SBHO Integrated Clinical Review Tool									
Agency/Provider								Location	**Auditors Notes**
Review Date								**For Providers:** Please enter in the location of where to find the required information in this column.	**For Auditor:** This column is to be used to help score the required items. Note: Underline items are hyperlinks.
SBHO Clinical Reviewer									
Scoring: Met (2), Partially Met (1), Not Met (0), or N/A.									
		Client ID	**Client ID**	**Client ID**	**Client ID**	**Client ID**			
Behavioral Health assessment/Assessment									
Requirements for assessment is referenced in WAC 388-877-0610, Access to Care Standards (ACS), 42 CFR Part 2,SBHO Policy, PIHP Contract, and Behavioral Health State Contract (BHSC) Contract.									
#	**Requirement**	**Score**	**Score**	**Score**	**Score**	**Score**	**Comments**	**Location**	**Auditor's Notes**
1	Date of Request for Services								Enter date.
2	Date of assessment.								Enter date.
3	Days Between Request and assessment (Initiated within 10 working days from request of services)	**0**							Self-calculating.
4	Date of First Routine service								Enter date.
5	Days Between Request and First Routine Service	**0**							Self-calculating.
6	The first service occurred within 28 days.								
7	If routine service did not occur within 28 days there is adequate documentation explaining why.								N/A within 28 days.
8	If the individual did not receive a first routine appointment within 28 days, engagement efforts were adequate and appropriate to the individual.								
9	The assessment includes the presenting problems as described by the individual and others providing support to the individual, with consent if age 13 or older.								Under age 12 with agency discretion.
10	There is sufficient information to demonstrate medical necessity to access to care services, including justification of a DSM-5 diagnosis and criteria.								Access to Care Standards
11	Initial assigned level is appropriate for individual's diagnosis, symptomatology, and service. Criteria adheres to guidelines in current SBHO Levels of Care, including ASAM/PPC.								SBHO 7.03 MH LOC and 7.08 SUD LOC
12	GAIN-SS completed at time of assessment and is included in determining medical necessity.								
13	The assessment documents history of substance abuse (including tobacco) or problem and pathological gambling and treatment. Including type of substance, route of administration, and amount, frequency, and duration of use.								
15	There are current releases of information, with specific end dates, from people who provide active support, such as family, friends, community supports.								May include primary care, housing, DSHS, Social Security, SUD treatment, pharmacy, etc.

16	The assessment is culturally and age relevant, according to CLS standards. Including a developmental history. A specialist consultation was completed when required or clinically indicated.								1. Ethnic Minorities: When clinically indicated; 2. Children: In all cases; 3. Geriatric: When clinically indicated; and 4. Developmental Disability: When clinically indicated.
17	The assessment includes the current physical health status.								Includes medications.
18	If there is a PCP, the name is documented. If the individual does not have a PCP, they are referred to one.								Include EPSDT for individuals under 21.
19	The assessment documents any previously accessed inpatient or outpatient services and/or medications to treat a mental health condition.								
20	Documentation of screening for support employment services.								WAC 388-845-2100
21	The assessment indicates whether they are under the supervision of the department of corrections (DOC).								Refer to RCW 71.05.445 for notification requirements.
22	There is an identification of risk of harm to self or others, suicidal or homicidal ideation. Pregnant women (PPW) and intravenous use (IUID) (SUD only). Referral to appropriate services.								
23	**SUD only:** HIV brief risk intervention is documented.								
24	The assessment includes a recommendation of a course of treatment.								
25	Referrals to specialized (non-standard) services appropriate to the individual needs are documented in the clinical chart, including additional assessment tools to justify medical necessity for those services.								For example: PACT, WISe, Supported Employment, Residential, Permanent Supported Housing.
26	The assessment includes sufficient clinical information to justify determined Access to Care Standards (ACS) by an appropriate credentialed professional.								Includes: Behavioral Health diagnosis, documented impairments and needs determined, intervention is reasonably necessary to improve functioning, expected benefit from intervention, and need cannot be met by other systems or supports. Assessment indicates ASAM dimension and/or current level of care (LOC) specific to the individual's needs.

