Quality Assurance is best conducted through review of documentation combined with regular observation of staff.

All information is documented and legible in the child record.

These prompts could be used in addition to any compliance and management oversight supervision that is already being conducted

REFERRAL AND PRE-ENROLLMENT:

Referral and initial contact documentation includes:

___ Date, time and source of initial referral
___ Details about concern according to referral source
___ Date and time of initial contact with family
___ Details about the family's developmental (and other) concerns for child
___ Initial information gathered about child's functional abilities

EVALUATION:

Documented for every child, including those found to be not eligible:

Documentation reflects that the team:

___ Included appropriate professionals to address identified concerns

___ Referred to information already documented (parent does not have to repeat)

___ Probed for and recorded relevant clinical information about the child during administration of the BDI-2 (applying clinical expertise)

___ Probed for and recorded information about the functional abilities of the child during administration of the BDI-2 (applying clinical expertise)

___ Considered application of Qualitative Determination of Delay when appropriate based on details about identified concerns, clinical information, functional abilities of child and BDI-2 score patterns.

___ Report or Progress note by LPHA includes:

- Presenting problem or reason for referral (basis for CPT code)
- Relevant history and current observations of the child
- Clinical assessment of the child's functional abilities
- Reporting of and Interpretation of test scores
- Review of other records (if applicable)