

Schizophrenia /Suicide Management Clinical Practice Guideline Audit Checklist

REVIEWER INFORMATION
Reviewer Name _____
Date of Review _____ CMC ID _____ Health Plan Code _____
PATIENT INFORMATION
Patient ID _____ Date of Birth _____
PROVIDER INFORMATION
Provider Name (Last, First)/Group Name /Credentials _____
Provider ID (MIS Number) _____
Date of Initial Assessment _____

DOMAIN 1: DIAGNOSTIC ASSESSMENT

The provider assessed for and found sufficient evidence to support the diagnosis of schizophrenia, and determined if complicating medical/psychiatric conditions were present. The initial evaluation included assessment for:

1a. POSITIVE & NEGATIVE SYMPTOMS (symptom presence and duration that meet DSM-IV-TR criteria)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
1b. A CO-MORBID SUBSTANCE-INDUCED DISORDER	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
1c. OTHER PSYCHIATRIC DISORDERS that could account for the symptoms or complicate treatment	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
1d. PSYCHOSOCIAL STRESSORS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
1e. MEDICAL CONDITIONS (that may cause symptoms or complicate treatment, e.g., brain tumor, complex partial seizure disorder, diabetes, morbid obesity, coronary artery disease, HIV or other infectious diseases)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
1f. MEDICATIONS (past and current medications and response)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
1g. COMPLIANCE (potential barriers to treatment compliance, e.g., history of noncompliance, unsupportive home environment)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
1h. DANGEROUSNESS TO OTHERS (history of and current potential)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
1i. REASON FOR RECURRENCE (if not first episode)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
2. PSYCHIATRIC REFERRAL: (if provider is a non-M.D., and there is no evidence of a recent psychiatric evaluation, there is documentation of a referral for a psychiatric evaluation)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
DOMAIN 1 SUBSCORE: _____			
# of items missed (number of "No's") _____			

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DOMAIN 2: SUICIDE RISK ASSESSMENT AND MANAGEMENT

During the initial evaluation, the provider conducted a thorough suicide risk assessment that, at a minimum, included assessment for:

3a. CURRENT SUICIDAL IDEATION AND PLANS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
3b. PAST SUICIDAL IDEATION AND ATTEMPTS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
3c. PRESENCE OF HIGH RISK FACTORS (such as significant behavior change in teens, advanced age/debilitating illness/male senior citizens, insomnia, substance use/abuse, anxiety, recent inpatient discharge, history of violence and/or gender identity disorder in teens)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If suicidal risk was found, the provider implemented a plan to manage the risk, which included:			
3d. Assessment of LETHAL INTENT; documentation shows interventions to address this with patient and response to measures	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
3e. Assessment for access to any weapons or LETHAL MEANS, if suicidal	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
4a. Developed plan to DIMINISH ACCESS TO WEAPONS/LETHAL MEANS, if suicidal	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
4b. Developed PLAN FOR MAINTAINING SOBRIETY and discussed the role of substance use in increasing suicide risk	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
4c. Attempted to INVOLVE FAMILY AND OTHER SUPPORT SYSTEM MEMBERS in suicide management plans, or documented why not appropriate	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
4d. Documented ACTUAL FAMILY/SUPPORT SYSTEM INVOLVEMENT in suicide management plan	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
4e. HALLUCINATION INTERVENTION (intervention to alleviate command hallucinations, if present)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
DOMAIN 2 SUBSCORE: _____			
# of items missed (number of "No's") _____			

DOMAIN 3: SCHIZOPHRENIA THERAPEUTIC INTERVENTIONS

The provider documents in the treatment plan:

5a. APPROPRIATE PSYCHOSOCIAL INTERVENTIONS (consistent with the phase of illness, e.g., diminishing arousal in the acute phase, increasing social skills and community functioning in the stable phase)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
5b. Measurable targets for each intervention	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
6. The provider delivered education about schizophrenia, its treatment, signs of relapse, and community resources, to the patient and family/caregivers	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
7. If the provider is a non-M.D., and a psychiatric referral had been made, the provider documented the results of that evaluation and any relevant adjustments to the treatment plan	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

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8. If evidence of a comorbid substance use disorder was found, the provider developed a plan to decrease use or seek/maintain sobriety	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
9. If evidence of a comorbid mental health disorder was found, the provider developed a plan to address the comorbid disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
If the provider is an M.D.:			
10a. The provider selected a first- or second-generation antipsychotic, implemented it as soon as feasible, or documented why not	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
10b. If initiating treatment with a second-generation antipsychotic, the provider documented baseline physical and lab results, including height, weight, lipid profile and fasting blood glucose, and documented periodic monitoring of these parameters	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
10c. If there have been several medication trials that were unsuccessful, or the patient presented with severe suicide risk, the provider considered clozapine or ECT	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
10d. If clozapine is prescribed, evidence of weekly laboratory monitoring for first 6 months and then every other week thereafter	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
11. If the provider finds there is evidence of potential patient non-compliance with treatment, provider plans interventions to address noncompliance (e.g., depot meds, outpatient commitment, medication groups, family support, self-help groups)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
DOMAIN 3 SUBSCORE: _____			
# of items missed (number of "No's") _____			
TOTAL SCORE: _____			
TOTAL # of items missed (number of "No's") _____			

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Instructions

1. Treatment Record Selection

Select medical records with a diagnosis of schizophrenia.

2. Audit Process

Using this audit tool, review the minimum necessary sections of the medical record, including the medication sheet, initial evaluation, progress notes, consultant notes, lab results and treatment plans. If the chart tracks an episode of care greater than six months, score all of the items based on the past six months with the exception of the items with an asterisk (*). Those items should be documented in the provider's initial evaluation.

3. Scoring and Intervention Guidelines

After auditing multiple records per provider, calculate the average total scores of items missed, and then apply the table.

	Quantitative (Average score from all records reviewed)			Qualitative (If found on any record reviewed)
	0 - 3 average total score	3.1 - 6 average total score	> 6 average total score	
Actions	Essentially compliant, send letter A (unless qualitative applies)	Improvement opportunity, send letter B (unless qualitative applies)	Requires RNCC or designee review and letter C or individualized alternative to letter C (unless qualitative applies)	If item missed is 4a, or if both 4b and 4c are missed, then should go to RNCC or designee review and letter C, or alternative to letter C