27	Appropriate referrals have been made to external providers, resources, and programs, specific to the need reported by the individual.								May include primary care, housing, DSHS, Social Security, SUD treatment, pharmacy, etc.
Individual Service Plan (ISP)									
Requirements for Initial Individual Service Plan (ISP) is referenced in WAC 388-877-0620, WAC 388-877-0640, WAC 388-877-0714, WA PACT Standards, SBHO Policy, PIHP Contract, and Behavioral Health State Contract (BHSC) Contract.									
#	**Requirement**	**Score**	**Score**	**Score**	**Score**	**Score**	**Comments**	**Location**	**Auditor's Notes**
1	The ISP was initiated during the first session following the assessment with at least one goal identified by the individual or if applicable, the individual's parent or legal representative.								
2	Address issues identified by the individual, parent or representative; terminology understandable by the individual and the family; document that the plan was mutually agreed upon and a copy was made to the individual (e.g. client voice).								
3	Includes measurable goals or objectives, or both, and interventions, that are clear and measurable (e.g. Specific, Measurable, Attainable, Realistic, and Time sensitive (SMART)).								
4	The ISP is updated every 180 days to address applicable changes in identified needs and achievement of goals.								If **group**: The plan indicates a defined problem, goal, and intervention specific to the clients needs. If **day treatment**: The plan indicates a defined problem, goal, and intervention specific to day treatment services (*including one of the following* : basic living and social skills, and educational, vocational, pre-vocational, and day activities).
5	The ISP documents the plan was reviewed and updated to reflect any changes in the individuals treatment needs, or as requested by the individual or, if applicable, the individuals parent or legal representative.								
6	Review for completion or approval by a appropriately credentialed professional.								E.g. MHP, CMHS, CDP, or CDPT.
7	**SUD only:** The ISP must be reviewed to determine the need for continued services using ASAM criteria.								
8	**SUD Intensive Inpatient only:** An ISP has been created and signed by the individual within five days of admission**.**								

9	**PACT Individualized Treatment Plan only:** The plan delineates roles and responsibilities of the team members who will carry out the services indicated in the ITP.								
10	**PACT Individualized Treatment Plan only:** The plan indicates planned interventions, addressing when, where, and provided by whom, that can be daily, weekly, and/or monthly indicated.								
Clinical Record									
Requirements for Clinical Record is referenced in WAC 388-877-0640, WAC 388-877-1111 to 388-877-1140, WAC 388-877-0805, RCW 71.05.585, 42 CFR Pt. 2, WA PACT Program Standards, SBHO Policy, PIHP Contract, and Behavioral Health State Contract (BHSC) Contract.									
#	**Requirement**	**Score**	**Score**	**Score**	**Score**	**Score**	**Comments**	**Location**	**Auditor's Notes**
1	The clinical record indicates individual received a copy of the counselor disclosure requirements as required for the counselors credential.								
2	Verify face sheet/demographics.								Required: Employment status, Education, marital status, living arrangement, language, ethnicity, sexual orientation, race, military, and smoking status.
3	Documentation of the individual response when asked if under: department of corrections (DOC) supervision; civil or criminal court ordered mental health or substance use disorder treatment; and there is a court order exempting the individual participant from reporting requirements.								A copy of the court order must be included in the clinical record if exemption from reporting requirements.
4	The clinical record documents that the individual has been informed of RCW 71.05.445, regarding mental health services for individuals under department of corrections (DOC) supervision.								RCW 71.05.445
5	The clinical record documents the individual has been informed of HIPAA.								
6	The clinical record documents the individual has been informed of confidentiality requirements under 42 CFR Part 2.								
7	Progress notes, including group notes, must include date, time, duration, participant's name, name of staff and appropriate credential.								
8	Progress notes must include a brief summary of the session, interventions utilized, and response to interventions.								If **group**: Description of each group's purpose and individualized response to intervention.
9	Documentation of coordination with any system or organizations the individual identifies as being relevant to treatment, with the individual's consent or if applicable, the consent of the individual's parent or legal representative.								E.g. Department of Corrections, DSHS, SS, PCP, etc.

10	**Day Treatment only:** Day treatment services show participation as evidenced by one of the following services: training in basic living and social skills, and educational, vocational, pre-vocational, day activities, and may include therapeutic treatment.								
12	**Discharge From Outpatient Services (Without Notice) only:** Discharge statement if the individual left without notice.								
13	**Discharge From Outpatient Services (With Notice) only:** Discharge summary was completed within 7 working days of the individual's discharge.								Discharge summary must include: day of discharge, finalized continuing care plan, legal statute, and if applicable, current prescribed medication.
14	The clinical record includes a crisis plan, if one has been developed.								
15	Documentation of any requested verification documents to external sources.								E.g. courts, department of corrections (DOC), department of licensing, and the department of social and health services, or Health Care Authority (HCA).
16	The clinical record contains properly completed Releases of Information (ROI's), if applicable.								Note: Inclusive of 42 CFR Part 2, if a Part 2 agency.
17	The clinical record contains medication records for the individual if applicable.								
18	The clinical record contains laboratory and/or urinalysis reports if applicable.								
19	The clinical record indicates the individual and legal representative is informed of their individual rights at the time of admission and in a manner that is understandable.								
20	**If individual turns 18 (eighteen) during treatment episode:** Clinical record provides documentation the right to have an advanced directive.								
21	**PACT only:** The average number of contacts by either PACT primary practitioner or ITT member, face-to-face per individual per week shall be 3 contacts per week.								ITT: Individual Treatment Team
22	**Crisis services only:** A brief summary of encounter, names and relationships of individuals involved, nature of the crisis (Outreach only), outcome, such as a follow-up plan, including any referrals for services, including emergency medical services.								

