N. DATA REQUIREMENTS

Data Collection and Retention

- The contractor shall maintain daily records of services provided, including dates of service, times of service, total time of service, types of services provided, persons served, and progress of clients in meeting the objectives of the case plan. Data shall be recorded in accordance with the specifications in the EHR User's Manual. Service entry shall be kept up to date and the data shall be entered into the SmartCare Data System within a timely manner.

Accuracy of Data

- Providers are responsible for ensuring that all client information, including addresses and demographic data, is accurate and meets State reporting requirements for Client Statistical Information (CSI). Providers must have processes for checking/updating client data and following the appropriate procedures when data corrections are needed. (*See Section I*)

- In addition, Full-Service Partnership (FSP) programs are required to ensure that all required member data is current and up to date in both the EHR and State Database.

Financial Eligibility and Billing Procedures

- Each provider is responsible for specific functions related to determining client financial eligibility, billing, and collections. The **Financial Eligibility and Billing Manual** is available on the Optum Public Sector website for providers as a guide to determine financial eligibility, billing, and collection procedures. This manual includes the following procedure categories:

    - Determining financial eligibility
    - Billing, collections and payment procedures
    - Corrections, adjustments and special requirements

- This manual is not intended to replace the EHR User's Manual or intended to be a comprehensive "Insurance and Medicare Billing" guide. It is meant to augment existing resource materials.

Medi-Cal Administrative Activities (MAA)

- Federal and State regulations (Welfare and Institutions Code, Section 14132.47, Medi-Cal Administrative Activities) permit counties to earn federal Medi-Cal reimbursement for activities necessary to properly and efficiently administer a State's Medicaid (Medi-Cal) plan.

These MAA activities are focused on assisting individuals in accessing the Medi-Cal Program and the services it covers through such functions as Medi-Cal and mental health outreach, facilitating Medi-Cal eligibility determinations, MAA coordination and claims activities, and other designated activities.

- Organizational providers may be permitted to provide MAA services and claim them. The BHP requires that each organizational provider have a county-approved MAA Claiming Plan prior to claiming MAA services and that each provider complies with all applicable State and federal regulations. To claim for MAA activities, a provider must follow a set of procedures described in detail in the *MAA Instruction Manual* developed by the State Department of Health Care Services.

- The MAA Coordinator provides technical assistance and training on MAA to providers. The coordinator can also assist with claiming and procedural questions or train staff on MAA.

- There is a Medi-Cal Administrative Activities Procedures Handout for providers claiming MAA activities with an approved MAA claiming plan. This handout may be used for reference and training purposes. The handout and the MAA Community Outreach Service Record can be found on the Optum website.

Mental Health Services Act (MHSA)

MHSA Community Services and Support (CSS)

- CSS providers are tasked with gathering program-specific information outlined in their contract and tracking data on the Quarterly Status Report (QSR). Additionally, CSS providers administer applicable treatment outcome data, and responses are recorded by the Contractor's staff within the EHR or as otherwise directed by the County. This database permits client results to be compiled for individual cases and by program.

MHSA Prevention and Early Intervention (PEI)

- PEI providers are tasked with gathering specific demographic data and entering a four-question general survey into mHOMS. The mHOMS database is utilized to hold the data and is managed by the County's Data Centers (HSRC and CASRC). Data can be entered directly into the mHOMS database, or the Data Centers will extract from the contractor's database and enter it into mHOMS. Program-specific outcome and process data, as outlined in the contract, is captured in the Quarterly Status Report (QSR).

MHSA Innovation

- Innovation providers are tasked with gathering specific demographic data and entering a general question survey into mHOMS. The mHOMS database is utilized for gathering the data and is managed by the County's Data Centers (HSRC and CASRC). Data can be entered directly into the mHOMS database, or the Data Centers will extract data from the contractor's database and enter it into mHOMS. Program-specific data, as outlined in the contract, is captured in the Quarterly Status Reports (QSR).

MHSA Workforce Education and Training (WET)

- WET providers are tasked with gathering specific demographic data. The mHOMS database is utilized for gathering the data and managed by the County's Data Centers (HSRC in conjunction with and CASRC). Data can be entered directly into the mHOMS database or the Data Centers will set up for extracts from contractor's database into mHOMS. Program specific data as outlined in contract is captured in the Quarterly Status Reports (QSR).

MHSA Full-Service Partnerships (FSP)

- Several providers participate in MHSA Full-Service Partnerships, which provide mental health services to clients and link them with various community supports designed to increase self-sufficiency and stability. These providers are required to participate in a State data collection program (DCR), which tracks initial, specialized client assessments, ongoing key incident tracking, and quarterly assessments. The State has set timeframes for the provision of each type of data.

Systemwide State Required Performance Measures

External Quality Review Organization

- California's External Quality Review Organization (EQRO) plays a crucial role in monitoring and evaluating the quality of care provided to Medi-Cal beneficiaries. CalEQRO is an independent entity contracted by the State to assess the performance of Behavioral Health Plans and ensure compliance with federal and state standards. The assessment of timeliness standards are detailed in the table below.

EQRO MH Metrics	Standard
First Non-Urgent Appointment Offered	10 Business Days
First Non-Urgent Appointment Rendered: *BHP Defined*	10 Business Days
First Non-Urgent Psychiatry Appointment Offered	15 Business Days

First Non-Urgent Psychiatry Service Rendered: *BHP Defined*	15 Business Days
Urgent Services Offered (Including all Outpatient Services)	48 Hours (Prior Authorization not Required); 96 Hours (Prior Authorization Required)
Non-Urgent Follow-up Appointments with a Non-Physician	Offered within 10 Business Days of the Prior Appointment
No show Rate-Psychiatry: *BHP Defined*	20%
No Show Rate-Clinician: *BHP Defined*	15%
Follow-Up Services After Psychiatric Hospitalization: 7 days & 30 days	BHP: 3 Business Days Reported: 7 + 30 Days

Healthcare Effectiveness Data and Information Set (HEDIS)

- HEDIS is a widely used set of performance measures in the healthcare system. These metrics are standardized by the National Committee for Quality Assurance (NCQA) and are used by health plans to assess performance in various areas of care and service. HEDIS metrics are updated annually by NCQA to reflect current clinical guidelines and healthcare priorities. HEDIS metrics provide a comprehensive framework for evaluating the effectiveness, safety, and patient-centeredness of healthcare services across different populations and settings. State required HEDIS metrics for Specialty Mental Health Services are detailed in the table below.

HEDIS State Metrics	Standard
AMM: Antidepressant Medication Management	1st year baseline reporting followed by >50th percentile (or 5% increase over baseline if <50th percentile)
SAA: Adherence to Antipsychotic Medications for Individuals with Schizophrenia	
FUM: Follow-Up After Emergency Department Visit for Mental Illness	
FUH: Follow-Up After Hospitalization for Mental Illness	
APP: Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics (SMHS + Foster care)	
APC: Use of Multiple Concurrent Antipsychotics in Children and Adolescents (SMHS: Foster care)	
ADD: Follow-up Care for Children Prescribed Attention Deficit Hyperactivity Disorder Medication (SMHS: Foster care)	
APM: Metabolic Monitoring for Children and Adolescents on Antipsychotics (SMHS: Foster care)	

Outcome Mandated Metrics/Assessments	Frequency Standard
Mental Health Statistics Improvement Program (MHSIP) Consumer Satisfaction Survey	Annually

Data Collection and Retention

- All treatment programs shall enter outcomes into the EHR for all clients. Data entry shall be completed promptly upon data collection at designated intervals, including intake, UM/UR authorization cycle, or every 6 months (whichever occurs first), and discharge.

Outcome Tools and Requirements

- Measuring outcomes is an integral aspect of the System of Care principles. Standard outcomes have been established for all CYF treatment providers. Specialized programs may have individual program outcomes in addition to or in lieu of standard outcomes measured by all programs.

Additional Outcome Measures

- Additional statistical data may be required in your specific contract. This may involve using additional tools for Evidence-Based Programs or specific parts of the system. Your contract may also require the manual collection of data on certain outcomes from client charts, such as the number of hospitalizations, readmissions, arrests, or changes in the level of placement/living situation. The data collected should be submitted on your QSR or as directed by your Program's COR or Health Plan Operations, QA unit.

Level of Care Specific Outcomes (Adults and Older Adults)

Patient Reported Outcome Assessments, Adults and Older Adults

Adult Outcome Suggested Assessments	Frequency Standard
Milestones of Recovery Scale (MORS)	Intake, 6 Months, Discharge
Level of Care Utilization System (LOCUS)	Intake, 6 Months, Discharge
Recovery Markers Questionnaire (RMQ)	Intake, 6 Months, Discharge
Illness Management and Recovery (IMR)	Intake, 6 Months, Discharge

- ***Milestones of Recovery Scale (MORS)***
    - MORS is a single-item evaluation tool the clinician uses to assess a client's degree of recovery. Ratings are determined by considering three factors: the client's level of risk, their level of engagement within the mental health system, and their level of skills and support. The MORS form must be completed within 30 days of the client's admission, every 6 months thereafter, and at discharge. Clinicians at outpatient programs complete MORS.

- ***Level of Care Utilization System (LOCUS)***

    - The LOCUS is a short assessment of client current level of care needs and is completed by program staff. Program staff should complete a LOCUS for all clients within 30 days of their initial intake assessment, every 6 months thereafter, and at discharge.

- ***Recovery Markers Questionnaire (RMQ)***

    - A consumer-driven assessment of the client's own state of mind, body, and life, and involvement in the recovery process. The RMQ is used to assess the client's recovery from the client's perspective. Program staff must collect the intake RMQ during the client's first 30 days in the program. All clients should complete follow-up RMQs every 6 months and at discharge.

- ***Illness Management and Recovery (IMR)***

    - The IMR is used to assess the client's recovery from the clinician's perspective. It ranks a client's biological vulnerability and socio-environmental stressors. The IMR also includes questions about changes in a person's residential, employment, or education status. Staff must complete the IMR within 30 days of their initial intake assessment. Follow-up IMRs should be completed every 6 months after intake and at discharge for all clients.

- **Outcome Measures Manual**

    - For more information about outcomes measures, the Outcome Measures Manual is available on the Optum website.

State Required Patient Reported Outcomes, Adults

- Consumer Satisfaction Surveys are valuable tools for assessing and enhancing patient-centered care within the mental health system. By systematically collecting and analyzing consumer feedback, they contribute to improved service delivery, better patient outcomes, and greater accountability in mental health care provision.

Mental Health Statistics Improvement Program (MHSIP) Consumer Satisfaction Survey

- The MHSIP is a tool designed to gather feedback from individuals who have received mental health services. It aims to assess their satisfaction with various aspects of care and their experiences with mental health providers.

Patient Reported Outcome Assessments (Children and Youth)

Outcome Mandated Metrics/Assessments	Frequency Standard
CANS-Child and Youth	Intake, 6 Months, Discharge (ONLY if discharging from the system of care- the client is NOT enrolled in any other program).
Pediatric Symptom Checklist, Parent/Caregiver (PSC): 3-18 years of age (Medication-only excluded)	Intake, 6 Months, Discharge
Youth Services Survey, Youth (YSS-Y): 13 years of age or older	Annually
Youth Services Survey, Family (YSS-F): Caregivers of youth up to age 18	Annually

The Child and Adolescent Needs and Strengths (CANS)

- The CANS assessment is designed to support decision-making in child and adolescent services, particularly within mental health and child welfare systems. It evaluates the needs of children and youth, determines appropriate services, and monitors progress over time.

- CANS results shall be used to support medical necessity, treatment planning and clinical progress made in treatment. CANS results are interrelated to the CalAIM Assessment and shall also be utilized as Service Necessity Criteria for Intensive Service Requests (ISR) and Specialty Mental Health DPRs.

- The 50 items in the CANS assessment are required. Follow-up modules are optional and can be an additional tool available to the program if it chooses to utilize them.

- Data recorded in the database shall be supplied to CASRC via direct drop-off or traceable mailing to ensure compliance with HIPAA regulations.

CANS Completion Timelines and Discharges

- In SmartCare, CANS and PSC are *client-level documents*, they are no longer program-level documents. This means:

    - For youth in multiple programs, CANS and PSC are streamlined in SmartCare so that only one set of assessments are due for each youth. Instead of each program completing its own assessment, providers will collaborate to determine the best provider to perform the assessment, thereby reducing redundancies and improving client care

- Programs will not complete a Discharge CANS or PSC when discharging a youth that remains open to another program; the program that the youth remains open to will continue to follow the CANS and PSC reassessment schedule

- SmartCare CANS and PSC include alerts and reminders to help staff and managers know when the assessments are due. Tracking Widget - 2023 CalMHSA

CANS Training:

- With approved training, anyone with a bachelor's degree can learn to complete the tool reliably, although some applications or more complex versions of the CANS require a higher educational degree or relevant experience.

- To administer the CANS, you must be certified by the PRAED Foundation. Once you pass the certification test, your certification is valid for one year. You must pass the certification test annually to be certified. Once a practitioner is certified by PRAED, they may complete any version of the CANS. Annual training (and in some cases additional training) and certification is required for providers who administer the CANS as well as their supervisors.

- Resource: IP- CANS Manual/Reference Guide

CANS Requirements

- All child, youth, and transitional-age youth 6 to 21 years old in an outpatient treatment program shall have the CANS completed at:
  - 1. Initial intake to the program,
  - 2. Every 6 months and
  - 3. At discharge from the program.

- Data must be entered into SmartCare Electronic Health Record:
  - Initial CANS must be entered within 30 days of intake date
  - Every 6 months
  - Discharge CANS must be entered within 7 days from discharge date

    - *Please note: In SmartCare, outcome measures can only be entered every 6 months. For UM cycle purposes, some program may have unique/specific requirements for outcome measures and should use the most recent measure for these purposes.*

- See SmartCare CANS/PSC link on the Optum website '*SmartCare*' tab for more information.

CANS Exceptions

- New admissions to a program who are within 6 months of turning 21 at intake are not required to complete the CANS assessment.

- If the CANS was completed within 60 days from the discharge date, a discharge CANS does not need to be administered. The prior CANS will be accepted as the discharge measure.

- Medication-only cases are excluded from the CANS measure**s.**

    - Outcome measures identify the effects of mental health treatment. Once clients transition from "Meds Plus" to "Meds Only," they will not be required to enter outcome measures in the EHR. Administer and record CANS and PSC as a discharge assessment upon transition to "Meds Only".

    - Administer and record CANS and PSC as an intake assessment if the client returns to treatment services (Meds Plus) from meds only as a new episode in the EHR.

CANS Discharge Outcomes Objectives

- At discharge, 95% of clients ages 6-21 whose episode lasted 60 days or longer have CANS data available for initial and discharge assessment. At discharge, 100% of clients ages 6-21 whose episode lasted 60 days or longer, their initial CANS shall have at least one actionable need (2 or 3) on the *Child Behavioral and Emotional Needs*, *Risk Behaviors,* or *Life Functioning* domain.

- For 80% of clients ages 6-21 whose episode lasted 60 days or longer, with an actionable need (rating of 2 or 3) on the *Child Behavioral and Emotional Needs, Risk Behaviors,* or *Life Functioning* domain, their number of needs shall lower by at least 3 from initial to discharge assessment, indicating improvement in symptoms/functioning.

- For 80% of clients ages 6-21 whose episode lasted 60 days or longer, with an actionable need (rating of 2 or 3) on the *Child Behavioral and Emotional Needs, Risk Behaviors,* or *Life Functioning* domains, their number of strengths shall increase by at least 1 from initial to discharge assessment, indicating the development of a strength.

Pediatric Symptom Checklist (PSC)

- The PSC is provided to caregivers of children and youth 3-18 years of age at admission into the program, UM cycle or every 6 months (whichever occurs first) and at discharge.

DATA REQUIREMENTS

- Data must be entered into SmartCare Electronic Health Record:
  - Initial PSC must be entered within 30 days of intake date
  - Every 6 months
  - Discharge PSC must be entered within 7 days from discharge date

    - *Please note: In SmartCare, outcome measures can only be entered every 6 months. For UM cycle purposes, some program may have unique/specific requirements for outcome measures and should use the most recent measure for these purposes.*

- When no parent/guardian is available, an individual in a caretaking capacity (i.e., residential staff, social worker, relative, etc.) may complete the measure.

- Most current PSC scores above the clinical cutoff should be considered during UM/UR Authorization, supporting medical necessity and clinical effectiveness.

- All responses shall be recorded by program staff in the EHR or as otherwise directed by the County. This database, when utilized, shall permit client results to be compiled for individual cases and by program

- See "PSC Explanation Sheet" on the Optum *UCRM* tab for further information.

PSC Exceptions

- Medication-only cases are excluded from the PSC measure.

- Programs exempt from completing the PSC (such as TBS or DEC) shall maintain written exception documentation from COR on file.

PSC Discharge Outcomes

- At discharge, 75% of clients ages 3-18 whose episode lasted 60 days or longer have Parent PSC data available for both Initial and Discharge assessments demonstrating completion rate.

- For 80% of discharged clients ages 3-18 whose episode lasted 60 days or longer, the Parent PSC total score shall show a 3-point improvement (reduction in symptoms) between Initial and Discharge assessments.

- Report the number of clients ages 3-18 who scored at or above the clinical cutoff on the initial PSC assessment.

- 80% of discharged clients whose episode lasted 60 days or longer shall show improvement on the PSC by either falling below the clinical cutoff or having a 3-point reduction in symptoms.

- Report the number of discharged clients ages 3-18 whose episode lasted 60 days or longer, whose Initial Parent PSC total score was above the clinical cutoff, and whose total score was below the clinical cutoff at discharge, demonstrating improvement.

