Behavioral Health Department
Alameda County Health

Clinical Quality Review Team (CQRT) Glossary

Specialty Mental Health Services (SMHS) Residential Programs

CQRT Checklist Items	Glossary
Admission/Consent	
1. Admission Agreement meets all required elements	The admission agreement outlines the services to be provided, expectations and rights of the client regarding house rules, client involvement in the program, and fees.
2. Proof that client signed and was offered a copy of the admission agreement	• The admission agreement is signed on the day of admission by client (or representative) and staff. • There is evidence that the client was offered a copy of the admission agreement.
3. Informing materials	• 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. *NOTE: If telehealth services are provided, also check that the telehealth consent requirements are met. Resource: Informing Materials List | ACBH Providers Website (acgov.org)
4. Informed consent for medication is documented, as appropriate	For all prescribed psychiatric medications, the following information must be included in the note: • The nature of the patient's mental health 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including the likelihood of improving or not improving without such medication, and that consent, once given, may be withdrawn at any time by stating such intention to any member of the treating staff.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 for over 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 the administration of those medications. Resource: Medication Consent Form
5. Authorization to release information is valid	ROI is completed in full, signed and dated by the member or their authorized representative.
6. Level of Care Tool is completed	The beneficiary's symptoms meet the access criteria for residential services as indicated by the Level of Care Determination Tool. Resource: Level of Care Determination Tool for Residential Services
Assessment	
7. Assessment meets all required elements	• The Mental Health Assessment includes: Health and psychiatric histories, psychosocial skills, social support skills, current psychological, educational, vocational, other functional limitations, and medical needs, meal planning, shopping, and budgeting skills. • Psychosocial factors noted on the assessment, or elsewhere in the chart, include information about the client's physical, cultural, and communication needs, or lack thereof. • The assessment is signed by a registered, waivered, or licensed LMHP. • Includes required co-signatures based on scope of license. • The beneficiary's meal planning, budgeting, and shopping skills were assessed on admission • The assessment was updated when the client's condition changed or as clinically appropriate. Resource: CalAIM Documentation Guide

8. Services meet Access Criteria and/or Medical Necessity	• Documentation in the medical record meets access criteria for each delivery system:
	  • Access Criteria (Persons under age 21): The person is experiencing significant trauma placing them at risk of future mental health conditions. These include those who are homeless, involved in child welfare or juvenile justice or those who scored in the high-risk range on a DHCS approved Trauma Screening tool (e.g. Pediatric ACES and Related Life-Events Screener (PEARLS) tool, ACE Questionnaire.
	  • Access Criteria (Persons over age 21): The person has significant impairment in social, occupational, or other important life activities and/or there is reasonable probability of significant deterioration in important area of life functioning, AND the significant impairments listed above are due to a diagnosed or suspected mental health disorder.

	• Documentation in the medical record meets medical necessity criteria for each delivery system:
	  • Medical Necessity (Persons under age 21): the service is necessary to correct or ameliorate a mental illness or condition discovered by a screening service. These services can be delivered to sustain, support, improve or make more tolerable a mental health condition.
	  • Medical Necessity (Persons over age 21): the service is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.
	Resource: ACBH Screening Tool

9. If risk occurred in the past 90 days, there is a comprehensive risk assessment and safety plan.	• Risk refers to danger to self, danger to others, or any other behaviors that might create risk of harm to the client or others. • A comprehensive risk assessment and safety plan should be in the chart and reviewed with client.
Problem List	
10. The problem list is present and includes all required elements.	• A Problem List should be started as soon as possible once the client is admitted. • It should include all required components as noted in the CalAIM Documentation Guide. • End dates are added only when problems are resolved or deferred. • The problems on the list should be generally consistent with the chart notes and be updated to reflect the client's current issues.
Treatment/ Care Planning	
11. A Treatment Plan is present and includes all required elements	• Initial plan for Crisis Residential is completed within 72 hours of episode opening. • Initial plan for Adult Residential is complete within 30 days of episode opening. • Plan is consistent with diagnosis. • Plan includes a statement of specific treatment needs and goals and a description of specific services to address identified treatment needs. • Plan is revised when significant change occurs (e.g. in service, diagnosis, focus of treatment, etc.). • There is documentation that a copy of the Treatment Plan is provided to the client. • There is evidence in the clinical record that the client was involved in treatment planning. • The Plan is signed/dated by client/ legal representative, or there is documentation of refusal or unavailability to sign.