23	**Crisis services only:** Documentation included family members, significant others, and other relevant treatment providers, as necessary, to provide support to the individual in crisis.								
24	**Crisis services only:** Documentation if current crisis plan on file was noted.								
25	**Crisis services only:** Documentation to indicate a staff remained with the individual in crisis in order to provide stabilization and support until the crisis was resolved or referral to another service was accomplished.								
26	**LRA only:** Either the individual service plan or a separate plan specifically addresses the conditions of the LRA order and plan for transition to voluntary treatment.								
27	**LRA only:** Consumer has signed LRA rights.								
28	**LRA only:** If the individual is on a 90-day or a 180-day LRA, the individual has been evaluated monthly by an MHP with regard to release from or continuation of an involuntary treatment order.								
29	**LRA only:** If the individual is on an LRA they receive psychiatric medication services at least once every seven days for the first 14 days following discharge from the inpatient facility, and at least once every 30 days after that.								If not 30 days after discharge: Unless otherwise changed by the prescriber as document in the medical note.
Outpatient Care Coordination for Inpatient Stay									
Requirements for Outpatient Care Coordination for Inpatient Stay is referenced in RCW 71.05, WAC 388-877-0805, SBHO Policy, PIHP Contract, and Behavioral Health State Contract (BHSC) Contract.									
#	**Requirement**	**Score**	**Score**	**Score**	**Score**	**Score**	**Comments**	**Location**	**Auditor's Notes**
1	There are rehabilitative case management services to assist discharge from inpatient care and minimize risk of readmission.								
2	Contact with the liaison or hospital treatment team occurs within three working days of an enrolled individual's admission to the hospital.								Contact must include a provisional placement plan for the individual to return to the community that can be implemented when the individual is determined to be ready for discharge.
3	There was an offered appointment within 7 days of discharge.								
4	There was an effort to ensure a psychiatric medication evaluation or appointment within 30 days of discharge, if on psychiatric medications.								
5	Contact with the individual by phone within 3 days of discharge from an inpatient facility, even if the individual chooses to access services with non-BHO provider.								

Medication Services *(If applicable)*									
Requirements for Medication Services is referenced in WAC 388-877-0712, SBHO Policy, PIHP Contract, and Behavioral Health State Contract (BHSC) Contract.									
#	**Requirement**	**Score**	**Score**	**Score**	**Score**	**Score**	**Comments**	**Location**	Auditor's Notes
1	The individual is receiving clinical services and is therefore not medication only ("meds only").								Evidence of clinical services for clients receiving psychiatric services.
2	The individual or if applicable, their parent, family member and/or guardian provided informed consent for new medications, including the potential benefits and side effects.								
3	The clinical record contains the following information: name, dosage, frequency, and method of giving each medication, if laboratory monitoring is required, and purpose of the medication prescribed. The medical provider assessed the individual for side effects of prescribed medications and interactions between medications.								
4	The medications prescribed have been reviewed by the prescriber at least every 3 months.								If there is a change in medication and/or a dosage, it is documented in the clinical record.
Practice Guidelines *(If applicable)*									
Requirements for Practice Guidelines referenced in 42 CFR 438.23, SBHO Policy, and PIHP Contract.									
#	**Requirement**	**Score**	**Score**	**Score**	**Score**	**Score**	**Comments**	**Location**	Auditor's Notes
1	Verify Diagnosis.								Adults: Schizophrenia, Bipolar, PTSD; Child: Child and Youth Trauma Disorders; and SUD: AOD Treatment.
2	Medication evaluated for utilization.								
3	Psychoeducation, including assessment results and treatment options.								Examples: Diagnosis, medication, family/supports, stress management, OST, abstinence.
4	Interventions that are relevant to specific diagnosis.								Examples: Schizophrenia: Assertive outreach; Bipolar: High Risk Behaviors, Sleep Disruption, Crisis Planning for Mood or behavioral changes; PTSD: Trauma-informed approaches; Child: Trauma informed approaches; SUD: Interventions to specific AOD diagnosis.

5	If there is documentation of other co-occurring mental health issues and/or co-morbid medical issues, are they documented in the assessment? If so, is there referral and coordination documented.								MH, SUD, and/or medical referrals.
WISe Review									
Requirements for WISe Review is referenced in WISe Manual (2014), WAC 388-877-0610, and WAC 388-877-0620, SBHO Policy, PIHP Contract, and Behavioral Health State Contract (BHSC) Contract.									
#	**Requirement**	**Score**	**Score**	**Score**	**Score**	**Score**	**Comments**	**Location**	Auditor's Notes
1	A full CANS assessment was completed within 30 days of the WISe screen (enrollment into WISe).								Wise Manual Link
2	A full CANS Assessment was completed every 90 days after the initial Full CANS Assessment.								
3	A Family Narrative has been completed.								
4	There is evidence of family and youth voice in the Cross System Planning.								Are there signatures and evidence a copy of the CSCP and all revisions were given to family? Quotes? Verbiage for the youth and family?
5	The Cross System Plan incorporates the Individual Service Plan (ISP) or there is a separate ISP in the chart. It was competed with 30 days after the first routine appointment.								
6	The Cross System Plan includes the following:	**Scoring: Y/N**	**Scoring: Y/N**	**Scoring: Y/N**	**Scoring: Y/N**	**Scoring: Y/N**			
	· Family Vision Statement								
	· Team Mission Statement								
	· Useful Strengths (CANS)								
	· Additional Strengths (Team)								
	· Background Needs (CANS)								
	· Targeted Needs (CANS)								
	· Needs Statements (Team)								
	· Anticipated Outcomes (CANS)								
	· Targeted Outcome Statements (Team)								
	· Strategies and Interventions (Team)								
	· Useful Strengths Activities (Team)								
	· Action Steps for Team Members (Team)								
	· Strengths to Build (CANS)								
	· Strengths Building Activities (Team)								
7	Safety/Crisis Plan was completed and a copy was given to the youth and family.								
8	A complete list of participants and their contact information is included in Cross Systems Planning and is documented.								
9	CFT notes indicate CFTs occurred at least every 30 days.								

10	CFT notes include a list of attendees.								Attendees are those invited as preferred by the youth and family and as indicated on the CANS assessment and assessment as relevant to the youth and family.
11	CFTs are facilitated by a WISe trained Care Coordinator, who typically facilitates and coordinates services and supports.								
12	Notes document that the family and youth were offered the support of a Peer Certified Youth and/or Family Partner.								
13	The CFT:	**Scoring: Y/N**	**Scoring: Y/N**	**Scoring: Y/N**	**Scoring: Y/N**	**Scoring: Y/N**			Evidence should be found in updated Cross System Care Plan and meeting notes.
	· Evaluates progress towards meeting needs and the effectiveness of indicated strategies.								
	· The CFT adjusts strategies to meet changes in the needs and outcomes, creating the most effective mix of services and supports.								
	· The CFT evaluates whether there is progress towards the designated outcomes. The team adjusts the outcomes to guide next steps.								
	· The CFT adds members and strives to create a mix of formal, informal and natural supports.								
	· The CFT acknowledges successes and adds to strengths as they are identified.								
14	There is documentation of transition planning within the CFT meetings to address successful transition away from formal supports as informal supports are in place and providing needed support.								Evidence is found in CFT meeting notes, CSCP and Crisis plan.
Crisis/DCR Services									
Requirements for Crisis/DCR Services is referenced in WAC 388-877-0900 to WAC 388-877-1154, WAC 388-877-0905, SBHO Policy, PIHP Contract, and Behavioral Health State Contract (BHSC) Contract.									
#	**Requirement**	**Score**	**Score**	**Score**	**Score**	**Score**	**Comments**	**Location**	**Auditor's Notes**
1	Documentation includes source of referral and/or identity of caller, as well as relationship of the caller, if not the individual, and nature of the crisis.								E.g. family member, neighbor, friend, guardian, or conservator.
2	Documentation of the outcome of the phone call, including the following: follow-up contacts made, referrals made. Clear documentation of a follow-up plan, basis for a decision not to respond in person (if telephone call initially), and any referrals for services.								E.g. emergency medical services

