# Audit Tool

## Information

<table>
<thead>
<tr>
<th>Code</th>
<th>Agency Name</th>
</tr>
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<tbody>
<tr>
<td>137</td>
<td>Blue Mountain Counseling</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Client Id</th>
<th>Client Name</th>
<th>Reviewer</th>
<th>Review Date</th>
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<tbody>
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Comments:

Note: The scale used in this tool is as follows (0=*n/a, 1=not met, 2=met)

## Intake

1. The Intake was done by a mental health professional, as evidenced by signature with credentials.: *

   § WAC 388-877-0610; WAC 388-877A-0130; PIHP

   Comments:

2. The Intake was completed within 30 working days of its initiation.: *

   § PIHP 15.3.9; WAC 388-877A-0130

   Comments:

3. The time period from request for mental health services to first Routine services appointment offered must not exceed 28 calendar days.: *

   § PIHP 5.6.3.10.2.2.2.7

   Comments:

4. There is evidence that cultural and age relevant issues were assessed during Intake. If the Enrollee is under 21 years of age, the intake contains developmental history of the Enrollee.: *

   § WAC 388-877-0660; PIHP 5.8.8.4

   Comments:
5. The Intake documents presenting problem(s) as described by the individual, and are inclusive of input from people who provide active support to the individual, if requested or if the individual is less than 13 years old.: *

6. The Intake documents the individual’s current health status, including any medication the individual is taking.: *

7. The Intake documents DSM 5 diagnosis(s) as covered by the Access to Care Standards for BHOs, AND there is sufficient information to justify the diagnosis and establish medical necessity.: *

8. An assessment of risk for suicide/homicide and self-harm was completed AND, if warranted, a referral for provision of emergency/crisis services was made.: *

9. There is evidence that, during the Intake process (i.e., within 30 days of the initial intake session) that the individual was asked whether s/he is under supervision of the department of corrections, or volunteered that information.: *

10. The Intake includes a recommendation regarding the course of treatment.: *

11. If there was an EPSDT referral, there is evidence that the Physician, ARNP, PA, trained public health nurse or RN who made the EPSDT referral was contacted following Intake: *
12. The initial assessment must include and document the medical provider’s name. If the enrollee does not identify a primary care provider, there is evidence that the CMHC provider assisted the Enrollee in calling the 1-800 number to locate a physical health care provider. 

§ PHP 10.9.3.6, 12.2.1.1
Comments:

13. There is evidence that the service plan was consumer-driven and strength-based. The service plan was initiated with at least one goal identified by the individual (or legal representative) at the time of Intake or during the first routine service appointment following the Intake.

§ WAC 388-877A-0135, 388-877-0620 PHP 15.3.8
Comments:

14. The medical record contains a completed service plan that was developed within the 30 days following the first routine services appointment after the Intake.

§ WAC 388-877A-0135
Comments:

15. The service plan addresses age, gender, cultural, and disability issues identified by the individual or family member or legal representative if applicable, and incorporates consumer-identified strengths.

§ WAC 388-877-0620
Comments:

16. The service plan contains measureable goals and/or objectives that assist the individual and clinician in demonstrating progress toward identified recovery goals.

§ WAC 388-877-0620
Comments:

17. The service plan contains language that is understandable to the individual and the individual's family or legal representative. Documentation demonstrates that the individual participated in service plan development and mutually agrees with it as evidenced by signature or written quote. A copy of service plan was provided to the individual.
18
If the service plan was not generated by a Mental Health Professional, approval by an MHP is demonstrated via MHP signature.: *

Comments:

19
There is evidence that the service plan was reviewed at least every 180 days, and was updated to reflect any changes in the individual’s needs or desires concerning treatment. The review process includes assessment of the level of care and the effectiveness of the plan of treatment, and discussion with the individual regarding progress toward the treatment goals, and changes in the level of functionality in daily activities. The service plan is updated to address applicable changes in identified needs, strengths and achievement of goals and objectives.: *

Comments:

20
The service plan defines the contribution of formal and informal supports to achieve outcomes, including coordination with any family service plan when the child is under three years of age, AND there is evidence that the individual (or his/her legal representative) has consented to the sharing of information necessary to coordination between the provider and these support systems.: *

Comments:

21
If the individual has suspected or identified physical health problems, the service plan identifies them and includes plans to address them.: *

Comments:

Service Delivery

22
Transition Age Youth issues are addressed with consideration for a comprehensive plan to link cross systems when applicable, which might include transition to meaningful employment, education, technical training, housing, community support and natural supports.: *

Comments:
23. If the individual's primary language is not English, or the individual has a sensory impairment, appropriate mechanisms were employed for all interactions. *

§ PHIP 10.0.3.4, 11.0.2.1 and 11.3.2
Comments:

24. Services are provided in the least restrictive setting at locations convenient for the consumer (home, community, etc.). *

§ PHIP 15.3.0
Comments:

25. If the individual had an LRA order, periodic evaluation occurred at least monthly while the order was in effect to determine readiness for release from the Order. A copy of the LRA order is contained in the clinical record. *

§ WAC 388-077A-0195
Comments:

26. If the individual had an LRA order, services were provided at least weekly for the first 14 days, and monthly during the 90 and 180 day periods of involuntary commitment, unless there is documentation that a physician or Psychiatric ARNP determined that another schedule was more appropriate. *

§ WAC 388-077A-0195
Comments:

27. If the individual has been prescribed medication, the prescriber was appropriately licensed and there is documentation that the prescriber reviewed the medication for effects, interactions and side effects. The name and purpose of each prescribed medication is provided. Identification of medications requiring laboratory monitoring and a frequency schedule for monitoring must be provided, as well as reasons for changing or stopping any medication. *

§ WAC 388-077A-0180
Comments:

28. If the individual has been prescribed medications and target symptoms for each medication have been identified. *
29
If the individual has been prescribed medication, there is documentation demonstrating that sufficient information was provided to enable informed consent by the individual or his/her legal guardian to the medication AND that it was provided in consultation with the individual AND that consent occurred.: *

§ WAC 388-977A-0180
Comments:

Save

Clinical Record

30
The Contractor must ensure that medical necessity is established and documented, and that the Access to Care Standards for BHOs for mental health has been met. The Notice of Authorization must be contained in the Enrollee's chart.: *

§ PIRP 10.9.3.1
Comments:

31
There is evidence in the medical record that consumer (or legal representative) received and understands the consumer's rights statement.: *

§ WAC 388-977-0600
Comments:

32
The Contractor must inform all Enrollees of their right to a Mental Health Advance Directive, and must provide technical assistance to those who express an interest in developing and maintaining one. This requirement includes Individuals diagnosed with a Substance Use Disorder as per RCW 71.32, which states that "Mental disorder" means any organic, mental, or emotional impairment which has substantial adverse effects on an individual's cognitive or volitional functions. The Contractor must inquire whether Enrollees have active Medical Advance Directives, and must provide those who express an interest in developing and maintaining Medical Advance Directives with information about how to initiate a Medical Advance Directive. If the Enrollee provides a current copy of an Advance Directive, it must be maintained in the Enrollee's clinical record.: *

§ PIRP 11.6.1.11.6.2.11.6.5
Comments:

33
The medical record contains either a copy of guardianship papers or other legal documentation pertaining to custody, if applicable, or documentation of efforts to obtain such materials.: *

§ WAC 388-065-0610
Comments:
If the individual is receiving high intensity services, or is at risk of hospitalization, the record includes documentation concerning the need for a crisis plan AND/OR any crisis plan that was developed. If a crisis plan is present, there must be evidence of the individual's involvement in its development, and it must reflect strategies intended to stabilize the individual, prevent further deterioration, and provide services in the least restrictive environment available. *

§ PHP 15.3.7
Comments:

If the consumer is a member of a special population, and there is evidence of a need for consultation with or oversight by a specialist, documentation of that consultation is included in the record.: *

§ WAC 388-577-0020/ PHP 15.3.16
Comments:

The clinical record demonstrates congruence between the Intake Assessment, Service Plan, and Service delivery (including extraordinary treatments and deviations from treatment plan), documents objective progress toward achieving treatment goals, and reflects attention to changes in the individual's circumstance.: *

§ PHP 10.5.3.1
Comments:

If there is indication that abuse, neglect or exploitation is suspected or evident, the clinical record includes documentation demonstrating that it was reported to the appropriate authorities.: *

§ WAC 388-577-0640
Comments:

If the provider has information indicating that an individual on a less restrictive alternative or department of corrections order, there is documentation that the department of corrections was notified in the manner required by WAC.: *

§ WAC 388-577-0640
Comments:

The clinical record includes a either a consent for treatment signed by the consumer or his/her legal representative, or a copy of the detention or involuntary treatment order.: *

§ WAC 388-577-0640
Comments:

The record contains an authorization to release information that is signed by the consumer or legal guardian if any information is
41. Documentation of service delivery throughout the clinical record (i.e., Intake, Service Planning, and Service Delivery) reflects attention to the GCBH Practice Guidelines relevant to the individual’s care. (Recovery-Oriented Healthcare - Employing Strengths-Based Assessment and Prescribing of Psychiatric Medications to Children and Adolescents).

42. If the individual experienced crisis, documentation reflects a brief summary of each crisis service encounter, including the date, time, and duration of the encounter, the names of the participants, and a follow-up plan, including any referrals for services, including emergency medical services.