ADVENTHEALTH ANNUAL COMPETENCY REVIEW

Name of PEPCS Employee_____ Date: _____

Patient file (CEU) # _____ Date evaluation completed _____

CL – Clinician AUD – Auditor

Item	Meets	Does not meet	N/A	**COMMENTS**	**Date**	**CL**	**AUD**
MHH/M1 complete (as scanned)							
SLUMS completed (as scanned							
Insurance forms (Tricare, etc.)							

Electronic Documentation

Criteria	**Meets**	**Does not meet**	N/A	**COMMENTS**	**Date**	**CL**	**AUD**
Charge for Service							
Columbia and comments							
SLUMS comments (60+)							
AUDIT C							
Timeline of Presentation							
Circumstances of Presentation							
Mental Health History/Timeline							
Medications/Compliance							
Relevant Medical History							
Sleep/appetite/wt/energy							
Suicide Ideation Present/Past							
Suicide Attempts – Past/Present							

Criteria	Meets	Does Not Meet	N/A	Comments	Date	CL	AUD
Suicide plan/Intent							
Suicide Protective Factors							
Homicidal Ideation Present/Past							
Homicide Attempts – Present/Past/Hx Violence							
Homicide plan/intent							
Homicide Protective Factors							
Psychotic sxs – specific descriptors							
Grave Disability - basis							
Cognitive/memory function							
Insight/Judgment							
Record Review -Details							
Collateral/Phone #s							
Psychosocial history							
Abuse/Neglect/Trauma/ Exploitation history							
Cultural Comment (need 3)							
Patient Strengths (need 3)							
Access to Guns/Weapons/ Pills/Other Lethal Means							
Diagnosis with F Codes and criteria							
Reasons for Disposition							
Stanley-Brown Safety Plan							
Insurance Auth if inpatient							
Disposition Efforts, Insurance efforts							
Disposition Details if completed by clinician							
Warm Handoff Information							

CRITERIA	MEETS	Does Not Meet	N/A	COMMENTS	Date	CL	AUD
Referrals (2) if discharged							
Overall							
Clarity of Writeup							
Internal Consistency of Evaluation							
Why Now vs Baseline							
Justification of DX using DSM Criteria/current vs. by HX							
REVIEWED with ED Provider and Nurse							

Clinician Signature _____ Date: _____

Auditor Signature _____ Date: _____

COMMENTS: