

County of San Mateo
Behavioral Health and Recovery Services
Alcohol and Other Drug Services
Contracted Treatment Provider Evaluation
FY 2015-2016

Provider:	Date:
Modality:	
AOD Analyst:	
Provider Attendees:	

Evaluation:

Y = Yes, in Compliance

NI = Needs Improvement; it is strongly suggested that the provider implement recommended actions.

CAP = Corrective Action Plan Required; provider must submit a Corrective Action Plan no later than 30 days after this report is received to address this deficiency.

NA = Not applicable

Clinical Chart Review						
Avatar Client ID#:					Chart is: Open <input type="checkbox"/> Closed <input type="checkbox"/>	
Modality:			Facility:		Funding Source:	
	Y	NI	CAP	NA		Standard
1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DHCS AOD Program Certification Standards 17015	Intake or Admission form
2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DHCS AOD Program Certification Standards 17015	Demographic data
3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DHCS Treatment Standards for Substance Use Disorders: A Guide for Services Section 5300	Assessments
4	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DHCS AOD Program Certification Standards 17015	Consent to treatment form that is signed and dated by both client and staff
5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DHCS AOD Program Certification Standards 17015 and 21000	Confidentiality form that is signed and dated by both client and staff
6	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DHCS AOD Program Certification Standards 17020	Case file shows evidence of review/continuous quality management
7	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DHCS AOD Program Certification Standards 13000	Legible Progress Notes signed and dated by the counselor
8	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DHCS AOD Program Certification Standards 13000	Progress notes directly refer to the Treatment plan goals, and both group session and individual session progress notes are individualized.
9	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DHCS AOD Program Certification Standards 12055	Documentation of referrals to services or agencies
10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DHCS AOD Program Certification Standards 21000	Program rules, regulations and activities expected of clients
11	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DHCS AOD Program Certification Standards 21000	Fee Determination
12	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DHCS AOD Program Certification Standards 21000	Client grievance procedure

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13	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DHCS AOD Program Certification Standards 22000	Participant Rights form
14	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DHCS AOD Program Certification Standards 21000	Reasons for termination
15	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DHCS AOD Program Certification Standards 17015	Authorization to release information
16	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DHCS AOD Program Certification Standards 17015	Referral Source and Reason for Referral
17	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DHCS AOD Program Certification Standards 12020 and 17015	Health Questionnaire
18	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DHCS AOD Program Certification Standards 12070	Progress notes, Treatment Plan, counseling session sign-in sheets, and other documentation show evidence that the client receives a minimum of: 20 structured activity hours/month including 2 hours of individual counseling (Residential) 3 hours day and 3 days per week (IOP) 1 hour individual and 2 hours groups per month (Outpatient)
19	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DHCS AOD Program Certification Standards 12070	Recovery or Treatment Plan includes ALL of the following: •Problems experienced by participant •Objectives that address each problem with target dates •Action Steps to accomplish each objective with target dates
20	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DHCS AOD Program Certification Standards 12070	Treatment plan is developed within 14 days (for Residential Programs) or 30 days (for OP and IOP Programs) of admission. NRT programs – 28 days
21	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DHCS AOD Program Certification Standards 12070	Treatment Plan is reviewed and revised at least every 90 days. (Signed and dated by both the participant and the counselor.)
22	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DHCS AOD Program Certification Standards 12070	The initial Treatment Plan and all updates or revisions are signed and dated by both the counselor and participant.
23	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DHCS AOD Program Certification Standards 12085	Discharge Summaries include ALL of the following: •Criteria for discharge •Reason for discharge •Description of treatment episode services •Current AOD usage •Vocational/educational achievements •Legal status •Continuing Recovery or Exit Plan •Transfers or referrals •Participant's comments

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24	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DHCS AOD Program Certification Standards 16010	For Detox files only: A referral plan
25	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DHCS AOD Program Certification Standards 17015	Continuing recovery or treatment exit plans written prior to discharge. (Closed files only.)
26	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DHCS AOD Program Certification Standards 17015	Discharge Summary including date and reason for discharge. (Closed files only.)
27	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DHCS AOD Program Certification Standards 17015	Consent to follow-up. (Closed files only.)
Notes/Observations:						

Analyst Signature:	Date:
Supervisor Signature:	Date: