



# Hudson River Region BHO

## Behavioral Health Review Mental Health

Name:  Age:  Insured ID:   
County:  PH Plan:   
High need:

Does the consumer have a history of D/A service:  Yes  No

Has the consumer signed an ROI:  Yes  No

Level of care  IMH  ID  IR  
Type of review:  First  Cont'd Stay  Step Down  Discharge

Facility name:

Episode:  Admission date:  Admission hour:

Readmission:  Yes  No  Unknown Readmission to the same provider:  Yes  No

Date of review:

Reviewer's name:  Title:  Phone:

Clinician of record:  Phone:  Ext:

Housing status at admission:

Education:  Occupation:  Legal:

Legal guardian:  Yes  No

Did the consumer have a behavioral health care coordinator prior to inpatient event:  Yes  No

Was the behavioral health care coordinator contacted by the hospital during inpatient stay:  Yes  No

Was the current or prior MH outpatient provider contacted:  Yes  No



discharge:

Did the hospital on the previous admission send copies of the d/c plan and summary of treatment to the OP provider prior to the first appointment:  Yes  No

Were the multi-systems needs of the youth adequately assessed in the discharge plan:  Yes  No

Did the discharge plan adequately assess the need for referrals or linkages for provisions of basic need:  Yes  No

Did the discharge plan adequately assess whether the child has a parent/s who is/are able to care for him/her, or if there is no parent, the inpatient provider contacted:  Yes  No

Did the discharge plan adequately assess post discharge educational needs:  Yes  No

Presenting Problem:

**Assessment of Dangerousness**

Suicidal Ideation:  Y  N

Hx of Suicidal Ideation:  Y  N  U

Suicidal Attempts:  Y  N

Hx of Suicidal Attempts:  Y  N  U

Plan:  Y  N

Means:  Y  N

Access to Weapons:  Y  N

**Last review for this stay**

Suicidal Ideation:  Y  N

Hx of Suicidal Ideation:  Y  N  U

Suicidal Attempts:  Y  N

Hx of Suicidal Attempts:  Y  N  U

Plan:  Y  N

Means:  Y  N

Access to Weapons:  Y  N

Homicidal Ideation:  Y  N

Hx of Homicidal Ideation:  Y  N  U

Homicidal Attempts:  Y  N

Hx of Homicidal Attempts:  Y  N  U

Plan:  Y  N

**Last review for this stay**

Homicidal Ideation:  Y  N

Hx of Homicidal Ideation:  Y  N  U

Homicidal Attempts:  Y  N

Hx of Homicidal Attempts:  Y  N  U

Plan:  Y  N

Means:  Y  N  
Access to Weapons:  Y  N

Means:  Y  N  
Access to Weapons:  Y  N

Assaultive Behavior:  Y  N  
Hx of Assaultive Behavior:  Y  N  U  
Aggressive Behavior:  Y  N  
Hx of Aggressive Behavior:  Y  N  U  
Self Injurious Behavior:  Y  N  
Hx of Self Injurious Behavior:  Y  N  U  
Able to Contract for Safety  Y  N

**Last review for this stay**  
Assaultive Behavior:  Y  N  
Hx of Assaultive Behavior:  Y  N  U  
Aggressive Behavior:  Y  N  
Hx of Aggressive Behavior:  Y  N  U  
Self Injurious Behavior:  Y  N  
Hx of Self Injurious Behavior:  Y  N  U  
Able to Contract for Safety  Y  N

Auditory:  Y  N  
Visual:  Y  N  
Command:  Y  N  
Hx of Command:  Y  N  U  
Delusions:  Y  N  
Paranoia:  Y  N

**Last review for this stay**  
Auditory:  Y  N  
Visual:  Y  N  
Command:  Y  N  
Hx of Command:  Y  N  U  
Delusions:  Y  N  
Paranoia:  Y  N

**Mood**

Labile:  Depressed:   
Erratic:  Manic:   
Appropriate:

**Last review for this stay**

Labile:  Depressed:   
Erratic:  Manic:   
Appropriate:

**Affect**

Blunted:  Restricted:   
Elated:  Congruent:   
Appropriate:

Blunted:  Restricted:   
Elated:  Congruent:   
Appropriate:

**Interventions**

Ability to Care for Self:  Y  N  U

**Last review for this stay**

Y  N  U

Appetite:

Sleep:

Insight:

Judgment:

Impulse Control:

Memory:

Socialization:

Co-Occurring Disorder:  Yes  No

Provider's Plan for Follow-up treatment:

**Diagnosis**

Axis:  Diagnosis:  ← Repeating Rows

Axis:  Diagnosis:

**MNC Criteria:**  Mihalik © 2003-2011 The Mihalik Group. All rights reserved.

Treatment Continuation Criteria: Each of the following Treatment Continuation Criteria is required throughout the episode of care.