- Report the number of clients ages 3-18 whose episode lasted 60 days or longer, with a 3-point improvement (reduction in symptoms) between Initial and Discharge assessments, demonstrating improvement.

Youth Services Survey (YSS): Client Satisfaction

- Currently administered annually to all clients and families who receive services during a selected one-week interval specified by the County BHP (excluding detention programs, medication-only cases, inpatient, and crisis services). The annual survey will be conducted in the Spring of each year. The survey returns are scanned to facilitate tabulation; therefore, the original printed forms provided by the BHP must be used.

    - Youth aged 13 and over complete the Youth Services Survey with the attached comments page.

    - Parents/caregivers of children and youth up to age 18 complete the Youth Services Survey-Family.

    - Surveys are to be administered to ensure full confidentiality, as directed by the Child and Adolescent Services Research Center (CASRC).

    - Completed surveys shall be completed via the secure link or delivered by hand to CASRC within 3 business days after each survey period has been completed, adhering to HIPAA regulations.

YSS Exceptions

- Medication-only cases are excluded from the YSS measure.
  Programs exempt from completing the PSC (such as TBS or DEC) shall maintain written exception documentation from COR on file.

YSS Satisfaction Outcomes

- Submission rate of YSS-Y and YSS-F shall meet or exceed the 80% standard established by the County of San Diego Children's Mental Health.

- Aggregated scores on the YSS-Y and the YSS-F shall show an average of 80% or more respondents responding "Agree" or "Strongly Agree" for at least 75% of the individual survey items.

- Clients receiving services from a Substance Use Disorder counselor at an FSP Subunit shall show an average of 80% or more respondents responding "Agree" or "Strongly Agree" on each of the 7 supplemental items.

State Required Patient Reported Outcomes (Children and Youth)

- Patient outcomes are fundamental measures used to assess the quality and effectiveness of healthcare services. These outcomes provide crucial insights into the impact of interventions, treatments, and overall care delivery on patients' health and well-being. Patient-reported outcomes (PROs) offer valuable perspectives directly from patients regarding their health-related quality of life, pain levels, functional status, and overall satisfaction with the care received. These indicators provide a holistic view of how well healthcare services meet the needs and expectations of patients beyond mere clinical effectiveness. Mandated assessments and patient-reported outcomes are included in the table below. Further details regarding each measure are also provided.

Additional Children and Youth Outcome Objectives

- All Providers

    - 100% of all clients, ages 16 and older, shall be assessed for transitional service needs as evidenced by documentation in the medical record.

    - 100% of all clients shall be assessed for domestic violence issues as evidenced by documentation in the medical record.

    - 100% of all clients shall be assessed to determine the need for referral to a primary care physician as evidenced by documentation in the medical record.

- 80% or more of all clients shall receive at least one face-to-face family treatment contact/session per month with the client's biological, surrogate, or extended families (who are able).

- Outpatient Providers

  - 90% of clients will not require psychiatric hospitalization or re-hospitalization during the outpatient episode.

  - Outpatient programs shall meet or exceed the minimum productivity standard for annual billable time by providing at least 54,000 minutes per year (50% productivity level) for clinic, school, and community-based programs per FTE, unless otherwise specified in the program's Statement of Work.

  - Psychiatrist shall maintain a minimum of 75% productivity level.

  - RN shall maintain a minimum productivity level of 55%.

  - Case Management services provided by a case manager shall meet or exceed the minimum productivity for annual billable time by providing at least 32,400 minutes per year (30% productivity level) per FTE, unless otherwise specified in the program's Statement of Work.

  - Clinical staff shall carry a minimum client load of 40 unduplicated clients per FTE per year unless otherwise specified in the program's Statement of Work.

  - Case Managers shall carry a minimum client load of 20 unduplicated clients per FTE per year unless otherwise specified in the program's Statement of Work.

- Day Treatment Providers

  - The contractor shall ensure that billable client days are produced for 90% of the annual available client days, based on five (5) days per week or a 230-day year.

  - 95% of clients will be discharged to a lower level of care unless otherwise specified in the contract.

  - 95% of clients will avoid psychiatric hospitalization or re-hospitalization during the Day Treatment episode.

Research Projects Involving Children's Mental Health Clients

- Some providers may develop research projects or test additional outcome tools with methods that utilize BHP clients. All such projects must be reviewed by the BHP's Research Committee. Approval is required prior to implementation. For more information on BHS research procedures contact BHSResearch.HHSA@sdcounty.ca.gov.