MENTAL HEALTH PROFESSIONALS' PEER HEALTH ASSISTANCE PROGRAM

Practice Monitor Report

Licensee ______________________________________ License Number ______________________________

Telephone Number _____________________________ E-mail Address _______________________________

Address ____
Street City ZIP

Practice Monitor's Name ____

CAC III LPC LAC LCSW LMFT Licensed Psychologist

Telephone Number ____________________________ E-mail Address_______________________________

Address ____
Street City ZIP

This report is being submitted for the month(s) of ___________________through ___________________

Date(s) of Visit(s) ________________________________ Number of Records Reviewed ______________

This is report # (number of report submitted) ________

Based on the Stipulation and Final Agency Order/Rehabilitation Contract, this report will review (check):

☐ Diagnostic and Treatment Planning Skills, inclusive of formulation and implementation of treatment planning	☐ Clinical knowledge and experience, inclusive of knowledge of strengths and limitations of the theoretical orientation chosen
☐ Ability to make an imminent risk assessment, as appropriate or necessary	☐ Ability to ensure appropriate termination, including criteria for termination and readmission for treatment
☐ Boundaries, transference and countertransference	☐ Ethics
☐ Supervision	☐ Record Keeping
☐ Fiscal Activity	☐ Practice management
☐ Other ______________________________	☐ Other ______________________________

Email: reports@peerassist.org

Fax: Last name A-L 720.213.1007
Last Name M-Z 720.213.0002

Mail: Peer Assistance Services
2170 S. Parker Road, Suite 229
Denver, CO 80231

In Person: Peer Assistance Services, Inc.
2170 S. Parker Road, Suite 229
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or Peer Assistance Services, Inc.
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Physical Facility	**1** **Deficient**	**2** **Needs Improvement**	**3** **Consistent Improvement**	**4** **Satisfactory**	**N/A**
1. Satisfactory general appearance, cleanliness, and orderliness of reception and business areas?					
2. Is office space organized to increase the therapeutic experience of the clients?					
Observations and Comments: **Please provide a narrative statement of your observations. Include the following: deficiencies, areas of concern, is the licensee practicing at standard of care, areas for improvement, plan of action, etc.**					
***Areas that marked below the grade of 4*: Please explain and give the processes that have been put into place to meet a satisfactory (4) grade.**					

Staff Management	**YES**	**NO**
1. Is the staff aware of the licensee's Final Agency Order (FAO), Stipulation and Order, and/or the Mental Health Professional Rehabilitation Contract? *(The purpose of question is to avoid inadvertent disclosure)*	Who?	
2. Does the licensee keep odd hours? Chronic tardiness or absence? Early arrivals or late departures? Frequent bathroom breaks?	Observations:	
3. Does any staff member keep odd hours? Chronically tardy or absent? Arrive early or depart late? Frequent bathroom breaks?	Who? Observations:	

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4. Does the licensee or any staff member exhibit mood swings, slurred speech, excitability, hand tremor, or sweating??	Who? Observations:	
7. Does the staff work together to ensure the practice is run smoothly?	Who? Observations:	
8. Does the staff appear to support the practitioner?	Who? Observations:	

***Observations and Comments*: Please provide a narrative statement of your observations. Include the following: any deficiencies, is the licensee practicing at standard of care, any areas of concern, any areas for improvement, plan of action, etc.**

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Record Keeping	**1** **Deficient**	**2** **Needs Improvement**	**3** **Consistent Improvement**	**4** **Satisfactory**	**N/A**
1. a. Do the record entries reviewed follow a consistent and logical order in all or most charts reviewed?					
b. Are they legible?					
c. Are records appropriately signed?					
2. a. Is there a Disclosure Statement?					
b. Is the information about the practice monitor included in the disclosure statement?					
c. Is there an appropriate emergency contact?					
d. Are there appropriate HIPAA forms/consents?					

Observations and Comments: **Please provide a narrative statement of your observations. Include the following: any deficiencies, is the licensee practicing at standard of care, any areas of concern, any areas for improvement, plan of action, etc.**

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Clinical Knowledge	**1** **Deficient**	**2** **Needs Improvement**	**3** **Consistent Improvement**	**4** **Satisfactory**	**N/A**
1. a. Does the licensee understand different theoretical orientations, their advantages and limitations?					
b. Are appropriate modalities used?					
2. a. Is supervision or consultation utilized appropriately?					
b. Is there knowledge of transference and countertransference and are those managed effectively?					
c. Is continuing education obtained regularly?					
3. a. Is there a full diagnosis and treatment plan?					
b. Is the licensee up to date with current research in order to implement a correct treatment plan?					
c. Is literature utilized in treatment planning?					
d. Does the licensee review the treatment plan and make changes as necessary?					
4. a. Is the licensee able to make imminent risk assessment, as appropriate or necessary?					
b. Can the licensee list factors shown to increase risk for suicide or assaultiveness?					

Observations and Comments: **Please provide a narrative statement of your observations. Include the following: any deficiencies, is the licensee practicing at standard of care, any areas of concern, any areas for improvement, plan of action, etc.**

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Boundaries	**1**	**2**	**3**	**4**	**5**
	Deficient	**Needs Improvement**	**Consistent Improvement**	**Satisfactory**	**N/A**
1. Are there appropriate boundaries between the Licensee and the clients?					
2. Is supervision utilized if the Licensee notices that s/he is not maintaining consistent boundaries with clients?					

Observations and Comments: **Please provide a narrative statement of your observations. Include the following: deficiencies, areas of concern, is the licensee practicing at standard of care, areas for improvement, plan of action, etc.**
etc.

***Areas that are marked below the grade of 4*: Please explain and give the processes that have been put into place to meet a satisfactory (4) grade.**

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Fiscal Activities	YES	NO
1. Are billings and insurance claims handled properly?		

Observations and Comments: **Please provide a narrative statement of your observations. Include the following: any deficiencies, is the licensee practicing at standard of care, any areas of concern, any areas for improvement, plan of action, etc.**
Areas that are marked below the grade of 4**: Please explain and give the processes that have been put into place to meet a satisfactory (4) grade.**

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Based on the Stipulation requirements and/or my observations, the following areas need to be addressed (this area can also include areas not specifically addressed by the Stipulation: ______________________________________
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Based on the Stipulation requirements and/or my observations, I discussed the following with the Licensee (Be specific as to what exactly was addressed and if any resolutions and/or changes have been made):
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The Licensee is seeing clients outside of his/her specialty area. Yes No
If yes, please explain.____
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I have reviewed _______files this months. The number represents all active cases for the Licensee and I feel it is/is not an adequate number of cases. Please provide an explanation/intervention if you circled that the number is not adequate____
____
____
____
____

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Overall review and comments: ____
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Licensee:

I hereby certify that I do not work with the Practice Monitor (unless pre-approved by the Board), and am not related to him/her, nor do I provide any remuneration to him/her or his/her practice other than the fee he/she has agreed to receive for monitoring services.

☐ The Practice Monitor has reviewed this completed document with me.

Signature of the Licensee ____ Date ___________________

Practice Monitor:

I hereby certify that I do not work with the Licensee (unless pre-approved by the Board), and am not related to him/her, nor do I receive any remuneration from him/her or his/her practice other than the fee he/she has agreed to pay for monitoring services. I have no conflict of interest in carrying out these duties and I can be an impartial representative of the Board. The Licensee is practicing psychotherapy and/or addiction counseling practice, as applicable, in accordance with generally accepted standards of practice and with skill and safety for the clients.

☐ I have reviewed this document with the Licensee.

Signature of the Monitor ____ Date___________________

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