3	The outcome and justification of the crisis intervention is clearly documented.								Detained, Not Detained, LRA Revocation. Including plan for future crisis, if not detained.
4	**If individual has crisis plan:** DCR noted review of existing crisis plan.								
5	**If Hospital Setting:** DCR documented consultation with examining emergency room physician.								
6	There are appropriate referrals and coordination with other systems or settings, specifically if individual has a mental health care provider.								Documentation of communication and coordination with the individual's mental health care provider, if indicated and appropriate.
7	Safety needs and risk factors adequately addressed for individual, DCR, and location. Crisis services are provided in a setting that provides for the safety of the individual and staff member(s).								Location: agency, facility, hospital, or staff.
8	Less restrictive alternatives were adequately investigated and documented, including the crisis services provided, crisis planning, and alternatives to hospitalization were reviewed.								
Mental Health Residential Care/Treatment									
Requirements for Mental Health Residential Care/Treatment is referenced in WAC 346-337, WAC 388-78A-2050, WAC 388-78A-2170, WAC 388-78A-2180, SBHO Level of Care Guidelines, SBHO Policy, PIHP Contract and Behavioral Health State Contract (BHSC) Contract.									
#	**Requirement**	**Score**	**Score**	**Score**	**Score**	**Score**	**Comments**	**Location**	**Auditor's Notes**
1	**SUD only:** The clinical record documents the individual has had a TB test or screen.								
2	Evidence that the individual's clinical presentation demonstrates a need for this residential level of care.								
3	Verify a health care screen on each individual has been conducted upon admission and updated as changes occur or when additional health care needs are identified.								
4	Verify the individual is involved in activities offered at the residential facility.								Client encouraged to participate and/or client participated in group activity.
5	The individual has a history or recent episode of failing to live independently in the community due to their behavioral health illness.								
6	There is evidence that efforts are being made to help the individual learn independent living skills in order to eventually move to a lower level of care.								
7	The individual is currently enrolled in outpatient services or is in the process of being authorized and assigned to outpatient services.								

E & T Admission									
Requirements for E & T Admission and assessment is referenced in WAC 388-877--1124, WAC 388-877-1126, WAC 388-877-1128, WAC 388-877-1134, WAC 388-877-1120, WAC 346-337-110, RCW 71.34.355, SBHO Policy, PIHP Contract and Behavioral Health State Contract (BHSC) Contract.									
#	Requirement	Score	Score	Score	Score	Score	Comments	Location	Auditor's Notes
1	The individual received a psychosocial evaluation.								Psychosocial by an MHP.
2	There is an admission diagnosis and information that the diagnosis was based upon.								
3	**Adult only:** Determination that the individual would be better served by placement in a chemical dependency facility, provide referral to an approved treatment program.								
4	If the individual has an Advance Directive, it is followed as nearly as possible considering the circumstances.								
5	**For anti-psychotic medications only :** If the physician administered anti-psychotic medications over a individual's objections or lack of consent documentation is complete.								All of the following were present: indication of reason, and a second opinion is documented OR an emergency existed requiring the involuntary medication (likelihood or harm to self/others, AND no alternative to anti-psychotic medications).
6	There is a discharge plan, including plan for follow-up outpatient mental health appointment within 7 days of discharge.								
7	**Involuntary Individuals:** There is documentation of daily contact with a MHP for the purpose of observation, evaluation, release from involuntary commitment to accept voluntary treatment, and discharge from the facility to accept voluntary treatment upon referral.								
8	**Seclusion & Restraint only:** Authorization and a face-to-face assessment from a physician was obtained within 1 hour of initiating seclusion or restraint and face-to-face observation and monitoring should be continuous.								
9	**Seclusion & Restraint only:** The individual was informed of the reasons for use of seclusion or restraint and the specific behaviors which must be exhibited in order to gain release from these procedures.								
10	**Seclusion & Restraint only:** There is documentation of staff observation of the individual at least every fifteen minutes and observation recorded in the individual's clinical record.								

11	**Seclusion & Restraint only:** If the use of restraint or seclusion exceeds twenty-four hours, a licensed physician assessed the individual and write a new order if the intervention will be continued. This procedure is repeated again for each twenty-four hour period that restraint or seclusion is used.								
12	**Seclusion & Restraint only:** All assessments and justification for the use of seclusion or restraint are documented in the individual's medical record.								
13	**Seclusion & Restraint only, Child only:** The child was not restrained or secluded for a period in excess of two hours without having been evaluated by a mental health professional. The child was directly observed every fifteen minutes and the observation recorded in the individual's clinical record.								
14	**Child only:** Is there documentation that a Children's MH Specialist evaluated the child within 24 hours of admit?								
15	**Child only:** If child was voluntarily admitted without parental consent, the parent is notified within 24 hours of admit.								
16	**Child only:** The child was evaluated by the facility, including the need for SUD treatment and/or need for restricting the right to communicate with parents.								
17	**Child only:** The child was advised of their rights.								
Comments:									