To:	**BHS Short-Term Residential Therapeutic Program (STRTP) Contracted Service Providers**
From:	**BHS Children Youth and Families**
Date:	**November 20, 2020**
Title:	**Interim STRTP Regulations Version 2 – Effective February 28, 2020** **Replaces Interim STRTP Regulations Version 1 and Interim Mental Health Program Approval Protocol**

On February 28, 2020, the Department of Health Care Services (DHCS) issued **Information Notice 20-005, Statewide Criteria for Mental Health Program Approval for Short-Term Residential Therapeutic Programs (STRTP)**, superseding Version 1 STRTP Regulations released in MHSUDS Information Notice No. 17-016. Per DHCS, the Interim STRTP Regulations (Version 2) were effective immediately as of February 28, 2020.

Licensed STRTPs who had not yet received a Mental Health Program Approval, shall use the requirements outlined in the Interim STRTP Regulations (Version 2) to obtain approval from DHCS. STRTPs who have an existing Mental Health Program Approval were given 60 calendar days from February 28, 2020 to come into compliance with the STRTP Interim Regulations (Version 2).

The BHS-CYF Continuum of Care Reform (CCR) team has developed a side by side comparison to highlight the updates outlined in Version 2, as well as updated forms to comply with the revised requirements, which were reviewed in draft format during the BHS-CYF Program Manager STRTP breakout session on July 9, 2020. Please review the finalized attached **"DHCS Interim STRTP Version 1 and Version 2 Regulations Comparison Guide"** for details regarding significant updates in Version 2. The CCR team has also updated the attached **"Abbreviated STRTP Interim Regulations (Version 2) Guide"** which highlights significant changes between RCL 13-14 requirements and STRTP Version 2 requirements. Both documents are intended to serve as guides with reference to source documents.

To assist STRTPs with meeting the updated Interim STRTP Regulations (Version 2), the following forms have been updated or released (see BHS Provider Information Notice dated November 20, 2020 "STRTP Forms – Revised Forms Effective November 2020" for all STRTP forms):

- Updated **"Client Plan"** – STRTP text updated November 20, 2020
- Updated **"Transition Determination Plan"** – November 20, 2020
- Updated **"Prior Authorization for Day Services Request"** *(for STRTP Day Program/Hybrid providers only)* – Updated November 20, 2020
- New **"STRTP Utilization Management Request"** *(for STRTP Outpatient providers only)* – Replaces the retired "Interim STRTP Outpatient Intensive Services Request" form – November 20, 2020

Attachments

- DHCS Interim STRTP Version 1 and Version 2 Regulations Comparison Guide - *released November 20, 2020*
- Abbreviated STRTP Interim Regulations (Version 2) Guide – *updated November 20, 2020*
- Client Plan – *updated November 20, 2020*
- Transition Determination Plan – *updated November 20, 2020*
- Transition Determination Plan Explanation Form – *updated November 20, 2020*
- Prior Authorization for Day Services Request – *updated November 20, 2020*
- Prior Authorization for Day Services Request Explanation form – *updated November 20, 2020*
- STRTP Utilization Management Request – *released November 20, 2020*
- STRTP Utilization Management Request Explanation Form – *released November 20, 2020*

For More Information:

- Contact your Contracting Officer's Representative (COR) or
- Seth Williams, BHS Program Manager, Seth.Williams@sdcounty.ca.gov , 619-584-3042

To:	**BHS Short-Term Residential Therapeutic Program (STRTP) Contracted Service Providers**
From:	**BHS Children Youth and Families**
Date:	**November 20, 2020**
Title:	**Interim STRTP Regulations Version 2 – Effective February 28, 2020** **Replaces Interim STRTP Regulations Version 1 and Interim Mental Health Program Approval Protocol**

References

- DHCS MHSUDS Information Notice No.: 20-005 Dated February 28, 2020: Statewide Criteria for Mental Health Program Approval for Short-Term Residential Therapeutic Programs and Enclosure 1 – Interim STRTP Regulations (Version 2)
- DHCS MHSUDS Information Notice No.: 17-016 Dated May 5, 2017; Statewide Criteria for Interim Mental Health Program Approval for STRTP and Enclosure 2 – Draft Interim STRTP Regulations

cc: Optum Public San Diego

For More Information:

- Contact your Contracting Officer's Representative (COR) or
- Seth Williams, BHS Program Manager, Seth.Williams@sdcounty.ca.gov , 619-584-3042

DHCS Interim STRTP Version 1 and Version 2 Regulations Comparison Guide:

This tool serves as an overview summary; STRTPs are to review and follow the full Interim STRTP Regulations (Version 2)

Version 2 Section	Version 1 Requirement – 5/5/2017	Version 2 Requirement – 2/28/20
Definitions and Terms		
2	The following definitions in Version 1 have been removed from Version2: "Direct service program staff", "progress notes", "seriously emotionally disturbed", "needs and services plan"	The following definitions that were not in Version 1 have been added to Version 2: "**Arrival", "authorized legal representative", "child", "mental health plan", "placing agency", "STRTP", "mental health progress notes", "STRTP mental health program staff", "trauma", "treatment plan"**
Mental Health Program Approval Application Content		
3	Application updated to **DHCS Form 3131**	
3	Shall have program statement aligning information in Section 5 of **STRTP Regulations Version 2**	
STRTP Mental Health Program Approval of Separate Premises		
4	A separate mental health approval is required for each STRTP located on separate premises. A separate mental health approval is not required for separate residential units on adjoining lots provided the STRTP operates as one program using the same administrator and head of service	No Change
STRTP Mental Health Program Statement		
5	Program Statements submitted after 2/28/20 shall include policies and procedures for the guidelines in Section 5, part (a) through (c), in **Version 2 of the STRTP Interim Regulations** when completing the applying for Mental Health Program Approval. Updates include a procedure for **documenting progress notes**, a procedure for **directly providing the minimum mental health services**, and a procedure for **admission and transition** *Local San Diego practice requires concurrently submitting the Program Statement to the County BHS COR when submitting to DHCS	
5	Program Statements submitted prior to 2/28/20 shall have **60 days** to update the Program Statement to STRTP Interim Regulations Version 2. Per DHCS the Program Statements will be reviewed according to Version 2 Regulations during the annual DHCS Site Visit **Local San Diego practice requires concurrently submitting the Program Statement updates to the County BHS COR when submitting to DHCS	
Notification to Department or Delegate		
6	STRTP shall notify the Department and delegate of any of the following: a change in the head of service, change to its name, change of location of the short-term residential therapeutic program, and change of the mailing address of the short-term residential therapeutic program	The STRTP shall notify the Department and delegate in writing **within ten (10) calendar days** of changes to its name, location, mailing address, or head of service. If there is a change to the head of service, **the notification shall include documentation that the new head of service meets qualifications required for the position** *Local San Diego practice requires concurrently notifying the County BHS COR of the changes when informing DHCS
6	The STRTP shall notify the Department and delegate in writing prior to any increases or decreases in licensed bed capacity	No Change *Local San Diego practice requires providing a written alert to the County BHS COR prior to any increases or decreases in licensed bed capacity as it would require BHS concurrence for any contract changes

DHCS Interim STRTP Version 1 and Version 2 Regulations Comparison Guide:

This tool serves as an overview summary; STRTPs are to review and follow the full Interim STRTP Regulations (Version 2)

Version 2 Section	Version 1 Requirement – 5/5/2017	Version 2 Requirement – 2/28/20
6	New Requirement	The STRTP shall notify the Department and delegate in writing when the STRTP is **no longer certified to provide specialty mental health services** pursuant to section 1810.435, subdivision (d) **within seventy-two (72) hours from the date the certification expires or is terminated** *Local San Diego practice requires concurrent notification to the County BHS COR
Client Record Documentation and Retention		
7	The STRTP shall ensure that each child in the STRTP has an accurate and complete client record, kept confidential according to federal and state privacy laws, and retained for a minimum of 10 years	No Change
7	The following Client Record items from Version 1 have been removed in Version 2: Intake summary, needs and services plan, monthly clinical review reports	The following Client Record items that were not in Version 1 have been added to Version 2: **Signed informed consent for treatment, mental health assessment (known as "BHA"), admission statement, treatment plan (known as "Client Plan"), CFT notes, clinical review report and transition determination (included in "STRTP Prior Authorization for Day Services Request" (DSR)** or "**STRTP UM Request"), physicians orders related to mental health care, medication reviews, written informed consent for prescribed medication** *Local San Diego forms are utilized to meet each of the above Client Record items
Mental Health Assessment		
8	"BHA": Completed by licensed mental health professional	"BHA": Completed by licensed mental health professional **or waivered/registered professional**
8	"BHA": Final Approved within 5 calendar days	No Change
Admission Statement		
9	Intake Summary: Completed by Head of Service within 5 calendar days of intake	**Admission Statement:** Completed by head of service within 5 calendar days of intake

DHCS Interim STRTP Version 1 and Version 2 Regulations Comparison Guide:

This tool serves as an overview summary; STRTPs are to review and follow the full Interim STRTP Regulations (Version 2)

Version 2 Section	Version 1 Requirement – 5/5/2017	Version 2 Requirement – 2/28/20
Treatment Plan		
10	Completed Needs and Services Plan (known as "Client Plan"): Reviewed and signed by licensed mental health professional, head of service, or designee (i.e. associate MFT, MSW)	Completed **Treatment Plan** (known as "Client Plan"): Reviewed and signed by a licensed mental health professional, **waivered/registered professional**, or head of service **(*designee removed*)**
10	Completed Needs and Services plan (known as "Client Plan"): Reviewed by a member of mental health program staff at least every 30 days	No change
10	New Requirement in Version 2	**Treatment Plan** (known as "Client Plan") : Includes **anticipated length of stay** *Local San Diego "Client Plan" form (revised in November 2020) includes updated Treatment Plan requirements per the Interim STRTP Regulations Version 2
10	Needs and Services Plan (known as "Client Plan"): Include transition goals that are general indicators of the child's readiness for transition to alternative treatment settings, which may include returning to the child's home	**Treatment Plan** (known as "Client Plan"): Includes one or more transition goals that **support the rapid and successful transition of the child back to community based mental health care** *Local San Diego "Client Plan" form (revised in November 2020) includes updated Treatment Plan requirements per the Interim STRTP Regulations Version 2
10	New Requirement in Version 2	**Treatment Plan** (known as "Client Plan"): Have **a trauma-informed perspective, which includes planned services to promote the child's healing from any history of trauma** *Local San Diego "Client Plan" form (revised in November 2020) includes updated Treatment Plan requirements per the Interim STRTP Regulations Version 2
10	New Requirement in Version 2	Copy of the "Client Plan" provided to placing agency within **10 days** of placing agency request *Local San Diego practice is for the "Client Plan" to be provided to the PSW with the "Progress Report to CWS" form within 30 days of intake, at reassessment, and at discharge for all clients with an open CWS case – In addition 10 day timeline must be met upon request

DHCS Interim STRTP Version 1 and Version 2 Regulations Comparison Guide:

This tool serves as an overview summary; STRTPs are to review and follow the full Interim STRTP Regulations (Version 2)

Version 2 Section	Version 1 Requirement – 5/5/2017	Version 2 Requirement – 2/28/20
Progress Notes		
11	New Requirement in Version 2	Minimum of **one daily mental health progress note, 7 days a week** The daily progress note shall document the following when applicable: (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 supports, 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 Only information or events that are applicable should be included in that day's progress note If a progress note for a specialty mental health service is provided, this replaces the requirement for the daily mental health progress note *Local San Diego practice is for the STRTP Mental Health program staff to provide and document SMHS each day to meet the daily mental health progress note requirement Since the mental health program may not be in operation all 7 days a week, the daily mental health progress note requirement may be met through the STRTP residential staff completing a paper note on a template developed by the STRTP on days the mental health program staff are not present (per DHCS). If completed by the residential staff, the paper note shall include at least one item from daily mental health progress note requirements #1-6 above and be stored in the hybrid medical record chart.

DHCS Interim STRTP Version 1 and Version 2 Regulations Comparison Guide:

This tool serves as an overview summary; STRTPs are to review and follow the full Interim STRTP Regulations (Version 2)

Version 2 Section	Version 1 Requirement – 5/5/2017	Version 2 Requirement – 2/28/20
11	New Requirement in Version 2	In addition to the Daily Mental Health Progress Note, a progress note is required whenever there is a **significant change in condition or behavior**, or a **significant event** Review Section 11 B-1 and B-2 for a description of a significant event and consideration of the child's history of trauma Significant changes or events requiring such a note may include: events requiring crisis intervention; therapy sessions with major breakthroughs on trauma history; or, changes in behavior and symptoms like suicidal ideation or self-harm *Local San Diego practice is to utilize SMHS Progress note templates to document significant changes or events
11	Progress notes final approved within 24 hours of service	Progress notes final approved within **72 hours** of service
Medication Assistance, Control and Monitoring		
12	All youth in a STRTP must be assessed by psychiatrist	No Change
12	Psychiatrist signs written medication review every 6 weeks (42 days) for each child prescribed psychotropic medication	Psychiatrist signs written medication review every **45 days** for each child prescribed psychotropic medication *Local San Diego practice is to utilize "Medication Progress Note" Service Code 24-28 Progress Note templates to document medication review
12	Psychiatrist review course of treatment every 90 days for children not prescribed psychotropic medication; signs progress note that includes results of review	No Change *Local San Diego practice is to utilize "STRTP Medication Not Prescribed" Service Code 11 Progress Note template to document course of treatment review
Mental Health Treatment Services		
13	Structured on site mental health services available 7 days a week	No Change
13	STRTP ensures the following services are available: Mental Health, Medication Support, Day Treatment, Day Rehab, Therapy, Targeted Case Management, Psychiatrist, Psychologist, EPSDT	STRTP shall **provide the following mental health treatment services directly on site**: Crisis Intervention, Mental Health, Targeted Case Management STRTPs shall **make available the following mental health treatment services according to the child's treatment plan:** Day Treatment, Day Rehab, Medication Support, EPSDT, Psychiatric Nursing

DHCS Interim STRTP Version 1 and Version 2 Regulations Comparison Guide:

This tool serves as an overview summary; STRTPs are to review and follow the full Interim STRTP Regulations (Version 2)

Version 2 Section	Version 1 Requirement – 5/5/2017	Version 2 Requirement – 2/28/20
Clinical Review, Collaboration and Transition Determination		
14	Clinical Review every 90 Days: Completed by a licensed mental health professional *Local San Diego practice was to meet the Clinical Review requirement through the "STRTP Intensive Services Request" completed every 90 days. However, on January 1st, 2020 the additional requirement for Prior Authorization for Day Services was implemented	Clinical Review every 90 days: Completed by a licensed mental health professional or **waivered/registered professional** *Local San Diego practice has shifted to meet the Clinical Review requirement through the "Prior Authorization for Day Services Request" (DSR) (revised in November 2020) or "STRTP Outpatient UM Request," (released in November 2020), replacing the STRTP Intensive Services request. Both the DSR and STRTP Outpatient UM Request are reviewed and co-signed by a Licensed Mental Health Professional
14	Includes summary of types and frequency of services, impact of these services on client plan goals, input from CFT and justification for continued stay or transition	Includes summary of services, justification for continued stay or transition, **whether the STRTP continues to meet the specific therapeutic needs of the child and collaboration with the CFT** *Local San Diego forms "DSR" or "STRTP Outpatient UM Request" are utilized to document this requirement
14	New Version 2 Requirement	**STRTP mental health program staff shall meet at least once every ninety (90) days, or more often if needed, to discuss the diagnosis, mental health progress, treatment planning, and transition planning for the child. STRTP mental health program staff shall obtain information from direct care staff about their observations, if any, for the child. The head of service, licensed mental health professional or waivered/registered professional shall attend each meeting along with other mental health program staff that provide mental health services to the child** *Local San Diego forms "DSR" or "STRTP Outpatient UM Request" are utilized to document this requirement
Transition Determination Plan		
15	Transition Determination Plan: Completed and signed by member of mental health program staff prior to discharge	No Change *Local San Diego "Transition Determination Plan" form (revised in November 2020) includes updated Transition Determination Plan requirements per the Version 2 Interim STRTP regulations
n/a	"Discharge Summary": Completed within 7 days of discharge from program	No change *Local San Diego "STRTP Discharge Summary" form is utilized to document this requirement

DHCS Interim STRTP Version 1 and Version 2 Regulations Comparison Guide:

This tool serves as an overview summary; STRTPs are to review and follow the full Interim STRTP Regulations (Version 2)

Version 2 Section	Version 1 Requirement – 5/5/2017	Version 2 Requirement – 2/28/20
Head of Service		
16	1 FTE Head of Service employed 40 hours per week (Can be physician, psychologist, LCSW, MFT, registered nurse, or waivered/registered professional, or serving under the direction of one of those professionals. Exceptions must be approved by DHCS)	No Change
16	Head of Service shall be responsible for ensuring that children receive appropriate mental health treatment services, that the mental health treatment services are documented, and reports are completed timely as required by these regulations	**Updated Head of Service responsibilities:** 1. Maintaining a safe, healthy, and therapeutic environment at the STRTP 2. Ensuring that each child admitted to the program has a mental health assessment 3. Ensuring that each child in the STRTP has commonality of needs with the other children in the STRTP, including whether the child's presence is adverse to the safety or mental health needs of the child or other children admitted to the STRTP 4. Ensuring the mental health services identified on each treatment plan are provided and appropriate to meet the individual needs of the child 5. Monitoring the quality of the mental health services provided to the children 6. Making arrangements, including transportation, for children to receive mental health services that cannot be provided by the STRTP 7. Arrangements for special provision of mental health services to children with disabilities including visual and auditory impairment 8. Ensuring that documentation and recordkeeping requirements are met 9. Development of mental health staff schedules, training schedules, mental health treatment service schedules, medication schedules, and any other schedules for the operation of the STRTP mental health program * DHCS regulations and local San Diego practice require STRTP Day Program providers to submit an annual **Day Services schedule** to QI, which requires initial written authorization; and prior written authorization for any changes *Local San Diego practice involves STRTP Outpatient providers submitting the **projected weekly mental health services schedule** annually to the BHS COR for review (new STRTP contracts include language outlining requirement for annual submission)

DHCS Interim STRTP Version 1 and Version 2 Regulations Comparison Guide:

This tool serves as an overview summary; STRTPs are to review and follow the full Interim STRTP Regulations (Version 2)

Version 2 Section	Version 1 Requirement – 5/5/2017	Version 2 Requirement – 2/28/20
16	New Regulation in Version 2	A single legal entity operating more than one STRTP may request **program flexibility to have a single head of service** employed forty (40) hours per week to manage a **maximum of thirty (30) beds split among a maximum of five (5) STRTPs** in good standing that are located on separate premises Flexibility may be approved if criteria **1 A-F** are met in Section 16: A. The head of service shall have a designated primary office at one of the STRTPs; B. No facility shall be more than five (5) miles distance from the head of service's primary office C. The head of service shall be reachable at all times during their scheduled shift D. Each facility shall have a designated individual in an acting capacity when the head of service is not on-site E. The head of service shall be on-site at each facility for a minimum of two (2) hours at least three (3) times per week F. The head of service shall maintain a time study, which indicates specific time spent at each facility A facility that is unable to meet the time or distance requirements may apply in writing to the Department directly for program flexibility, which shall be approved on a case by case basis * Local San Diego practice requires existing BHS providers to concurrently inform the BHS COR of request submission
Staff Characteristics		
17	Child to Staff ratio - MHRS or higher (Daily ratio based on census) 6:1	No Change
17	Child to Licensed mental health professional ratio 12:1	Child to Licensed or **Registered/Waivered ratio** 12:1 *STRTPs to consider the local San Diego requirement of maintaining a minimum staffing of **1 direct FTE licensed clinician to 3 direct FTE license eligible clinical staff** (including trainees/students) while building programming for DHCS required child to Licensed or Registered/Waivered ratio

DHCS Interim STRTP Version 1 and Version 2 Regulations Comparison Guide:

This tool serves as an overview summary; STRTPs are to review and follow the full Interim STRTP Regulations (Version 2)

Version 2 Section	Version 1 Requirement – 5/5/2017	Version 2 Requirement – 2/28/20
17	"Adequate numbers" of mental health staff shall be awake, employed, present, and on duty 7 days a week from 7am to 11pm	"Adequate numbers" of STRTP mental health staff scheduled, present, awake and on duty **5 days a week between 9am to 5pm. STRTP shall develop a daily STRTP mental health program staff schedule** * Local San Diego practice requires STRTP Day Program and STRTP Outpatient providers to submit make available staffing schedules (daily STRTP mental health program staff schedule) upon request by BHS COR or during annual desk or site review
17	The short-term residential therapeutic program shall have a psychiatrist on the premises or available 24 hours per day	The STRTP shall have a psychiatrist available to provide psychiatric services **as specified in these regulations.** Services shall include but are not limited to: medication review at minimum every 45 days for each child prescribed medication and review the course of treatment at minimum every 90 days for children who are not prescribed medication * Local San Diego practice requires psychiatric services to be provided on STRTP site
In-Service Education		
18	20 hours STRTP required training for all mental health staff (shall include but not limited to: Trauma, suicide prevention, Assaultive/self-injurious behavior, cultural competence, communication skills, confidentiality, client rights, psychotropic medications)	**24 hours per calendar year** STRTP required training for all mental health staff included in child : staff ratios per section 17 "Staff Characteristics" (shall include but not limited to: Trauma, suicide prevention, assaultive/self-injurious behavior, cultural competence, communication skills, confidentiality, client rights, psychotropic medications, **P&P applicable to the STRTP**). Of the 24 hours, training shall include at least **8 hours of preventing and managing assaultive and self-injurious behaviors training, to be taken prior to commencing any employment duties involving direct contact with children at the STRTP, and per calendar year** * Local San Diego practice requires specification of training completion date on the QSR Staffing Tab

Abbreviated STRTP Interim Regulations (Version 2) Guide

Section	Requirement DHCS MHSUDS Information Notice No.: 20-005 Dated February 28, 2020: Statewide Criteria for Mental Health Program Approval for Short-Term Residential Therapeutic Programs and Enclosure 1 – Interim STRTP Regulations (Version 2) DHCS MHSUDS Information Notice No.: 17-016 Dated May 5, 2017; Statewide Criteria for Interim Mental Health Program Approval for STRTP and Enclosure 1 – Interim Mental Health Program Approval for STRTPs	RCL 13-14 Prior to STRTP	STRTP Version 2 2.28.20
Service Delivery			
13	Structured on site mental health **services available 7 days a week** (M-F 9am-5pm via SMHS provider minimum 5 days a week)	Not required	X
Staff Characteristics			
17	**Child to Staff ratio** - MHRS or higher (direct service staff) (Ratio based on daily census)	Not required	6:1
17	**Child to Licensed or registered/waivered mental health professional ratio** Local San Diego requirement of maintaining a minimum staffing of 1 direct FTE licensed clinician to 3 direct FTE license eligible clinical staff (including trainees/students)	8:1 Licensed/ eligible	12:1 licensed or registered/ waivered
17	"Adequate numbers" of STRTP mental health staff scheduled, present, awake and on duty 5 days a week between 9am to 5pm STRTP shall develop a **daily STRTP mental health program staff schedule**	Not required	X
16	**1 FTE Head of Service** (Can be physician, psychologist, LCSW, MFT, registered nurse, or waivered/registered professional, or serving under the direction of one of those professionals. Exceptions must be approved by DHCS)	1 Per Program	1 Per STRTP site may request program flexibility to have a single Head of Service for more than 1 site
Medication Monitoring			
12	**Psychiatrist** signs written **medication review** at minimum every 45 calendar days for each child prescribed psychotropic medication	Every 6 wks (42 days)	45 Calendar Days
12	**Psychiatrist reviews course of treatment** every 90 calendar days for children not prescribed psychotropic medication; signs note that includes results of review	Psychiatrist 24 hr/day	90 Calendar Days
In Service Education			
18	**24 hours** of STRTP required training annually for all mental health staff included in child to staff ratio	Not required	Annually
Documentation			
9	**Admission Statement** completed by Head of Service within 5 calendar days	Not required	Within 5 Calendar Days
8	**BHA** completed and final approved by licensed or registered/waivered mental health professional within 5 calendar days	Within 30 days	Within 5 Calendar Days
10	Completed Treatment Plan (known as **Client Plan**) is reviewed and signed by a licensed mental health professional, waivered/registered professional, or head of service	Within 30 Days	Within 10 Calendar Days
10	Completed Treatment Plan (known as **Client Plan**) is reviewed by a member of the mental health program staff at least every 30 days	Not required	Every 30 Calendar Days
14	Clinical Review (included in **Prior Authorization for Day Services Request** or **STRTP Outpatient UM Request**) completed every 90 Days Completed by licensed or registered/waivered mental health professional, reviewed and co-signed by a licensed mental health professional (Includes summary of services, input from CFT, justification for continued stay or transition and whether the STRTP continues to meet the specific therapeutic needs of the child)	Not Required	Every 90 Calendar Days licensed or registered/waivered co-signed by licensed
11	Minimum of one daily mental health **Progress Note**, 7 days a week **Progress Notes** final approved within 72 hours of service	Within 5 days of service	Daily within 72 hours of service
15	**Transition Determination Plan** is completed and signed by member of mental health program staff prior to discharge	Not required	Prior to D/C
n/a	**Discharge Summary** is completed within 7 days of discharge from program (modified form for STRTP)	X	Within 7 calendar days of D/C

County of San Diego Mental Health Services
CLIENT PLAN

Client Name: **Case #:**

Program Name: **Unit/SubUnit:**

Client Plan Begin Date: **Client Plan End Date**:

PLANNING TIERS

Strength: (Identify client strength(s) from the Strengths Table. These are what the client/support persons/staff identifies as general strengths for the client. Identify strength and individualize. Document strength(s) and how the client will utilize his/her strength(s) to meet the treatment objective(s) in the narrative areas below)

Strength: (Choose from Strengths Table):
Narrative:
Strength: (Choose from Strengths Table):
Narrative:
Strength: (Choose from Strengths Table):
Narrative:
Strength: (Choose from Strengths Table):
Narrative:

Area of Need: (Choose from Area of Need Options. This is an area in which a level of impairment is identified by the client/support persons/staff. Identify the need and individualize. Document the client's specific emotional/behavioral/psychiatric need for treatment. Use client's own words to individualize. For youth residing in a STRTP, Area of Need shall include client's need for rapid and successful transition back to community-based mental health care and include the anticipated length of stay in the STRTP.)

Area of Need:
Narrative:

Goal: (Enter Goal determined by Area of Need selected.)

Goal:
Narrative: SEE OBJECTIVE(S) PLANNING TIER

Objective: (Identify an objective from the Objectives listed under the Area of Need selected. These are action steps that the client will focus on in order to achieve his/her goal. Identify the objective and individualize.

County of San Diego Mental Health Services
CLIENT PLAN

Please Note: (If there are several Areas of Need being the focus of treatment it is possible to choose one general Objective and then list the Objectives numerically. All Areas of Need must be addressed in an Objective Tier. Objective(s) shall be specific, observable, measurable and related to the Area of Need. For youth residing in a STRTP, objectives shall address transition goals that support the rapid and successful transition of the client back to community based mental health care and consider the impact of client's history of trauma in planning objectives.)

