New York Strengthening Treatment Access and Retention - Quality Initiative (STAR-QI)
Data Items Glossary

Item	Item Description
Provider (REQUIRED)	The provider number and name (linked).
Program (REQUIRED)	A name and number that corresponds to the Program/PRU# (Number assigned by OASAS to the program—the program reporting unit number. A "program" is sometimes referred to as a service unit, a treatment unit or a PRU.)
Provider Client ID	This is the CDS Provider Client ID, the unduplicated patient identification number assigned by the provider. Enter this number as soon as it is assigned (whether at 1st Request, Assess or Admit)
Sex (REQUIRED)	Enter male or female
Birth Date	The client's birth date in mm/dd/yyyy format.
Last 4 SSN	Enter the last 4 numbers of the client's social security number, if unavailable enter 0000.
Last Name 2 Char (REQUIRED)	Enter the first two characters of client last name (maiden name if applicable). Same item as used in the OASAS Client Data System tracking id.
First Request for Service Date (REQUIRED)	Enter the date of the initial request for service (mm/dd/yyyy). This will be the date on which the individual requests an appointment for an initial visit for assessment or intake. This is **not** the date of the appointment. A request for service which does not result in an appointment date being set will not be recorded here. (Providers may have other means to track requests for service that have not received an appointment date.) NOTE: The **First Request for Service Date** begins the data collection process. All data entry must have a date for **First Request for Service Date**.
Previous Discharge Date	If the individual is being referred or transferred from another treatment program unit, enter the date of discharge from previous program unit (mm/dd/yyyy) **otherwise leave blank**. This date will typically occur after the **First Request for Service Date** since the referring or transferring unit will likely have arranged the referral prior to discharge. NOTE: **Previous Discharge Date** is collected in order to determine when the client is available for assessment or admission. For instance, a request for service may occur a week or more before the client is discharged from the referring program. **Previous Discharge Date** will also be used to indicate which clients have been referred from another program as part of a continuous treatment episode.
Did the Client Show for First Appointment?	Enter one of the following codes as appropriate: Yes = The client appeared for the first scheduled appointment No = The client may have appeared for a subsequent appointment, but not the first. NOTES: 1) The client may call to reschedule the appointment prior to the appointment time; this rescheduling would be entered as YES. 2) If a client does not call to reschedule before the appointment arrives, this would be entered as a NO. 3) If a client misses an appointment, and does not contact anyone to reschedule for 30 days, then completion status should be switched to "done" and that episode is closed. If the client calls back after 30 days have passed to schedule an appointment, a new episode should be created with the date of that phone call as the First Request for Service.
First Assessment Date	Enter the date on which the client received his/her first assessment service (mm/dd/yyyy). This is **not** the first appointment date **unless** the client in fact received the assessment service on the scheduled first appointment date. If the client **does not** receive an assessment service, **leave blank**. (The client may not need to be assessed if assessment and/or discharge planning has been conducted by another provider or program unit.) NOTES: • The First Assessment Date could occur prior to discharge from a referring or transferring program. • Do not count screening done as part of an outreach service or orientation that occurs before assessment as an assessment, such activity can be tracked in one of the 2 flex items discussed below. • The First Assessment Date will always be on or after the First Request for Service Date. If the client is assessed on the same day as the initial request for service, the dates will be the same. The assessment date is always on or before the admission date.

Item	Item Description
Second Assessment Date	If the client receives a second assessment service, enter the date of this service (mm/dd/yyyy), otherwise leave blank. The **Second Assessment Date** will always be after the **First Assessment Date**.
Third Assessment Date	If the client receives a third assessment service, enter the date of this service (mm/dd/yyyy), otherwise leave blank. The **Third Assessment Date** will always be after the **Second Assessment Date**.
Assessment Disposition	Enter one of the following codes as appropriate: 1 = Admitted (There must be a Date of Admission) 2 = Referred (The client is not being admitted) 3 = Other (The client is not being admitted for other reasons, e.g., no treatment needed, refusal of treatment) 4 = Not Completed 5 = Transferred in (There must be a Date of Admission. This usually refers to those clients transferred in from another PRU within the same provider.) NOTE: Codes 2, 3 and 4 "close" the STAR-QI episode and no further data beyond this item is entered except for the **Completion Status**. If the client requests service at a later date, that request starts a new STAR-QI episode.
Admission Date	Enter the admission date (mm/dd/yyyy). If the client is not admitted, leave blank. This is the same date as reported to the OASAS Client Data System. Which states: *The Admission Date is the date of the **first treatment service** following the level of care determination. For purposes of reporting, a patient may not be admitted more than once in a calendar day.* The Admission Date always occurs ON or after the **First Request for Service Date** and ON or after any Assessment dates that have been entered.
Second Date of Service	Enter the date of the second treatment visit (mm/dd/yyyy). If no second treatment visit has been received, leave blank. The **Second Date of Service** will always occur after the **Admission Date.**
Third Date of Service	Enter the date of the third treatment visit (mm/dd/yyyy). If no third treatment visit has been received, leave blank. The **Third Date of Service** will always occur after the **Second Date of Service.**
Fourth Date of Service	Enter the date of the fourth treatment visit (mm/dd/yyyy). If no fourth treatment visit has been received, leave blank. The **Fourth Date of Service** will always occur after the **Third Date of Service.**
Discharge Date	Enter the date of discharge (mm/dd/yyyy). If the client has not been discharged, leave blank. This is the same date as reported to the OASAS Client Data System. The date of discharge is the date of the last treatment service. NOTE: Entry of **Discharge Date** "closes" the data episode (but it is not the last item of data required – **Discharge Status** is also required). If the client requests services at a later date, that request starts a new data episode.
Discharge Status	If you enter a **Discharge Date** you must also enter a **Discharge Status**. Enter one of the following codes as appropriate: 1 = All treatment goals met 2 = Half or more goals met 3 = Not Complete: Max Bene CL Disc 4 = Not Complete: Some goals met 5 = Not complete: No goals met 6 = Transferred Out 9 = Automatically discharged NOTE: Codes 1 and 2 are considered successful completion of treatment.
Completion Status	This field is used to help track the status of clients. **In Process** means an episode is still in process and**/OR** that the client has not been discharged yet. **Done** means that either the client was discharged, referred out, or contact with the client has not been made in 30 days. **Missing or Unavailable** means there are missing data elements in the episode, but that all efforts to locate those missing elements have been exhausted.
Flex Item 1	Item to collect program specific data - limited to 10 characters (no commas or apostrophes).
Flex Item 2	Item to collect program specific data - limited to 10 characters (no commas or apostrophes).
Flex Item 3	Item to collect program specific data - limited to 10 characters (no commas or apostrophes).
Flex Item 4	Item to collect program specific data - limited to 10 characters (no commas or apostrophes).