L. 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 members 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.

Data Accuracy

Providers are responsible for ensuring that all member 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 member data and following the appropriate procedures when data corrections are needed. In addition, Full-Service Partnership (FSP) programs are required to ensure that all required data is current and up to date in any designated system.

Access Times Monitoring

BHS will monitor program data for compliance with access times standards monthly, that includes a review of NOABD data to ensure NOABD's are issued when lack of compliance is indicated. When non-compliant programs will be notified, technical assistance will be provided. A written report documenting noncompliance will be issued by BHS and providers are required to submit a Corrective Action Plan (CAP) to BHS within thirty (30) days of the report for approval. BHS shall verify corrections as resolved.

Mental Health Statistics Improvement Program (MHSIP) Consumer Satisfaction Survey

Consumer Satisfaction Surveys are valuable tools for assessing and enhancing client-centered care within the mental health system. By systematically collecting and analyzing consumer feedback, they contribute to improved service delivery, better member outcomes, and greater accountability in mental health care provision. Provider participation in the survey process is critical to get an accurate picture of how well each provider and the mental health system as a whole are meeting member needs. 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.

On an annual basis, BHS selects a one (1) week time period in which all Outpatient providers, including Case Management, are required to administer the Mental Health survey. This survey consists of a Mental Health Statistics Improvement Program (MHSIP) section, which measures member satisfaction with services. This survey should be administered to ***all*** members receiving services during the week, ***including members receiving medications only*****.** UCSD Health Services Research Center (HSRC) is contracted by the BHP to handle the adult survey process. HSRC distributes the blank survey forms, collects the completed forms, and compiles provider and countywide satisfaction data. Providers will be notified by HSRC of the exact survey period. Survey returns are scanned and then tabulated, therefore, original printed forms provided by the BHP must be used.

Providers are strongly requested to send in completed surveys according to HSRC instructions at the end of the survey period. Each participating provider will receive a report comparing their results on the survey with the average results for their level of care. The criteria and guidelines for the Adult MHSIP Survey are subject to change as determined by DHCS. Providers will be notified of changes affecting them.

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 Medi-Cal Administrative Activities (MAA) 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.

Monthly/Quarterly Status Report (M/QSR)

Contracted providers are required to submit a completed Monthly Status Report (MSR) and/or Quarterly Status Report (QSR) within twenty (20) calendar days after the end of the report month. The COR reviews the status report for needed information on compliance and contractual requirements. The Quality Assurance Unit (QA) tracks and trends data, provides analysis and issues reports as needed for the Department of Health Care Services (DHCS), BHS Administration, the Quality Review Council and other groups.

The status report may include:

- A narrative (including General Information, Program Description, Activities/Events, Community Outreach, Emerging Issues, Quality Improvement Activities),
- Outcomes,
- Data Summaries for Units/Subunits
- Staffing & Personnel
- Member Suggestions & Transfer Requests
- Notices of Action
- Additional Information Requested by the COR.

Systemwide State Required Performance Measures

Member 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 member's health and well-being. Member -reported outcomes (PROs) offer valuable perspectives directly from members 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 members beyond mere clinical effectiveness. Mandated assessments and member-reported outcomes are indicated in the information below.

California's External Quality Review Organization (EQRO) plays a crucial role in monitoring and evaluating the quality of care provided to Medi-Cal members. Cal EQRO is an independent entity contracted by the State to assess the performance of Behavioral Health Plans and ensure compliance with federal and state standards. Requirements include Network Adequacy Validation (NAV), Performance Measure Validation (PMV)- also known as HEDIS, and Performance Improvement Projects (PIP) requirements. The tables below outline the NAV, PMV and PIP for the County of San Diego.

Healthcare Effectiveness Data and Information Set (HEDIS/PMV)

HEDIS is a recognized set of performance metrics in healthcare, standardized by the National Committee for Quality Assurance (NCQA) for evaluating care and service performance. While the NCQA develops and oversees HEDIS, the Centers for Medicare & Medicaid Services (CMS) also manages specific HEDIS measures to promote high-quality, safe and equitable care. HEDIS metrics are updated annually to reflect current clinical guidelines and priorities, providing a framework for assessing healthcare effectiveness, safety, and client-centeredness across various populations. The state-mandated HEDIS metrics for SMHS are detailed in the table below:

EQRO MH Metrics - NAV	Standard
Outpatient Non-Urgent Non-Psychiatry SMHS (BHP Timely Access Standards Selected for Validation)	Offered an appointment within ten (10) business days of request for service
Non-Urgent Psychiatric Services (BHP Timely Access Standards Selected for Validation)	Offered an appointment within fifteen (15) business days of request for services
All SMHS Urgent Appointments (BHP Timely Access Standards Selected for Validation)	Forty-eight (48) hours without prior authorization Ninety-six (96) hours with prior authorization

Performance Improvement Projects	Standard
Clinical	Follow-Up After Emergency Department Visit for Mental Illness (FUM).
Non-Clinical	Improve timely access from first contact from any referral source to first offered appointment for any specialty mental health service (SMHS).

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

Member and Performance Outcomes

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

outcomes measured by all programs. Outcome measures and explanation sheets are located on the Optum Website > *UCRM* tab.

Additional statistical data or outcome requirements may be included in specific program contracts. This may involve using additional tools for Evidence-Based Programs or specific parts of the system. Specific contracts may also require the manual collection of data on certain outcomes from member 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 the QSR or as directed by the program's COR, Health Plan Operations, COE, or the QA unit.

Measures for Programs Serving Adults and Older Adults

The Level of Care Utilization System (LOCUS) is used by programs serving Adults/Older Adults. The LOCUS is a short assessment of member current level of care needs and is completed by program staff with the appropriate training. The Level of Care Utilization System (LOCUS) is available in SmartCare for staff who have completed the five (5) hour initial LOCUS training offered through the American Association of Community Psychiatry (AACP). It is expected that providers completing the LOCUS will do so within their scope of practice, and after completing all necessary training. Providers may access resources on LOCUS training at: AACP- Login.

Program staff should complete a LOCUS for all members within thirty (30) days of their initial intake assessment and every six (6) months thereafter to evaluate level of care as clinically appropriate. Programs utilizing the LOCUS shall enter the information into the EHR in a timely manner. Additional outcome measures may be completed at the program's discretion or instruction of their Center of Excellence (COE) fidelity contractor if delivering an applicable evidence-based practice.

Measures for Programs Serving for Children and Youth

Outcomes measures and data entry trainings are available on the UCSD Children & Youth Outcomes Measures website. Information on CANS certification, a requirement for administration, is available on the System of Care Outcomes for Children, Youth and TAY website. All outcomes' data will be completed within the electronic health record and then entered in the "*Other* "data is manually collected by providers and submitted on a quarterly basis (QSR). The data is useful in determining trends and patterns in service provision and demand, as well as, identifying opportunities for improvement. In conjunction with new State mandates for quality improvement and monitoring member progress, the BHP is extending the Client Outcomes tracking to all programs through data reports and the QSR.

Participating programs shall report their outcomes data according to defined timelines. The Program Monitor/COR will review the results, check for adherence to the outcome standard, and identify if a plan of correction is needed. The QA unit will track trends for the data provided on the QSR and the quarterly Child, Youth & Families mHOMS DES report produced by CASRC. The specific outcomes procedures by level of care, the outcomes tools, and reporting requirements can be obtained by contacting your Program Monitor/COR and/or the Child and Adolescent Services Research Center (CASRC).

State Required Outcomes for Programs Serving Children & Youth

Outcome Mandated Metrics/Assessments	Frequency Standard
CANS-Child and Youth: 0-21 years old	Intake, Six (6) months, Discharge (ONLY if discharging from the system of care- the member is NOT enrolled in any other program).
Pediatric Symptom Checklist, Parent/Caregiver (PSC): Three to eighteen (3-18) years of age (Medication-only members excluded)	Intake, Six (6) months, Discharge
Youth Services Survey, Youth (YSS-Y): Thirteen (13) years of age or older	Annually
Youth Services Survey, Family (YSS-F): Caregivers of youth up to age eighteen (18)	Annually
Medication Only Members: Per BHIN 18-048, the CANS and PSC must be completed for all cases, including medication only members.	

The Child and Adolescent Needs and Strengths (CANS)

Per DHCS, the CANS is a structured assessment for identifying youth and family actionable needs and useful strengths. It provides a framework for developing and communicating about a shared vision and uses youth and family information to inform planning, support decisions, and monitor outcomes. Providers will complete the CANS (California CANS) form through a collaborative process which includes children ages six (6) and youth up to age twenty (20), and their caregivers (at a minimum). The CANS version being used is the CANS Core Item set. The CANS will need to be completed at the beginning of treatment, updated every six (6) months following the first administration, and at the end of treatment. For more information please see: DHCS- Functional Assessment Tools.