Objective #1:

Narrative:

Objective #2:

Narrative:

Objective #3:

Narrative:

Interventions: (Identify each regularly used interventions. Service codes are considered interventions – Each intervention must be individualized for how it will be used to assist the client achieve each Objective listed. For every objective utilizing an intervention, describe the specific strategies used and how the strategies will address the functional impairment(s) or prevent deterioration or if under 21, allow developmental progress or correct/ameliorate the condition.)

Intervention:

Frequency: **Duration:**

Narrative:

Intervention:

Frequency: **Duration:**

Narrative:

Intervention:

Frequency: **Duration:**

Narrative:

Intervention:

Frequency: **Duration:**

Narrative:

Intervention:

Frequency: **Duration:**

Narrative:

Intervention:

Frequency: **Duration:**

Narrative:

Intervention:
Frequency: **Duration:**
Narrative:

Intervention:
Frequency: **Duration:**
Narrative:

Intervention:
Frequency: **Duration:**
Narrative:

Intervention:
Frequency: **Duration:**
Narrative:

County of San Diego Mental Health Services
CLIENT PLAN

Explained in client's primary language of:

No ☐ (if no, document reason):

Explained in guardian's primary language of:

No ☐ (if no, document reason):

Client offered a copy of the plan:

Yes ☐

No ☐ (if no, document reason):

SIGNATURES:

Client:_____ **Date**: _____

☐ **Refused to sign** **Explanation:**

Parent/Guardian Signature: _____ **Date:** _____

Conservator Signature: _____ **Date:** _____

Other Signature: _____ **Date:** _____

Signature of Staff Requiring Co-Signature:

_____ **Date:** _____

_____ **ID Number:** _____

Printed Name

***Signature of Staff Completing/Accepting Client Plan:**

_____ **Date:** _____

_____ **ID Number:** _____

Printed Name

San Diego County Mental Health Services
Short-Term Residential Program (STRTP)
TRANSITION DETERMINATION PLAN

***Client Name:**	**Client Preferred Pronouns:**
***Case #:**	***STRTP Name:**
***Date of Admission:**	***Anticipated transition date:**

- Transition Determination Plan to be completed prior to child or youth's discharge from the STRTP.

***1. REASON FOR ADMISSION:** *Describe events in sequence leading to admission to your program. Describe primary need upon admission*:

***2. REASON FOR DISCHARGE FROM STRTP PLACEMENT:** *Choose most appropriate reason for transition. If selecting Other or Alternate STRTP/Residential Setting, provide explanation for reason for transition:*

☐ Higher level of care ☐ Lower level of care ☐ Client did not return/AWOL
☐ Alternate STRTP/Residential Setting ☐ Other *Explain*:

***3. LIVING PLACEMENT UPON DISCHARGE FROM STRTP**: *Choose most appropriate placement. If other provide explanation of living placement:*

☐ Biological Family ☐ Extended Family Member ☐ Non-Related Extended Family Member
☐ Resource Family ☐Foster Family Agency ☐ Extended Foster Care/Transitional Housing Program ☐ San Pasqual Academy ☐ Alternate STRTP ☐ Other *Explain*:
Specific Name of caregiver and relationship to youth:

***4. COURSE OF TREATMENT DURING THE CHILD'S ADMISSION:** *Include mental health treatment interventions and the child or youth's response. Include the child's transition plan goals and child's progress toward those goals*

***5. MENTAL HEALTH DIAGNOSIS AND FOLLOW UP REQUIRED:**

a. Current Diagnosis: *List all diagnosis in order of priority*
b. Symptoms related to diagnosis and follow up required:
c. Goals and expected outcomes for follow up treatment:

***6. RECOMMENDATIONS REGARDING TREATMENT THAT IS RELEVENT TO THE CHILD'S CARE:** *Review with child or youth prior to transition. Use child or youth's own language when applicable.*

a. Resiliency Strategies:

- Preferred activities or hobbies
- Soothing or calming techniques
- Identified sources of support (person, place, object)
- Caregiving strategies that promote resiliency
- Other

b. Triggers: *Include social, emotional or environmental factors that may decrease the child or youth's ability to be successful in next placement.*

c. Other: *Any other pertinent information which will enhance the child or youth's successful transition.*

***7. SUBSTANCE USE TREATMENT RECOMMENDATIONS:**

☐ Not Applicable ☐ Yes *explain*:

***8. MEDICAL INFORMATION:**

a. Medical and Dental Services Received While Residing in the STRTP

Service	Date	Follow Required (yes/no)	Next Appointment Date	Next Appointment Time	Upcoming Due Dates (If no appt. scheduled)

b. Current Medications (Non-Mental Health)

Medication	Dose	Frequency

c. Psychotropic Medications - Attach documentation from prescribing physician, such as JV220, for potential and reported side effects of medication

Medication	Dose	Frequency

d. Allergies and Adverse Medication Reactions

9. EDUCATIONAL INFORMATION: Include grade, grade level functioning, educational needs, education plans (for example IEP or 504 plan) and follow up required.*

a. Current grade:
b. Educational strengths:
c. Educational needs:
d. Educational Plans (i.e. Individualized Education Plan, 504 plan, other):
e. Date the school was notified of discharge from the STRTP:

***10. REFERRAL(S)**:

☐ Wraparound ☐ TBS ☐ FFAST ☐ CASS ☐ School-Based Therapy ☐ Outpatient Mental Health Clinic ☐ TERM Provider ☐Teen Recovery Center (TRC) ☐Incredible Families ☐ Other explain:

Referral Contact Information:

Type of Service	Program Name	Program Contact Name	Program Contact Phone Number	Appointment Date if Applicable

☐ Client or caregiver declined referral(s)

Explained in client's primary language of:

No ☐ (if no, document reason):

Explained in guardian's primary language of:

No ☐ (if no, document reason):

Client offered a copy of the Transition Determination Plan:

Yes ☐

No ☐ (if no, document reason):

Copy of Transition Determination Plan offered to: (Check the following as applicable. Copy shall be made available to at least one of the following)

Parent ☐ **Conservator** ☐ **Guardian** ☐ **Other** ☐ If other, relationship:

Copy of Transition Determination Plan offered to: (Copy shall be made available to one of the following)

Placing Agency Representative: ☐ CWS PSW ☐ Juvenile Probation Officer

Placing Agency Representative Contact Information: Name Phone Number

Date Placing Agency Representative notified of transition from the STRTP:

SIGNATURES:

Client:_____ **Date**: _____

☐ **Refused to sign** **Explanation:**

Parent/Guardian Signature: _____ **Date:** _____

Conservator Signature: _____ **Date:** _____

Placing Agency Representative Signature: _____ **Date:** _____

Other Signature: _____ **Date:** _____

Signature of Staff Completing Transition Determination Plan:

_____ **Date:** _____

_____ **ID Number:** _____

Printed Name

2020

San Diego County Mental Health Services
Short-Term Residential Therapeutic Program (STRTP)
TRANSITION DETERMINATION PLAN

WHEN: Completed and signed prior to the child's/youth's discharge from a Short-Term Residential Therapeutic Program (STRTP).

ON WHOM: All children/youth placed in the STRTP.

COMPLETED BY: A licensed/registered/waivered mental health clinician.

MODE OF COMPLETION: Entered in the Electronic Health Record (EHR).
*A copy shall be provided, as applicable, to the parent, guardian, conservator, or person identified by the court to participate in the decision to place the child/youth in the STRTP.

REQUIRED ELEMENTS:
Client name: Enter the client's name.
Client Preferred Pronouns: Enter pronouns based on child's preference.
Case number from EHR: Enter the client's unique client number.
STRTP name: Enter the name of the STRTP facility.
Date of admission: Enter the date the client was admitted to the program.
Anticipated transition date: Enter the planned date of discharge from the STRTP (not including aftercare services provided by the STRTP).

1. **Reason for Admission**
   - Describe events in sequence leading to admission into the STRTP.
   - Describe primary need upon admission to the STRTP.
2. **Reason for Discharge from STRTP Placement**
   - Choose the most appropriate reason for discharge from the drop-down menu (higher level of care, lower level of care, alternate STRTP/residential setting, client did not return/AWOL, other)
   - If a child/youth transitions to a family or home-based placement select- Lower level of care.
   - If the child/youth was hospitalized or incarcerated select- Higher level of care.
   - If other is selected, provide an explanation of reason for transition.
3. **Living Placement upon Discharge from STRTP**
   - Choose the most appropriate living placement from the drop-down menu (biological family, extended family member, non-related extended family member, resource family, foster family agency, extended foster care/transitional housing program, San Pasqual Academy, alternate STRTP, other).
   - If other is selected, provide explanation of living placement at discharge.
   - Provide the specific name of caregiver and relationship to youth.
4. **Course of Treatment during the Child's Admission**
   - Provide summary services provided over the course of treatment.
   - Include mental health treatment interventions (frequency/duration) used to promote stability in placement, client's response to interventions, and outcomes of treatment provided.
   - Include the child's transition plan goals and progress made toward those goals during treatment
5. **Mental Health Diagnosis and Follow Up Required:**
   - List all current diagnosis in order of priority.
   - Provide a brief description of symptoms and follow up required to address symptoms.
   - Include goals and expected outcomes of follow-treatment (once child transitions from STRTP).

San Diego County Mental Health Services
Short-Term Residential Therapeutic Program (STRTP)
TRANSITION DETERMINATION PLAN

6. **Recommendations Regarding Treatment that are Relevant to the Child's Care**
   - The following questions (a-c) should be reviewed with the child/youth prior to transition. Use the child/youth's own language when applicable.
     a. **Resiliency Strategies:** Identify the child/youth's preferred activities, hobbies and soothing or calming techniques. Identify persons of support, transitional objects, or other strategies that will contribute to child or youth's success in next placement. Include specific caregiving strategies that promote resiliency and wellbeing.
     b. **Triggers:** Discuss with child/youth social, emotional or environmental factors that may trigger traumatization or otherwise decrease the child/youth's ability to be successful in next placement. Discuss methods to reduce triggering events and promote stability.
     c. **Other:** Include recommendations not previously listed to improve safety, permanency and well-being with transition that are pertinent to the child/youth's successful transition.
7. **Substance Use Treatment Recommendations:**
   - If applicable provide an explanation of substance use treatment recommendations.
8. **Medical Information:**
   a. List Medical and Dental services and date of services received while admitted to the STRTP.
      - Indicate if follow up is required, and the scheduled date and time of appointment if applicable.
      - If follow up is needed and appointment is yet to be scheduled, provide the upcoming due dates for the service.

   b. List current non-psychotropic medications including dose and frequency.
   c. List current psychotropic medications including dose and frequency. Attach documentation from the prescribing physician, such as the JV220 that contains potential or reported side effects of medication and provide to caregiver along with copy of Transition Determination Plan
   d. Note any allergies and adverse medication reactions as listed on JV220.
9. **Educational Information**
   - Include grade, grade level functioning, educational needs, education plans (for example IEP or 504 plan) and follow up required.
     a. Enter child/youth's current grade, if on summer break enter grade that will begin the following school year.
     b. Enter Educational strengths, which may include academic skills, preferred academic subjects, extracurricular activities, educational goals as expressed by the child/youth, etc.
     c. Enter educational needs/areas in which child/youth requires academic support.
     d. Enter educational plans child/youth has in place and/or any recommendations to begin process to make an educational plan.
        - Include next scheduled educational meeting or follow up required.
     e. Provide the date the school was notified of child or youth's discharge from the STRTP.
10. **Referral(s)**
    - Check all that apply (Wraparound, TBS, FFAST, CASS, School-Based Therapy, Outpatient Mental Health Clinic, TERM provider, Teen Recovery Center TRC, Incredible Families or other).
    - If other, explain referral.
    - Include referrals to providers of mental health and non-mental health services not listed in medical information.
    - If no referrals provided, provide explanation for reason why no referrals were provided.

San Diego County Mental Health Services
Short-Term Residential Therapeutic Program (STRTP)
TRANSITION DETERMINATION PLAN

Preferred Language

- Document the client's and the caregiver/guardian's primary/preferred language.
- Was the Transition Determination Plan explained in the client's and caregiver/guardian's primary language? Mark yes or no.
- If no, include reason why the Transition Determination Plan was not explained in the primary language noted.

Copies of Transition Determination Plan

- It is required for a copy to be offered to the client and as applicable, to the parent, guardian, conservator, or person identified by the court to participate in the decision to place the child/youth in the STRTP.
- It is required for copy of the Transition Determination Plan to be offered to the placing agency representative.
- Note the placing agency (CWS PSW or Juvenile Probation Officer) representative name and phone number.
- Provide the date the placing agency representative was notified of child/youth's transition from the STRTP

Signatures

Obtain signatures from client, parent, guardian, conservator, placing agency, and/or person identified by the court to place the youth in the STRTP.

Print, Sign and date the assessment in the appropriate signature section include CCBH ID number

BILLING: Can only occur when connected to a direct client service

County of San Diego Mental Health Plan

Prior Authorization Day Services Request (DSR)

Submit At Least 5 Business Days Prior To Projected Start Date

Please Check: ☐ **Initial Request (prior to services)**
☐ **Continuing Request (STRTP and STEPS required every 90 Days, SPA every 180 Days)**

FAX TO: (866) 220-4495
Optum Public Sector San Diego
Phone: (800) 798-2254, Option 3, then Option 4

CLIENT INFORMATION

Client Name: _____

Client ID: _____

Client Date of Birth: _____

Placing/Referring Agency: ☐CWS ☐Probation ☐ Dual Placement ☐ Other: _____

Out of County Client - Through: ☐ CWS ☐ Probation

Out of County Client - Must Include Either:

☐ AB1299; for STRTP only, a copy of Notice of Presumptive Transfer (foster youth)

☐ AAP/KinGAP; for STRTP must include SAR copy and written COR approval to serve youth under County contract due to discharge to San Diego residence

DAY PROGRAM INFORMATION

Legal Entity: _____ **Program Name:** _____ **Phone**: _____

Fax: _____ **Unit#:** _____ **Day Program Subunit#**: _____

SCOPE, AMOUNT AND DURATION OF DAY SERVICES REQUEST

SCOPE AND DURATION OF AUTHORIZATION REQUEST (To Be Completed Prior to the Provision of Day Services, Choose one):

☐ STRTP Hybrid Day Rehab and Outpatient Services (Up to 90 days)

☐ STEPS Day Intensive (Up to 90 days)

☐San Pasqual Academy (SPA) Day Rehab (Up to 180 Days)

AMOUNT OF DAY SERVICES REQUESTED (Program Not to Exceed Day Program Schedule Approved by BHS Quality Management)

☐ Up to 5 Days Per Week ☐ Up to 6 Days Per Week

MEDICAL NECESSITY CRITERIA FOR DAY SERVICES

DIAGNOSIS: Provide the Title 9 included diagnoses that are the focus of mental health treatment.

Diagnosis 1: **Diagnosis 2:** **Diagnosis 3:**

Title 9 Medical Necessity Criteria: Must respond to questions #1-3 for all requests, and #4 for continuing requests

1. **Client demonstrates impairment as a result of the included diagnosis** (*choose at least one*):

   ☐ Significant impairment in an important area of life functioning (e.g., living situation, daily activities, or social support) **OR**
   Explain: _____

   ☐ A reasonable probability of significant deterioration in an important area of life functioning **OR**
   Explain: _____

   ☐ A reasonable probability a person under 21 years of age will not progress developmentally as individually appropriate
   Explain: _____

2. **Day Services intervention criteria** *(must complete A, B, and C):*

   A. ☐ The focus of the Day Services will address the condition/impairment. Explain: _____

   B. ☐ The focus of the Day Services will significantly diminish the impairment, prevent significant deterioration or allow the child to progress developmentally as appropriate. Explain: _____

   C. ☐ The condition would not be responsive to physical health care-based treatment.

Day Services Necessity Criteria: *(Set by the Mental Health Plan (MHP) per DMH Letter No. 02-01)*

3. Client requires structured Day Services in order to move from higher level of care to lower level of care or to prevent deterioration and admission to a higher level of care. Describe: _____
4. **Continuing service requests only -** Current treatment goals have not been met. **Describe progress** toward treatment goals or how progress is expected to be made during the next authorization cycle: _____

ANCILLARY SERVICES REQUEST (INTERNAL)

STRTP and SPA must request ancillary authorization if client is going to receive Day Services and Outpatient Services from the same provider/program

STRTP/SPA/STEPS must submit a stand-alone (external) Ancillary Specialty Mental Health Services (SMHS) Request Form for any client receiving Day Services and SMHS from another provider/program

Outpatient Subunit#: _____

1. **SELECT THE AMOUNT OF OUTPATIENT SMHS REQUESTED PER DAY (Inclusive of all Individual, Collateral, ICC, IHBS and Group SMHS provided by Day Service provider in addition to Day Program Services):**

   ☐ Up to 8 hours per day

2. **MEDICAL NECESSITY FOR OUTPATIENT SMHS (must select at least one):**

   ☐ Requested service(s) is not available during day program hours. Describe why service is not available: _____

   ☐ Continuity or transition issues make these services necessary for a limited time. Describe the need: _____

   ☐ These concurrent services are essential for coordination of care. Describe why services are essential: _____

CLINICAL REVIEW REPORT: Section 14 of Interim Mental Health Program Approval for STRTP

FOR STRTP CONTINUING (90 DAY) REQUESTS ONLY

1. **Describe the type and frequency of services that have been provided by the STRTP during the previous 90-day review period:**

   ☐ Day Services - Describe the type and frequency of Day Services provided by the STRTP during the past 90 days:
   _____

   ☐ Outpatient Services (OP) - Describe the type and frequency of OP services provided by the STRTP during the past 90 days:
   _____

2. **Describe the impact of these services towards the achievement of Client Plan Goals (include progress toward goals of transitioning to lower level of care):** _____

3. **Date of most recent mental health program staff meeting, which must include Head of Service or Licensed or Registered/Waivered Mental Health Professional, where diagnosis, mental health progress, treatment planning, and transition planning were discussed** (must occur at least every 90 days and prior to submittal of DSR): _____

4. **Date of most recent CFT meeting** (must occur at least every 90 days and prior to submittal of DSR): _____

   The CFT/mental health program staff agree that the STRTP continues to meet the specific therapeutic needs of the youth:
   ☐ **Yes** ☐ **No** ☐ **Other** _____

   The CFT Meeting Summary and Action Plan is available based on UM reviewer request: ☐ **Yes** ☐ **No**

5. **Clinical Review Recommendation**: ☐ Continued treatment in STRTP ☐ Transition from the STRTP, include transition recommendation _____ ☐ Other _____
   - ❖ **Recommendation for transition or continued treatment must be supported in client record and CFT documentation**

Program Clinician (Print): _____ **Credentials:** _____

Signature: _____ **Date:** _____

Licensed Clinician (Print): _____ **Credentials:** _____

Co-Signature: _____ **Date:** _____

- ❖ **Co-Signature required if Program Clinician is not a Licensed Mental Health Professional**

FOR OPTUM USE ONLY

Optum completes and retains. Within 5 business days of Optum receipt, authorization determination status will be viewable to the requesting provider in the CCBH Clinicians Home Page Authorizations Tab.

DAY SERVICES PRIOR AUTHORIZATION DETERMINATION

☐ **Day Services scope, amount and duration authorized: START DATE:_____END DATE: _____**

Day Service request is ☐ denied ☐ modified ☐ reduced ☐ terminated or ☐ suspended as follows: _____

NOABD was issued to the beneficiary and provider on the following date: _____

ANCILLARY SERVICES DETERMINATION (INTERNAL)

☐ **Internal Ancillary OP SMHS authorized: START DATE:_____END DATE: _____**

Internal Ancillary OP SMHS request is ☐ denied ☐ modified ☐ reduced ☐ terminated or ☐ suspended as follows: _____

NOABD was issued to the beneficiary and provider on the following date: _____

CLINICAL REVIEW REPORT DETERMINATION

☐ **Clinical Review Report is complete and addresses all four components; see Clinical Review Report section**

Follow up for the Clinical Review Report will occur through the County CCR team when indicated.

ANCILLARY SERVICES DETERMINATION (EXTERNAL)

(External authorization requests are submitted to Optum when indicated through a separate Ancillary SMHS Request Form)

☐ **External Ancillary SMHS authorized: START DATE:_____END DATE: _____**

External Ancillary SMHS request is ☐ denied ☐ modified ☐ reduced ☐ terminated or ☐ suspended as follows: _____

NOABD was issued to the beneficiary and provider on the following date: _____

Optum clinician Signature/Date/Licensure:

2020

County of San Diego Mental Health Plan
Prior Authorization Day Services Request (DSR)

COMPLETED BY:

1. Licensed/Waivered Psychologist
2. Licensed/Registered/Waivered Social Worker or Marriage and Family Therapist
3. Licensed/Registered Professional Clinical Counselor
4. Physician (MD or DO)
5. Nurse Practitioner

CO-SIGNATURE:

- Prior Authorization Day Service Requests must be completed by or co-signed by a Licensed Mental Health Professional
- Co-signature from Licensed Mental Health Professional indicates they have reviewed and agree with the findings of the request

COMPLETION REQUIREMENTS:

1. Prior Authorization Day Services Request form is completed by the Day Services provider and submitted to Optum via FAX (866) 220-4495 for all clients prior to the initial provision of Day Services
2. Continuing Prior Authorization Day Services Requests are completed by the Day Services provider and submitted prior to expiration of the initial authorization period (within 90 days for STRTP and STEPS, and 180 days for San Pasqual Academy)
3. Continuing Prior Authorization Day Services Requests shall be submitted at least 5 business days prior to the expiration of Day Services Authorization, and can be submitted up to 10 business days prior to the expiration
4. Prior authorization shall be obtained before Day Services are initiated. For hybrid programs, Outpatient Services may be provided prior to the authorization of Day Services

DOCUMENTATION STANDARDS:
The following elements of the Prior Authorization Day Services Request form shall be addressed:

1. Client Information

- Include Name, Client ID and Date of Birth
- Include the Placing or Referring agency
- For Out of County clients, the request shall include either:
  - (STRTP only) A copy of the Notice of Presumptive Transfer Form for foster youth placed through AB1299 Presumptive Transfer in a STRTP or
  - A copy of the SAR for youth placed through AAP/KinGAP. For youth in a STRTP the request shall include written COR approval, obtained by emailing the COR, to serve youth under the County contract due to planned discharge to a San Diego residence.

2. Day Program Information

- Include Legal Entity, Program Name, Phone number, Fax number, Unit number, and Day Services Program Subunit number

3. Scope, Amount and Duration of Day Services Request

- Identify the scope and duration of Day Services to be provided (STRTP – 90 days, STEPS – 90 days or SPA – 180 days).
- Include the amount of services requested (select Up to 5 Days Per Week or Up to 6 Days Per Week) which shall not exceed the Day Program schedule that has been approved by BHS QM

4. **Medical Necessity Criteria for Day Services**
   - **Diagnosis -** Provide the name of the Title 9 included diagnoses that are the focus of mental health treatment
   - **Title 9 Medical Necessity Criteria**
     1. Select and explain at least one area of client impairment that is a result of the Title 9 included diagnoses
     2. Day Services intervention criteria A, B and C must be met for client to meet medical necessity for Day Services:
        A. Select and explain how Day Services will address the client's condition/impairment
        B. Select and explain how the Day Services will significantly diminish the impairment, prevent significant deterioration of the impairment, or allow the child to progress developmentally as appropriate
        C. Select if the condition would not be responsive to physical health care-based treatment
   - **Day Services Necessity Criteria**: Set by the Mental Health Plan (MHP) per DMH Letter No. 02-01
     3. Describe client's needs for Day Services in order to move from a higher level of care to a lower level of care, or to prevent deterioration and admission to a higher level of care
     4. For **continuing service requests only** – Describe progress made towards treatment goals during the current authorization period, and/or explain how progress is expected to be made towards treatment goals during the next authorization cycle

5. **Ancillary Services Request (Internal)**
   - STRTPs and SPA must complete the Ancillary Request section for the STRTP or SPA to provide Day Services and Outpatient Specialty Mental Health Services (SMHS) during the course of treatment
   - If youth at SPA are receiving Day Services, in addition to Day Services SPA shall only provide the Outpatient SMHS of Intensive Care Coordination (ICC) for the purpose of a Child and Family Team (CFT) meeting outside of Day Service hours
   - STRTP hybrid Day Service and Outpatient programs shall only provide select Outpatient SMHS outside of scheduled Day Service hours, or during scheduled Day Service hours if the youth is unable to attend the Day Program that day

     The following Outpatient SMHS are never allowed to be claimed on the same day that Day Services have been claimed:

     - Collateral
     - Case Management

     Additionally, the following SMHS are never allowed to be claimed as Outpatient Services at any time while a client is enrolled in Day Services, as they are bundled with Day Services

     - Assessment
     - Client Plan

   - For Outpatient SMHS that are provided on the same day as Day Services, the provider must document rationale for ancillary Outpatient SMHS, inclusive of:

     1. Reason why; requested service(s) is not available during day program hours
     2. Reason why; continuity or transition issues make these services necessary for a limited time
     3. Reason why; these concurrent services are essential for coordination of care

- Provide the Day Program Outpatient Subunit number
    1. Select the amount of Outpatient SMHS requested per day (up to 8 hours)
    2. Select and describe at least one reason Outpatient SMHS are medically necessary in addition to Day Services
- Note; if the client is receiving ancillary SMHS from **another program or provider**, the Day Services Provider shall coordinate with the separate Outpatient Provider to **complete a stand-alone Ancillary SMHS Request Form**

6. **Clinical Review Report:** Required by the Interim STRTP Regulations Version 2 section 14 titled "Clinical Reviews, Collaboration, and Transition Determination"
    - Clinical Review Report section is completed for STRTPs requesting continued Day Services. SPA and STEPS, which are not STRTPs, shall therefore always leave this section blank. STRTPs shall also leave this section blank on the initial Prior Authorization Day Services Request
        1. Describe the type and frequency of services provided during the previous 90-day authorization period for both Day Services and Outpatient Services
        2. Describe the impact of services toward the achievement of Client Plan Goals and include goals of transitioning to lower level of care
        3. Provide the date of the most recent mental health program staff meeting, which must include Head of Service, or Licensed or Registered/Waivered Mental Health Professional, where diagnosis, mental health progress, treatment planning, and transition planning were discussed (must occur at least every 90 days and be completed prior to submittal of the DSR)
        4. Provide the date of the most recent CFT meeting (must occur at least every 90 days and prior to submittal of the DSR)
            a. Indicate if the CFT/treatment team agrees that the STRTP continues to meet the specific therapeutic needs of the youth (answer yes, no or other - if other explain)
            b. Indicate if the "CFT Meeting Summary and Action Plan" form is available based on UM reviewer request (answer yes or no). Copy of "CFT Meeting Summary and Action Plan" is only provided if requested by the UM reviewer
        5. Provide a Clinical Review Recommendation for: Continued Treatment in the STRTP, Transition from the STRTP, or Other
            - If Transition is selected, describe the recommendation for transition
            - If Other is selected, describe the treatment recommendation
    - The Clinical Review Report shall be reviewed for completion by Optum upon submittal
    - The Clinical Review Report shall be reviewed by the BHS Continuum of Care Reform (CCR) team, who will follow up directly with the program when indicated
    - Recommendation for transition or continued treatment must be supported in the client record and CFT documentation
7. **Signature(s)**
    - Must include the printed/typed name, credentials, signature and date of the Program Clinician completing the request

- Must include the printed/typed name, credentials, signature and date of a Licensed Mental Health Professional if the Program Clinician completing the request is not a Licensed Mental Health Professional

---

OPTUM AUTHORIZATION SECTION

- ❖ The following sections are completed by Optum upon receipt from the Day Services provider
- ❖ Optum will review and retain the Prior Authorization Day Services Request (DSR) form
- ❖ Within 5 business days of Optum receiving the DSR, authorization(s) will be viewable in the CCBH Clinician Home Page Authorizations Tab

- **Day Services Prior Authorization Determination**
  - When the scope, amount and duration of services are authorized, the start date and end date shall be viewable to the requesting provider in the CCBH Clinician Home Page Authorizations Tab. Day Services authorizations will be indicated as "Medi-Cal/DT" with the legal entity name in the "Benefit Plan" column (see image below)
  - When the Prior Authorization Day Service Request is denied, modified, reduced, terminated, or suspended a NOABD shall be issued by Optum to the Medi-Cal beneficiary and requesting provider

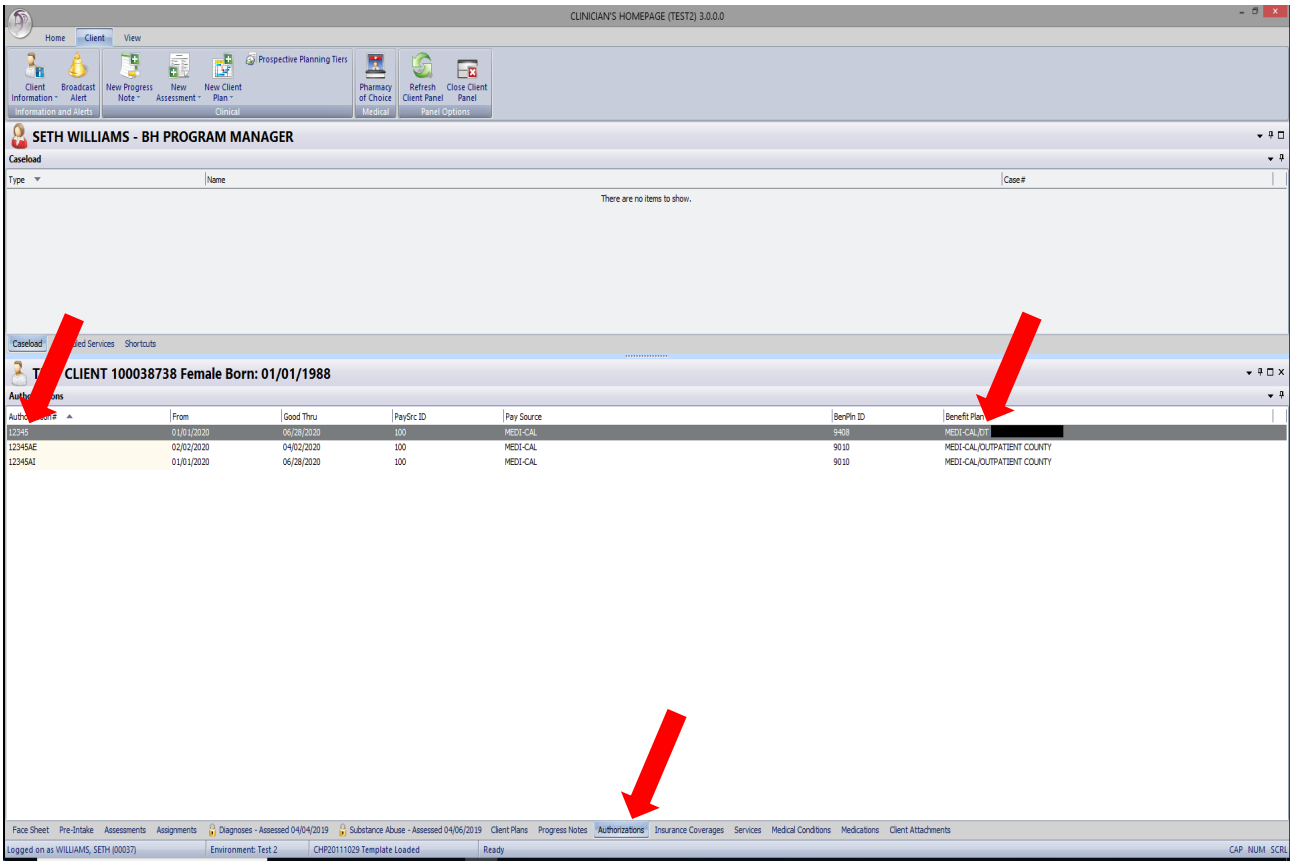
- **Ancillary Services Determination (Internal)**
  - When the Internal Ancillary Outpatient Services are authorized, the start date and end date shall be viewable to the requesting provider in the CCBH Clinician Home Page Authorizations Tab. Internal Ancillary Services will be indicated by an "AI" next to the authorization number in the "Authorization #" column (see image below)
  - When the Prior Authorization Day Service Request is denied, modified, reduced, terminated, or suspended a NOABD shall be issued by Optum to the Medi-Cal beneficiary and requesting Day Service provider

- **Clinical Review Report Determination** (completed by STRTPs only)
  - For STRTP providers Optum shall review the Clinical Review Report for completion. If incomplete, Optum shall send notification to the requesting provider to resubmit with required data elements
  - Optum shall send the completed Clinical Review report to the BHS CCR team for review
  - The BHS CCR team shall follow up with the STRTP regarding the Clinical Review Report when indicated

- **Ancillary Services Determination (External)**
  - When an ancillary Specialty Mental Health Provider (SMHP) begins treatment, a stand-alone "Ancillary SMHS Request" form must be submitted to Optum by the Day Service provider to request ancillary SMHS from a separate program/provider in addition to Day Services
  - When external ancillary services are authorized, the start date and end date shall be viewable to the requesting provider and the ancillary SMHP in the CCBH Clinician Home Page Authorizations Tab. External ancillary services will be indicated by an "AE" next to the authorization number in the "Authorization #" column (see image below)

- When the External Ancillary Services Request is denied, modified, reduced, terminated, or suspended a NOABD shall be issued by Optum to the Medi-Cal beneficiary and the requesting Day Service Provider, who shall communicate with the ancillary SMHP within 3 business days
- See "Ancillary SMHS Request" form and explanation form for additional information

CCBH Clinician Home Page Authorizations Tab:



Note: The Prior Authorization Day Services Request (DSR) form replaces the Intensive Services Request (ISR) form effective 1/1/2020

References: DHCS MHSUDS INFORMATION NOTICE NO.: 19-026 Dated 5/31/19: Authorization of Specialty Mental Health Services

DMH LETTER NO.: 02-01 Dated 4/16/2002: Clarification Regarding Medi-Cal Reimbursement for Day Treatment for Children and Youth in Group Home Programs

DMH INFORMATION NOTICE NO.: 02-06 Dated 10/1/02: Changes in Medi-Cal Requirements for Day Treatment Intensive and Day Rehabilitation

DHCS MHSUDS Information Notice No.: 20-005 Dated February 28, 2020; Statewide Criteria for Mental Health Program Approval for STRTP and Enclosure 1 – Interim STRTP Regulations Version II

STRTP UTILIZATION MANAGEMENT (UM) REQUEST
CYF - Outpatient Treatment

FOR CCR SUBMISSION: THE CLIENT NAME AND NUMBER MUST BE REDACTED (utilize initials vs. full client name)

A. Program UM Cycle:

☐ STRTP follows a 90 Day UM Cycle

B. CURRENT SERVICES:

☐ Therapy ☐ CM/ICC ☐ Rehab/IHBS ☐ Meds

Youth & Child and Family Team (CFT) requesting additional services?

☐ YES ☐ NO ☐ Other

Explain:

ADMISSION DATE:

DIAGNOSIS:

☐ Pathways to Well-Being Enhanced Services (Subclass)

DESCRIPTION OF SYMPTOMS:

C. Psychiatric Hospitalizations: ☐ YES ☐ NO

Provide most recent dates of hospitalization and relevant history when applicable:

Other Behavioral Health Services Client is Receiving *when applicable*:

D. Child and Adolescent Needs and Strengths (CANS)

Date of most current CANS (*Required at UM Cycle)*:

Number of CANS 'High Need' (items rated a '3') (*from current Assessment Summary)*:

Number of CANS 'Help is Needed' (items rated a '2') (*from current Assessment Summary)*:

List the CANS 'Strengths to Leverage' items (*from current Assessment Summary)*:

☐ *CANS Assessment Summary is available for UM reviewer*

E. Pediatric Symptom Checklist (PSC): (*Required at UM Cycle)*

Date of most current Parent PSC:

☐ Parent did not complete

Date of most current Youth PSC:

☐ Not applicable, child is 10 years old or younger

☐ Youth did not complete

	Parent PSC Score	Youth PSC Score	Clinical Cutoff Score
Attention Problems Subscale (0-10)			At-Risk if score is 7 or higher
Internalizing Problems Subscale (0-10)			At-Risk if score is 5 or higher
Externalizing Problems Subscale (0-14)			At-Risk if score is 7 or higher
***Total Scale Score**			

***Parent:** *Total score of 28 or higher for ages 6-18 or scale score of 24 or higher for ages 3-5 indicates impairment*

***Youth:** *Score of 30 or higher for ages 11-18 indicates impairment*

☐ *PSC Assessment Summary is available for UM reviewer*

F. ☐ **Updated Client Plan completed prior to UM request** (reviewed by STRTP UM Committee)

G. PRIMARY ELIGIBILITY CRITERIA:

☐ Client continues to meet **Medical Necessity** and demonstrates benefit from STRTP services

☐ **CANS** indicate at least one actionable need (rated 2 or 3) on the 'Child Behavioral and Emotional Needs', 'Risk Behaviors' OR 'Life Functioning'

☐ Client meets the criteria for **Serious Emotional Disturbance** based upon the following:

As a result of a mental disorder the child has substantial and persistent impairment in at least two of the following areas:

- ☐ Self-care and self- regulation
- ☐ Family relationships
- ☐ Ability to function in the community
- ☐ School functioning

AND One of the following occurs:

☐ Child has been removed from home due to a mental disorder

☐ Mental disorder/impairment is severe and has been present for six months, or is highly likely to continue for more than one year without treatment.

