Behavioral Health Department
Alameda County Health

STRTP CQRT Glossary

August 2024

CQRT CHECKLIST ITEM	GLOSSARY
Admission/Consents	
1. Admission Statement meets all required elements.	The head of service will do the following within 5 calendar days. • Review the child's referral documentation and any previous mental health assessments, if available • Assess the needs and safety of the child and other children at the STRTP. • Confirm that admitting the child is appropriate by not needing a higher level of care (inpatient) and the STRTP will maintain the safety and well-being of child and others. • Confirm the child meets at least one of the following conditions: (A) The child has been assessed as meeting the medical necessity criteria for Medi-Cal Specialty Mental Health Services (SMHS) (B) The child has been assessed as seriously emotionally disturbed, (C) The child requires emergency placement. (D) The child has been assessed as requiring the level of services provided by the STRTP in order to meet their behavioral or therapeutic needs. • If the referral is made through the IPC, documentation that the referral packet has been reviewed. Resource: STRTP Admission Statement
2. Informing Materials are reviewed and signed	• The ACBHD Informing Materials packet is reviewed with the member/authorized representative before or during the intake appointment, whenever there are changes to the documents and when requested by member/authorized representative. • The Informing Materials Acknowledgement of Receipt page is fully completed, with all boxes checked, and signed based on above timeframes. Resource: Provider Website Informing Material Page *NOTE: If telehealth services are being provided, also check that the telehealth consent requirements are met
3. Informed consent for Medication is documented, as appropriate	For all psychiatric medications prescribed, the following information must be included in the note: • The nature of the patient's mental condition • The reasons for taking such medication, including the likelihood of improving or not improving without such medication, and that

	consent, once given, may be withdrawn at any time by stating such intention to any member of the treating staff. • The reasonable alternative treatments available • The type, range of frequency and amount (including use of PRN orders), method (oral or injection), and duration of taking the medications. • The probable side effects of these drugs known to commonly occur, and any particular side effects likely to occur with the particular patient. • Possible side effects of taking anti-psychotic medication beyond three months, including persistent involuntary movement of the face or mouth, possible similar movement of the hands and feet, and that these symptoms of tardive dyskinesia are potentially irreversible and may appear after medications have been discontinued. • A notation that the patient understands the nature and effect of medications and consents to administration of those medications. Resource: 7-9-medication-consent-form-2023.pdf (acgov.org)
4. Documentation that the youth was examined by a psychiatrist at least once during their stay	Each child shall be examined by a psychiatrist at least once during the child's stay at the STRTP. Source: STRTP-Regulations-version II (ca.gov) Section 12a, page 19
5. Authorization to Release Information is valid	ROI is completed in full, signed and dated by the member or their authorized representative.
6. Court orders or judgments are in the client record	A copy of any available legal documentation regarding the physical or legal custody of the child, conservatorship or guardianship of the child, the child's probation, or the child's juvenile court dependency or wardship. Source: STRTP-Regulations-version II (ca.gov) pg. 11
7. Child and Family Team Meetings Notes are in the client record	Copies of Child and Family Team meeting notes must be in the chart.
Assessment	
8. Assessment contains all required elements.	The mental health assessment shall address the following: 1. Presenting problem, including the history of the presenting problem(s), family history, and current family information. The presenting problem shall include the reason(s) for the child's referral to the STRTP. 2. A mental status examination.

	3. Mental Health History, including previous treatment, inpatient admissions, therapeutic modalities, such as medications and psychosocial treatments, and response. If available, include information from other sources of clinical data, such as previous mental health records, and relevant psychological testing or consultation reports. 4. Medical History, including physical health conditions, name and address of current source of medical treatment, prenatal and perinatal events, developmental, and other medical information from medical records or consultation reports. The medical history shall include: (A) All present medical condition(s), (B) Medications, including information about medications the child has received, or is receiving, to treat mental health and medical conditions, including duration of medical treatment, (C) The absence or presence of allergies or adverse reactions to medications, (D) Documentation of an informed consent for medications, (E) All medications currently prescribed and dosages. 5. Risks to the child and/or others. 6. Substance Exposure/Substance Use, including past and present use of tobacco, alcohol, caffeine, CAM (complementary and alternative medications), over the counter, and illicit drugs. 7. Psychosocial factors and conditions affecting the child's physical and mental health, including living situation, daily activities, social support, sexual orientation, gender identity, cultural and linguistic factors, academics, school enrollment, and employment. 8. History of trauma. 9. Child Strengths, including the child's strengths in achieving needs and services plan goals related to the child's mental health needs, challenges, and functional impairments as a result of the mental health diagnosis. 10. A complete diagnosis consistent with the presenting problems, history, mental status examination and/or other clinical data. 11. Any additional clarifying information.
9. Meets Access Criteria/Medical Necessity	The child has been assessed as meeting the medical necessity criteria for Medi-Cal SMHS, as provided for in Section 1830.205 or 1830.210 of Title 9 of the California Code of Regulations. Resource: Optional ACBHD Access Criteria Screening Tool

