PARTNERSHIP HEALTHPLAN OF CALIFORNIA
SUBSTANCE USE INTERNAL QUALITY IMPROVEMENT COMMITTEE
MEETING AGENDA

Date: March 16, 2021 **Time: 10:00-11:30 AM** **Location: WebEx**

Substance Use Internal Quality Improvement Subcommittee (SUIQI)

A committee comprised of appropriate PHC and County staff tracks progress towards successful completion of quality initiatives, surveys, audits, and accreditation for the PHC's Substance Use Services* oversight. The SUIQI meeting frequency will be determined at a later date, closer to the implementation of the benefit. Activities and progress are reported to the IQIC. This also includes

- Review of Utilization Management retroactive and appeals review
- Review of inter-rater reliability for peer review and utilization management
- Review of quality of service, quality of facility, and access complaints and grievances
- Investigation of potential over-use, under-use, and misuse of services.
- Review of policies related to provision of SU services

Members of the committee include the Clinical Director, Behavioral Health, the CMO, and representatives from the Provider Relations, Member Services, Claims, Compliance, Behavioral Health and Quality Departments.

Invited Participants - PHC					
La Rae Banks	Grievances & Appeals	Michelle Gazzigli	Quality - NR	Rachel Peterson	Quality
Katherine Barresi	Care Coordination	Liz Gibboney	Chief Executive Officer	Dolores Plascencia	Configuration
Sonja Bjork	Chief Operating Officer	Angela Guevarra	Care Coordination - SR	Matt Ramsey	Care Coordination
Mark Bontrager	Administration	Jessica Hackwell	Health Services	Erika Robinson	Quality
Rebecca Boyd Anderson	Care Coordination	Ruth Hood	Health Services	Diana Rose	Quality
Heather Brandeburg	Provider Relations	Peggy Hoover	Health Services	Chloe Schafer	Administration
Dani Carpenter	Provider Relations	Mary Kerlin	Provider Relations	Kevin Spencer	Member Services
Elena Carter	Grievances & Appeals	Margaret Kisliuk	Administration	Nancy Steffen	Quality - NR
Doreen Crume	Health Services	Jackie Krznarich	Quality	Lauri Stevenson	Quality - NR
Tahereh Daliri Sherafat	Member Services/Provider Relations – NR	Laurel McCarthy	Care Coordination	Nicole Talley	Administration
Jeff Devido	Clinical Director, BH	Melissa McCartney	Care Coordination - NR	Amy Turnipseed	Administration
Alison French	Beacon	Wendy Millis	Administration	Wendi West	Director - NR
Rachel French	Quality	Robert Moore	Chief Medical Officer		
Karen Garnick	Quality	Dani Ogren	Finance		
Invited Participants- Counties					
Elvira Schwarz	Humboldt	Barbara Longo	Lassen	Katie Cassidy	Shasta
Emi Botzler-Rogers	Humboldt	Tiffany Armstrong	Lassen	Paige Greene	Shasta
Kaleigh Emry	Humboldt	Jenine Miller	Mendocino	Sarah Collard	Siskiyou
Michelle Thomas	Humboldt	Rendy Smith	Mendocino	Toby Reusze	Siskiyou
Nancy Starck	Humboldt	William Riley	Mendocino	Emery Cowan	Solano
Paul Bugnaki	Humboldt	Michael Traverso	Modoc	Sandra Sinz	Solano
Raena West	Humboldt	Stacy Sphar	Modoc		

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
SUBSTANCE USE INTERNAL QUALITY IMPROVEMENT COMMITTEE
MEETING AGENDA

		Lead	Time	Page #
I.	**Approval of Minutes**	Wendy Millis	10:00	
II.	**New Business**		10:05	
	- Conflict of Interest & Confidentiality Agreement - Wellness and Recovery Program Updates	Wendy Millis Margaret Kisliuk Nicole Talley Michelle Gazzigli		
III.	**Discussion – Review of Data**		10:20	
	- Referrals to Treatment Beacon Referrals Actual vs Indicated LOC by County - Paid Claims By Member County/LOC Demographics Info ~~- CalOMS~~ ~~Participation in treatment~~ - Treatment Perception Survey Results			
IV.	**Presentation – Grievance and Appeals**	Kori Watkins	10:35	
V.	**Discussion – EQRO Review**	Wendy Millis Nicole Talley	10:50	
VI.	**Discussion – New policies and BHINs**	Wendy Millis Nicole Talley	11:15	
	- MCQP1025 – Substance Use Disorder (SUD) Site Review and Medical Record Review - MCCUP2028 - Residential Substance Use Disorder Treatment Authorization - MPUD3001 – UM Program Description - Draft BH Ins – None to report on this month			
VII.	**Adjournment – next meeting May 18 10:00-11:30 AM**	Wendy Millis	11:30	

Wellness and Recovery

Beacon Referrals -- Jan 2021 / Fiscal YTD

Referral Outcomes

	Jan'21	YTD
Connected to Provider	141	1,022
Left Message for Provider	139	893
Declined Referral	24	146
Other	8	118
TOTAL	312	2,179

Referrals by Level of Care

Actual LOC	Jan'21	YTD
1.0 Outpatient	28	261
2.1 Intensive Outpatient	18	164
3.1 Residential (Low Intensity)	178	1,230
3.2 Withdrawal Mgmt (Res.)	79	397
3.5 Residential (High Intensity)	2	68
NTP/OTP	3	23
Other	4	36
TOTAL	312	2,179

Referrals by County

County of Resp	Jan'21	YTD
Humboldt	61	403
Lassen	2	43
Mendocino	44	317
Modoc	4	35
Shasta	98	662
Siskiyou	12	128
Solano	91	591
TOTAL	312	2,179

Wellness and Recovery

Jan 2021 - Actual vs Indicated LOC by County

		Mbr County / Screening Done By											
		HUMBOLDT		LASSEN	MENDOCINO		MODOC		SHASTA		SISKIYOU		SOLANO	
Actual LOC	Indicated LOC	Beacon	Provid..	Beacon	Beacon	Provid..	Beacon	Provid..	Beacon	Provid..	Beacon	Provid..	Beacon	Provid..
1.0 Outpatient	1.0 Outpatient	2	16		1	5		1	2	2			22	3
	2.1 Intensive Outpatient		2											
	3.1 Residential (Low Intensity)												1	2
2.1 Intensive Outpatient	1.0 Outpatient											2		
	2.1 Intensive Outpatient	1			1							1	13	
	3.1 Residential (Low Intensity)								2					
	3.2 Withdrawal Mgmt (Res.)												1	
	Other											1		
3.1 Residential (Low Intensity)	2.1 Intensive Outpatient	1			3				1					
	3.1 Residential (Low Intensity)	33	5	1	28				62	2	7	4	30	2
	3.2 Withdrawal Mgmt (Res.)	7									1	1	2	1
	3.5 Residential (High Intensity)								1					
	NTP/OTP				1									
3.2 Withdrawal Mgmt (Res.)	3.1 Residential (Low Intensity)					1								
	3.2 Withdrawal Mgmt (Res.)	16	10	1	9	3	3		25	1	4	1	20	
	3.7 Withdrawal Mgmt (Inpt.)								1					
3.5 Residential (High Intensity)	3.5 Residential (High Intensity)	1	1			1			1					
NTP/OTP	NTP/OTP		15		1				1				1	13
Other	2.1 Intensive Outpatient						1							
	3.2 Withdrawal Mgmt (Res.)					1			1				1	
	Other								1			1		
Grand Total		61	49	2	44	11	4	1	98	5	12	11	91	21

Wellness and Recovery Overview of Paid Claims by Member County

This dashboard tracks health services by Wellness and Recovery program across the participating counties. Data gathered from paid claims.

Refreshed on: 3/15/2021 6:30:49 AM

Health Analytics

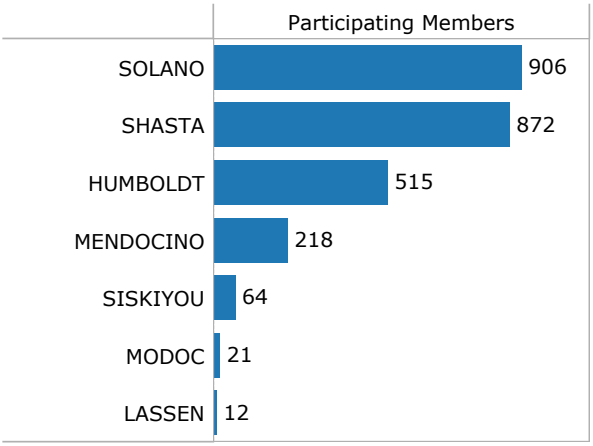
by: Revanth Kasireddy

7/1/20 to 2/1/21	3/8/21	2,592	69,274
Service Date	Max Paid Date	Total participating Members	Total Visits

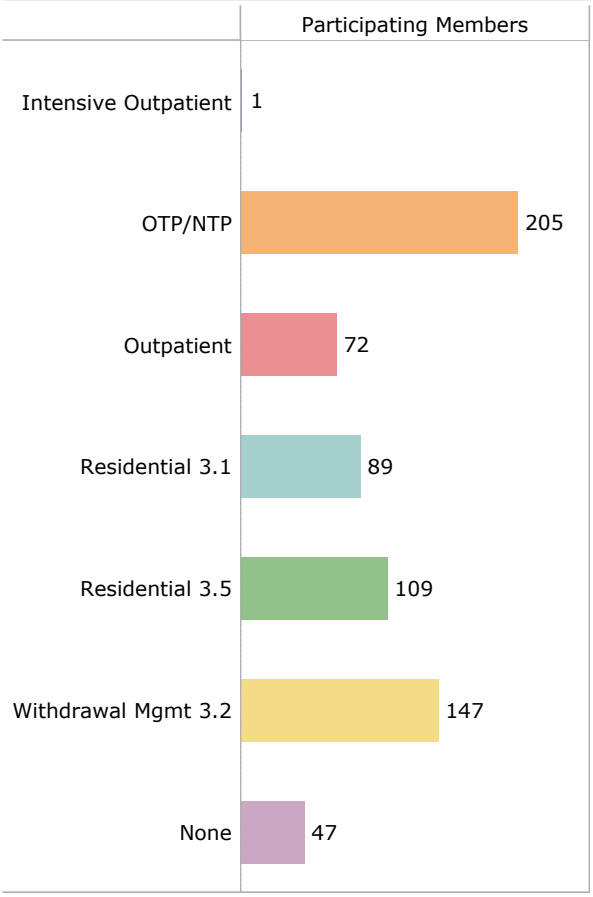
Service date
7/1/2020 to 2/..

View by Members/ Total Visits
Participating Members

By County



By Level of Care



By County and By Level of Care

Mbr County	Level of Care	Participating Members
HUMBOLDT	Intensive Outpatient	1
	None	47
	OTP/NTP	205
	Outpatient	72
	Residential 3.1	89
	Residential 3.5	109
	Withdrawal Mgmt 3.2	147
LASSEN	Residential 3.1	10
	Residential 3.5	1
	Withdrawal Mgmt 3.2	4
MENDOCI..	Intensive Outpatient	1
	Outpatient	151
	Residential 3.1	62
	Residential 3.5	10
	Withdrawal Mgmt 3.2	42
MODOC	Intensive Outpatient	1
	Outpatient	16
	Residential 3.1	10
SHASTA	Intensive Outpatient	109
	OTP/NTP	362
	Outpatient	348
	Residential 3.1	220
	Residential 3.5	14
	Withdrawal Mgmt 3.2	35
SISKIYOU	Intensive Outpatient	4
	OTP/NTP	12
	Outpatient	14
	Residential 3.1	36
	Residential 3.5	3
	Withdrawal Mgmt 3.2	5
SOLANO	Intensive Outpatient	64
	None	5
	OTP/NTP	585
	Outpatient	143
	Residential 3.1	141
	Residential 3.5	1
	Withdrawal Mgmt 3.2	75

Wellness and Recovery Demographics of Paid Claims

Demographic distribution of our members

Refreshed on: 3/15/2021 6:30:49 AM

Health Analytics

by: Revanth Kasireddy

County:
All

Service date
7/1/2020 to ..

view by Members/ Total Visits
Participating ..

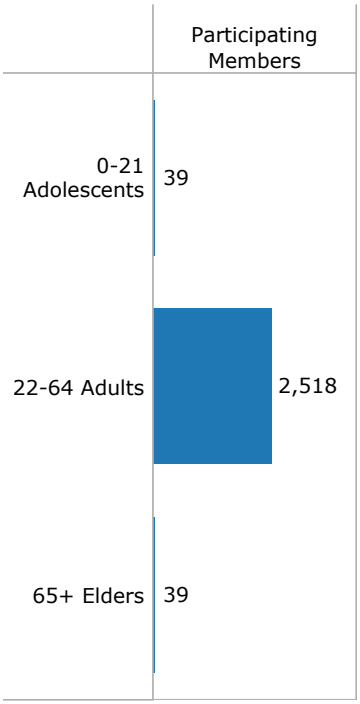
Mbr County
All

By Gender

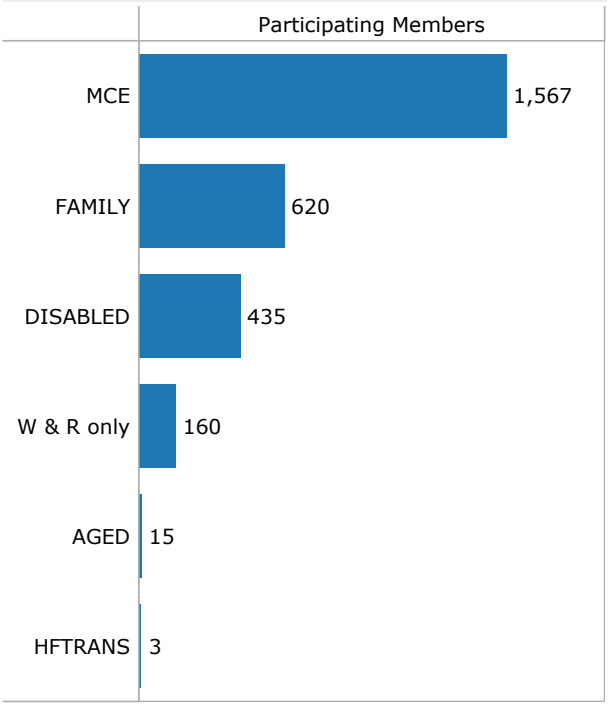
1,226
47.3%

1,366
52.7%

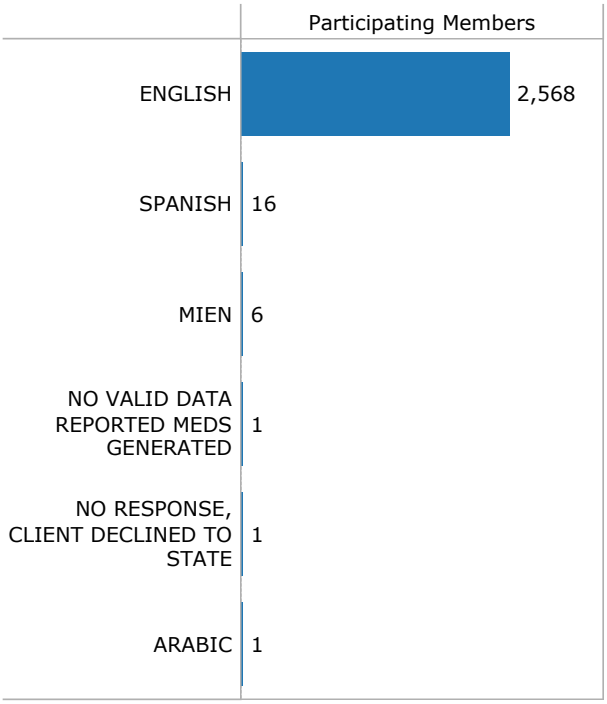
By Age Group



By AIDCAT



By Language



% of Participation by Ethnicity

Race and Ethnicity group	Member Count	Participation Men
WHITE	140,410	1,754
HISPANIC	69,737	216
OTHER	22,414	426
ASIAN/PACIFIC ISLANDER	20,274	42
BLACK	24,615	225

Wellness and Recovery Demographics of Paid Claims

Demographic distribution of our members

Refreshed on: 3/15/2021 6:30:49 AM

Health Analytics

by: Revanth Kasireddy

County:
HUMBOLDT

Service date
7/1/2020 to ..

view by Members/ Total Visits
Participating ..

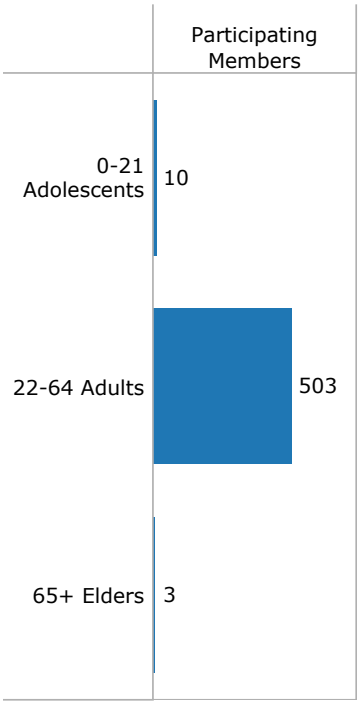
Mbr County
HUMBOLDT

By Gender

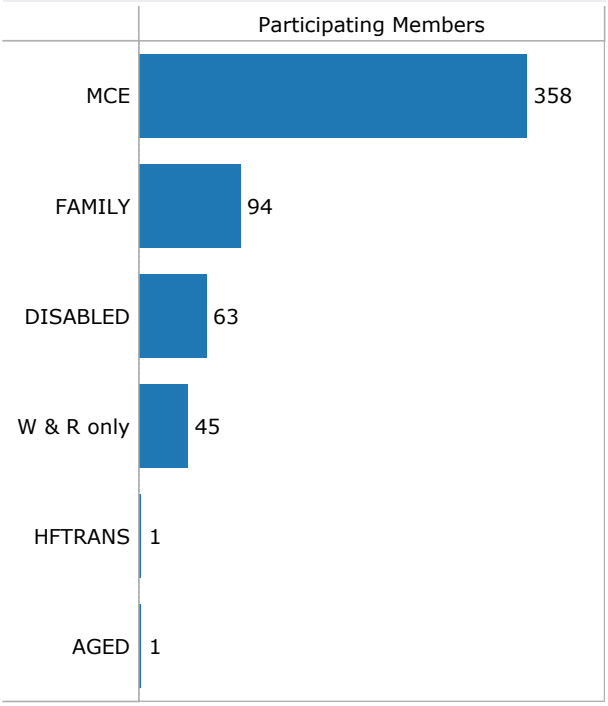
227
44.1%

288
55.9%

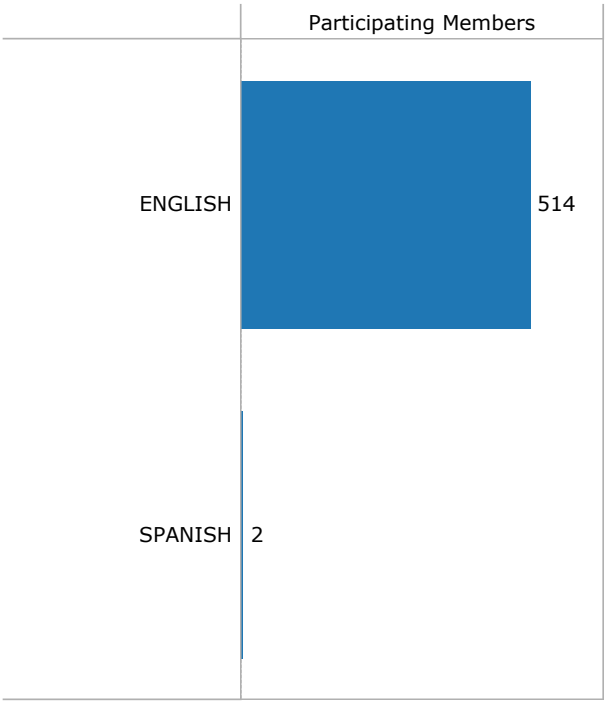
By Age Group



By AIDCAT



By Language



% of Participation by Ethnicity

Race and Ethnicity group	Member Count	Participation Men
WHITE	32,760	386
HISPANIC	7,796	30
OTHER	844	93
ASIAN/PACIFIC ISLANDER	1,752	3
BLACK	1,009	8

Wellness and Recovery Demographics of Paid Claims

Demographic distribution of our members

Refreshed on: 3/15/2021 6:30:49 AM

Health Analytics

by: Revanth Kasireddy

County:
LASSEN

Service date
7/1/2020 to ..

view by Members/ Total Visits
Participating ..

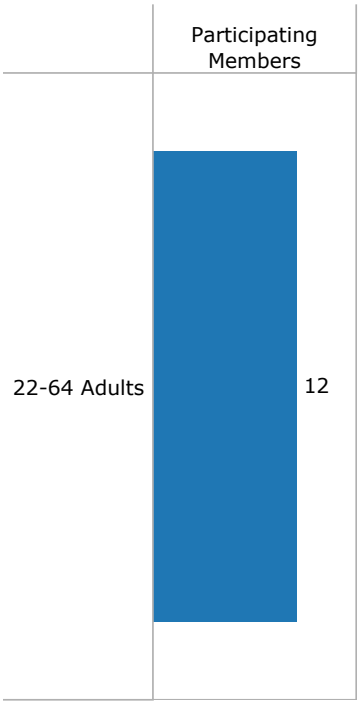
Mbr County
LASSEN

By Gender

7
58.3%

5
41.7%

By Age Group



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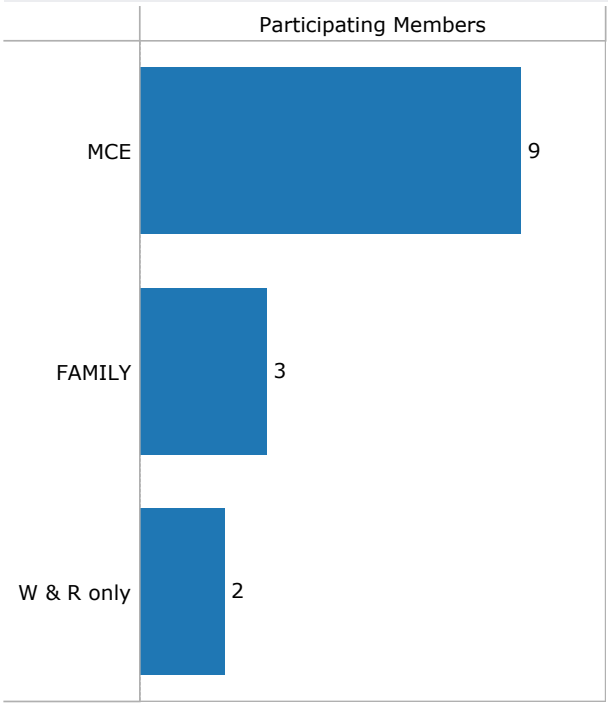
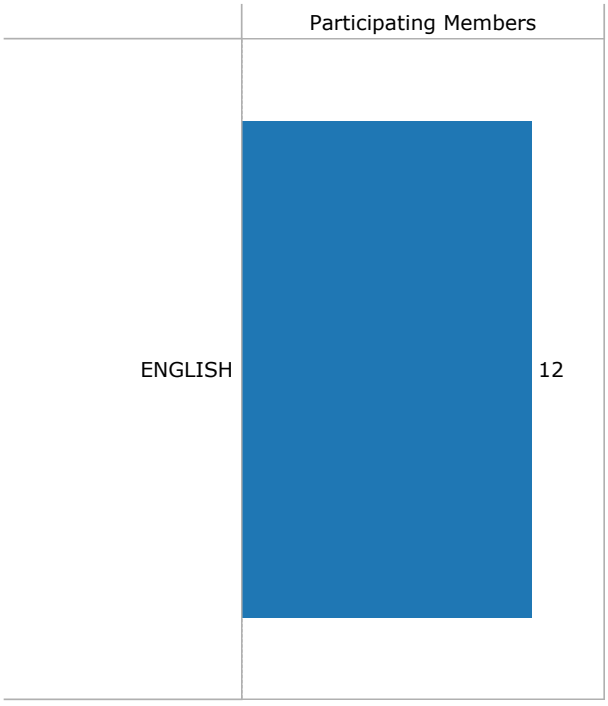


By Language



% of Participation by Ethnicity

Race and Ethnicity group	Member Count	Participation Men
WHITE	5,378	10
HISPANIC	983	1
OTHER	83	1

Wellness and Recovery Demographics of Paid Claims

Demographic distribution of our members

Refreshed on: 3/15/2021 6:30:49 AM

Health Analytics

by: Revanth Kasireddy

County:
MENDOCINO

Service date
7/1/2020 to ..

view by Members/ Total Visits
Participating ..

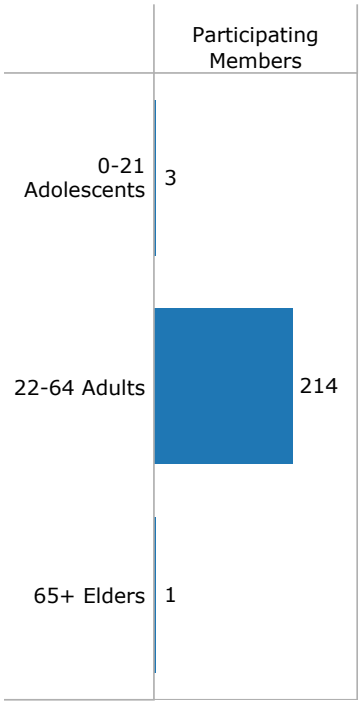
Mbr County
MENDOCINO

By Gender


96
44.0%


122
56.0%

By Age Group



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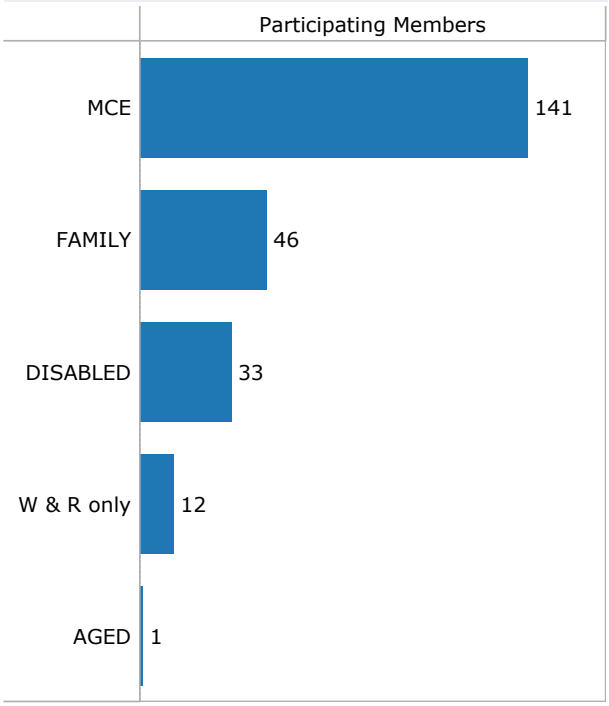

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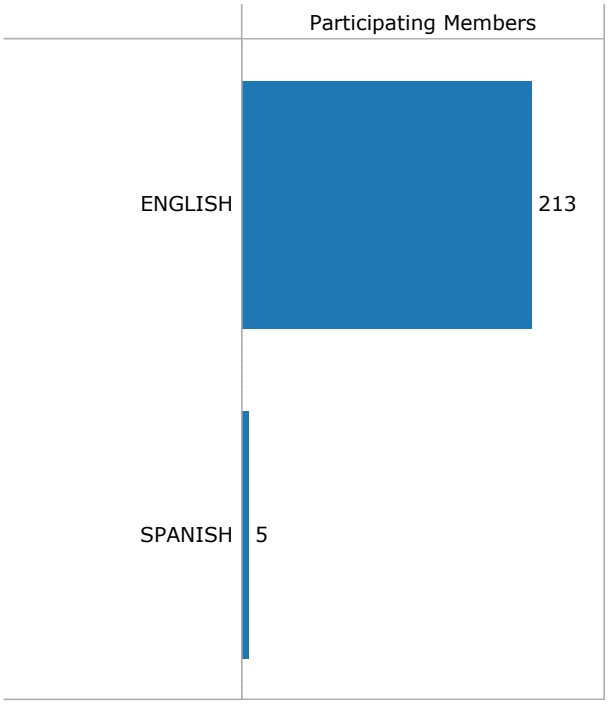


% of Participation by Ethnicity

Race and Ethnicity group	Member Count	Participation Men
WHITE	19,769	163
HISPANIC	12,840	30
OTHER	423	24
ASIAN/PACIFIC ISLANDER	699	1
BLACK	334	3

Wellness and Recovery Demographics of Paid Claims

Demographic distribution of our members

Refreshed on: 3/15/2021 6:30:49 AM

Health Analytics

by: Revanth Kasireddy

County:
MODOC

Service date
7/1/2020 to ..

view by Members/ Total Visits
Participating ..

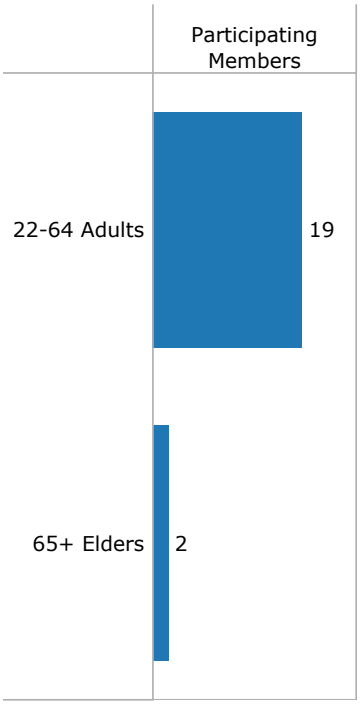
Mbr County
MODOC

By Gender

12
57.1%

9
42.9%

By Age Group



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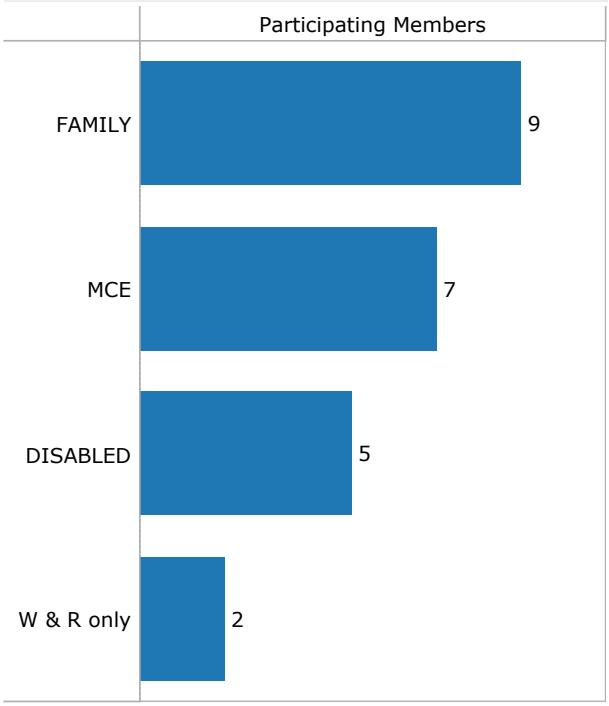

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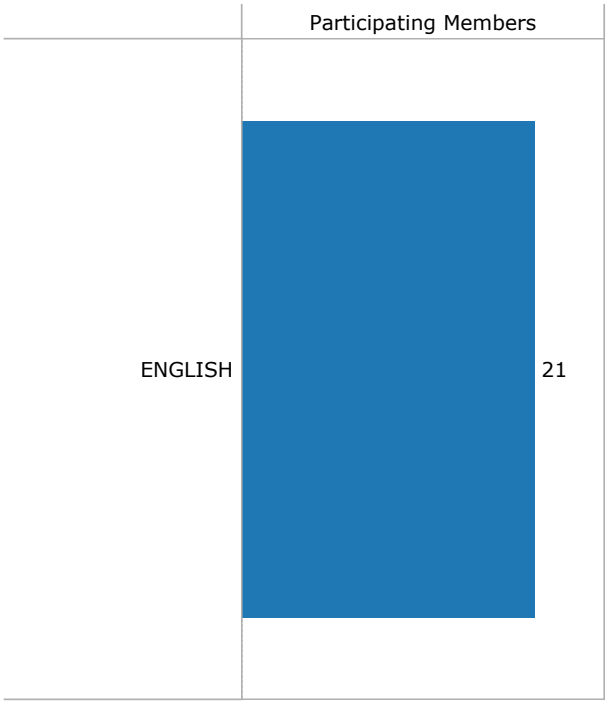


% of Participation by Ethnicity

Race and Ethnicity group	Member Count	Participation Men
WHITE	2,214	17
OTHER	15	3
BLACK	38	1

Wellness and Recovery Demographics of Paid Claims

Demographic distribution of our members

Refreshed on: 3/15/2021 6:30:49 AM

Health Analytics

by: Revanth Kasireddy

County:
SHASTA

Service date
7/1/2020 to ..

view by Members/ Total Visits
Participating ..

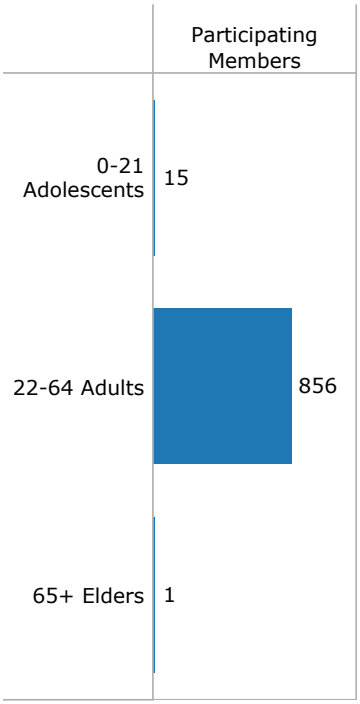
Mbr County
SHASTA

By Gender

422
48.4%

450
51.6%

By Age Group



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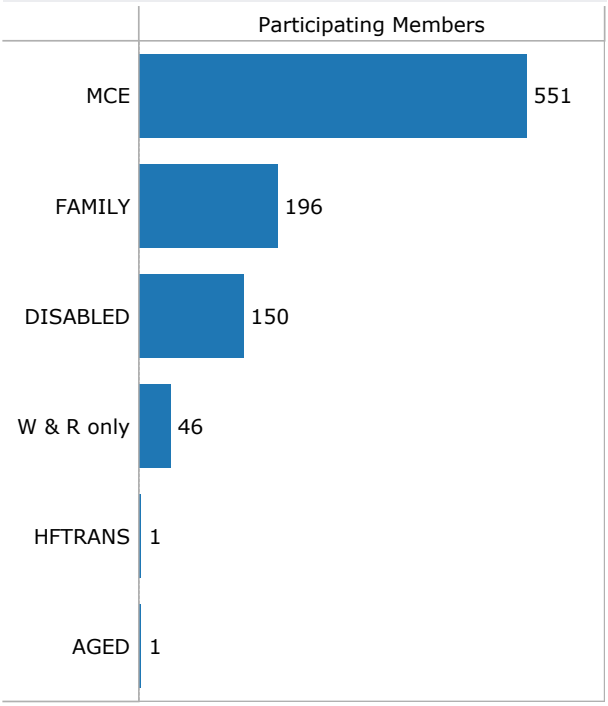

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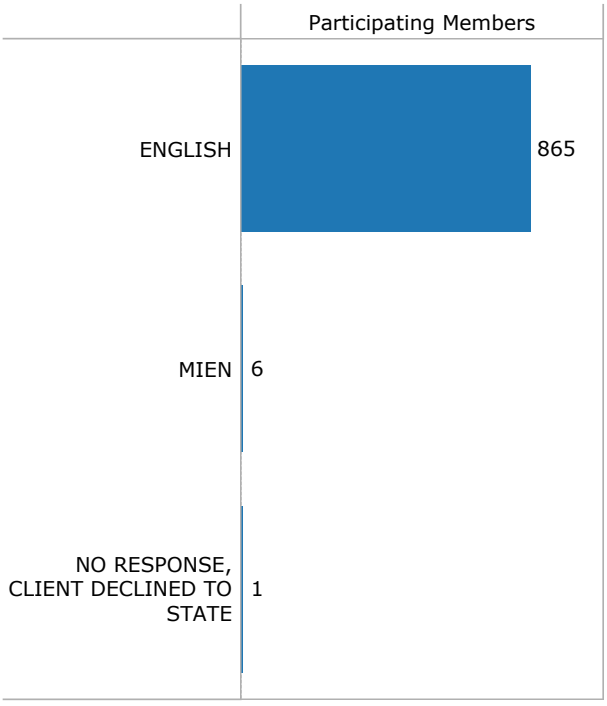


% of Participation by Ethnicity

Race and Ethnicity group	Member Count	Participation Men
WHITE	44,107	734
HISPANIC	6,975	32
OTHER	716	77
ASIAN/PACIFIC ISLANDER	2,550	13
BLACK	1,060	23

Wellness and Recovery Demographics of Paid Claims

Demographic distribution of our members

Refreshed on: 3/15/2021 6:30:49 AM

Health Analytics

by: Revanth Kasireddy

County:
SISKIYOU

Service date
7/1/2020 to ..

view by Members/ Total Visits
Participating ..

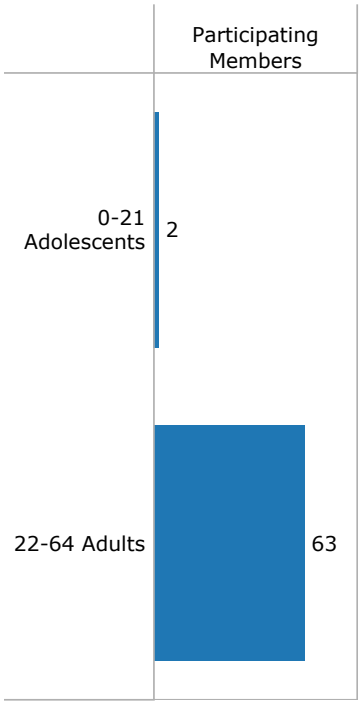
Mbr County
SISKIYOU

By Gender


37
57.8%


27
42.2%

By Age Group



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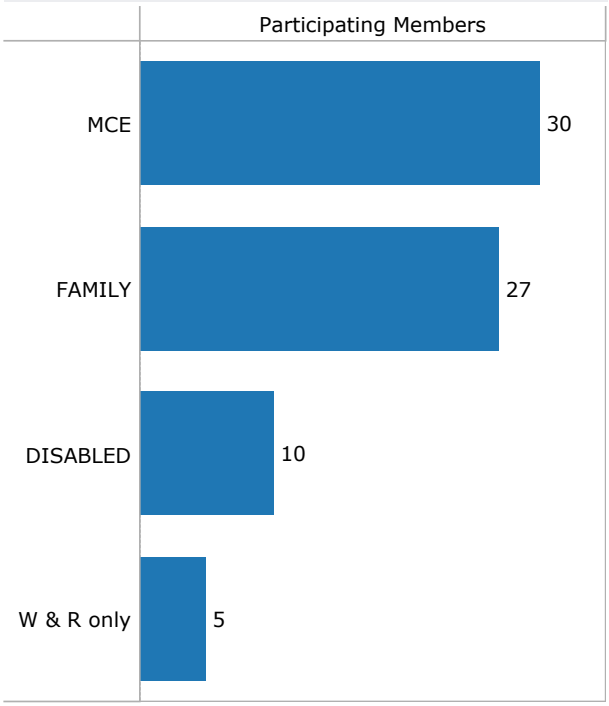

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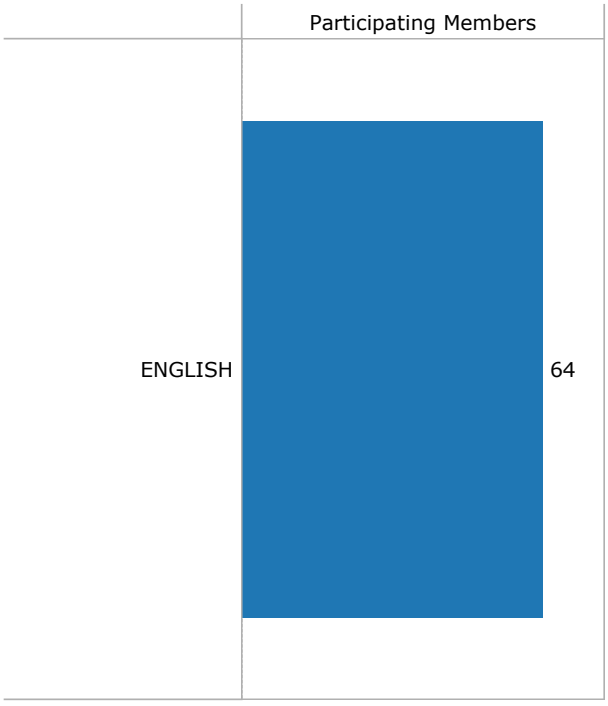


% of Participation by Ethnicity

Race and Ethnicity group	Member Count	Participation Men
WHITE	11,928	51
HISPANIC	2,386	2
OTHER	321	10
ASIAN/PACIFIC ISLANDER	417	1

Wellness and Recovery Demographics of Paid Claims

Demographic distribution of our members

Refreshed on: 3/15/2021 6:30:49 AM

Health Analytics

by: Revanth Kasireddy

County:
SOLANO

Service date
7/1/2020 to ..

view by Members/ Total Visits
Participating ..

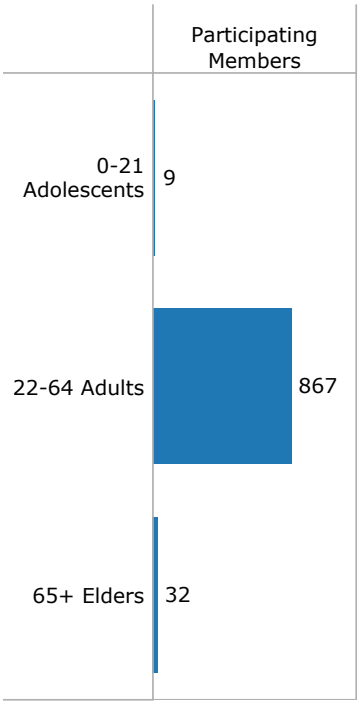
Mbr County
SOLANO

By Gender

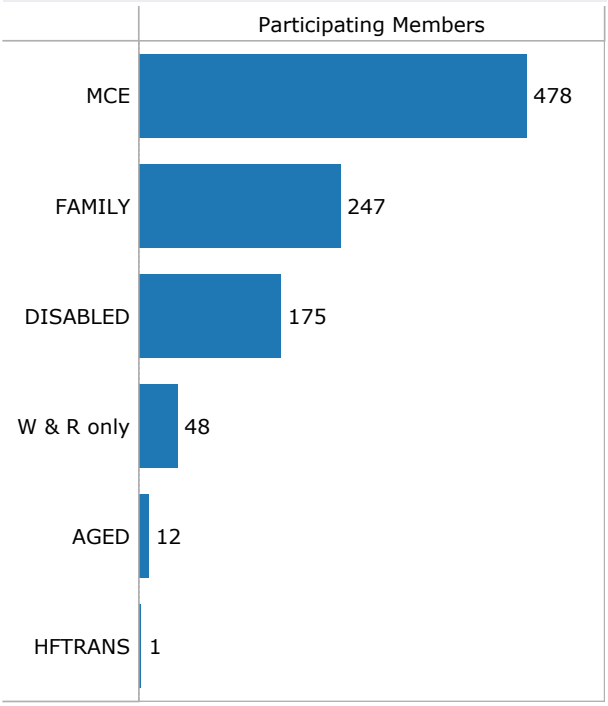
433
47.8%

473
52.2%

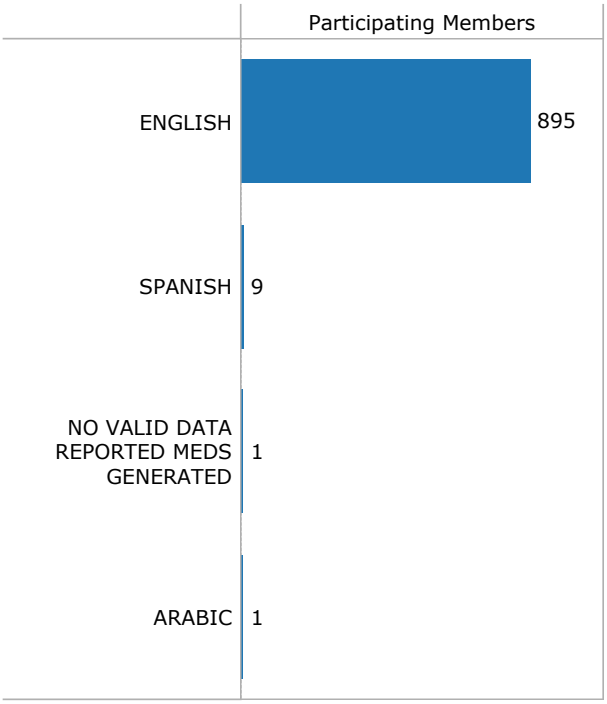
By Age Group



By AIDCAT



By Language



% of Participation by Ethnicity

Race and Ethnicity group	Member Count	Participation Men
WHITE	24,254	407
HISPANIC	38,757	122
OTHER	20,012	218
ASIAN/PACIFIC ISLANDER	14,856	25
BLACK	22,174	190

Treatment Perceptions Survey (TPS) – Adults

PHC Wellness and Recovery Program Report
N=383

November 2020 Survey Period

Prepared on 2/9/2021 by the University of California, Los Angeles

Integrated Substance Abuse Programs

*For regional model/county use only – not for public release. If the regional model/counties choose to release these reports to the public, it is recommended they follow the Data De-Identification Guidelines (DDG) prepared by the California Department of Health Care Services.

Version 2020 v1.0

Table 1. Number of survey forms returned by treatment setting

	Outpatient/ Intensive Outpatient	Residential	Opioid/ Narcotic Treatment Program	Detoxification/ Withdrawal Management	Partial Hospitalization	Missing***	Total
Number of programs *	10	16	4	2	.	1	33
Contra Costa_PHC	.	2	.	.	.	1	3
Humboldt_PHC	2	7	1	.	.	.	10
Lake_PHC	.	1	.	.	.	.	1
Mendocino_PHC	2	2	.	1	.	1	6
Shasta_PHC	3	3	1	.	.	1	8
Siskiyou_PHC	1	.	.	.	.	.	1
Solano_PHC	2	1	2	1	.	.	6
Number of forms returned with responses received **	148	140	80	3	.	12	383
English	148	139	80	3	.	12	382
Spanish	.	1	.	.	.	.	1
Survey methods							
Paper/data entry	100	110	78	3	.	.	291
Online survey	41	30	.	.	.	12	83
Automated phone survey	7	.	2	.	.	.	9

* In this report, program is defined as a unit having a unique combination of CalOMS Provider ID and treatment setting and/or Program Reporting Unit ID (optional) as indicated in the provider list or in the data file submitted to UCLA.

** Only includes survey forms when at least one of the 15 questions are answered. Excluded forms: N=0.

*** Includes records where CalOMS Provider ID or treatment setting were missing in the phone or the online survey.

Table 2. Demographics of survey respondents

Demographics	N	%
Gender (Multiple responses allowed)	.	.
Female	169	44.1
Male	199	52.0
Transgender	1	0.3
Other gender identity	3	0.8
Decline to answer/missing	11	2.9
Age group	.	.
18–25	31	8.1
26–35	146	38.1
36–45	116	30.3
46–55	48	12.5
56+	19	5.0
Decline to answer/missing	23	6.0
Race/ethnicity (Multiple responses allowed)	.	.
American Indian/Alaska Native	27	7.0
Asian	4	1.0
Black/African American	18	4.7
Latinx	28	7.3
Native Hawaiian/Pacific Islander	1	0.3
White	267	69.7
Other	23	6.0
Unknown/missing	25	6.5
How long received services here	.	.
First visit/day	10	2.6
2 weeks or less	53	13.8
More than 2 weeks	309	80.7
Missing	11	2.9

Table 3. Number of responses (percent) for each survey question and average score

Survey Question	Strongly Disagree(1)	Disagree(2)	Neutral(3)	Agree(4)	Strongly Agree(5)	Average Score
Domain: Access						**4.4**
01 Convenient Location	5 (1.4%)	9 (2.5%)	33 (9.0%)	108 (29.6%)	210 (57.5%)	4.4
02 Convenient Time	3 (0.8%)	9 (2.4%)	25 (6.7%)	104 (27.8%)	233 (62.3%)	4.5
Domain: Quality						**4.6**
03 I Chose My Treatment Goals	2 (0.5%)	7 (1.9%)	24 (6.5%)	128 (34.5%)	210 (56.6%)	4.4
04 Staff Gave Me Enough Time	0 (0.0%)	6 (1.6%)	18 (4.8%)	116 (31.2%)	232 (62.4%)	4.5
05 Treated with Respect	2 (0.5%)	4 (1.1%)	22 (5.9%)	76 (20.3%)	271 (72.3%)	4.6
06 Understood Communication	0 (0.0%)	2 (0.5%)	20 (5.3%)	93 (24.8%)	260 (69.3%)	4.6
07 Cultural Sensitivity	2 (0.6%)	5 (1.4%)	28 (7.7%)	85 (23.4%)	243 (66.9%)	4.5
Domain: Care Coordination						**4.4**
08 Work with Physical Health Providers	2 (0.6%)	5 (1.4%)	45 (12.5%)	105 (29.1%)	204 (56.5%)	4.4
09 Work with Mental Health Providers	1 (0.3%)	7 (2.0%)	39 (11.1%)	94 (26.7%)	211 (59.9%)	4.4
Domain: Outcome						**4.6**
10 Better Able to Do Things	0 (0.0%)	2 (0.5%)	23 (6.2%)	110 (29.6%)	236 (63.6%)	4.6
Domain: General Satisfaction						**4.6**
11 Felt Welcomed	0 (0.0%)	4 (1.1%)	16 (4.3%)	87 (23.4%)	265 (71.2%)	4.6
12 Overall Satisfied with Services	0 (0.0%)	4 (1.1%)	15 (4.0%)	99 (26.7%)	253 (68.2%)	4.6
13 Got the Help I Needed	1 (0.3%)	7 (1.9%)	28 (7.6%)	105 (28.5%)	228 (61.8%)	4.5
14 Recommend Agency	0 (0.0%)	6 (1.7%)	15 (4.1%)	86 (23.7%)	256 (70.5%)	4.6

Note: Domain averages based on surveys with complete data within each domain.

Figure 1. Percent of survey respondents in agreement by survey questions and five domains

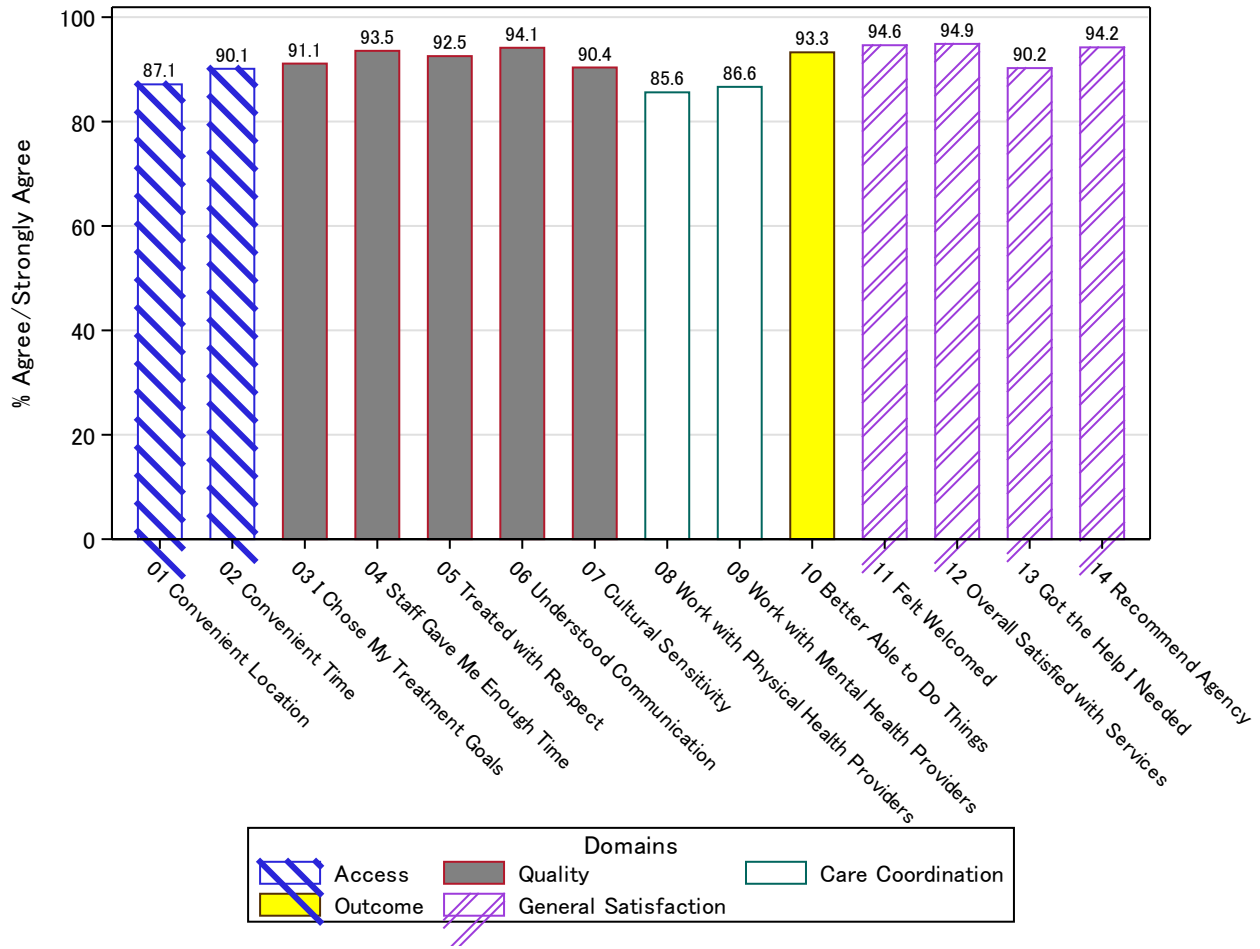


Figure 2. Average score (questions 1–14) by treatment settings

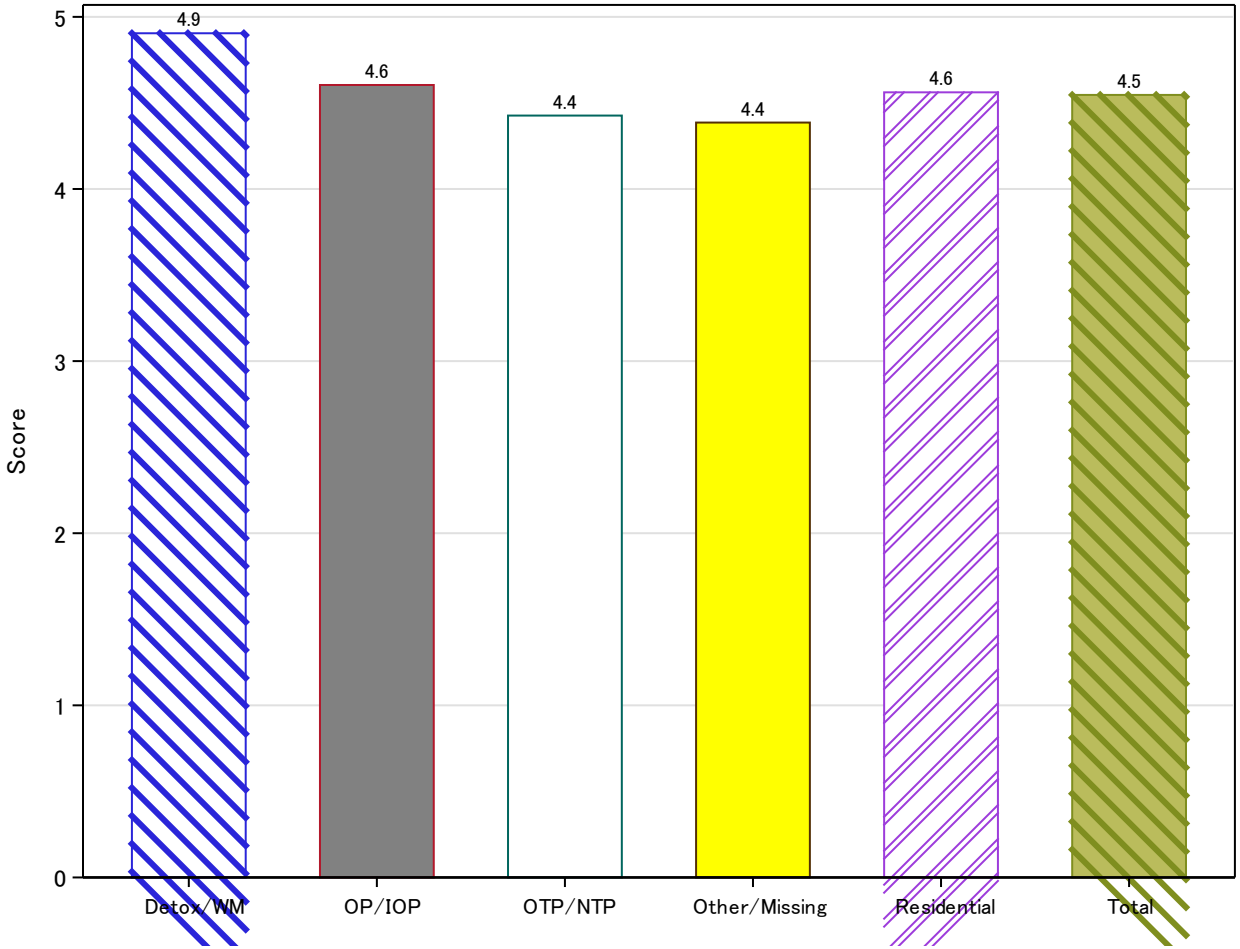


Table 4. Percent of survey respondents in agreement by each survey question and year

Domain	Survey Question	% Agreement 2017	% Agreement 2018	% Agreement 2019	% Agreement 2020	Difference in Percentage (from 2019 to 2020)
Access	01 Convenient Location	N/A	N/A	N/A	87.1	N/A
Access	02 Convenient Time	N/A	N/A	N/A	90.1	N/A
Quality	03 I Chose My Treatment Goals	N/A	N/A	N/A	91.1	N/A
Quality	04 Staff Gave Me Enough Time	N/A	N/A	N/A	93.5	N/A
Quality	05 Treated with Respect	N/A	N/A	N/A	92.5	N/A
Quality	06 Understood Communication	N/A	N/A	N/A	94.1	N/A
Quality	07 Cultural Sensitivity	N/A	N/A	N/A	90.4	N/A
Care Coordination	08 Work with Physical Health Providers	N/A	N/A	N/A	85.6	N/A
Care Coordination	09 Work with Mental Health Providers	N/A	N/A	N/A	86.6	N/A
Outcome	10 Better Able to Do Things	N/A	N/A	N/A	93.3	N/A
General Satisfaction	11 Felt Welcomed	N/A	N/A	N/A	94.6	N/A
General Satisfaction	12 Overall Satisfied with Services *	N/A	N/A	N/A	94.9	N/A
General Satisfaction	13 Got the Help I Needed	N/A	N/A	N/A	90.2	N/A
General Satisfaction	14 Recommend Agency	N/A	N/A	N/A	94.2	N/A

* In the 2017 TPS survey, the wording of question #12 was 'I like the services offered here.'

Table 5. Ranking of programs by percent in agreement with Q12 (overall satisfied with services)

county	Rank	Program	Number of participants *	Q12	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q13	Q14
Contra Costa_PHC	1	070060_PHC	25	**100**	79	92	88	92	100	96	100	84	92	100	100	91	100
Contra Costa_PHC	1	070040_PHC	5	**100**	100	100	100	100	100	100	100	100	100	100	100	100	100
Contra Costa_PHC	.	Missing Provider ID***	9	**100**	100	77	88	77	100	88	100	100	100	100	88	100	100
Humboldt_PHC	1	121215_PHC	11	**100**	100	90	90	100	90	100	80	90	90	90	100	90	100
Humboldt_PHC	1	121366_PHC	8	**100**	75	100	75	100	100	100	100	100	100	100	100	100	100
Humboldt_PHC	1	121210_PHC	7	**100**	100	100	100	100	100	85	85	85	100	100	100	100	100
Humboldt_PHC	1	121208_PHC	4**	**100**	100	100	80	100	100	100	100	100	100	100	100	100	100
Humboldt_PHC	1	121693_PHC	3**	**100**	100	100	100	75	100	100	75	100	75	100	100	100	100
Humboldt_PHC	1	121333_PHC	1**	**100**	100	100	100	100	100	100	100	100	100	100	100	100	100
Humboldt_PHC	1	121563_PHC	1**	**100**	100	100	100	100	100	100	100	0	0	0	100	0	100
Humboldt_PHC	1	121577_PHC	1**	**100**	100	100	.	0	100	100	100	100	100	100	100	100	100
Humboldt_PHC	26	121557_PHC	8	**75**	87	62	87	87	87	75	100	83	66	100	87	62	75
Humboldt_PHC	30	121205_PHC	0**	**.**	.	.	.	.	.	.	.	.	.	.	.	.	.
Lake_PHC	24	171726_PHC	13	**92**	66	92	84	84	100	92	76	84	83	84	83	91	83
Mendocino_PHC	1	230004_PHC	9	**100**	100	100	100	100	88	100	100	100	100	100	100	100	100
Mendocino_PHC	1	232305_PHC	8	**100**	87	100	100	100	100	100	100	87	100	87	100	100	100
Mendocino_PHC	1	230010_PHC	7	**100**	100	100	83	100	100	100	83	60	66	100	100	100	100
Mendocino_PHC	1	230009_PHC	1**	**100**	100	100	100	100	100	100	100	100	0	100	100	0	100
Mendocino_PHC	.	Missing Provider ID***	1**	**100**	.	100	0	100	100	100	0	0	.	100	100	100	100
Shasta_PHC	1	454620_PHC	23	**100**	95	86	91	91	86	90	81	86	91	90	91	82	100
Shasta_PHC	1	454535_PHC	14	**100**	93	93	93	100	80	100	78	92	84	92	92	100	100
Shasta_PHC	19	454528_PHC	44	**97**	90	90	100	97	95	97	97	95	97	97	95	95	97
Shasta_PHC	21	454537_PHC	21	**95**	95	91	100	100	100	100	95	95	95	100	100	100	95

Shasta_PHC	22	454661_PHC	44	**93**	72	81	88	93	88	95	88	79	75	93	95	88	97
Shasta_PHC	26	454523_PHC	8	**75**	50	75	50	75	62	62	62	71	62	62	75	75	75
Shasta_PHC	29	454453_PHC	1**	**0**	0	0	0	0	0	0	0	0	0	0	0	0	0
Shasta_PHC	.	Missing Provider ID***	1**	**100**	100	100	.	100	100	100	100	100	100	100	100	100	100
Siskiyou_PHC	28	474701_PHC	14	**71**	85	85	92	84	85	85	100	69	78	76	100	78	83
Solano_PHC	1	484825_PHC	11	**100**	100	100	100	100	100	100	100	100	100	100	100	100	100
Solano_PHC	1	484803_PHC	2**	**100**	100	100	100	50	100	100	100	100	100	100	100	50	100
Solano_PHC	20	484821_PHC	28	**96**	92	100	96	96	96	92	88	70	88	96	92	92	96
Solano_PHC	22	484806_PHC	31	**93**	84	84	90	93	87	90	84	74	72	84	93	77	83
Solano_PHC	25	484809_PHC	7	**85**	83	100	66	100	85	100	100	100	85	100	71	100	57

* Number of survey participants that answered Q12 for ranking purposes. Ns may vary for each survey question.
** Sample sizes < 5 : Interpret findings with caution. Individual TPS reports will not be provided for programs with Ns<3.
*** Provider ID was missing for these survey participants.

Table 6. Number of responses (percent) for the telehealth question (#15 How much of the services you received was by telehealth?)

Telehealth	Outpatient/ Intensive Outpatient	Residential	Opioid/ Narcotic Treatment Program	Detoxification/ Withdrawal Management	Partial Hospitalization	Missing	Total
None	63 (42.6%)	63 (45.0%)	8 (10.0%)	1 (33.3%)	. (. %)	. (. %)	135 (35.2%)
Very little	31 (20.9%)	44 (31.4%)	33 (41.3%)	1 (33.3%)	. (. %)	. (. %)	109 (28.5%)
About half	18 (12.2%)	13 (9.3%)	21 (26.3%)	1 (33.3%)	. (. %)	1 (8.3%)	54 (14.1%)
Almost all	16 (10.8%)	6 (4.3%)	8 (10.0%)	. (. %)	. (. %)	3 (25.0%)	33 (8.6%)
All	5 (3.4%)	4 (2.9%)	4 (5.0%)	. (. %)	. (. %)	7 (58.3%)	20 (5.2%)
Missing	15 (10.1%)	10 (7.1%)	6 (7.5%)	. (. %)	. (. %)	1 (8.3%)	32 (8.4%)
Any Telehealth (Regional)	70 (47.3%)	67 (47.9%)	66 (82.5%)	2 (66.7%)	. (. %)	11 (91.7%)	216 (56.4%)
Any Telehealth							
Contra Costa_PHC	. (. %)	26 (86.7%)	. (. %)	. (. %)	. (. %)	9 (90.0%)	35 (87.5%)
Humboldt_PHC	9 (75.0%)	20 (58.8%)	2 (100.0%)	. (. %)	. (. %)	. (. %)	31 (64.6%)
Lake_PHC	. (. %)	8 (61.5%)	. (. %)	. (. %)	. (. %)	. (. %)	8 (61.5%)
Mendocino_PHC	11 (73.3%)	4 (44.4%)	. (. %)	1 (100.0%)	. (. %)	1 (100.0%)	17 (65.4%)
Shasta_PHC	33 (48.5%)	6 (12.5%)	37 (82.2%)	. (. %)	. (. %)	1 (100.0%)	77 (47.5%)
Siskiyou_PHC	8 (57.1%)	. (. %)	. (. %)	. (. %)	. (. %)	. (. %)	8 (57.1%)
Solano_PHC	9 (23.1%)	3 (50.0%)	27 (81.8%)	1 (50.0%)	. (. %)	. (. %)	40 (50.0%)

Treatment Perceptions Survey (TPS) – Youth

PHC Wellness and Recovery Program Report
N=5

November 2020 Survey Period

Prepared on 2/9/2021 by the University of California, Los Angeles

Integrated Substance Abuse Programs

*For regional model/county use only – not for public release. If the regional model/counties choose to release these reports to the public, it is recommended they follow the Data De-Identification Guidelines (DDG) prepared by the California Department of Health Care Services.

Version 2020 v1.0

Table 1. Number of survey forms returned by treatment setting

	Outpatient/ Intensive Outpatient	Residential	Opioid/ Narcotic Treatment Program	Detoxification/ Withdrawal Management	Partial Hospitalization	Missing***	Total
Number of programs *	1	.	.	.	.	.	1
Humboldt_PHC	1	.	.	.	.	.	1
Number of forms returned with responses received **	5	.	.	.	.	.	5
English	5	.	.	.	.	.	5
Survey methods							
Paper/data entry	5	.	.	.	.	.	5

* In this report, program is defined as a unit having a unique combination of CalOMS Provider ID and treatment setting and/or Program Reporting Unit ID (optional) as indicated on the survey forms or in the data file submitted to UCLA.

** (1) Only includes survey forms when at least one of the 18 questions are answered. (Excluded forms: N=0.)
(2) Only includes survey forms when respondents are between the ages of 12 and 20. (Excluded forms: N=0.)

*** Includes records where CalOMS Provider ID or treatment setting were missing in the phone or the online survey.

Table 2. Demographics of survey respondents

Demographics	N	%
Gender (Multiple responses allowed)	.	.
Female	4	80.0
Male	1	20.0
Age group	.	.
12–15	2	40.0
16	2	40.0
17+	1	20.0
Race/ethnicity (Multiple responses allowed)	.	.
American Indian/Alaskan Native	1	20.0
Latinx	2	40.0
White	3	60.0
How long received services here	.	.
Less than 1 month	2	40.0
1–5 months	1	20.0
6 months or more	2	40.0

* Includes EPSDT youth ages 18–20 who received services in youth programs (N=1).

Table 3. Number of responses (percent) for each survey question and average score

Survey Question	Strongly Disagree(1)	Disagree(2)	Neutral(3)	Agree(4)	Strongly Agree(5)	Average Score
Domain: Access						**4.1**
01 Convenient Location	0 (0.0%)	0 (0.0%)	1 (20.0%)	2 (40.0%)	2 (40.0%)	4.2
02 Convenient Time	0 (0.0%)	0 (0.0%)	0 (0.0%)	4 (80.0%)	1 (20.0%)	4.2
03 Good Enrollment Experience	0 (0.0%)	0 (0.0%)	1 (20.0%)	3 (60.0%)	1 (20.0%)	4.0
Domain: Quality						**4.3**
05 I Received the Right Services	0 (0.0%)	0 (0.0%)	1 (20.0%)	2 (40.0%)	2 (40.0%)	4.2
06 Treated with Respect	0 (0.0%)	0 (0.0%)	0 (0.0%)	3 (60.0%)	2 (40.0%)	4.4
09 Cultural Sensitivity	0 (0.0%)	0 (0.0%)	0 (0.0%)	4 (80.0%)	1 (20.0%)	4.2
15 Provided Family Services	0 (0.0%)	0 (0.0%)	0 (0.0%)	2 (50.0%)	2 (50.0%)	4.5
Domain: Therapeutic Alliance						**4.4**
04 Worked with Counselor on Goals	0 (0.0%)	0 (0.0%)	1 (20.0%)	1 (20.0%)	3 (60.0%)	4.4
07 Counselor Listened	0 (0.0%)	0 (0.0%)	0 (0.0%)	2 (40.0%)	3 (60.0%)	4.6
08 Positive/Trusting Relationship with Counselor	0 (0.0%)	0 (0.0%)	1 (20.0%)	1 (20.0%)	3 (60.0%)	4.4
10 Counselor Interested in Me	0 (0.0%)	0 (0.0%)	0 (0.0%)	4 (80.0%)	1 (20.0%)	4.2
11 Liked Counselor	0 (0.0%)	0 (0.0%)	1 (20.0%)	2 (40.0%)	2 (40.0%)	4.2
12 Counselor Capable of Helping	0 (0.0%)	0 (0.0%)	0 (0.0%)	3 (60.0%)	2 (40.0%)	4.4
Domain: Care Coordination						**4.1**
13 Health/Emotional Health Needs Being Met	0 (0.0%)	0 (0.0%)	0 (0.0%)	4 (80.0%)	1 (20.0%)	4.2
14 Helped with Other Issues/Concerns	0 (0.0%)	0 (0.0%)	1 (20.0%)	3 (60.0%)	1 (20.0%)	4.0
Domain: Outcome						**3.8**
16 Better Able to Do Things	0 (0.0%)	0 (0.0%)	2 (40.0%)	2 (40.0%)	1 (20.0%)	3.8
Domain: General Satisfaction						**4.0**
17 Overall Satisfied with Services	0 (0.0%)	0 (0.0%)	1 (20.0%)	2 (40.0%)	2 (40.0%)	4.2
18 Recommend Services	0 (0.0%)	0 (0.0%)	2 (40.0%)	2 (40.0%)	1 (20.0%)	3.8

Note: Domain averages based on surveys with complete data within each domain.

Figure 1. Percent of survey respondents in agreement by survey questions and six domains

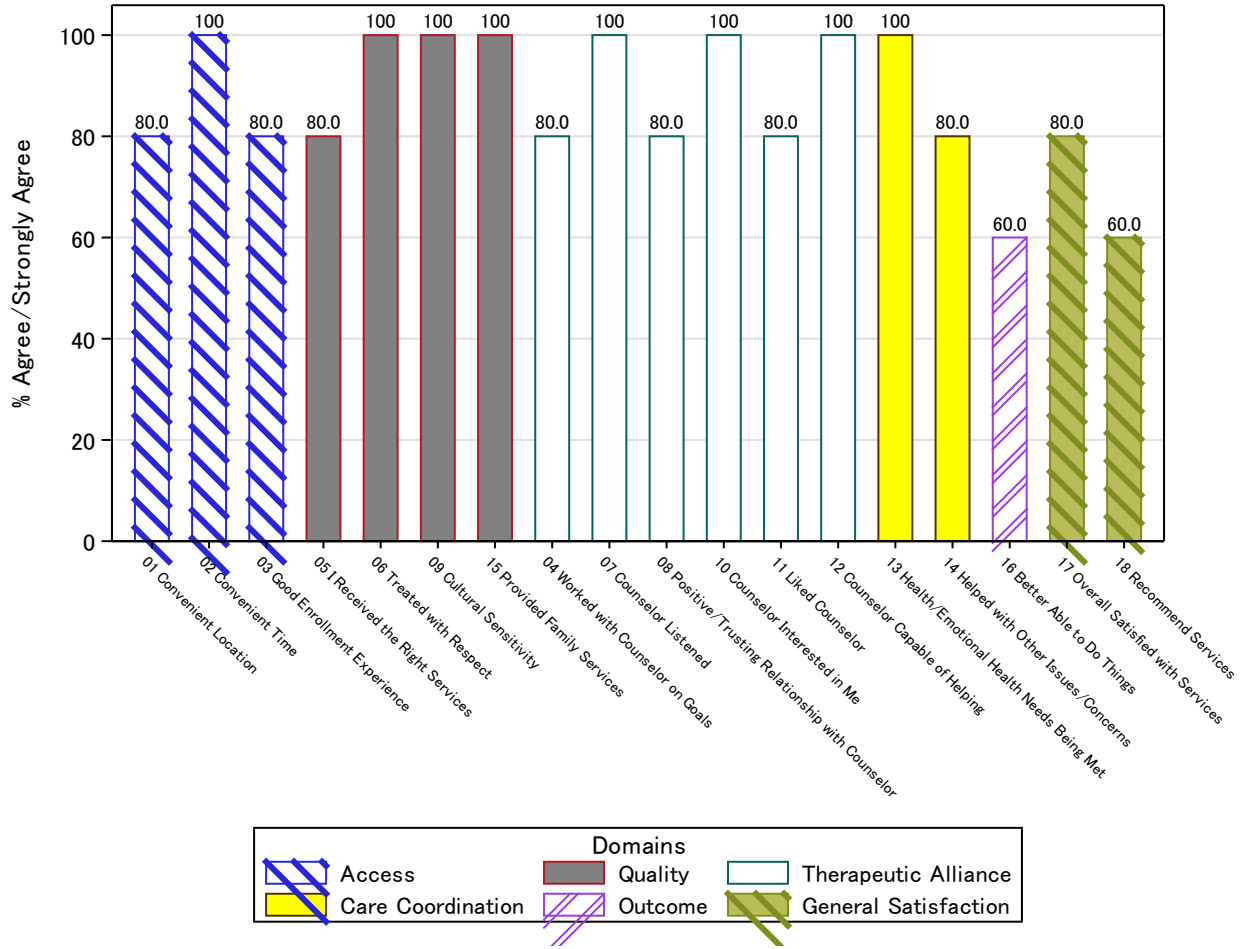


Figure 2. Average score (questions 1-18) by treatment settings

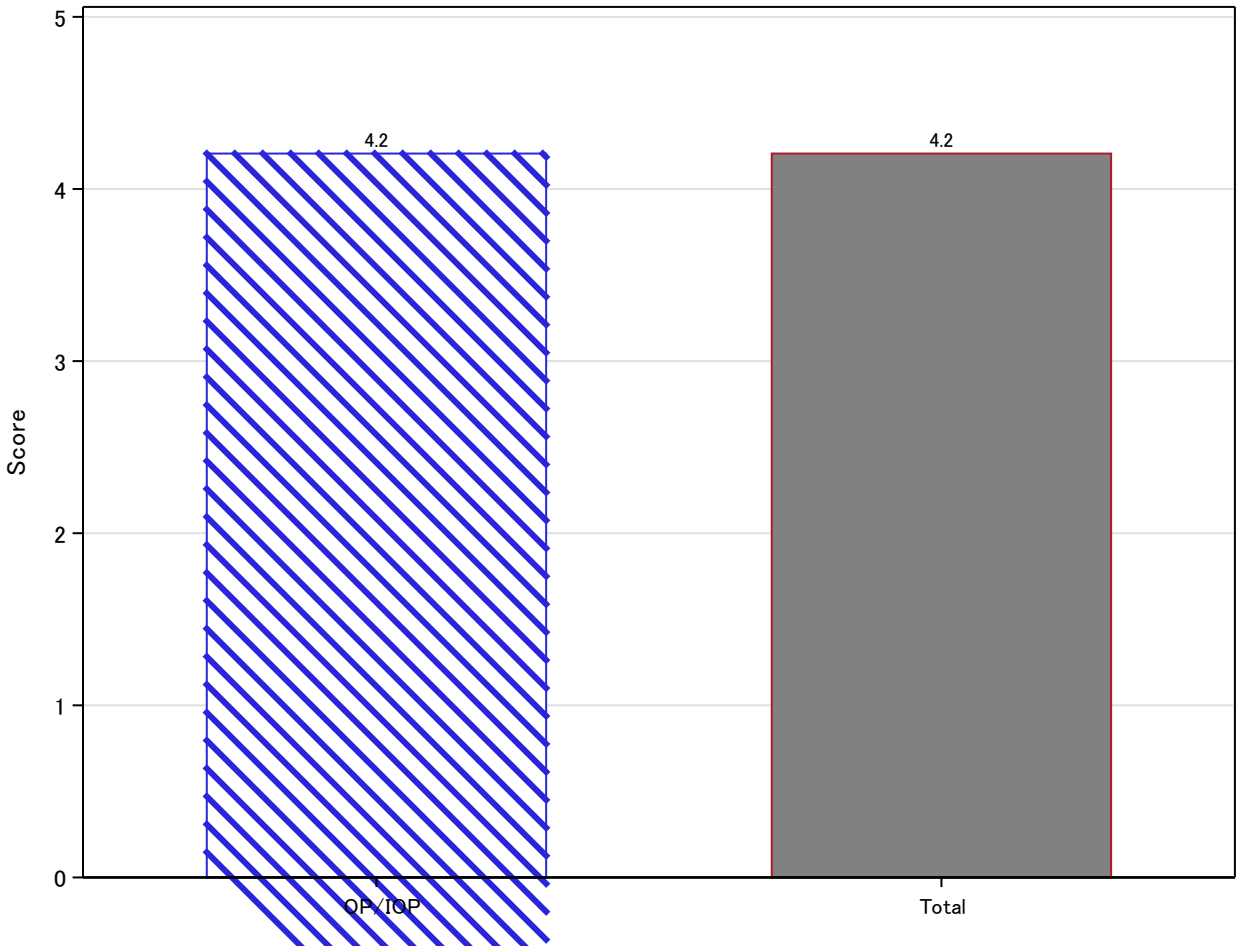


Table 4. Percent of survey respondents in agreement by each survey question and year

Domains	Survey Question	% Agreement 2018	% Agreement 2019	% Agreement 2020	Difference in Percentage (from 2019 to 2020)
Access	01 Convenient Location	N/A	N/A	80.0	N/A
Access	02 Convenient Time	N/A	N/A	100	N/A
Access	03 Good Enrollment Experience	N/A	N/A	80.0	N/A
Quality	05 I Received the Right Services	N/A	N/A	80.0	N/A
Quality	06 Treated with Respect	N/A	N/A	100	N/A
Quality	09 Cultural Sensitivity	N/A	N/A	100	N/A
Quality	15 Provided Family Services	N/A	N/A	100	N/A
Therapeutic Alliance	04 Worked with Counselor on Goals	N/A	N/A	80.0	N/A
Therapeutic Alliance	07 Counselor Listened	N/A	N/A	100	N/A
Therapeutic Alliance	08 Positive/Trusting Relationship with Counselor	N/A	N/A	80.0	N/A
Therapeutic Alliance	10 Counselor Interested in Me	N/A	N/A	100	N/A
Therapeutic Alliance	11 Liked Counselor	N/A	N/A	80.0	N/A
Therapeutic Alliance	12 Counselor Capable of Helping	N/A	N/A	100	N/A
Care Coordination	13 Health/Emotional Health Needs Being Met	N/A	N/A	100	N/A
Care Coordination	14 Helped with Other Issues/Concerns	N/A	N/A	80.0	N/A
Outcome	16 Better Able to Do Things	N/A	N/A	60.0	N/A
General Satisfaction	17 Overall Satisfied with Services	N/A	N/A	80.0	N/A
General Satisfaction	18 Recommend Services	N/A	N/A	60.0	N/A

Table 5. Ranking of programs by percent in agreement with Q17 (overall satisfied with services)

county	Rank	Program	Number of participants *	Q17	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Q13	Q14	Q15	Q16	Q18
Humboldt_PHC	1	121210_PHC	5	**80**	80	100	80	80	80	100	100	80	100	100	80	100	100	80	100	60	60

* Number of survey participants that answered Q17 for ranking purposes. Ns may vary for each survey question.

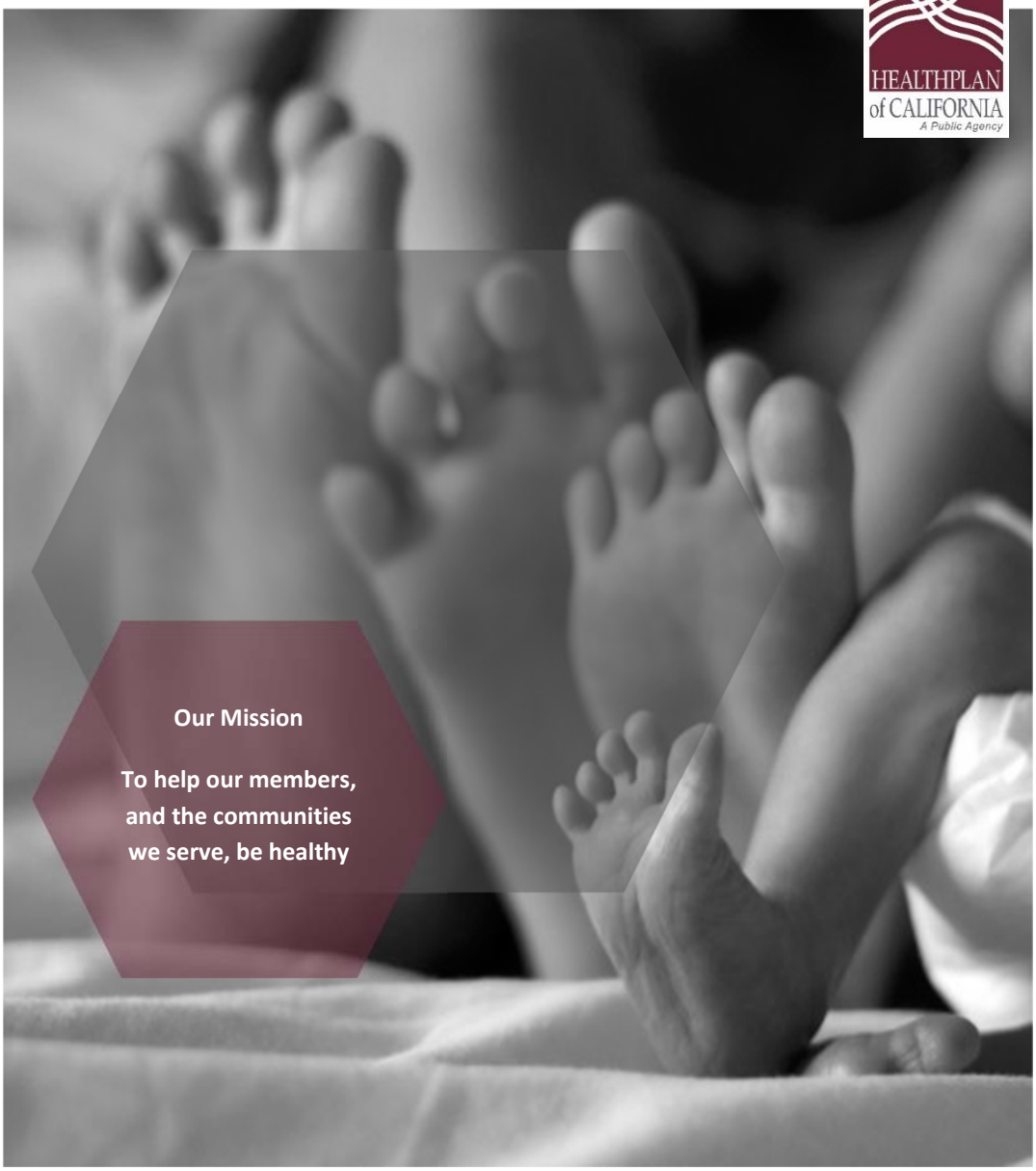
** Sample sizes < 5 : Interpret findings with caution. Individual TPS reports will not be provided for programs with Ns<3.

*** Provider ID was missing for these survey participants.

Table 6. Number of responses (percent) for the telehealth question (#19 How much of the services you received was by telehealth?)

Telehealth	Outpatient/ Intensive Outpatient	Residential	Opioid/ Narcotic Treatment Program	Detoxification/ Withdrawal Management	Partial Hospitalization	Missing	Total
None	1 (20.0%)	. (. %)	. (. %)	. (. %)	. (. %)	. (. %)	1 (20.0%)
Very little	1 (20.0%)	. (. %)	. (. %)	. (. %)	. (. %)	. (. %)	1 (20.0%)
Almost all	2 (40.0%)	. (. %)	. (. %)	. (. %)	. (. %)	. (. %)	2 (40.0%)
All	1 (20.0%)	. (. %)	. (. %)	. (. %)	. (. %)	. (. %)	1 (20.0%)
Any Telehealth (Regional)	4 (80.0%)	. (. %)	. (. %)	. (. %)	. (. %)	. (. %)	4 (80.0%)
Any Telehealth							
Humboldt_PHC	4 (80.0%)	. (. %)	. (. %)	. (. %)	. (. %)	. (. %)	4 (80.0%)

GRIEVANCE & APPEALS
THE PULSE REPORT



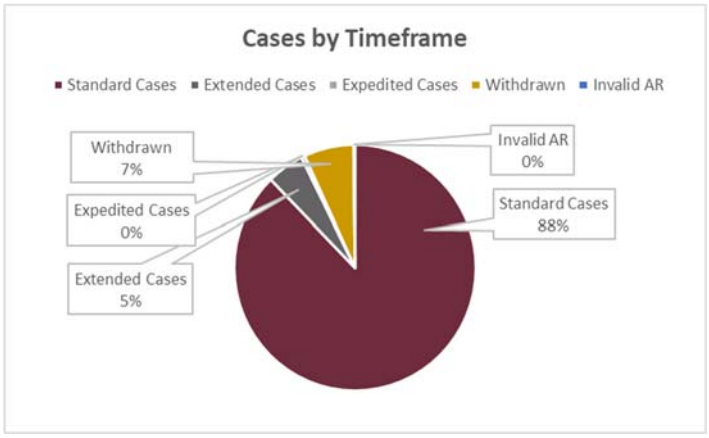
INSIDE THIS ISSUE

G&A PULSE REPORT

VOLUME 1 | MARCH 2021

Welcome to our very first G&A PULSE Report! The purpose of this report is to provide objective updates to all stakeholders regarding trending disruptions that members experience as expressed through Appeals, Grievances, Exempt Grievances, and State Hearings. Reports will be published quarterly.

Partnership HealthPlan of California (PHC) is committed to member satisfaction. When members understand their PHC Medi-Cal benefits, understand how to access them, and service meets expectations, we believe members are likely to seek care and maintain their health. We invite all members to tell us about their concerns or challenges they encounter so that we can help remove any barriers. We take great pride in the trust that members have in us to resolve their concerns.



4Q20 TOTAL # INVESTIGATED CASES			
Case Type	# Cases	Avg Days	% Grand TTL
Grievance	680	25	63.8%
Exempt	190	1	17.8%
Appeal	155	25	14.6%
State Hearings	36	80	3.4%
Grievance-Invalid AR	2	4	0.2%
Grievance-2nd Level	2	12	0.2%
Grand Total	1,065	23	100.0%

4Q20 TRENDS

THE NUMBERS

There were 1,065 cases investigated of which 99.8% were investigated timely. All members were notified that their case was received within five (5) days of receipt, resulting in 100% timely notice. An Administrative Law Judge approved a member's request for a continuous rotation bed in a State Hearing (see CCS Related page for more information).

TOP TRENDS DURING 4Q20

The #1 member-reported issue based on volume is the provider's service. Members disagreed with their provider's plan of care, experienced communication issues, or had problems scheduling appointments. Communication-related problems involve barriers, breakdowns, or disagreements with providers. They often result in members requesting a change in their primary care provider. Also notable, members contested denied lodging under the non-medical transportation benefit or requesting longer lodging requests than initially approved.

OTHER NOTEWORTHY MENTIONS

Diagnostic Testing - The number of Appeals regarding diagnostic testing doubled from 3Q20 to 4Q20, 9 cases to 17 respectively. The most commonly disputed benefit was a denied MRI. Medical records demonstrating medical necessity by meeting PHC Policies and/or InterQual® criteria was submitted through the Appeal process, resulting in approval on most Appeal cases.

Diabetic Supplies - Members continued to report service issues with Solara Medical Supplies. There were notable delays, incorrect supplies, and/or damaged glucometer supplies shipped to members. Customer Service wait times were reportedly one-hour long, Treatment Authorization Requests (TAR) were delayed, and Solara failed to ship products that were ready for shipment. The Provider Relations team is working with Solara to improve service.

In 4Q20, only 0.70 cases filed per every 1,000 PHC members

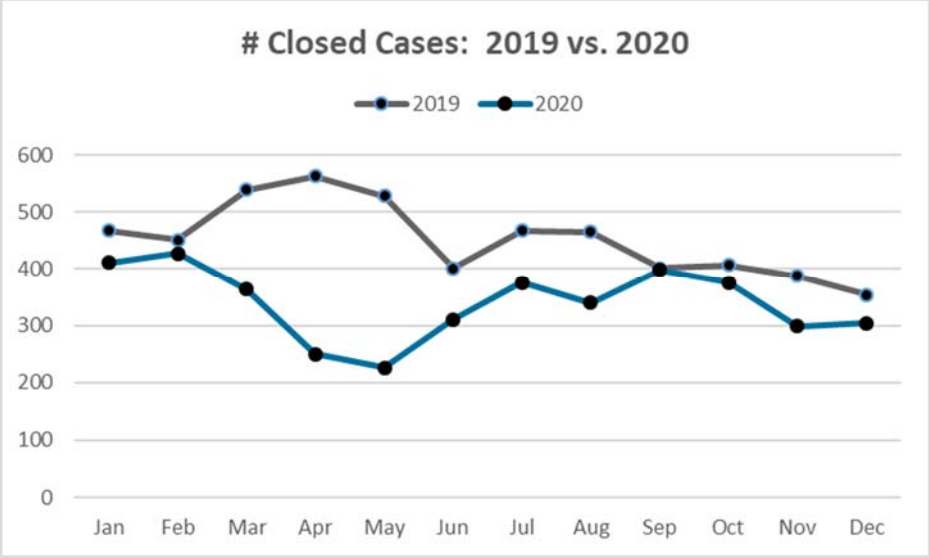
Amrit did a great job listening to me. Five stars for her help!

-Yelp Reviewer

KEY STATISTICS

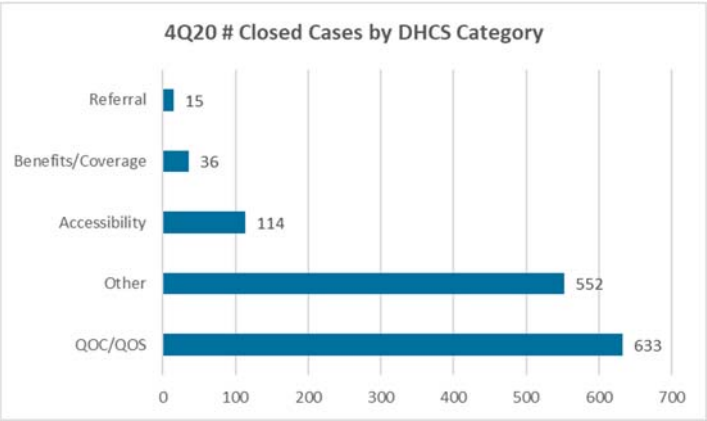
CHARTS OF KEY REPORTING TRENDS

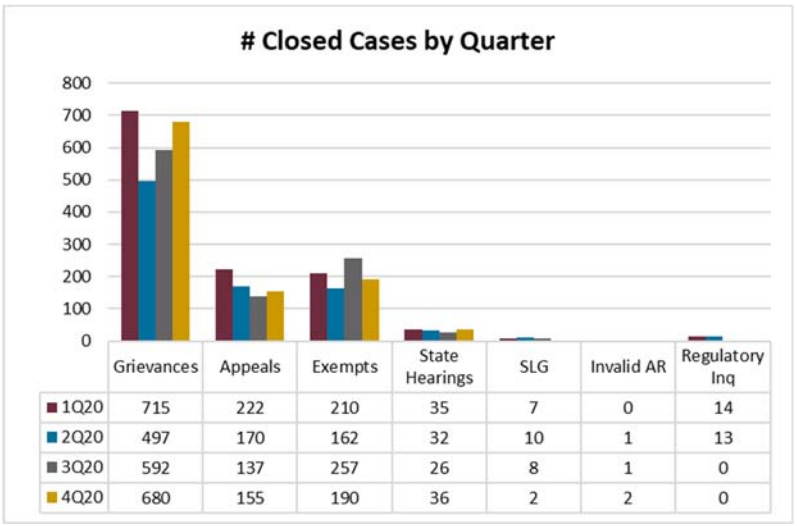
The following charts represent key data metrics used to track and trend Appeals, Grievances, Second Level Grievances, and State Hearings over time.



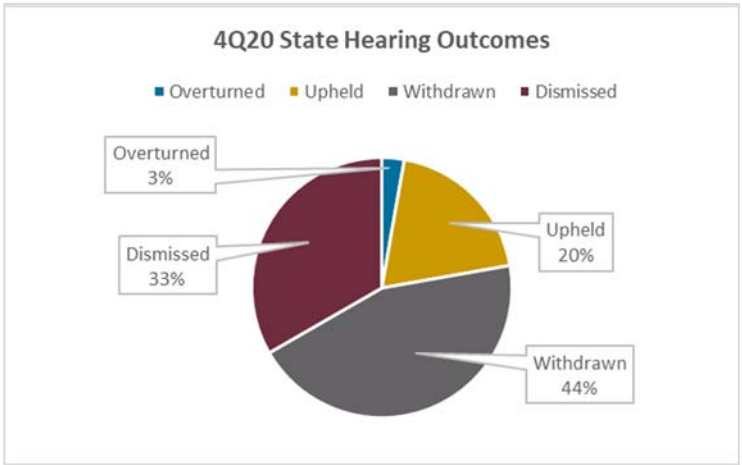
PHC provided coverage to 583,949 members in December 2020, the highest membership in PHC's history

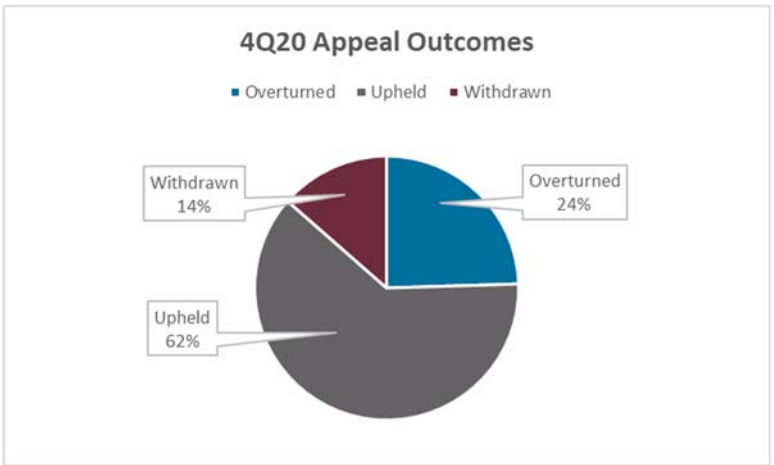
# Closed Cases by Quarter			
1Q20	2Q20	3Q20	4Q20
1,203	885	1,021	1,065





	Grievances	Appeals	Exempts	State Hearings	SLG	Invalid AR	Regulatory Inq
1Q20	715	222	210	35	7	0	14
2Q20	497	170	162	32	10	1	13
3Q20	592	137	257	26	8	1	0
4Q20	680	155	190	36	2	2	0





DEMOGRAPHICS

CHARACTERISTICS OF FILING MEMBERS

The following charts represent key demographic data of members who filed an Appeal, Grievance, Second Level Grievance, or State Hearing during 4Q20.

4Q20 % CASES BY AGE

MBR Age	% Cases
Age 0-17	11.42%
Age 18-45	29.96%
Age 46-65	47.89%
Age 66-100	10.72%
Grand Total	**100.00%**

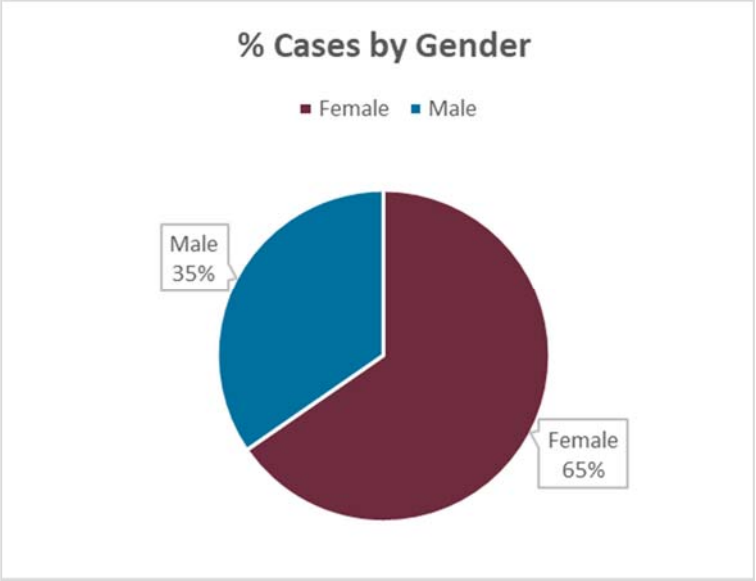
4Q20 % CASES BY ETHNICITY

MBR Ethnicity	% Cases
White	65.47%
Hispanic	13.62%
Other	11.25%
African American	5.89%
Alaskan Native or American Ind	2.28%
Other Asian	0.44%
Vietnamese	0.26%
Asian Indian	0.18%
Cambodian	0.18%
Filipino	0.18%
Guamanian	0.09%
Hawaiian	0.09%
Korean	0.09%
Grand Total	**100.00%**

4Q20 % CASES BY LANGUAGE

MBR Language	% Cases
English	92.71%
Spanish	6.59%
American Sign Language	0.18%
Unknown	0.18%
Tagalog	0.18%
Vietnamese	0.18%
Grand Total	**100.00%**

The most common filing member was a white female between 45-65 years old who lives in Shasta County and speaks English



4Q20 % CASES BY MBR COUNTY

MBR County	% Cases
Shasta	17.66%
Solano	17.40%
Sonoma	13.88%
Humboldt	10.19%
Marin	9.40%
Yolo	7.03%
Siskiyou	6.06%
Lake	4.66%
Napa	4.39%
Mendocino	3.87%
Del Norte	2.72%
Lassen	1.41%
Modoc	0.88%
Trinity	0.44%
Grand Total	**100.00%**

Shasta county members represented 10.8% of all PHC's total membership, yet they filed the most cases

W&R RELATED

THE BENEFIT REVIEWED

Effective July 1, 2020, PHC offers a new Wellness & Recovery (W&R) benefit. It provides coverage for those who strive to be free of drug and/or alcohol addictions. Services include outpatient treatment, intensive outpatient treatment, residential treatment, withdrawal management, opioid treatment, medication assisted treatment, recovery services, and case management. Available on www.partnershiphp.org, the Drug Medi-Cal Organized Delivery System Wellness and Recovery Handbook provides a detailed description of each benefit. The W&R benefit is available to PHC members and non-PHC members who live in Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, and Solano counties.

TRENDING STATISTICS & ISSUES

There were four (4) new W&R cases reported in 4Q20. This represents 0.4% of all 1,065 reported concerns. With only four cases filed, there were no trends identified. However, one case revealed a general opportunity to improve education regarding the availability of the residential treatment benefit to those under 18 years old. The W&R Member Handbook states 30-days of residential treatment is available to youths when medically necessary and prior authorization has been approved by PHC. Furthermore, members who are eligible for Early Periodic Screening, Diagnosis, and Treatment (EPSDT) screening may be eligible to waive the 30-day limit if medical necessity establishes a need for ongoing residential treatment. Investigations also identified a need to make it easier for members to locate residential treatment facilities who can serve the youth population on PHC's website. Until such enhancements are implemented, PHC's Care Coordination team can help any member find a qualifying treatment facility and coordinate the necessary approvals.

4Q20 W&R Case Inventory	
# Total New Cases	4
# of Received Grievances	4
# of Received Appeals	0
# Total Closed Cases	5
# of Grievance Resolutions	5
# of Appeal Resolutions	0

4Q20 DHCS Appeal Outcomes	
Appeal Resolution Outcomes	
# of Appeals Resolved in Favor of PHC	0
# of Appeals Resolved in Favor of Member	0

4Q20 DHCS Grievance Categories	
Access to Care	1
Quality of Care	0
Program Requirements	0
Failure to Respect Enrollee's Rights	0
Interpersonal Relationship Issues	3
Other	0

DHCS REPORTING

The Department of Health Care Services (DHCS) has unique requirements for reporting W&R Cases. The three tables within this section reflect the counts provided by PHC on behalf of participating W&R-counties to DHCS, as mandated quarterly. For 4Q20, there were four (4) cases received related to members' experience with the W&R program, while five (5) cases were closed from the previous quarter. Note that there were no Appeal cases or State Hearings filed.

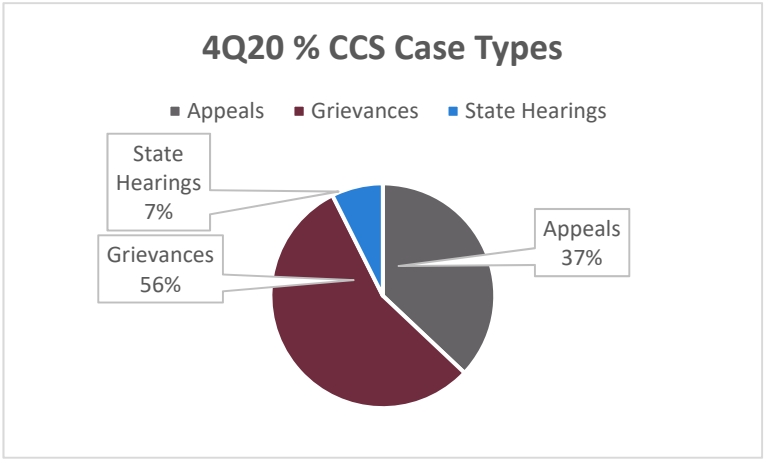
CCS RELATED

THE BENEFIT REVIEWED

Since January 1, 2019, PHC has offered California Children Services (CSS) through PHC's Whole Child Model (WCM). It provides coverage for children under 21 years old with certain diseases, physical limitations, or chronic health problems. This benefit offers improved coordination of care for CCS and non-CCS services. Like all Medi-Cal-coverage, PHC does not determine a member's eligibility for CCS services. Members must consult with their local county, who will notify PHC.

TRENDING STATISTICS & ISSUES

There were 27 total CCS-related cases reported by members in 4Q20. This represents 2.5% of all 1,065 reported concerns. The most contested benefit was durable medical equipment (DME). There were no notable trends within the DME category. Members filed a variety of cases regarding wheelchairs, specialty beds, diabetic supplies, and other supply needs. The second most contested benefit was gas mileage reimbursement claims denied under the Non-Medical Transportation benefit. Members filed cases seeking reimbursement for claims filed beyond the 90-day time filing limit or when they encountered problems with their driver's credentials.



LOST STATE HEARING

There was one State Hearing overturned by an Administrative Law Judge (ALJ) from the Department of Social Services. The member was diagnosed with cerebral palsy, was immobile, needed continuous head elevation, and required a higher level of care to prevent stage 3-4 pressure ulcers. Cared for by home health nurses, the parents requested a continuous lateral rotation hospital bed for the member. The ALJ approved coverage for a specialized rotation bed by Freedom Bed™, absent of PHC not offering an identifiable solution that meets the member's holistic medical needs at a lower cost.

DISCRIMINATION & QUALITY HEALTHCARE

PHC monitors all reported cases to ensure all members have quality, equal and just access to healthcare services. We are pleased to report there were no discrimination cases filed by any CCS members during 4Q20. One member reported their provider was negligent in managing their health by refusing to perform testing, ultimately missing the diagnosis of nasopharyngeal cancer later identified during a hospitalization. The case was referred to PHC's Quality Improvement department for a comprehensive clinical review of the provider's care.

DISCRIMINATION

IN RESPONSE TO A SOCIAL MOVEMENT

PHC stands strong against discrimination. It clouds our vision – to be the most highly regarded managed care plan in California. It interrupts our mission – to help our members, and the communities we serve, be healthy. It interferes with our responsibility. We are proudly responsible for the healthcare of every single member in our diverse population. We want to know that all members are treated equally and have the same opportunities to seek care. This is why we revisited our policies and procedures on how we handle discrimination.

On October 13, 2020, our Physician Advisory Committee (PAC) approved the newly revised PHC Policy CGA022, formally called the Member Discrimination Grievance Procedure. The policy ensures that all Members are aware of their discrimination rights, know how to report a violation to PHC, can identify discrimination categories protected by civil rights law, and understands the investigation process. We also made internal changes to improve the process and guard against discrimination.

DISCRIMINATION CATEGORIES

PHC recognizes federal and state civil rights laws. If federal civil rights laws do not provide protection against a reported incident, we will explore protection under California civil rights laws. The goal is to ensure all personal rights are invoked. Because we honor both federal and state laws, we recognize an expanded number of categories protected by all civil rights laws.

Age	Gender Identity	Nationality	Limited English Proficiency
Disability	Gender Expression	Race or Ethnicity	Group or Character Associations
Basis of Sex	Sex Sterotypes	Religion	Auxiliary Aids Services
Gender	Sexual Orientation	Language Assistance Services	Genetic Information

Refer to PHC Policy CGA022 for a working definition of each category. The policy also explains how we guard against discrimination in the context of healthcare. For example, members cannot be denied any covered services or availability of a service due to any of the categories above.

4Q20 DISCRIMINATION TRENDS

There were 31 cases of alleged discrimination during 4Q20. Of the 31 cases, 23 of the reported incidents fell under one of the federal or state civil rights laws. The most common category of discrimination was race, followed by disability. Investigations found that that discrimination likely occurred in one (1) case. All cases were referred to the Office of Civil Rights for review and further investigation.

QUALITY ASSURANCE

3Q20 INTER-RATER RELIABILITY RESULTS

The quarterly Inter-Rater Reliability (IRR) audit provides physician oversight over clinical decisions made by PHC's Grievance Registered Nurse team. A list of cases are forwarded to PHC's Chief Medical Officer (CMO) that were not previously reviewed by a PHC Medical Director, of which a sample size is selected and evaluated.

The 4Q20 IRR results are still under evaluation; however, 3Q20 results are complete. A sample size of 30 cases was evaluated and all clinical assessments were deemed accurate. However, there were other areas for improvement. First, if the nature of the case includes attributes of discrimination protected by civil right laws even though a member may not use the term, it should be investigated as a discrimination case. Secondly, member allegations of discrimination that do not fall under any civil rights law should result in a non-discriminatory DHCS case classification (e.g., Quality of Service). Thirdly, members should be informed on their rights to contact the DHCS Ombudsman Office when reporting health care concerns regarding Skilled Nursing Facilities. Lastly, deploy deeper investigations when the offending party is not providing an appropriate response or solution to the member-reported issue(s). The cases were further reviewed for operational improvements: achieve greater efficiencies in processing cases, record correct provider information associated with cases, capturing all DHCS/NCQA reporting identifiers, and improve investigations of Second Level Grievances.

CASES PROCESSED TIMELY

DHCS requires PHC to investigate cases within specific investigation Turnaround Times (TAT), ranging from 72 hours to 44 days. If a member's health, life, or limb is in immediate danger, the case must close within 72-hours. If not, the case must be investigated within 30-calendar days. A 14-day extension is allowed if the additional time is believed to benefit the member. DHCS also requires PHC to acknowledge receipt of a member's case by mail by the fifth day.

4Q20 Timeliness Performance				
Performance Category	Performance Goal	# Late	Performance Result	Status
Investigations	98.00%	2	99.8%	
Ack-Letters	98.00%	0	100.0%	

For 4Q20, There were only two (2) late cases out of 839 cases subject to DHCS-TAT, resulting in stellar performance. Workflow improvements were implemented throughout 2020 to improve timeliness of acknowledgement letters (a.k.a., ack-letters), resulting in zero (0) late letters by 4Q20.

MEMBER EXPERIENCE

NCQA SPOTLIGHT - A SPECIAL EDITION

This NCQA Spotlight edition highlights member dissatisfaction reported over an annual period. More specifically, an analysis was conducted to reveal increases in dissatisfaction in 2020, compared to 2019. This edition of the PULSE Report includes Supplemental Reports that should be referenced when reading the NCQA Spotlight pages.

MEMBER SATISFACTION, NOT DISSATISFACTION

PHC monitors member dissatisfaction year-round through Appeals, Grievances and Second Level Grievances. Statistical trends are analyzed and proactively managed in anticipation of member satisfaction survey results.

Every year, PHC surveys our members to assess their overall satisfaction with their PHC Medi-Cal plan. General surveyed areas are:

- ✓ Getting care quickly
- ✓ Getting needed care
- ✓ Quality of provider's communication
- ✓ Customer service
- ✓ Claim processing

NO THRESHOLD FINDINGS

Good news! An analysis of all cases found there was no significant increase in member dissatisfaction from 2019 to 2020 across the broad NCQA categories of access, attitude/service, billing/financial, quality of care, or quality of practitioner office. In fact, there was a reduction in the number of reported concerns in all categories. This is mostly attributed to the COVID-19 pandemic, as fewer members sought healthcare services. Consequently, there was a 24% decrease in the total number of reported cases in 2020 compared to 2019. Refer to the Supplemental PULSE Reports titled NCQA ME.7 Member Experience Threshold Report for more information.

DRIVERS AND OPPORTUNITIES

Although there were no improvement opportunities identified in analyzing the broad NCQA-categories, a deep dive of cases provided insightful improvement opportunities. This is important work as we can forecast member dissatisfaction that may be revealed in the upcoming Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey.

Members reported 370 concerns regarding the quality of communication with their providers. This represents 15.3% of the 2,414 Grievances in 2020. There was a wide variety of issues. Some members found their provider office unresponsive to their inquiries, condescending in their communication, not forthcoming about their treatment, or failed to listen to their concerns. Some members experienced problems with interrupters. Other members experienced a breakdown in communication between them and their provider, some requesting a change in their primary care provider.

The Provider-Focus section highlights reported delays in receiving needed care and receiving it quickly, along with language barriers problems. Members filed cases requesting reimbursement after choosing to pay out-of-pocket for medications while the TAR process was underway. Members are typically discouraged from paying out-of-pocket, as such expense is not reimbursable if the TAR is denied.

THE UM EXPERIENCE

REPORTING PERIOD

This NCQA Spotlight highlights trends discovered from January 1, 2020 to December 31, 2020.

OVERVIEW

Members have the right to contest denied benefits when they are not happy with the decision. This is reason for an Appeal. An Appeal requires PHC to reconsider the original decision to approve a benefit in full or part.

However, sometimes members express dissatisfaction regarding the approval process itself. PHC's authorization process is intended to work smoothly between the providers and PHC, keeping members out of the middle. It requires clinical information or discussions about a member's health in order to assess medical necessity, secure necessary approvals, and coordinate care. This section reports our findings about members who encountered problems during the authorization or referral process.

DELAYED ACCESS TO SPECIALISTS

In 2020, there was an increase in member dissatisfaction regarding access to specialists through the Referral Authorization Form (RAF) process. There were 45 Grievances in 2020, resulting in 0.09 cases per 1,000 members. This is statistically significant compared to a lower trend in 2019 with only 14 Grievances reported, resulting in 0.03 cases per 1,000 members. Of the 45 cases, members alleged in 51% that their providers delayed the RAF process and in 16% the provider refused to submit a RAF request. Other reported reasons were that PHC either delayed or denied their RAF (4%) or expressed concerns over lack of specialty providers (8%). The increased trends can mostly be contributed to the COVID-19 pandemic when access to elective services, frequently completed by specialist providers, was limited nationwide across our healthcare system.

# Reported Concerns With TAR Process	
Medication	51
DME	37
Ancillary	6
Diagnostic	4
Surgery	3
Other	3
Total	104

DISSATISFACTION WITH TAR PROCESS

There was a significant increase in member dissatisfaction in the TAR process from 2019 to 2020. In 2020, 104 cases were reported compared to three (3) cases reported in 2019. This increased the number of filed cases per 1,000 members from 0.01 to 0.21. Of the 104 cases, 49% were related to medications. Reasons of dissatisfaction varied widely. In many cases, members chose to pay out-of-pocket for these expenses. Members reported problems with pharmacies being out of stock of their medications, lower quantities disbursed, and lack of coordination with other medical coverage. Some members were upset that their medical records did not met medically necessary criteria in the Appeal process. Other members were upset that their Medi-Cal coverage did not cover non-formulary medications or over-the-counter products such flax seeds. Eligible expenses were reimbursed. When denied, members were educated on their State Hearing rights, as applicable. PHC will create new Reporting Interests (RI) categories to track and trend key concerns in the future.

Members also reported problems with a variety of durable medical equipment, representing 36% of their dissatisfaction. Of these 37 cases, 18 were related to CPAP supplies and wheelchairs. CPAP concerns generally reflect concerns over delayed supplies or receiving the CPAP machine. Members also reported problems regarding wheelchairs. Members were unhappy that requests for power wheelchairs were denied, wanted special wheelchair accessories, and reported broken wheelchairs. Members continued to report delays by Solara Medical Supplies for diabetic supplies.

104 cases represent .03% of all cases filed in 2020

The remaining 15% of Grievances regarding benefits, billing, or financial issues, were related to diagnostic testing, surgery, or ancillary services such as physical therapy, speech therapy, chiropractic, and/or acupuncture services. Members typically requested a quicker review process, wanted services longer than PHC would approve, or were dissatisfied with denied Appeals. Refer to the Supplemental PULSE Reports titled NCQA UM.18 Member Experience/UM Threshold Report for more information.

PROVIDER FOCUSED

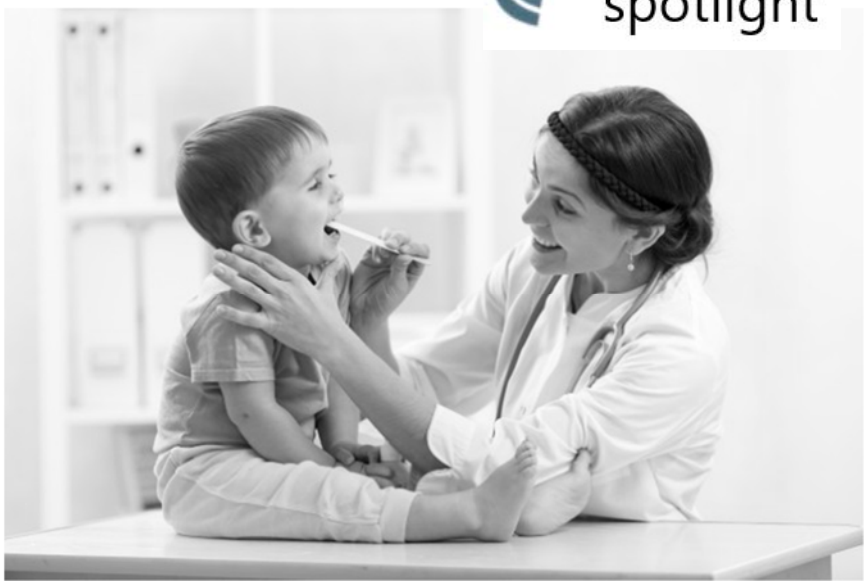
REPORTING PERIOD

This NCQA Spotlight highlights trends discovered from January 1, 2020 through December 31, 2020.

APPOINTMENTS

PHC monitors member-reported dissatisfaction regarding issues that prevent members from scheduling timely appointments with their providers. The PHC Medi-Cal Handbook defines timely access to care as the following:

Urgent Care	48 hours
Non-urgent: w/PCP	10 Business Days
Non-urgent: w/Specialist	15 Business Days
Non-urgent: w/Mental Health	10 Business Days
Non-urgent: w/Ancillary Service	15 Business Days
Telephone Wait Times	10 minutes



Investigations show that members are not typically aware of these standards. Members are educated about the appropriate timeframes during the Grievance process, as applicable. However, the health system faced unprecedented challenges during 2020 as the COVID-19 pandemic took shape. Providers had to minimize elective treatment, postpone preventive services, function with smaller staff, and discover new capacities in managing COVID-19 patients.

# Reported Concerns		
Appointment Barriers by County		
NR	Shasta	10
NR	Humboldt	6
NR	Del Norte	1
SR	Marin	12
SR	Solano	9
SR	Sonoma	4
SR	Napa	4
SR	Lake	1
SR	San Francisco	1
	Total	**48**

APPOINTMENT DELAYS WITH PROVIDERS

Primary Care Providers – As the bandwidth of providers' capacity was restricted during the pandemic, members reported 39 concerns against their primary care providers for untimely appointments in 2020. Reported problems were long wait times, office hours, unable to connect with the provider via the telephone, and/or the provider refused to see the member. Of those cases, 26 originated from southern counties, with Marin County leading as the most impacted area. Members reported the majority of cases against Marin Community Clinics.

Specialists – Access to specialists are approved by PHC through the RAF process. PHC monitors timely appointments with high-volume or high-impact specialty providers, which are defined as cardiologist, dermatologists, ophthalmologist, orthopedist, general surgeon, or OB/GYN. There were nine (9) cases filed against specialty providers, of which one (1) was a high-volume specialist. Reported problems were appointment unavailability and unable to connect with the provider via the telephone.

MEETING CULTURAL & LINGUISTIC NEEDS

# Reported Concerns		
CE&L Concerns by County		
NR	Shasta	2
SR	Solano	6
SR	Sonoma	4
SR	Marin	2
SR	Yolo	1
	Total	**15**

PHC monitors our provider network to ensure it meets the cultural, ethnic, racial, gender and linguistic needs of our diverse membership. Members reported 15 cases against medical groups, individual doctors, office staff, nurse practitioners, and/or physician assistants who did not meet these needs. Southern counties incurred the largest number of cases with 13 filed. The most commonly reported problem was alleged discrimination due to race and language barriers. Typically, language barriers involve challenges with access to, quality with, or disagreement with the interpreter services. There were three (3) cases by one member against Santa Rosa Health by who claimed discrimination because she was white. An inactive participant in the Grievance process, the member was unable to provide substantive details during the investigation to make positive improvements in the healthcare system.

Grievances Only Reporting Period: 2019 vs. 2020								
	Previous Period: 2019			Current Period: 2020				
NCQA Category	Grievances	Avg PHC Mship	Grievances p/1,000	Grievances	Avg PHC Mship	Grievances p/1,000	Threshold	Threshold Met?
Access	742	481,518	1.5	528	488,359	1.1	1.70	Yes
Attitude/Service	1,461	481,518	3.0	1,400	488,359	2.9	3.34	Yes
Billing/Financial	669	481,518	1.4	399	488,359	0.8	1.53	Yes
Quality of Care	98	481,518	0.2	80	488,359	0.2	0.22	Yes
Quality of Provider Office	13	481,518	0.0	7	488,359	0.0	0.03	Yes
TOTAL	2,983	481,518	6.2	2,414	488,359	4.9	6.8	Yes

Appeals & Second Level Grievances Reporting Period: 2019 vs. 2020								
	Previous Period: 2019			Current Period: 2020				
NCQA Category	Appeals & SLG	Avg PHC Mship	Appeals & SLGs p/1,000	Appeals & SLG	Avg PHC Mship	Appeals & SLGs p/1,000	Threshold	Threshold Met?
Access	81	481,518	0.2	66	488,359	0.1	0.19	Yes
Attitude/Service	30	481,518	0.1	20	488,359	0.0	0.07	Yes
Billing/Financial	956	481,518	2.0	633	488,359	1.3	2.18	Yes
Quality of Care	0	481,518	0.0	0	488,359	0.0	0.00	Yes
Quality of Provider Office	0	481,518	0.0	0	488,359	0.0	0.00	Yes
TOTAL	1,067	481,518	2.2	719	488,359	1.5	2.44	Yes

Purpose of report: Grievance & Appeals evaluates Member Experience year-over-year to assess member dissatisfaction. If the number of cases per 1,000 members in the current period increases by more than 10% from the previous period, then the Threshold is triggered. An unmet NCQA Threshold(s) identifies growing areas of member dissatisfaction and intervention(s) maybe required. This report is published bi-annually. The March report provides an annual depiction of the two years under evaluation. The September report provides a mid-year update. All data is reported with a 95% confidence level.

Grievances Only Reporting Period: 2019 vs. 2020								
	Previous Period: 2019			Current Period: 2020				
NCQA Category	Grievances	Avg PHC Mship	Grievances p/1,000	Grievances	Avg PHC Mship	Grievances p/1,000	Threshold	Threshold Met?
Access	14	481,518	0.03	45	488,359	0.09	0.03	No
Attitude/Service	539	481,518	1.12	107	488,359	0.22	1.23	Yes
Billing/Financial	3	481,518	0.01	104	488,359	0.21	0.01	No
Quality of Care	0	481,518	0	0	488,359	0	0	Yes
QOPS	0	481,518	0	0	488,359	0	0	Yes
TOTAL	556	481,518	1.16	256	488,359	0.52	1.27	Yes

Purpose of report: It reflects a subset of data from the ME.7 Member Experience Report. Data reflects member-reported dissatisfaction related to experiences with the TAR and RAF process. If the number of cases per 1,000 members in the current period increases by more than 10% from the previous period, then the Threshold is triggered. An unmet NCQA Threshold(s) identifies growing areas of member dissatisfaction and an intervention(s) maybe required. This report is published bi-annually. The March report provides an annual depiction of the two years under evaluation. The September report provides an mid-year update. All data is reported with a 95% confidence level.

PARTNERSHIP HEALTHPLAN
OF CALIFORNIA

We are a non-profit community based health care organization that contracts with the State to administer Medi-Cal benefits through local care providers to ensure Medi-Cal recipients have access to high-quality comprehensive cost-effective health care. PHC is available to Medi-Cal-qualifying residences in Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity, and Yolo.

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Thursday, January 14th, 2021

Margaret Kisliuk
Northern Region Executive Director
Partnership HealthPlan of California (PHC)
4665 Business Center Drive
Fairfield, CA 94534

Notification of EQRO Reviews for DMC-ODS and Extra Ordinary Needs

Dear Director Kisliuk:

The purpose of this letter is to notify you of the upcoming FY 2020-21 External Quality Review with the Partnership Counties Drug Medi-Cal Organized Delivery System (DMC-ODS) on **Monday, April 26th – Friday, April 30th, 2021**. The review will be carried out by Behavioral Health Concepts, Inc. (BHC), the External Quality Review Organization for Drug Medi-Cal Organized Delivery System Services for California (CalEQRO). However, given the extra ordinary situations with COVID-19 we are working with the counties and health plans to be flexible in the timing and methods of completing the required external quality review activities. Please reach out to your lead reviewer as listed below to share the situation needs of your DMC-ODS as part of planning for this review. BHC is eager to work with you to meet this important quality requirement in a way that does not disrupt critical care for beneficiaries or client safety.

The lead quality reviewer will work with you and your staff on the site review logistics. The designated review team will include the following BHC team members:

- Rama Khalsa, Lead Quality Reviewer
- Maureen Bauman, Quality Reviewer
- Karen Baylor, Quality Reviewer
- Sue Nelson, Quality Reviewer
- Sharon Loveseth, Quality Reviewer
- Bill Ullom, Lead Information Systems Reviewer
- Joel Chain, Information Systems Reviewer
- Laura Bemis, Client/Family Member Consultant

One of the priorities for this review is safety for staff, beneficiaries, contract providers, and other stakeholders, while finding creative ways to obtain essential information on key quality activities linked to the federal protocols. The review may involve video sessions, conference call sessions, some onsite sessions at programs and county administration, if possible, and individual phone interviews. As usual, we will conduct document review and data analysis.

Since the COVID-19 safety recommendations are changing rapidly and physical social distancing is not always possible in some buildings, each review strategy and agenda will be unique. Our goal is to meet the individual needs and situation of that DMC-ODS program and its network of providers, as well as be in line with public health recommendations from state and local officials. Thank you in advance for your help and cooperation on this joint effort.

Please note: The directions for accessing important EQRO documents has changed.
Please read all instructions included in this correspondence.

As in previous years, the FY 2020-21 CalEQRO review will emphasize the DMC-ODS's systems, procedures, activities, and data that are designed to improve access, timeliness, quality, and outcomes of services. CalEQRO will review the elements outlined in the Key Components Review Standards FY 2020-21. All documents referred to in this packet can be found on our website: www.caleqro.com. Once on the website, click on the *Drug Medi-Cal EQRO* button, and under the *Review Schedule and Materials section,* click on the *Review Prep Materials* folder.

The review will emphasize the following priority issues:

- Access Call Center volumes, operations, linkage to care, and timeliness of access to appropriate care based on the American Society of Addiction Medicine (ASAM) assessment principles and dimensions.
- Use of quantifiable metrics for evaluating initiation and engagement in treatment as well as cultural competency activities including penetration rates, with a focus on improving access to underserved populations needing substance use disorders (SUD) treatment. Thus a Cultural Competence Plan based on CLAS standards is required.
- Evaluation of both information systems (IS) server and IS network adequacy, with the goal of improving the reliability and response time of electronic health records (EHR) and other key systems used at service delivery sites for DMC-ODS billing, clinical documentation, and service coordination; (come of these may be centralized and some by be at the county level or provider level and it will be important to try to document your current structure for us, particularly how you track timely response to requests for services, utilization of care, etc. other issues related to quality as well as billing.
- Medication Assisted Treatment (MAT) access at all levels of care and ASAM fidelity related to continuum of care and transitions in care.
- Evaluation of results of the Treatment Perception Survey (TPS) and areas that you have in your QI Plan identified for potential improvement; and,
- Support and collaboration with primary care, mental health services, and the health plan(s) and
- Your overall QI Plan for your DMC-ODS and system with measurable goals for year one.

The criteria for the client/family member focus groups are described later in this document on a separate page labeled "Client and Family Member Focus Group Guidelines." Ideally we would like to do four group in four different counties one per day at different locations and different levels of care or populations. For example, one youth, one peri-natal, one residential 3.1.3.3, or 3.5 and one outpatient adult so see a range or services and client needs.

The participation of the following groups will be required at different points during the review process; specific details will be developed during the planning phase and will be identified on the Site Review Agenda:

- Executive Leadership, including the DMC-ODS Director
- Information Systems and EHR staff
- Finance, Billing, and Operations
- Quality Improvement, Data Analysis, and Research
- Individuals involved in DMC-ODS Performance Improvement Projects (PIPs)
- Key line staff and supervisors within substance use treatment services (county-operated and/or contract providers) and these can be done in the counties on the same days as the client focus groups and at the same sites.
- MAT providers methadone and non-methadone ideally.
- Other key organizations or other stakeholders involved in collaboration with the DMC-ODS, particularly regarding integrated behavioral health and healthcare such a criminal justice and child welfare and mental health

The CalEQRO lead quality reviewer will begin the agenda development process shortly. In collaboration with Partnership designated staff member and UCLA quality improvement staff, the Quality Reviewer Rama Khalsa will develop a detailed agenda so that involved participants can appropriately plan their time.

Please have the staff person who will be coordinating this review contact the lead quality reviewer directly 855-385-3776 x 136 or Rama.Khalsa@bhceqro.com no later than **Thursday, February 25th, 2021** so that we may begin discussing and planning the review. Prior to the review, the quality reviewer will also facilitate access to the latest available DMC-ODS approved claims summaries, ASAM, CalOMS, and TPS data which you can download and share. Once your staff who will be facilitating the submission of your county's documents have been identified and the names shared with the lead quality reviewer, please have them follow the upload instructions for box.

Please retrieve the following documents from our website at www.caleqro.com for completion and submission at least 30 days prior to the review start date:

- Helpful reference materials to prepare for the review can be found here:
- Materials for DMC-ODS to *Complete and Submit* can be found here**:**
- *Additional documents required to be submitted for the review are listed within this letter on the Pre-Review Documentation List on page five.*

We look forward to working with you on planning and completing this review.

Sincerely,

Rama Khalsa, PhD
Assistant Executive Director, BHC CalEQRO

cc: Karen Baylor, PhD – Chief Operating Officer, BHC CalEQRO
Samantha Fusselman, LCSW, CPHQ – Director, BHC CalEQRO
Bill Ullom – Chief Information Systems Reviewer, BHC CalEQRO
Department of Healthcare Services (DHCS) EQRO
Maureen Bauman, LCSW, MPA– Quality Reviewer, BHC CalEQRO
Sue Nelson, EdD – Quality Reviewer, BHC CalEQRO
Sharon Loveseth, LAADC– Quality Reviewer, BHC CalEQRO
Joel Chain – Information Systems Reviewer, BHC CalEQRO
Michelle Gazzigli, LCSW – Wellness and Recovery Site Review and Improvement Specialist, PHC
Nicole Talley – Behavioral Health Program Manager
Wendy Mills – Program Manager
Kimberlee Cathey – Operations Manager, BHC Drug Medi-Cal EQRO
Darren Urada, UCLA
Vandana Joshi, UCLA
Kimberly Wimberly, UCLA

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Pre-Review Documentation List

Site review discussions are based upon pre-site review of the following DMC-ODS documentation.

Please submit the following items to your quality reviewer

By Approximately Friday, March 26th, 2021

Please see the attached instructions on how to upload the requested documents to our HIPAA-compliant online file sharing platform at www.Box.com.
Please consult with your Quality Reviewer if you have additional questions.

- ***Knowingly uploading documents or files containing Protected Health Information to BHC CalEQRO BOX system is strictly prohibited. PHI data must be "de-identified" prior to submission, and de-identified data should only be submitted if relevant to the Quality Review. An analysis of summary data is preferred in all cases.***

Please do not submit PDFs or combine all submissions into one large DOCUMENT, and do not use ZIP FILES. Instead please organize files submissions individually in WORD. Presentations on key topics during the review are fine.

- ***As all documents are submitted electronically,you do not need to create binders or hard copies for the on-site team. If there are additional materials that the DMC-ODS finds relevant to the review, please submit them electronically prior to the review along with the requested documents.***

Documentation Required for the Cal-EQRO Review	Date to BHC
HELPFUL REFERENCE MATERIALS TO PREPARE FOR THE REVIEW	
Claims Definitions for understanding data reports	
Key Components Standards and Review Tool (KCStaRT) with References	
PIP Development Tool Instructions & Checklist	
PIP Validation Tool	
Simplified PIP Development Tool	
Year 1 Performance Measures (PMs)	
Year 2 Performance Measures (PMs)	
MATERIALS FOR DMC-ODS TO COMPLETE AND SUBMIT	
Access Call Center Critical Indicators Form (BHC form)	
Continuum of Care Form (BHC form)	
Information System Capacity Assessment (ISCA) (BHC form)	
Network Adequacy Form (BHC form)	
PIP Development Tool (BHC form) **Can be used for both required PIPs Clinical and Non-clinical**	

Documentation Required for the Cal-EQRO Review	Date to BHC
Review Attendance Log (BHC form)	
Significant Changes & Initiatives (BHC form)	
Timeliness Assessment Form (BHC form)	
SUD Providers Waiting for PED DMC Certification Approval (BHC Form)	
ADDITIONAL DOCUMENTS REQUIRED TO UPLOAD TO BOX	
Additional analyses of ASAM Criteria Referral Data, Treatment Perception Survey and CalOMS *(optional)*	
Approved Implementation Plan with all attachments (Year One County only)	
Copy of Health Plan MOUs and Mental Health Plan MOUs (applicable if there is a separate department)	
Current Cultural Competence Plan and evaluation – including strategies, summary reports and meeting minutes associated with implementation of related activities over the past year related to SUD	
Current QI Work Plan and Evaluation – including strategies, summary reports and meeting minutes associated with implementation of related activities over the past year related to SUD	SUIQI
Detailed DMC-ODS Organizational charts	
Sample of an Access Call Center report from your county	
Sample of Timeliness data report from your county	
QIC meeting minutes since the inception of the DMC ODS & Grievance Logs	

Client/Family Member Focus Group Guidelines

Please review this thoroughly

The Client/Family Member Focus Group is an important component of the Drug Medi-CalEQRO Site Review process. Obtaining feedback from those who are receiving services provides significant information regarding quality, access, timeliness, and outcomes. Due to COVID 19 it may be necessary to hold these focus groups remotely using conference call technology and video technology. CalEQRO will work with the local program staff and DMC-ODS to develop a plan for focus groups that is safe and convenient for clients and family members as needed based on the circumstances.

The review may include one or more 90-minute client/family member focus group(s) with 6 to 8 participants. When held remotely through video conferencing, the clients may each be in separate locations or may all be socially distanced at a singular program site, like a residential treatment center. If feasible, we prefer that the participating clients be a culturally diverse group that includes a mix of existing clients and some new ones who initiated/utilized services within the past 12 months.

Please consult with the Lead Quality Reviewer regarding the type of clients to select for each focus group. Examples of focus groups may include:

- adult beneficiaries from a mixture of treatment modalities
- adult beneficiaries in outpatient treatment
- adult beneficiaries in residential treatment
- perinatal women in a mixture of treatment modalities
- youth beneficiaries from a mixture of treatment modalities
- adult beneficiaries in medication-assisted treatment

Logistical Guidelines

1. Plan for the attendance of 6 to 8 participants in each focus group as the ideal range). Many DMC-ODS counties schedule a few more than that to assure attendance of 6 to 8 participants. Drug Medi-Cal EQRO will provide gift cards for each focus group participant, clients can be informed about the gift cards and the DMC-ODS should be prepared to turn participants away should more than 8 people show up, as it impacts our ability to collect data and makes the groups difficult to facilitate. We are firm about this; thank you for being understanding.

2. Please do not invite participants who are best included in other sessions and might inadvertently inhibit client and family member input, such as:
    - Client/family member employees or advocates or any participants who represent the DMC-ODS in an official capacity
    - Staff members, Drug & Alcohol Advisory Board members, or other stakeholders who want to observe or participate

3. Schedule the group at a time and location that is convenient for clients and family members, though please avoid the morning of the first review day. Please coordinate that with the quality reviewer regarding any questions.

4. Please inform potential participants of the purpose of the 90-minute focus group – specifically that BHC is an external review organization and not affiliated with the county or DHCS. The group is intended to solicit comments about their experiences with the DMC-ODS programs and is not group therapy or a support group.

5. Advise the quality reviewer if participants with limited English proficiency are expected so that interpretation needs can be discussed.

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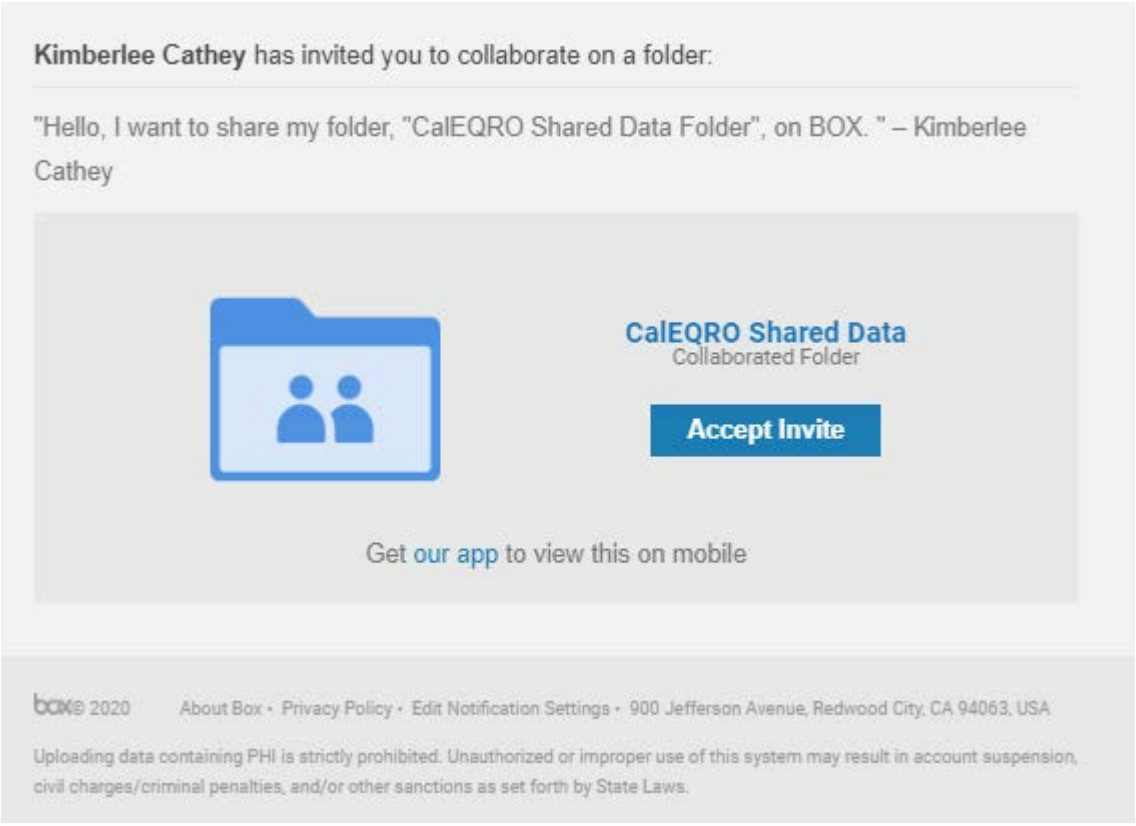
Uploading DMC-ODS Documents into Box

Document Overview:

This document will give county staff (only those specifically identified) step-by-step instructions on how to upload your DMC-ODS documents into Box, CalEQRO's HIPAA compliant cloud file-sharing platform.

