met the 50% attendance requirement for reimbursement.	100%	na
66	Unavoidable absences are explained with absence time being documented accurately and reflected within the Attendance logs.	100%	na
67	Significant Weekly Information includes examples of Process groups, Skill building groups and Adjunctive therapies provided during the week, including impairment, progress, and response.	80%	na
	PWB		
68	If Client meets criteria for enhanced services, PWB forms are completed and updated according to required timeline.	72%	na
69	If Client meets criteria for enhanced services, documentation of subclass or class identification is noted in the BHA for the review period.	100%	na
70	Client is identified in Client Categories Maintenance with the KTA identifier for the subclass or class.	71%	na
71	If subclass eligible, Client Plan has required intervention of SC 82 Intensive Care Coordination (and SC 83 Intensive Home Based Services is added if assessment indicates client is to receive IHBS).	82%	na
72	Documentation supports that a CFT (Child Family Team) meeting has occurred within 30 days of identification of subclass on the Eligibility form, and at a minimum of every 90 days thereafter.	59%	na
73	If CFT meeting timelines are not met, documentation includes clear reason for CFT meeting postponement and efforts to coordinate meeting in the near future.	56%	na

		Overall Compliance CYF	Overall Compliance AOA
74	When documenting a CFT meeting, progress note includes use of service indicator "Child Family Team CFT" in the field for "Provided To."	**39%**	**na**
	PIP		
75	During the review period, did the clinician document in a progress note that they assigned/reviewed therapeutic homework with the client and/or their caregiver? (For data tracking only; item not included in the MRR score)	**32%**	**na**