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). For more information please see the Outcome Measures Manual or contact mhoms@ucsd.edu.

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 as specified in their statement of work.

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. For more information on DCR, please visit UCSD DCR Training and Resources.

Systemwide State Required Performance Measures

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 new 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.

EQRO MH Metrics - NAV	Standard
Outpatient Non-Urgent Non-Psychiatry Specialty Mental Health Services (MHP Timely Access Standards Selected for Validation)	Offered an appointment within 10 business days of request for service
Non-Urgent Psychiatric Services (MHP Timely Access Standards Selected for Validation)	Offered an appointment within 15 business days of request for services
All Specialty Mental Health Service Urgent Appointments (MHP Timely Access Standards Selected for Validation)	48 hours without prior authorization 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

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 patient-centeredness across various populations. The state-mandated HEDIS metrics for Specialty Mental Health Services are detailed in the table below

DHCS CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

Behavioral Health Accountability Set (BHAS)
Measurement Year (MY) 2024 – Reporting Year (RY) 2025

County Mental Health Plan (MHP) Priority Measures

#	MEASURE REQUIRED OF MHP	MEASURE ACRONYM	MEASURE STEWARD	Methodology	Target (MPL)[i]
	County MHP Priority Measures				
1	Follow-Up After Emergency Department Visit for Mental Illness	FUM	NCQA	Administrative	>50th percentile (or 5% increase over baseline if <50th percentile)
2	Follow-Up After Hospitalization for Mental Illness	FUH	NCQA	Administrative	>50th percentile (or 5% increase over baseline if <50th percentile)
3	Antidepressant Medication Management	AMM	NCQA	Administrative	>50th percentile (or 5% increase over baseline if <50th percentile)
4	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	APP	NCQA	Administrative	>50th percentile (or 5% increase over baseline if <50th percentile)
5	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	SAA	NCQA	Administrative	>50th percentile (or 5% increase over baseline if <50th percentile)

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. All completed assessments should be entered into the EHR or respective system (i.e. mHOMS) at minimum in a timely manner.

Outcome Tools and Requirements

Measuring outcomes is an integral aspect of the System of Care principles. Standard outcomes have been established for all Child, Youth & Families 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: 0-21 years old	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

All children, youth, and transitional-age youth ages 0 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

3. At discharge from the program IF the client is not open to any additional programs

Data must be entered into SmartCare Electronic Health Record:

- Initial CANS - within 30 days of intake date
- Every 6 months in a timely manner
- Discharge CANS - within 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 who are 0-5 years old. Adult and Older Adult mental health programs serving TAY will be required to complete a CANS assessment for all TAY-age participants, 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

client with multiple serving providers, coordination is required for one submission for the client. 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.

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

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

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

New admissions to a program who are within 6 months of turning 21 at intake are not required to complete the CANS assessment. Medication-only cases are excluded from the CANS measures. 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.

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

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

Please note: In SmartCare, outcome measures should 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. 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.