10. If using a referral assessment, all documentation requirements are met.	• If using a previous assessment to admit the child, the assessment must have been completed no more than 60 days prior to the child's arrival and have been completed by a provider with the scope of practice to complete clinical assessments. • The previous assessment must be reviewed by a staff member with scope of practice to complete an assessment within 5 days of the client's arrival. • A note must be documented in the client's record indicating the assessment was reviewed and accepted and include any additional relevant clinical information.
11. Emergency documentation requirements are met.	If emergency placement, there is: • Documentation of 1:1 observation of the youth • As soon as possible and no later than within 72 hours, a clinical note/written determination by a licensed mental health professional (LMHP) or waivered/registered professional that the child requires the level of services and supervision provided at the STRTP to meet their behavioral and mental health service needs.
12. Coordination of Care is evident	• It is evident from the assessment and/or progress notes that efforts are being made to coordinate care with other providers as clinically appropriate. • Examples include, but aren't limited to, the presence of Releases of Information authorizing communication with other service providers and/or documented efforts to communicate with other providers.
13. Required CANS is completed	• Childhood Assessment of Needs and Strengths (CANS) is completed by day 60 of Episode Opening, every 6 months, and at discharge. • These tools must be completed by Registered, Waivered or Licensed LPHA or an MHRS who are certified by the Praed Foundation.
14. Required PSC-35 is completed	The Pediatric Symptom Checklist (PSC35) must be completed by day 60 of Episode Opening, every 6 months and at discharge. If not completed, there should be documentation of refusal or lack of response.
Treatment Plan	
15. Required treatment plan contains all required elements.	The Treatment Plan must be completed by staff with credentials to do so within 10 days of the youth's arrival at the STRTP and be updated with any mental health need change. Required elements include: 1. Anticipated length of stay.

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2. Specific behavioral goals for the child and specific mental health treatment services the STRTP shall provide to assist the child in accomplishing these goals within a defined period of time.
3. One or more transition goals that support the rapid and successful transition of the child back to community based mental health care.
4. The child and authorized legal representative's participation and agreement, documented in the client record. If the child is unable to agree or refuses to agree to the treatment plan, the child's authorized legal representative's participation and agreement shall be sufficient, but the child's inability or refusal shall be documented in the Client Record.
5. Include participation of the child and family team if one exists.
6. Documentation of review by a member of the STRTP mental health program staff at least every thirty (30) calendar days. and clarification of whether or not it is necessary to make changes to the treatment plan.
7. A trauma-informed perspective, which includes planned services to promote the child's healing from any history of trauma.

Source: STRTP Regulations Section 10 a 1 pg. 16Section 10 a 1 pg. 16
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<tr><td>16. Documentation that a copy of the treatment plan is provided.</td><td>The STRTP shall provide a copy of the treatment plan to the child's placing agency within 10 calendar days of the request of the placing agency and in compliance with all applicable privacy laws.</td></tr>
<tr><td colspan="2">Problem List</td></tr>
<tr><td>17. Problem List is present, contains required elements and is updated as clinically appropriate.</td><td>
• A Problem List should be started as soon as possible once the client is admitted and updated as appropriate to be consistent with the chart notes and reflect the client's current issues.
• It should include all required components: (A) Diagnoses identified by a provider acting within their scope of practice. (B) Diagnostic specifiers from the ICD-10 if applicable. (C) Problems identified by a provider acting within their scope of practice. (D) Problems or illnesses identified by the person in care and/or significant support person, if any. (E) The name and title of the provider that identified, added, or removed the problem, and the date the problem was identified, added, or removed.
• End dates are added only when problems are resolved or deferred.
• In Clinician's Gateway (CG), the Archive option is only used if a problem was added to the chart in error.
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<tr><td colspan="2">Safety Plan</td></tr>
<tr><td>18. There is a safety plan in place if client has had</td><td>• Risk refers to danger to self, danger to others or any other behaviors that might create risk of harm to the client or others.</td></tr>
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a risk of danger to self or others in the last 90 days.	• A comprehensive risk assessment and safety plan should be in the chart and reviewed with the client.
Progress Notes	
19. There is a minimum of 1 daily progress note each day.	Source: STRTP Regulations Section 11 A page 17
20. Progress note was completed within the required timeframe.	• Progress notes must be completed as soon as reasonable after a service has occurred – generally within 24 hours for a crisis service, and within three days for most other services. • If the progress note is completed more than 72 hours from the time of service, then it shall be designated late.
21. Progress notes contain all required elements.	All progress notes contain the following: 1. The specific service(s) provided to the child. 2. A child's participation and response to each mental health treatment service directly provided to the child. 3. Observations of a child's behavior. 4. Possible side effects of medication. 5. Date and summaries of the child's contact with the child's family, friends, natural support, child and family team, existing mental health team, authorized legal representative, and public entities involved with the child. 6. Descriptions of the child's progress toward the goals identified in the treatment plan. 7. Date of Service 8. Location of Service 9. If the service is provided in a language other than English, the language is noted. 10. Signed and dated by the person providing the service within their scope.
22. Separate progress notes indicate any significant events or changes that have occurred.	• Unexpected, unintended events that could or did lead to physical or emotional harm to the child, are documented in a distinct note, separate from other progress notes. This includes incidents which did not cause harm but could have caused harm, or where the event should have been prevented. • Whenever there is a significant event involving the child, the STRTP shall consider whether the child has a history of trauma and, if so, do the following: (1) Determine whether the child's history of trauma has precipitated the significant event. (2) Determine whether the significant event could be used to promote healing and growth from the child's history of trauma. (3) Determine whether the significant event has created a need for changes to the child's treatment plan. (4) Update the child's treatment plan with any additional services that the child needs,