OR The child displays:

☐ acute psychotic features (within the last month)

☐ imminent or recent high risk for suicide (within the last month)

☐ imminent or recent high risk of violence to others due to a mental disorder (within the last month)

H. STRTP ELIGIBILITY CRITERIA

Client has met the above criteria as indicated AND meets all of the following criteria (based on Interagency Placement Committee requirements for continued placement in a STRTP):

☐ Youth is experiencing emotional and behavioral problems in the home, community, and/or treatment setting

☐ Youth is not sufficiently emotionally or behaviorally stable to be treated outside of a structured 24-hour therapeutic environment; **and**

☐ Least restrictive environments have been tried and were unsuccessful; or are not appropriate to meet the youth's needs at this time

I. CLINICAL REVIEW REPORT:

1. **Describe the type and frequency of services provided by the STRTP during previous 90-day review period:**
2. **Describe the impact of these services toward the achievement of Client Plan Goals** (Include progress toward goals of transitioning to a lower level of care)
3. **Date of most recent mental health program staff meeting, which must include Head of Service or Licensed Mental Health Professional, where diagnosis, mental health progress, treatment planning, and transition planning were discussed** (must occur at least every 90 days and prior to submittal of STRTP UM Request)**:** _____
4. **Date of most recent CFT meeting where Clinical Review Recommendation was discussed** (must occur at least every 90 days and prior to submittal of STRTP UM Request): _____

The CFT/Treatment Team agree that the STRTP continues to meet the specific therapeutic needs of the youth:
☐ Yes ☐ No ☐ Other _____

The CFT Meeting Summary and Action Plan is available based on UM reviewer request: ☐ Yes ☐ No

5. **Clinical Review Recommendation:**

☐ Continued Treatment in STRTP; rationale for continued treatment:

☐ Transition from the STRTP, include transition recommendation:

☐ Other**:**

- **Recommendation for continued treatment or transition must be supported in client record and CFT documentation**

J. Requestor's Name, Credential:

Signature: _____ Date:

Licensed Clincian's Name, Credential:

Co-signature: _____ Date:

K. BHS CYF UM DETERMINATION / APPROVAL

☐ UM Approved ☐ Modified UM Request ☐ UM Not Approved

Approver's Name, Credential: Date range of approval: to (90 days)

Program transcribes BHS CYF determination onto form and attaches BHS CYF determination correspondence

2020

County of San Diego Mental Health Plan
Utilization Management Request (UM)
Short Term Residential Therapeutic Programs

COMPLETED BY:
- Licensed/Waivered Psychologist
- Licensed/Registered/Waivered Social Worker or Marriage and Family Therapist
- Licensed/Registered Professional Clinical Counselor
- Physician (MD or DO)
- Nurse Practitioner

SUBMITTED TO BHS CYF BY:
- Program Manager or Designated Program UM Committee

APPROVAL COMPLETED BY:
- BHS – CYF Continuum of Care Reform Liaison and/or BHS CYF COR

COMPLETION REQUIREMENTS:
- STRTP UM form is completed by the STRTP Mental Health Program staff and reviewed by the STRTP Program Manager or designated STRTP UM Committee
- Once reviewed and approved by the STRTP Program Manager/UM Committee, the STRTP UM Request is faxed or sent by secure email to the BHS CYF Continuum of Care Reform Liaison and/or BHS CYF COR (Transport Layer Security [TLS] or encrypted) or removing identifiable information (client initials only)
- BHS CYF reviews the STRTP UM and provides approval/modification within 5 business days
- STRTP UM Requests shall be submitted to BHS CYF within 90 days of arrival into the STRTP and within every 90 days thereafter
- STRTP UM Requests must have all required elements (listed below) completed within the form
- In addition to completing the STRTP UM form, the following tasks are required prior to submitting the UM request:
    - Updated CANS entered in CYF mHOMS
    - Updated PSC-35 entered in CYF mHOMS
    - Client Plan must be reviewed and new client signatures need to be obtained
    - Mental health program staff meeting, including the head of service or a Licensed or Waivered/Registered Mental Health Professional, must be held to discuss the Clinical Review Recommendation
    - CFT meeting to discuss specific therapeutic needs of the youth and treatment recommendations

DOCUMENTATION STANDARDS: ***The following elements of the STRTP UM Request form shall be addressed:***

A. Program UM Cycle: STRTP follows a 90 Day UM Cycle

B. Current Services: Identify current services, whether the Youth/Child and Family Team are requesting additional services, admission date, diagnosis, Pathways status, and description of symptoms

C. Psychiatric Hospitalizations: Provide information pertaining to recent hospitalizations; including most recent dates and other services client is receiving when applicable

D. Child and Adolescent Needs and Strengths: Provide completion date of CANS for current UM request. Utilize information from the CYF mHOMS Assessment Summary to identify the number of needs rated at a '2' (Help is Needed) and '3' (High Need). List the Strengths from the assessment summary that could be leveraged to meet treatment goals and reduce symptomology

F. Pediatric Symptom Checklist: Provide completion date of PSC and PSC-Y (when applicable) for current UM request. Utilize information from the CYF mHOMS PSC Assessment Summary to identify the total scale score for both the Parent PSC and Youth PSC. If the Parent PSC or Youth PSC was not completed for the current UM request, indicate on form

G. Updated Client Plan: Must update the client plan in CCBH prior to initiating the UM request. The updated client plan must be reviewed by Program UM Committee and presented to the youth/family for input and signatures

I. Primary Eligibility Criteria: First three items (Medical necessity, CANS and SED criteria) must be completed. An additional risk factor must be identified for 1) child has been removed from home due to a mental disorder or mental disorder/impairment is severe and has been present for 6 months, or is highly likely to continue for more than one year without treatment **or** 2) acute psychotic features, imminent or recent risk for suicide or imminent or recent risk for violence has been displayed in past month by the client

H. STRTP Eligibility Criteria: Client must meet all three STRTP eligibility criteria for continued treatment in a STRTP: 1) Experiencing emotional and behavioral problems in home, community and/or treatment setting 2) Not sufficiently emotionally or behaviorally stable to be treated out side of a structured 24-hour therapeutic environment **and** 3)Least restrictive environments have been tried and were unsuccessful; or are not appropriate to meet the youth's needs at this time

I. Clinical Review Report: Required by the Interim STRTP Regulations Version 2; Section 14 titled "Clinical Reviews, Collaboration, and Transition Determination"

1. Must describe the type and frequency of services provided during the previous 90-day authorization period
2. Must describe the impact of services toward the achievement of Client Plan Goals and include goals of transitioning to lower level of care
3. Must provide the date of the most recent mental health program staff meeting, which must include Head of Service, or Licensed or Registered/Waivered Mental Health Professional, where diagnosis, mental health progress, treatment planning, and transition planning were discussed **(must occur at least every 90 days and be completed prior to submittal of the STRTP UM Request)**
4. Must provide the date of the most recent CFT meeting **(must occur at least every 90 days and be completed prior to submittal of the STRTP UM Request)**
    - Indicate if the CFT/treatment team agrees that the STRTP continues to meet the specific therapeutic needs of the youth (answer yes, no or other - if other explain)
    - Indicate if the "CFT Meeting Summary and Action Plan" form is available based on UM reviewer request (answer yes or no). "CFT Meeting Summary and Action Plan" only required to be submitted if requested by the UM reviewer
5. Must provide a Clinical Review Recommendation for either: Continued Treatment in the STRTP, Transition from the STRTP, or Other
    - If Transition is selected, describe the recommendation for transition
    - If Other is selected, describe the treatment recommendation

❖ Recommendation for transition or continued treatment must be supported in the client record and CFT documentation

J. Requestor Name and Credential: Type in requestor's name and date. Provide signature prior to filing in Hybrid record. If requestor is not a licensed mental health professional, the STRTP UM Request must be reviewed and co-signed by a licensed mental health professional.

K. BHS CYF UM Determination/Approval: Program will fill in approval status based on BHS CYF COR/CCR Liaison determination, COR/CCR Liaison name and credential, and date range approved