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 Mental Health Assessment and shall also be utilized as Service Necessity Criteria for Intensive Service Requests (ISR) and Specialty Mental Health DPRs.

There are various versions of the CANS tailored to different populations. With the September 2024 shift to SmartCare, the system transitioned from utilizing the CANS-50 with additional modules to utilizing the IP-CANS which is also the required version through CDSS. Current DHCS guidance shall be followed – (BHIN 25-035)

CANS Completion Timelines and Discharges:

All children, youth, and transitional-age youth ages zero to twenty- one (0 to 21) years old in an outpatient treatment program shall have the CANS completed at:

1. Initial intake at case opening which is beginning of SMHS treatment and may or may not be the intake date to the program

2. Every six (6) months, following first administration

3. Within thirty (30) days of determining occurrence of a significant change or condition

4. At end of SMHS treatment (discharge from the program IF the member is not open to any additional programs)

Data must be entered into SmartCare Electronic Health Record:

- Initial CANS - within thirty (30) days of intake date
- Every six (6) months in a timely manner
- Significant Event – within thirty (30) days when indicated
- Discharge CANS - within seven (7) days from discharge date

The IP CANS replaces the former SD CANS versions (*EC* for ages 0-5, and *50* for ages 6-20). The EC Module will populate in the CA CANS document in SmartCare when being completed for those minors up to five years old (ages 0-5). Adult and Older Adult mental health programs serving TAY will be required to complete a CANS assessment for all TAY-age participants, ages eighteen to twenty-one (18 to 21 years old).

In SmartCare, CANS and PSC are *client-level documents*, they are no longer program-level documents. This means: When a reassessment and discharge is due for a member with multiple serving providers, coordination is required for one submission for the member. 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 member care.

In SmartCare, outcome measures should only be entered every six (6) months. For UM cycle purposes some programs may have unique/specific requirements for outcome measures (i.e. requiring CANS scores every three (3) months) the most recent measure should be used as long as they have been completed within the past six (6) months. See SmartCare CANS/PSC link on the Optum website 'SmartCare' tab for more information.

For youth open to multiple programs; if the member is still open to another program when discharging, the discharging program will not complete a Discharge CANS. The program that the member remains open to will continue to follow the CANS and PSC reassessment schedule. If the member is not open to any other programs, the discharging program will complete a Discharge CANS**.**

CANS Administrative Close	Discharge CANS
Member is not open to any other program.	Member is not open to any other program.
Previous CANS **was** completed within sixty (60) days of discharge date. The most recent CANS will be accepted as the discharge measure.	Previous CANS **was not** completed within sixty (60) days of discharge date.

CANS Training

The CANS can only be administered by staff who have completed the Certification process. To administer the CANS, you must be certified by the PRAED Foundation. Once you pass the certification test, your certification is valid for one (1) 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.

Resources: IP- CANS Manual/Reference Guide & Local Training Process: Outcomes for programs that serve Children, Youth & Families

CANS Exceptions

New admissions to a program who are within six (6) months of turning twenty-one (21) at intake are not required to complete the CANS assessment. Outcome measures identify the effects of mental health treatment. Once members 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 member returns to treatment services (Meds Plus) from meds only as a new episode in the EHR.

CANS Discharge Outcomes Objectives

- At discharge, one hundred percent (100%) of members ages six through twenty-one (6-21) shall have at least one actionable need (2 or 3) on the *Child Behavioral and Emotional Needs*, *Risk Behaviors,* or *Life Functioning* domain on their initial CANS.

- At discharge, minimum eighty percent (80%) of members ages six through twenty- one (6-21) with an actionable need (rating of 2 or 3) on the ***Life Functioning*** domain at initial assessment, shall have one fewer need at discharge (at least one item moved from a 2 or 3 to 0 or 1), indicating improvement in symptoms/functioning.

- At discharge, minimum eighty percent (80%) of members age 6-21 with an actionable need (rating of 2 or 3) on the ***Risk Behaviors*** domain at initial assessment, shall have one fewer need at discharge (at least one item moved from a 2 or 3 to 0 or 1), indicating improvement in symptoms/functioning.

- At discharge, minimum 80% of members ages six through twenty- one (6-21)with an actionable need (rating of 2 or 3) on the ***Child Behavioral and Emotional Needs*** domain at initial assessment, shall have one fewer need at discharge (at least one item moved from a 2 or 3 to 0 or 1), indicating improvement in symptoms/functioning.

Pediatric Symptom Checklist (PSC)

Per DHCS, the PSC-35 is a psychosocial screening tool designed to facilitate the recognition of cognitive, emotional, and behavioral problems so that appropriate interventions can be initiated as early as possible. Parents/caregivers will complete the PSC-35 (parent-completed version) for their children ages three (3) and youth up to age eighteen (18). The PSC-35 will need to be completed at the beginning of treatment, every six (6) months following the first administration, and at the end of treatment. For more information please see: Functional_Assessment_Tools

The PSC is provided to caregivers of children and youth ages three through eighteen (3-18) years of age at:

1. Initial intake **at case opening** which is beginning of SMHS treatment and may or may not be the intake date to the program

2. **Every six (6) months**, following first administration

3. At **end of SMHS treatment** (discharge from the program IF the member is not open to any additional programs)

All responses shall be recorded by program staff in the EHR or as otherwise directed by the County:

- Initial PSC - within thirty (30) days of intake date
- Every six (6) months -in a timely manner
- Discharge PSC - within seven (7) days from discharge date

Please note: In SmartCare, outcome measures should only be entered every six (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. See "*PSC Explanation Sheet*" on the Optum *UCRM* tab for further information.

PSC Exceptions

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, minimum fifty percent (50%) of members ages three through eighteen (3-18) years old shall show reliable improvement on the PSC by having a minimum six (6) point reduction in symptoms on the total scale score.

- At discharge, minimum fifty percent (50%) of members ages three through eighteen (3-18) shall score below the clinical cutoff on at least one scale (which was elevated on their initial assessment) and have at least a six (6) point reduction on the Parent PSC total scale score demonstrating clinically significant improvement.

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

Youth Services Survey (YSS): Member Satisfaction

A satisfaction survey is conducted annually within all organizational programs (excluding detention programs, medication only cases, inpatient, and crisis services) as required by the State to assess member satisfaction. The Youth Services Survey (YSS) is administered to all members receiving services during the one-week period by the Child and Adolescent Services Research Center (CASRC).

Youth aged thirteen (13) and older complete the Youth Services Survey with the attached comments page. Parents/caregivers of children and youth up to age eighteen (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). The survey returns are scanned to facilitate tabulation; therefore, the original printed forms provided by the BHP must be used. Completed surveys shall be completed via the secure link or delivered by hand to CASRC within three (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.

YSS Satisfaction Outcomes

Submission rate the YSS shall meet or exceed the eighty percent (80%) standard established by the County of San Diego Children's Mental Health. Aggregated scores on the YSS shall show an average of eighty percent (80%) or more respondents responding "Agree" or "Strongly Agree" for at least seventy-five percent (75%) of the individual survey items. Members receiving services from a Substance Use Disorder counselor at an FSP Subunit shall show an average of eighty percent (80%) or more respondents responding "Agree" or "Strongly Agree" on each of the seven supplemental items.

Additional Objectives for Programs Serving Children and Youth

All Providers

- One hundred percent (100%) of all members, ages sixteen (16) and older, shall be assessed for transitional service needs as evidenced by documentation in the medical record.

- One hundred percent (100%) of all members shall be assessed for domestic violence issues as evidenced by documentation in the medical record.

- One hundred percent (100%) of all members shall be assessed to determine the need for referral to a primary care physician as evidenced by documentation in the medical record.

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

Outpatient Providers

- Ninety percent (90%) of members 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 (fifty percent (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 fifty- five percent (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 (thirty percent (30%) productivity level) per FTE, unless otherwise specified in the program's Statement of Work

- Clinical staff shall carry a minimum case load of forty (40) unduplicated members per FTE per year unless otherwise specified in the program's Statement of Work.

- Case Managers shall carry a minimum case load of twenty (20) unduplicated members per FTE per year unless otherwise specified in the program's Statement of Work.

Day Treatment Providers

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

- Ninety-five percent (95%) of members will be discharged to a lower level of care unless otherwise specified in the contract.

- Ninety-five percent (95%) of members will avoid psychiatric hospitalization or re-hospitalization during the Day Treatment episode.

Research Projects Involving Children

Some providers may develop research projects or test additional outcome tools with methods that utilize BHP members. 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.