	taking into account the significant event, the child's history of trauma, and any other relevant psychosocial factors which may include the child's living situation, daily activities, social support, sexual orientation, gender identity, cultural and linguistic factors, academics, and school enrollment.
23. Separate progress notes for each additional specialty mental health service provided.	• If the child is a Medi-Cal beneficiary, the STRTP shall complete separate progress notes for each specialty mental health service provided. • If a progress note for a specialty mental health service is provided, this replaces the requirement for a daily mental health progress note.
24. Service were provided while client was not in lock-out setting, IMD, or jail.	Flag all progress notes billed during potential lock out for clinician to review. Source: Specialty Mental Health Billing Manual
Medication	
25. A physician or psychiatrist shall examine each child prior to prescribing any psychotropic medication.	• The examination shall include a screening to determine whether there are potential medical complications from the medication that could impact the child's mental health condition. • The examination shall be noted in the client record.
26. Physician or a psychiatrist, shall sign a written medication review for each child prescribed psychotropic medication.	• This review shall be completed as often as clinically appropriate, but at least every forty-five (45) days. Resource: STRTP Medication Review
27. The medication review contains all required elements.	The medication review shall include: 1. Observations of any side effects and review of any side effects reported by the child or noted in the client record. 2. The child's response to each psychotropic medication currently prescribed and the child's perspective on the effectiveness of these medications. 3. The child's compliance with taking psychotropic medication prescribed. 4. Justification for continuing to prescribe psychotropic medication and/or changing the child's medication plan. 5. A statement that the physician, psychiatrist has considered the goals and objectives of the child as listed in the child's needs and services plan and the treatment plan, and that the psychotropic medication prescribed is consistent with those goals and objectives.

28. Progress note documents a psychiatrist's review of youth who are not prescribed psychotropic medication.	A psychiatrist shall review the course of treatment for all children who are not on psychotropic medication to treat mental health conditions as clinically appropriate, but at least every 90 days and include the results of this review in a progress note signed by the psychiatrist at the time the review is completed. Resource: STRTP Not Prescribed Medication Review
29. The record contains required elements when medication is administered.	Required elements: 1. The date and time a prescription or non-prescription medication was taken 2. The dosage taken or refused 3. The child's response to medication Source: STRTP-Regulations-version II (ca.gov) Section 12 f page 20
Group Services	
30. Participant list for all group services provided.	When a group service is rendered, a list of participants is required to be documented and maintained by the provider. Source: BHIN 23-068 Documentation Requirements for SMH DMC and DMC-ODS Services.pdf
31. Group Progress notes	• Every participant shall have a progress note in their clinical record noting their attendance in the group and brief description of the client's response to the service. • Group progress notes include total number of beneficiaries participating in the service. • Notes for services involving one (1) or more providers also include: a) Total number of providers and their specific involvement in delivering the service, b) Time involved in delivering the service for each provider (includes travel and documentation).
Clinical Review	
32. Evidence of Clinical Review every 90 days.	The record must be reviewed every 90 days by a licensed/waivered/ registered mental health professional. This review must be documented in a progress note. Source: STRTP-Regulations-version II (ca.gov) Section 14 page 21
Transition Determination Plan	
33. Transition Determination Plan contains all required elements.	• A transition determination plan shall be developed, completed, and signed by a member of the STRTP mental health program staff prior to the date the child transitions out of the STRTP. • A copy shall be provided prior to or at the time of the child's transition, to the following, as applicable: parent, guardian, conservator, or person identified by the court to participate in the decision to place the child in the STRTP.

	• The transition determination plan shall include: (1) The reason for admission. (2) The reason for transition, referencing the child's transition planning goals, or another reason for the child to be transferred to an alternative treatment setting. (3) The course of treatment during the child's admission, including mental health treatment services, medications, and the child's response. (4) The child's diagnosis at the time of transition. Resource: Transition Determination Plan
34. Aftercare plan contains all required elements.	The child's aftercare plan includes the following components: 1. The nature of the child's diagnosis and follow-up required. 2. Medications, including side effects and dosage schedules. 3. Goals and expected outcomes for any follow up treatment. 4. Recommendations regarding treatment that are relevant to the child's care. 5. Educational information, including grade level functioning, and any special education needs. 6. Referrals to providers of medical and mental health services. 7. Other relevant information.