A/OA Outpatient Utilization Management Form

Utilization Management processes has been implemented as a way to monitor client’s progress and review criteria for continuation of services. Clients shall meet specific criteria and be reviewed through a Utilization Management process which shall be conducted internally by a Utilization Review Committee (URC) at all County and County Contracted Outpatient programs. The Utilization Management form must be completed in order to meet county requirements for UM. Programs are required to have a URC in place to **review records at least quarterly, with a minimum of 5 clients being selected**. Please see below for instructions on completion of each section. **The form shall be reviewed and signed by program manager or designee within 5 business days.**

**Section A:**

* This section **must** be completed for all clients evaluated by the URC in order to document rationale for the UM process.
* Keep in mind when reviewing a chart for UM, a clinician may not review their own client.

**Section B:**

* This section is to be completed, if in Section A, it was determined that review was **recommended** due to client being enrolled in services for 2 years or longer.
* This section shall be utilized to determine if additional services are needed to assist client in reaching their treatment goals or if discharge to a lower level of care is appropriate.
* Once additional areas have been identified, provide explanation as to how the recommendations will help enhance client’s continued treatment.

**Section C:**

* This section is to be completed, if in Section A, it was determined that review was due to a MORS rating of 6 or higher.
* It is **required** to complete this section for clients with a MORS rating of 6 or higher in order to justify ongoing services (JOS). Use this section to either document Justification for Ongoing Services (JOS) or transition to a lower level of care.
* This section may also be completed, if in Section A, it was indicated that UM was recommended by the treatment team. Use this section to document if additional services are recommended to assist client in reaching their treatment goals or if discharge to a lower level of care is appropriate.

**Section D:**

* This section is completed for all clients reviewed by the URC, regardless of the UM reason, in order to address the disposition.
* Use this section to document whether or not client has met criteria for on-going services or referral to a lower level of care.
* If client is referred to a lower level of care, indicate to which type of provider, the rationale for the provider identified, as well as comments related to client’s transition plan.

|  |  |  |
| --- | --- | --- |
| Client Name:       | CCBH Number:       | Program:       |

**Section A**

*\*Note: This section is* ***required*** *for each client being reviewed by the Utilization Management Committee (URC).*

Utilization Review Reason:

[ ]  Treatment Team Recommendation (See section C) [ ]  MORs rating of 6 or > (See section C)

[ ]  Enrolled in Program > 2 years (See section B) [ ]  Potential Discharge

Quarter/Date:

|  |  |
| --- | --- |
| Utilization Review Committee Chair Person:       | Credential:       |
| SAI Name:       | Credential:       |

Additional Participants (minimum of two additional participants; cannot review your own client):

|  |  |
| --- | --- |
|  Name:       | Credential:       |
|  Name:       | Credential:       |
|  Name:       | Credential:       |
|  Name:       | Credential:       |

MORs History (include the previous two dates and ratings):

|  |  |
| --- | --- |
| Date:       | MORs:       |
| Date:       | MORs:       |

**Section B:**

*\*Note: If section A indicated UM was* ***recommended*** *due to client being enrolled in services for 2 years or longer, complete this additional section to document either continued care or transition to a lower level of care.*

Overall Level of Functioning:

 Client Specific Issues (check all that apply):

[ ]  Relationships [ ]  Lack of Support System [ ]  Difficulties with ADLs

[ ]  Aggression [ ]  Domestic Violence [ ]  Substance Use

[ ]  Justice System Involvement [ ]  Other

Environmental Issues (check all that apply):

 [ ]  Lack of housing/housing complications [ ]  Employment issues

 [ ]  Lack of transportation [ ]  Financial hardship [ ]  Other

Clinical Issues (check all that apply):

 [ ]  Paranoia [ ]  Delusions [ ]  AH/VH [ ]  Substance Use [ ]  Suicide Attempts [ ]  Suicidal ideation [ ]  Danger to Others [ ]  Trauma [ ]  Med non-compliance [ ]  Lack of engagement in treatment [ ]  Need for continued clinic support [ ]  Other

Provide explanation and any treatment recommendations based on the above marked answers:

**Section C:**

*\*Note: If section A indicated that UM was due to a MORS rating of 6 or higher, this section is* ***required*** *as the Justification for Ongoing Services (JOS).*

 (client name)    was recommended by a member of the treatment team for review.

For on-going services at County or County Contracted Outpatient Program, as evidenced by one of the

following:

 Check all that apply and describe in comments section below:

[ ]  Client has been in Long Term Care, had a psychiatric hospitalization, or was in a crisis residential facility in the last year

[ ]  Client has been a danger to self or others in the last 12 months,

[ ]  Client’s impairment is so substantial and persistent that current living situation is in jeopardy or client is currently homeless

[ ]  Client’s behavior interferes with client’s ability to get care elsewhere, and/or

[ ]  Client has a complex psychiatric medication regimen and/or is on injectable medication

[ ]  Client is actively using substances

[ ]  Level of support and services cannot be duplicated at a lower level of care, which would risk client decompensation

 Comments and Treatment Plan:

**Section D:**

*\*Note: This section is* ***required*** *to be completed for all clients being reviewed by URC in order to address the Disposition.*

 [ ]  Treatment justification for on-going services is supported for an additional year

 [ ]  Treatment justification for on-going services is not supported (if not supported complete the following questions):

[ ]  Client is recommended for referral to Primary Care due to one or more of the following (check all that apply):

[ ]  No mental health related ED visits, PERT intervention START admissions or hospitalizations for >12 months

[ ]  Stable housing/social setting for 12 months

 [ ]  Low risk of harm

[ ]  High community support or independent

[ ]  No group or individual therapy in the last 6 months

[ ]  Medications within scope of primary care and/or no changes within past 6 months

[ ]  No group or individual therapy for the past 6 months

[ ]  Client self-report that they are ready to terminate

 [ ]  Client is recommended for referral to Fee for Service (FFS) or Medi-Cal Managed Care Plan (MCP)

 Psychiatry services due to one or more of the following (check all that apply):

[ ]  Moderate functioning

[ ]  Stable housing for 6 months

[ ]  Low risk of harm

[ ]  Moderate community support or independent

[ ]  Moderate illness management skills

[ ]  Complex medications not within scope of primary care and/or no changes within the past 6 months

[ ]  No hospitalizations or START admissions within the past 6 months

[ ]  No group or individual therapy for the past 6 months

Comments and Treatment Plan (be sure to include the name and contact information of referral recommendation, as well as information for boxes that were checked above and frequency of appointments):

Provider’s Printed Name and Credential:

Provider’s Signature: ­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: Click

Program Manager Printed Name and Credential:

Program Manager Signature: ­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: Click