	• Plan includes a typed or legibly printed name, signature of the service provider, and date of signature with designation: Licensed/Registered/Waivered/Trainee/MHRS/ Adjunct

12. Documentation of reviews by staff and client of the treatment/rehabilitation plan are present.	• The review is documented in a progress note or an updated treatment plan adhering to the following schedule:
	  • Short-term Crisis Residential Treatment Program: at least weekly.
	  • Transitional Residential Treatment Program: at least once every 30 days.
	  • Long Term Residential Treatment Program: at least once every 60 days.
	• Records demonstrate evidence of discharge planning activities throughout the treatment episode.

13. There is evidence that the agency arranged access to community programs to address treatment goals when the agency is unable to provide those services.	When an agency is unable to provide services mentioned in treatment goals, the agency must arrange access to the community programs and document this information in progress note or treatment plan.
14. A written discharge plan is present with all required elements.	The discharge plan includes an outline of services provided, goals accomplished, reason and plan for discharge, and referral follow-up plans.
Progress Notes	
15. All progress notes contain all required elements and meet timeliness standards.	• A minimum of one daily note is completed by the person who provided the mental health service or supervisor who was present on the day of claiming. • Date services are provided. • Type of service (assessment, therapy, groups, collateral) provided throughout the day. • ICD 10 code • The service provider's typed or legibly printed name, Medi-Cal credential, signature and date of signature. • Narrative sections include: Description of services provided throughout the day, including how the services addressed the person's behavioral health needs (e.g. symptoms, condition, diagnosis and/or risk factors). • Treatment plan changes or progress made towards achieving treatment goals. • Groups attended, significant information shared during groups, concerns about participation, insights or progress made during groups. • Next steps, including but not limited to, planned action steps by the provider or client, collaboration with the client, other providers, family or significant others and any updates to the problem list, as appropriate. • If non-reimbursable services were provided, the note clarifies that the time was not claimed.

	• Progress notes are finalized within 3 business days, or 24 hours for crisis services.
	• Progress notes for services involving one (1) or more providers, include:
	  • Total number of providers and their specific involvement in delivering the service
	  • Time involved in delivering the service for each provider (includes travel and documentation)
	  • Total number of beneficiaries participating in the service

16. Care coordination is evident	• It is evident from the assessment and/or progress notes that efforts are being made to coordinate care with other providers responsible for treatment plan goals, 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.
17. Participant list is provided for all group services.	When a group service is rendered, a list of participants is required to be documented and maintained by the provider, outside of the client record.
Billing	
18. Services were not provided while the client was in a Medi-Cal lock-out	• The program did not bill during Medi-Cal lock outs which include psych hospitalization, Institution for Mental Disease (IMD), Juvenile Justice Center, and jail. • Flag all progress notes billed during potential lock out for clinician to review. • Residential program did not bill on the day of discharge. Resource: ACBHD Lockout Grid

19. Admission assessment, Treatment Plan, and Discharge Summary are completed by staff that are adequately trained.	• The service provided was within the scope of practice of the provider delivering the service.
	• Staff must receive a minimum of one hour of instruction on the development and preparation of the:
	  • Admission assessment
	  • Treatment/rehabilitation plan
	  • Discharge Summary
	• Training shall include the expected content of documentation, methods used to prepare the document, timeframes for completion of documentation, and consultative sources to be utilized in preparing the document.
	• Training provided can be presented in a variety of methods.
	Resource: California Code of Regulations
	BHIN 23-068 Documentation Requirements