NORTH CAROLINA DIVISION OF AGING
NC AREA AGENCIES ON AGING

PERFORMANCE REVIEW: MENTAL HEALTH COUNSELING
Part I: Program Verification

Agency: Date:
Name of Subcontractor, if applicable:
Agency Staff Interviewed:
Signature of Reviewer: _____

PROGRAM DEFINITION (Standards sec. III) 1. Identify which of the allowable services are provided and check whether or not the service is provided under a subcontract:	√ Agency staff provides service	√ Subcontractor staff provides service
Case Consultation	☐	☐
Evaluation	☐	☐
Outpatient treatment	☐	☐

CLIENT ELIGIBILITY (Standards sec. IV)

2. The agency only serves persons age 60 years of age or older who are experiencing mental health problems or a family member caring for an eligible older person.

   (i.e., client records, outreach materials, service policies, etc.)

   Yes ☐ No ☐ NA ☐

SERVICE PROVISION (Standards sec. V)

<u>Outpatient Treatment</u> (Standards sec. V.C)

3. The agency's records show that the following services were NOT provided to an eligible adult as part of outpatient treatment supported by HCCBG Mental Health Counseling: partial hospitalization.

   (i.e., client records, etc.)

   Yes ☐ No ☐ NA ☐

4. The agency's records show that a written treatment plan was developed within 30 days of accepting an eligible older adult for outpatient treatment.

   (i.e., client records, etc.)

   Yes ☐ No ☐ NA ☐

STAFFING REQUIREMENTS (Standards sec. VII)

<u>Qualified Mental Health Professionals</u> (Standards sec. VII)

5. Worksheet A documents that Mental Health Counseling Services have been provided by qualified mental health professionals.

   Yes ☐ No ☐ NA ☐

WORKSHEET A: PROFESSIONAL CREDENTIALS

Mental Health Counseling services must be provided by a "qualified mental health professional" as defined in 10A NCAC 27G.0104:

- An individual who holds a license, provisional license, certificate, registration or permit issued by the governing board regulating a human service profession, except a registered nurse who is licensed to practice in the State of North Carolina by the North Carolina Board of Nursing who also has four years of full-time accumulated experience in MH/DD/SA with the population served; or
- A graduate of a college or university with a Masters degree in a human service field and has one year of full-time, post-graduate degree accumulated MH/DD/SA experience with the population served, or a substance abuse professional who has one year of full-time, post-graduate degree accumulated supervised experience in alcoholism and drug abuse counseling; or
- A graduate of a college or university with a bachelor's degree in a human service field and has two years of full-time, post bachelor's degree accumulated MH/DD/SA experience with the population served, or a substance abuse professional who has two years of full time, post-bachelor's degree accumulated supervised experience in alcoholism and drug abuse counseling; or
- A graduate of a college or university with a bachelor's degree in a field other than human services and has four years of full-time, post-bachelor's degree accumulated MH/DD/SA experience with the population served, or a substance abuse professional who has four years of full-time post-bachelor's degree accumulated supervised experience in alcoholism and drug abuse counseling.

Make additional copies of this worksheet as needed.	CHECK ONE		How did AAA determine if staff providing services are Qualified Mental Health Professionals according to 10A NCAC 27G.0104?
Mental Health Professional's Name	HCCBG Provider Staff?	Subcontractor Staff?	Type of documentation reviewed:
_____	☐	☐	☐ Current License Type: _____ *(e.g., LCSW, PHD, etc.)* Expiration Date: _____ ☐ Human Services Diploma Field: _____ *(e.g., psychology, sociology, etc.)* Type: _____*(e.g., MA, BA, BS, etc.)* ☐ Non-Human Services Diploma Field: _____ *(e.g., economics, biology, etc.)* Type: _____ *(e.g., MA, BA, BS, etc.)* ☐ Resume Experience Type: _____ Length of Experience: _____

Signature(s) of reviewer(s)_____ **Date**

WORKSHEET B: CLIENT/SERVICE RECORD REVIEW Reviewer should select an appropriate client sample from ARMS reports and agency logs. Make as many copies of this worksheet as needed.

Attach a copy of ARMS report ZGA-542 from which the Outpatient Treatment client sample was drawn. Month/Year reviewed _____

					IF CLIENT RECEIVED OUTPATIENT TREATMENT, COMPLETE THESE COLUMNS.						UNIT VERIFICATION
#	CLIENT NAME	Type of service provided to client? CC= Case Consultation E= Evaluation OT= Outpatient Treatment	Eligible client? Client DOB? Indicate documentation reviewed	If client received CC or E, provider maintains a log of such?	Date of most recent CRF (DAAS-101)?	CRF (DAAS-101) &/or DSS-5027* is complete?	CRF updated at least every 12 months?	If client received OT, the provider maintains a client record for client?	If client received OT, then Treatment Plan developed within 30 days of the initiation of out patient treatment?	If client received OT, Treatment Plan revised every 6 months from date of initial Treatment Plan or sooner if clinically indicated?	Total # of Units recorded in ARMS for Client Documentation Reviewed to determine if # of Units match invoices
1			☐ _____	☐		☐	☐	☐	☐	☐	
2			☐ _____	☐		☐	☐	☐	☐	☐	
3			☐ _____	☐		☐	☐	☐	☐	☐	
4			☐ _____	☐		☐	☐	☐	☐	☐	
5			☐ _____	☐		☐	☐	☐	☐	☐	
6			☐ _____	☐		☐	☐	☐	☐	☐	
7			☐ _____	☐		☐	☐	☐	☐	☐	

8			☐ _____	☐		☐	☐	☐	☐	☐	
9			☐ _____	☐		☐	☐	☐	☐	☐	
10			☐ _____	☐		☐	☐	☐	☐	☐	

* DSS-5027- only applicable for Departments of Social Services Records.

Signature of reviewer(s)_____Date

WORKSHEET C: SUMMARY OF DOCUMENTATION REVIEWED

1. Indicate where client/service source documentation reviewed by the AAA is located (check all that apply):

   ☐ HCCBG provider agency's office ☐ Subcontractor's office ☐ Other (specify:)

2. Check all documentation related to clients and services reviewed by the AAA during this monitoring visit.

   ☐ AAA reviewed HCCBG agency's completed monitoring tool documenting that the provider reviewed appropriate records for the subcontract.

   ☐ AAA reviewed HCCBG agency's log of case consultation and evaluation services provided.

   ☐ AAA reviewed HCCBG agency's client records (DAAS-101 and/or DSS-5027) for clients receiving Outpatient Treatment.

   ☐ AAA reviewed HCCBG agency's written treatment plan for clients receiving Outpatient Treatment.

   ☐ AAA reviewed HCCBG agency's consumer contributions documentation.

Signature of reviewer(s) _____ **Date**

Your comment and/or note section:
e.g., any corrections needed, what documentation were reviewed, any TA provided, any follow-up needed. **Please provide an explanation below if you answered n/a, no or left an answer blank.**