Louisiana - Provider Quality Monitoring Crisis Stabilization Record Tool

Effective Date: August 7, 2024

These audit tools can be used for various types of audits that a provider may require. They ensure you are meeting state regulatory requirements.

Assessment

Question

1. There is evidence that a referral is completed by Mobile Crisis Response (MCR), Behavioral Health Crisis Care (BHCC), Community Brief Crisis Support providers or Assertive Community Treatment (ACT) Teams.
2. There is evidence that the member is in psychiatric crisis and in need of temporary 24 hours a day, 7 days a week support to provide crisis relief, resolution, and intensive supportive resources.
3. There is evidence that the psychiatric diagnostic evaluation was completed.
4. There is evidence that if a psychiatric diagnostic evaluation was completed within 30 days by previous provider, an update to capture the member's current status must be added to the previous evaluation.
5. There is evidence that the psychiatric diagnostic evaluation of risk included mental status exam conducted by a licensed mental health professional (LMHP) or psychiatrist with experience regarding this specialized mental health service and practicing within the scope of his or her professional license.
6. There is evidence of initial assessment of Crisis Stabilization (CS) needs, including crisis resolution and debriefing. (Youth CS section)
7. There is evidence of ongoing assessment of CS needs, including crisis resolution and debriefing. (Youth CS section)

Medical Screen

Question

8. There is evidence that the preliminary assessment of youth's medical stability includes contact with the member, family members or other collateral sources (e.g., caregiver, school personnel) with pertinent information. (Youth CS section)
9. There is evidence a registered nurse or licensed practical nurse practicing within the scope of his or her license performed a medical screen to evaluate for medical stability.
10. There is evidence that the psychiatric diagnosis evaluation of risk included medical stability conducted by a licensed mental health professional (LMHP) or psychiatrist with experience regarding this specialized mental health service and practicing within the scope of his or her professional license.
11. There is evidence that assessment is built upon what is learned by previous crisis response providers or the (ACT) provider.

Involvement of family/natural support

Question

12. There is evidence of regular contact with family to prepare for the youth's return and his/her ongoing needs as part of the family. (Youth CS Section)
13. There is evidence of follow up with individual and individual's caretaker and/or family members. (Youth CS Section)
14. There is evidence that the assessment included contact with the member, family members or other collateral sources (e.g., caregiver, school personnel) with pertinent information for the purpose of the evaluation and/or referral to and/or coordination with other alternative behavioral health services at an appropriate level.
15. There is evidence that support was provided to the member, family and/or collateral supports.
16. There is evidence that education was provided to the member, family and/or collateral supports.
17. There is evidence that consultation was provided to the member, family and/or collateral supports.

Interventions

Question

18. There is evidence of documentation that supports the need for short-term and intensive supportive resources for the youth and his/her family. (Youth CS Section)
19. There is evidence that the interventions are driven by the member.
20. There is evidence that interventions are developed by the LMHP, psychiatrist or non-licensed staff in collaboration with the LMHP or the psychiatrist.
21. The is evidence the interventions are built on the strategies developed by the mobile crisis response (MCR), Behavioral Health Crisis Care (BHCC), and/or community brief support service (CBCS) service providers.
22. There is evidence that the short-term goals are developed to ensure stabilization.
23. There is evidence that the short-term goals were set to ensure symptom reduction.
24. There is evidence that the short-term goals were set to ensure restoration to a previous level of functioning.
25. There is evidence that the interventions were developed with input from the member, family and/or other collateral sources.
26. There is evidence that the interventions are developed for member to use post crisis to mitigate risk of future incidents until member engages in alternative services, if appropriate.
27. There is evidence that the brief interventions include using person centered approaches.
28. There is evidence that substance use was recognized and addressed in an integrated fashion and assessing the need for engagement in care, if applicable.

Care Coordination and Continuity of Care

Question

29. There is evidence that providers coordinated the transfer to primary medical care within 24 hours.
30. There is evidence that providers coordinated the transfer to community based behavioral health provider within 24 hours.
31. There is evidence that providers coordinated the transfer to Community Brief Crisis Support (CBCS) within 24 hours.
32. There is evidence that providers coordinated the transfer to Crisis Stabilization (CS) within 24 hours.
33. There is evidence that providers coordinated the transfer to Inpatient treatment within 24 hours.
34. There is evidence that providers coordinated the transfer to Residential substance use treatment within 24 hours.
35. There is evidence that readiness for discharge is evaluated daily.
36. There is evidence that a warm handoff with member's MCO to link member with no current BH provider and/or primary medical care provider to outpatient services as indicated.
37. There is evidence of a warm handoff with member's existing or new BH provider.
38. There is evidence that member records was provided to the existing or new BH provider or to another crisis service to assist with continuing care upon referral.
39. There is evidence that there was member involvement throughout the planning of services.
40. There is evidence that there was member involvement throughout the delivery of services.
41. There is evidence of consultation with physician and/or with other qualified providers to assist with youth's specific crisis. (Youth CS Section)

Follow-up

Question

42. There is evidence that telephonic follow up to the member and/or authorized member's caretaker and/or family up to 72 hours to ensure continued stability post crisis for those not accessing CBCS or higher levels of care.

43. There is evidence of additional calls/visits to member following the crisis unless the member indicates no further communication is desired as documented in the member's record.