SANDHILLS CENTER

Managing Mental Health, Intellectual/Developmental Disabilities and Substance Abuse Services
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Major Depressive Disorder Monitoring Tool – Clinical Self-Review Instructions	
Question on Tool	**Instructions/Guidelines (This is what clinical reviewers look for when reading each document)**
1. Is there a complete MH assessment including medical & psychiatric co-morbidity, psychosocial status, medications, inpatient history, suicidal ideation and substance abuse involvement?	Does the evaluation contain all the elements required by Clinical Coverage Policy 8C? Is there sufficient information documented within each domain to justify medical necessity of treatment? Could another clinician "Get the full picture" of your patient based on the information provided in each domain?
2. Has possibility of co-morbidity been examined throughout course of treatment? For example, could depressive symptoms be a product of trauma, etc.?	For example, sadness, isolation, decreased sleep and focus, loss of interest in activities, and increased irritability are diagnostic criteria in both MDD and PTSD. Trauma, like substance use, is often not disclosed during initial CCA by patient. An addendum to the CCA may be warranted in cases where disclosure occurs after initial CCA is completed
3. Is there documentation of medication management? a. If YES, is there evidence of coordination with prescribing physician? b. If NO, was an evaluation recommended? c. Is there evidence of follow-up on recommendation status?	If medication management is not appropriate, NA should be marked a. Evidence of coordination of care **could** include: • consent form for prescribing provider • Non-billable coordination of care note (separate from billable note) • Email, fax, or letter between therapist and prescribing provider b. Was medication management indicated as a possible need during intake evaluation? c. Evidence of follow-up **could** include: • Consent form for prescribing provider • Discussion of follow-up/results documented in service note • Discussion of barriers to medication evaluation if identified documented in service note; as well as how barriers addressed

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4. Does frequency of visits change based on symptoms?	Documentation to support increased number of visits for a period of time **could** include: Documented crisis in service notes justifying additional sessions for a period of time Adjustment to a new life event documented in service notes Identification of a new/revised diagnosis (Addendum to the CCA, or a new CCA required)
5. Does documentation include level of patient compliance with treatment recommendations?	Documented level of compliance would be found in service notes.
6. If non-compliant, were barriers addressed?	If client is non-compliant, the expectation would be that identified barriers to care would be documented in notes, along with how those barriers were addressed
7. Has there been a change in patient's treatment needs leading to revision/addition of goals? a. If YES, has an addendum to the assessment been completed?	If goals on the treatment plan, or a change of a diagnosis is required, an addendum to the current CCA or a new CCA (if it has been more than one year from the date of the current CCA) is needed. CCA/Addendum, along with the revised or new plan (plans must be completed annually as well) must be in the patient record.
8. Has there been a change in patient's behaviors leading to revision/addition of diagnosis? a. If YES, has an addendum to the assessment been completed?	
9. For patients with a history of SI/HI, or self-harm/cutting behaviors: Is an assessment for risk of harm to self or others done each visit?	Documentation to support if ongoing assessment would be appropriate **could** be found in the CCA, treatment plan, or service notes. If ongoing assessment is found to be appropriate, evidence to support that a risk assessment is completed each visit should be documented in service notes.
10. Were types of therapies utilized in treatment recommended in the CCA (Individual, Group, Family, etc)?	Types of therapy should be documented in the CCA as recommendations, and should also be documented in the treatment plan
11. Is psychoeducation included as part of treatment plan?	Best-practice standards, and CCP 8C, call for psychoeducation to be included in treatment for patient, as well as patient's involved family members. Evidence to support psychoeducation is taking place should be in service notes.
12. Does the treatment plan include relevant evidence-based modalities for each goal?	All goals in treatment plan should include the modality to be utilized to assist patient in reaching that goal. Examples of EBP modalities **could** include CBT, DBT, Psychodynamic Therapy, and Interpersonal Therapy. The expectation is that the initial treatment plan would have more generalized modalities, but would be revised throughout course of treatment to be more specific to what works with that patient.

13. Do the service notes reflect interventions from the modality specified in the plan?	Specific goal must be identified in each service note
14. Are interventions utilized in the session easily identified in the notes?	Specific interventions for the appropriate modality documented in the plan must be clearly documented in the service note for each day of service.
15. Do notes contain details of patient's response to treatment?	Found in service notes. Patient's response to the specific interventions utilized **during the session** must be detailed, and clearly documented. Would another clinician be able to assess which interventions were successful for this patient based on this write-up?
16. Has client shown progressive improvement throughout course of treatment? a. If NO, has patient been re-assessed to determine a more effective modality? b. Was the treatment plan updated with patient to reflect changes made?	Progress/lack of progress should be clearly documented in client response section of the service notes. If minimal progress has been made within a clinically appropriate period of time, or within time-limited enhanced service; patient should be reassessed to determine if new interventions are needed, or diagnosed needs to be revised. All changes to the treatment plan must be clearly documented, dated, and signed by therapist and patient
17. Does the treatment plan include discharge plan?	For Enhanced Services: Discharge plan must follow Corresponding Clinical Coverage Policy For OPT: Discharge plan should outline level of functioning patient could expect to achieve from course of treatment. Schedule for titration of services should be outlined based on patient's realistic level of functioning. **Please remember that North Carolina is a rehabilitative state. Services are in place to assist the patient in attaining a maintainable **BASELINE** level of functioning.
18. Is there evidence that patient was informed of possible medication side-effects?	Evidence could include documentation in service notes, psychiatric evaluation, or a separate document stating that patient was informed of possible side-effects.