

STAP PROVIDER QUALITY CHART AUDIT

PROVIDER NAME _____ LEVEL OF CARE STAP _____

PROVIDER ID _____

ADDRESS _____

CONTACT NAME: _____ PHONE # _____

REASON FOR REVIEW: ROUTINE RECORD REVIEW (documentation)
 QUALITY OF CARE
 ACTION PLAN FOLLOW UP
 OTHER _____

CHART IS _____ OPEN _____ CLOSED

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Enter the record identifier: MA ID:	
Member DOB:	Member County
List all AXIS I diagnoses: 1 _____ 2 _____ 3 _____ 4 _____	
AXIS II _____	
AXIS III _____	
AXIS IV _____	
AXIS V _____	
Note if any are missing Score under question 11	
Date of above diagnosis _____	
Name and degree of evaluator _____	

FOR DIAGNOSIS USE THE MOST RECENT DIAGNOSIS THAT IS SIGNED AND DATED BY AN EVALUATOR (AN M.D. OR PhD, or licensed psychologist)

Staff completing this chart audit

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QUESTIONS	DEFINITIONS
1. Each page in the treatment record contains the member's name or MAID number.	1.Each page in the treatment record contains the enrollee's name or ID number
2. Each treatment record includes the member's required demographics.	a. Member's address, b. Telephone # c. Emergency contact.
3. Each treatment record contains the HIPAA Privacy Notice, appropriate releases and Consent for treatment, signed or initialed by the member.	Statement of confidentiality or a HIPAA Notice of Privacy Practices is found in the medical record or there is documentation in the member's record that the member has received a copy of the Notice of Privacy Practices. Chart also must contain a signed consent for treatment and any releases that may be appropriate.
4. All entries in the treatment record must be signed by the responsible clinician. All entries in the treatment record are dated. The treatment record is legible to someone other than the writer.	Full signature of clinician, and degree or relevant identification number must appear after each entry. . Day, month and year on each entry Entries can be read at a normal pace. Reviewer is not required to excessively figure out individual words or phrases.
5. Presenting problems, along with relevant psychological and social conditions affecting the member's medical and psychiatric status are documented in the treatment record.	a. Presenting problems, b. Current symptoms, c. History of symptoms, d. Problem behaviors, e. Relevant psycho-social conditions affecting the patient's medical and psychiatric status
6. Special status situations, such as an imminent risk of harm or elopement potential, are prominently noted, documented and revised in the treatment record.	a. Evidence that the member was thoroughly evaluated upon initial assessment as to dangerousness to self, to others or elopement potential. b. If there is a recent history for these behaviors, the special status situations should be addressed at each documented contact by MHP, until they are resolved. If not a treatment issue mark as N/A
7. Food, drug, environmental allergies and adverse reactions or no known allergies are clearly and prominently documented in the treatment record.	Documentation of allergies, or no known allergies NKA, any adverse reactions, any sensitivity to pharmaceuticals or other substances are documented. Non-prescribing practitioners must document allergy and adverse reaction information if available.
8. The treatment record indicates prescribed medications, dosages and prescriber.	N/A if medications are not prescribed.
9. Medications distributed during STAP hours and at the STAP location must be labeled, correctly stored, administered, and made available to the members.	Documentations for medications distributed during STAP should include medication given, time of day, staff administering.

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10. A complete packet will be maintained in the medical record.	Recommendation of the Interagency Service Planning Team (ISPT) including POC, list of ISPT participants and treatment plan.
11. A DSM-IV/ICD9 diagnosis is documented with a signature and date from the evaluator.	All 5 axes must be present.
12. Treatment plans: 1) must be individualized 2) have measurable goals and objectives and identification of person responsible and modality 3) have estimated time frames for goal attainment or problem resolution 4) are signed by clinician/treatment team, parent/guardian and the member 5) based on assessment of strengths and therapeutic needs of the child and family	Plan must have documentation of specific behaviors to be addressed, that have been identified in the initial evaluation relate directly to the diagnosis.
13. The provider will make every effort to involve family members in the program experience and activities	Thorough documentation of all efforts to involve family members, their participation and the reason for their non-participation must be included in the medical record (progress notes, phone log, daily activity log)
14. Treatment plan goals and objectives must be documented in the progress notes.	Each progress note must be directly related to a goal in the treatment plan and the goal must be documented in the progress note. Documentation of community activities must have a direct relation to the treatment plan.
15. Documentation of progress or lack of progress must be found in the daily progress notes.	Progress notes must detail the child's response to therapeutic activities. Daily progress notes must be signed and dated by the rendering treatment staff, and present for each day the member attends STAP
16. Is there a crisis safety plan?	There is a separate document identified as a crisis safety plan is in the chart and is signed by the family and the clinician. (The crisis plan must be specific and individualized for this family and child including progressive steps to deal with the crisis) If a crisis occurred, there should be documentation of how stabilization was achieved.

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17. There is evidence that the clinical assessment is culturally relevant (i.e. addresses issues relevant to the member's race, religion, ethnicity, age, gender, sexual orientation, level of education, socio-economic level).	Cultural issues identified as a presenting problem in the assessment must be included in the treatment plan. N/A if none are identified.
18. A discharge summary/aftercare plan has been documented at the conclusion of STAP treatment.	A discharge summary when STAP is concluded should contain aftercare plan addressing transition to appropriate agencies and/or other services. The summary should contain a. Discharge diagnosis, b. Medications, dosages and frequency if applicable, c. status of goals, d. Treatment summary, e. Barriers to treatment if applicable, f. Crisis plan/relapse prevention plan as applicable.
Comments:	