- Met  Not Met
  1. The individual continues to meet the treatment initiation criteria each day that services are provided at this level or this is the least restrictive level of care available to safely treat the member.
  
- Met  Not Met
  2. There is an individualized plan of active treatment, developed with the individual as a part of the treatment team, that specifies the goals, interventions, time frames, and anticipated outcomes appropriate to:
    - a. Improve or prevent deterioration of the symptoms of, or impairment in functioning resulting from,
    - AND**
    - b. Address a co-morbid substance use disorder or condition, if one exists.
  
- Met  Not Met
  3. The treatment goals, interventions, time frames, anticipated outcomes, discharge plan, and criteria for discharge are clinically efficient and reasonable.
  
- Met  Not Met
  4. Treatment is being rendered in a timely and appropriately progressive manner.
  
- Met  Not Met
  5. There are daily progress notes describing the therapeutic interventions rendered and the individual's response.
  
- Met  Not Met
  6. As appropriate, there is involvement of members of the individual's social support systems, including family and educational systems when indicated, in the individual's treatment and discharge planning.

Advisor review required:  Yes  No

Reason:

**Medications**

Adherence to meds:  Yes  No

Family/Support educated on consumer's meds:  Yes  No

**PH/BH Integration**

Does the consumer have a physical health condition that interferes with activities of daily living:  Yes  No

Does the consumer's physical health condition influence their behavioral health disorder:  Yes  No

Is there a Health home:  Yes  No

Was Health home notified:  Yes  No

Is there a PCP:  Yes  No

PCP involved:  Yes  No

Height(inches):  Weight(lbs):  BMI:   Automatically Calculated

Smoker:  Yes  No Cessation discussed:  Yes  No

**Transition Planning**

Referral type	Level of care	Provider	Appt date
<input type="text"/>	<input type="text"/>	<input type="text"/>	00/00/0000
<input type="text"/>	<input type="text"/>	<input type="text"/>	00/00/0000

Was a PH referral indicated:  Yes  No

Was a MH referral indicated:  Yes  No

Was a D/A referral indicated:  Yes  No

Was a housing referral indicated:  Yes  No

AOT petition filed:  Yes  No

AOT petition outcome:

SPOA application submitted:  Yes  No

Service requested:

**Elements of D/C Plan:**

Crisis/Wrap Plan:  Yes  No

- Was consumer involved in D/C planning process:  Yes  No
- Was the consumer involved in provider selection:  Yes  No
- Was family/support system involved in d/c planning process:  Yes  No
- Was the supports involved in provider selection:  Yes  No
- Did the provider seek information about consumer preferences:  Yes  No
- Did the provider assess the consumer's treatment expectations:  Yes  No
- Is there evidence of a consumer's education about the MH or D/A system:  Yes  No
- Was the discharging staff knowledgeable about the community treatment options:  Yes  No
- Was a referral made to ACT/ICM/BCM:  Yes  No
- If ACT/ICM/BCM were involved prior to admission, did the inpatient program appropriately notify them of discharge:  Yes  No
- Did the hospital on the previous admission send copies of the d/c plan and summary of treatment to the OP provider prior to the first appointment:  Yes  No
- Were the multi-systems needs of the youth adequately assessed in the discharge plan:  Yes  No
- Did the discharge plan adequately assess the need for referrals or linkages for provisions of basic need:  Yes  No
- Did the discharge plan adequately assess whether the child has a parent/s who is/are able to care for him/her, or if there is no parent, the inpatient provider contacted:  Yes  No
- Did the discharge plan adequately assess post discharge educational needs:  Yes  No

Issues that interfere with consumer's recovery. Identify action steps planned to address barriers.

Barrier	Intervention
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

**Determination**

Days

From Date

To Date

Determination

Reason