Step 1 – Accept Box Invitation

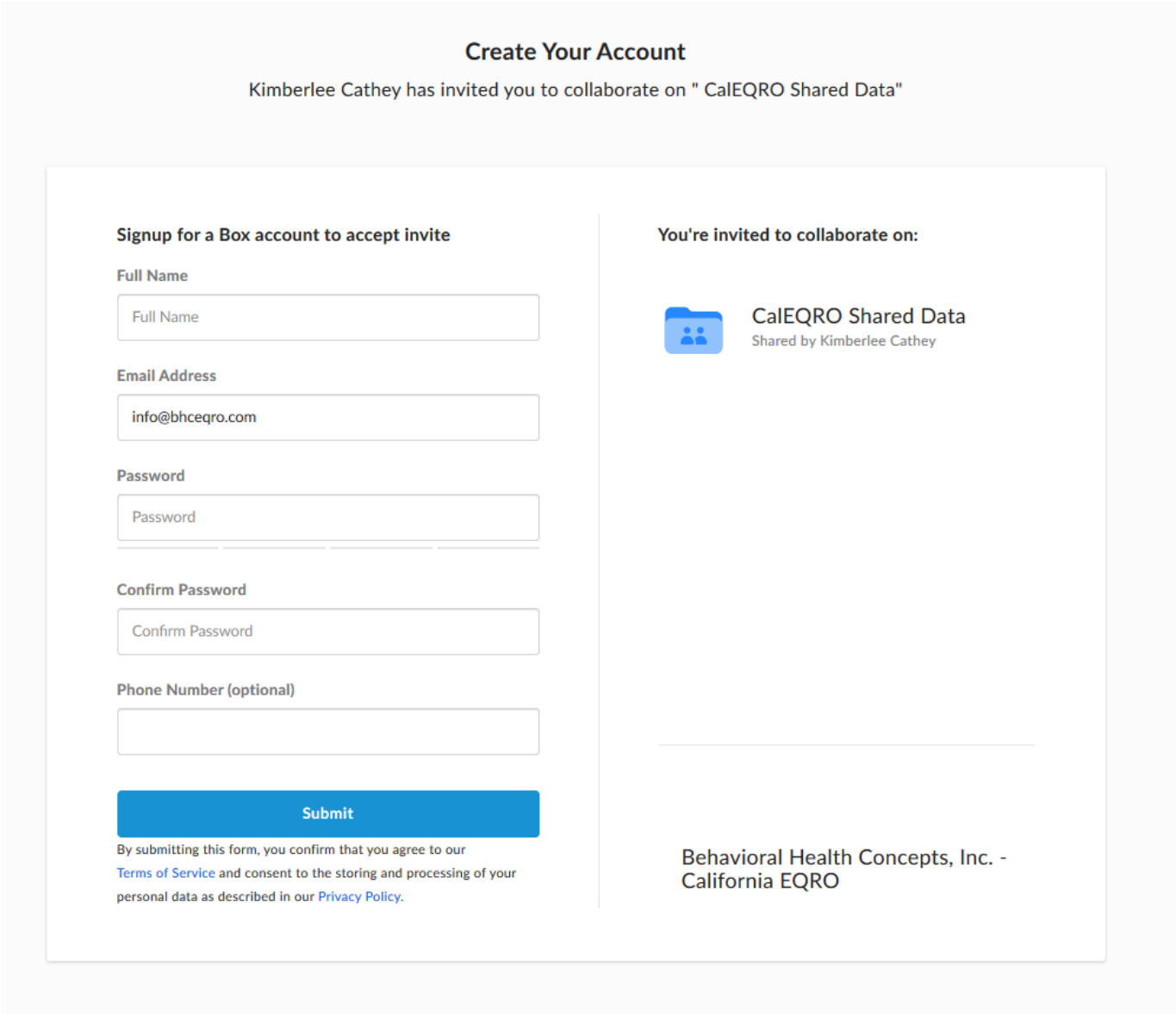
The CalEQRO review team will send you an email invitation to collaborate within your designated county folders, labeled: "CalEQRO Shared Data" (DMC-ODS's approved claims summaries and other helpful data which you can download and share) and "DMC-ODS Submitted Documents" (Upload documents within this folder). Please click on the box that says **Accept Invite**.



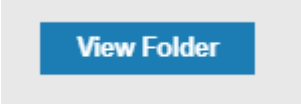
Step 2 – Create Box Account

After clicking on the “Accept Invite” button your web browser will launch and automatically navigate to Box.com. You will be asked to enter your full name and to create a password. Once the required information is entered, please click **Continue**.

If you already have a Box account used during a previous years submissions please click “Log in here”



Step 3 – Once you create an account, and you are invited to collaborate on the **"DMC-ODS Submitted Documents"** folder you will just have to click on the "View Folder".

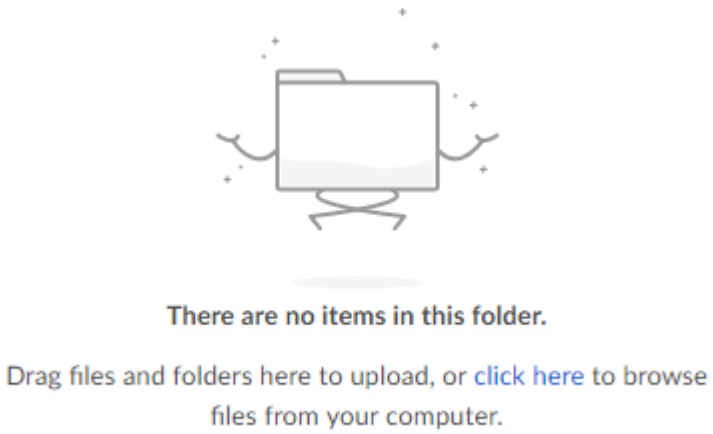


Step 4 – You are now in the "DMC-ODS Submitted Documents (FY2020-2021)" Folder

After creating your new Box account, you will be automatically re-directed to the **"DMC-ODS Submitted Documents (Upload documents within this folder)"**.

Step 5 – Upload Your Documents

Once you have navigated to within the DMC-ODS Submitted Documents sub-folder, you may start uploading your files and folders by **dragging and dropping**, or by using the **upload button**.



Partnership Health Plan Seven Northern County
EQRO Review Proposal

Background:

As part of the DMC-ODS contract, BHC is charged with reviewing each county after approximately one year of providing DMC-ODS services using CMS protocols, clinical and fiscal review requirements as identified in the California state contract. Eight California counties (Solano, Mendocino, Shasta, Humboldt, Siskiyou, Trinity, Modoc, Lassen)have submitted a single DMC-ODS implementation plan in a unique model with Partnership Health Plan (PHP), their Medicaid health plan for local Medi-Cal members. Partnership is a County Organized Health Plan (COHS) which is a unique model of a health plan in California with a special Board of Directors structure with public representation and key medical stakeholders as members. By federal regulation, there is a limited number of these types of plans allowed in California.

The PHP Seven County Plan includes a high level of integration in management of key federal quality requirements such as PIPs, ISCA and Performance Measures. One goal of the model is management of the treatment resources across the region as a single managed care network of SUD treatment resources. Beneficiaries would be able to access SUD care in any of the eight counties depending on their SUD needs identified in their ASAM assessment. There is also a unique fiscal model where the PHP is paid by DHCS on a per member per month basis but has contracts with the service providers across the region and pays them directly on a fee for service basis. In this way PHP assumes the risk for care management of the SUD population and their needs. Contracts exist between the counties and PHP whereby their SUD funds are transferred to the Health Plan which is responsible for all SUD treatment costs. It will be helpful to get update on unique aspects of the fiscal design, data exchanges etc.

In order to evaluate this unique model, BHC proposes the following structure and staffing:

Staffing will be similar to the Los Angeles County review with two lead reviewers Rama Khalsa and Karen Baylor, two second reviewers Maureen Bauman and Jan Tice, two Information System staff Bill Ullom and Melissa Martin, and two CFM consultants – Luann Baldwin and Robyn Walton. To

get insights on co-occurring disorders and the interface with mental health systems Saumitra Sen Gupta and/or Gale Berkowitz will be part of the team. In addition, to assist in data and program evaluation UCLA staff Darren Urada and Vandana Joshi will also be invited to be part of the team.

If the general concepts of the review structure are approved by DHCS, it is recommended BHC discuss the elements of the review with Partnership and the counties to develop the detailed agenda plan prior to going onsite so planning can take place similar to the other county reviews. Many key documents will need to be submitted via the Box cloud from the counties and Partnership, and data downloaded from DHCS as usual for claims, CalOMS, ASAM, Network Adequacy Documents and TPS from UCLA.

Structure of the Review:

Core CMS protocols will have sessions at the PHP's administrative office in Solano county with both PHP and county representation as appropriate. These sessions will include:

1. Opening Session with key activities in past year,
2. PIP sessions for the region, Access Call Center visit and focus group and data review,
3. Information System Assessment of Capacity (ISCA) for central office but discussing interface with provider network, counties, data exchange, data use,
4. Timeliness and Access data,
5. Network Adequacy issues for plan as a region?,
6. Contractor Network Providers Leadership Session,
7. BH County Leadership Session
8. Performance Measure Session, Data Use for Evaluation of Costs and Cost offsets/avoidance models.
9. Quality Improvement Plan,

10. Cultural Competence Plan session (assuming there is one for the DMC-ODS region as well as for the counties because of SAPT?),
11. Coordination/integration with health providers and MH including review of protocols/MOUs. Partnership is a COHS so assume no other health plan, but MOUs with county BH overall.
12. Exit session with PHP and county leadership

At the same time as the EQRO administrative office sessions are being conducted, there will be the following review activities at the seven counties with a mobile team visiting Monday through Thursday: 1. Client focus groups, and 2. Line staff groups, and 3. program site visits. One or two counties will be visited each day to conduct these focus groups and site visits. These will be identified prior to the on-site review and in collaboration with PHP and the counties, to include residential treatment programs, WM, outpatient, intensive outpatient programs, youth services, NTP/OTPs, OBOTs, and unique programs in the region serving ethnic, criminal justice or disabled populations, etc.

Conclusion:

This regional review will take 4.5 days and will include approximately 30-35 sessions. At the end of the week, there will be an exit session with administrative team and the leadership from the "mobile team" at the Partnership office with high level impressions of the key federal quality issues and program-linked STC issues of DMC-ODS program. The review is currently scheduled for April 26-30, 2020.

Data needed for this unique review:

BHC in collaboration with UCLA would like to do an expanded data evaluation. In addition to the claims data from the seven counties, it would be helpful to have FY 2019-20 PHP encounter and cost data for those beneficiaries with SUD diagnoses, to the extent it is available, to be able to evaluate medical offsets, specifically hospital inpatient days and ED visits. It would also be helpful to have outpatient visits where beneficiaries are

receiving any medication assisted treatments (MAT) or SUD counseling services through the FQHCs. Pharmacy data would be very helpful for these individuals using MAT or counseling in the Partnership health plan clinics with SUD diagnoses. UCLA has in their contract that they will get access to health data and costs to evaluate medical cost offsets. This is not in the BHC scope of work, but does relate to quality of care. It would be helpful to have access to this data even without patient identifications to evaluate some of these issues. Perhaps with UCLA coordination, some of the quality of care measures can be evaluated jointly and issues and recommendations to enhance care in integrated models.

BHC is happy to work with Partnership, the counties, UCLA with DHCS support to do a unique review and evaluation of this integrated regional approach.

Partnership County Report:

In addition to reviewing the PMs as a region and managed care SUD delivery system, BHC recommends that one report as regional managed care plan be developed. The DMC-ODS data from the eight counties will be combined for the performance measures.

Also, the ISCA would look at the PHP data system and its links to the local data systems so it will be very complex and unique. Local and regional systems both need evaluation. Not all county systems are the same so there will need to be some county and health plan IS system data.

Again, BHC would produce one large report encompassing all seven counties in an integrated report going through each protocol areas., Specific information separately identified for each county, such as penetration rates by ethnic group or age etc. may be complied upon request of DHCS but some of this information may need to be de-identified. BHC can provide a list of the typical information for DHCS consideration.

Obviously, this would be a unique report but would follow the general outline of the county reports with some additional sections for their unique features.

BHC is requesting written approval of this plan from DHCS.

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Continuum of Care –DMC-ODS/ASAM

DMC-ODS Levels of Care & Overall Treatment Capacity:

County: Review date(s):
Person completing form**:**

Please identify which programs are billing for DMC-ODS services on the form below.

Percent of all treatment services that are contracted: %

<u>County role for Access</u> and coordination of care for persons with SUD requiring social work/linkage to coordinate care and ancillary services.

Describe county role and functions linked to access processes (Access Call Center) and coordination of care linked to access services:

<u>Case Management</u>- Describe if it's done by DMC-ODS via centralized teams or integrated into DMC certified contract or county programs or both:

Monthly estimated billed units of case management:

Comments:

<u>Recovery Services</u> – Support services for clients in remission from SUD having completed treatment services, but requiring ongoing stabilization and supports to remain in recovery including assistance with education, jobs, housing, relapse prevention, peer support.

Pick 1 or more as applicable and explain below:

1) Included with program sites for linkage to treatment
2) Included with outpatient sites as step-down
3) Included with residential levels of care as step down
4) Included with NTPs as stepdown for clients in remission

Choices:
Total Legal entities offering recovery services:
Total number of legal entities billing DMC-ODS recovery services:
Monthly estimated billed units of case management**:**

Comments:

<u>Level 1 WM and 2 WM</u>: Outpatient Withdrawal Management – Withdrawal from SUD related drugs which lead to opportunities to engage in treatment programs (use DMC definitions).

Number of Sites:
Total number of legal entities billing DMC-ODS:
Estimated billed units per month:
How are you structuring it? - *Pick 1 or more as applicable and explain below*

1) NTP
2) Hospital-based outpatient
3) Outpatient
4) Primary care sites

Choice(s):

Comments:

Level 3.2 WM: Withdrawal Management Residential Beds- withdrawal management in a residential setting which may include a variety of supports.

Number of sites:
Total number of legal entities billing DMC-ODS:
Total number of beds:
Estimated billed days/units per month:
Pick 1 or more as applicable and explain below:

1) Freestanding
2) Within residential treatment center

Choice(s):

Comments:

NTP/OTP Programs- Narcotic treatment programs for opioid addiction and stabilization including counseling, methadone, other FDA medications, and coordination of care.

Total legal entities in county:
In county NTP: Sites Slots:
Out of county NTP: Sites Slots:
Total estimated billed counseling units per month:
Are all NTPs billing for non-methadone required medications? ☐ Yes ☐ No
Comments:

Non-NTP-based MAT programs - Outpatient MAT medical management including a range of FDA SUD medications other than methadone, usually accompanied by counseling and case management for optimal outcomes.

Commented [WM1]: Include PCP/physical health data.

Total legal entities: Number of sites:
Total estimated billed units per month:

Comments:

Level 1: Outpatient – Less than 9 hours of outpatient services per week (6 hrs./week for adolescents) providing evidence based treatment.

Total legal entities: Total sites:
Total number of legal entities billing DMC-ODS:
Average estimated billed units per month:

Comments:

Level 2.1: Outpatient/Intensive – 9 hours or more of outpatient services per week to treat multidimensional instability requiring high-intensity, outpatient SUD treatment.

Estimated billed hours per month:
Total legal entities: Total sites for all legal entities:
Total number of legal entities billing DMC-ODS:
Average estimated billed units per month:

Comments:

Level 2.5: Partial Hospitalization – 20 hours or more of outpatient services per week to treat multidimensional instability requiring high-intensity, outpatient treatment but not 24-hour care.

Total sites for all legal entities:
Total number of legal entities billing DMC-ODS:
Total number of programs:
Average client capacity per day:
Average estimated billed treatment units per month:

Comments:

Level 3.1: Residential Structured SUD treatment / recovery services that are provided in a 24-hour residential care setting with patients receiving at least 5 hours of clinical services per week.

Total sites for all legal entities:
Total number of legal entities billing DMC-ODS:
Number of program sites:
Total bed capacity:
Average estimated billed bed days/units per month:

Comments:

Level 3.3: Clinically Managed, High-Intensity Residential Services – 24-hour structured living environments with high-intensity clinical services for individuals with significant cognitive impairments.

Total sites for all legal entities:
Number of program sites:
Total number of legal entities billing DMC-ODS:
Total bed capacity:
Average estimated billed bed days/units per month:
(Can be flexed and combined in some settings with 3.5)

Comments:

<u>Level 3.5: Clinically Managed, High-Intensity Residential Services</u> – 24-hour structured living environments with high-intensity clinical services for individuals who have multiple challenges to recovery and require safe, stable recovery environment combined with a high level of treatment services.

Total sites for all legal entities:
Number of program sites:
Total number of legal entities billing DMC-ODS:
Total bed capacity:
Average estimated billed bed days/units per month:
(Can be flexed and combined in some settings with 3.5)

Comments:

<u>Level 3.7: Medically Monitored, High-Intensity Inpatient Services/ or WM</u> – 24-hour, professionally directed medical monitoring and addiction treatment in an inpatient setting. (May be billing Health Plan/FFS not DMC-ODS but can you access service??) ☐ Yes ☐ No

Number of program sites:
Total number of legal entities billing DMC-ODS:
Number of legal entities:
Total bed Capacity:
Average estimated billed bed days/units per month:

Comments:

<u>Level 4: Medically Managed Intensive Inpatient Services or WM</u> – 24-hour services delivered in an acute care, inpatient setting. (Billing Health Plan/FFS can you access services? ☐ Yes ☐ No Access)

Number of program sites:
Total number of legal entities billing DMC-ODS:
Number of legal entities:
Total bed capacity:
Average estimated billed bed days/units per month:

Comments:

<u>Recovery Residences</u> – 24-hour residential drug free housing for individuals in outpatient or intensive outpatient treatment elsewhere who need drug-free housing to support their sobriety and recovery while in treatment.

Total sites for all legal entities:
Number of program sites:

Bed capacity for women with children:

Total bed capacity:

Comments:

Are you still trying to get additional services Medi-Cal certified? Please describe:

ACCESS CALL CENTER AND OTHER ENTRY POINTS

CRITICAL INDICATORS FORM

FY 20-21 – V1

Below are important statistics for monitoring the timely and effective access for persons seeking Drug Medi-Cal services into your organized delivery system. The initial questions focus on your Access Call Center, although a later section is devoted to other entry points as well.

Please complete the information requested to the best of your ability and if there is a problem or challenge, please explain in the boxes at the end of the form. Thank You.

This first set of items refers to the basic infrastructure you have for your access call center operations.

1. **How many full-time equivalents (FTE) total staff are dedicated to the Access Call Center at this time? If you are in a combined call center with MH, estimate just the workforce supporting the DMC calls.**

   DMC FTEs

2. **What software do you use for tracking the call metrics for your Access Call Center operations?**

   Vendors Name

   Software Name and version:

   How often are reports generated? (Please upload to BOX at least one sample report)

   Real time ☐ Daily ☐ Weekly ☐ Monthly ☐ Other ☐ Please specify below

3. **Are you able to link access log data from callers to their electronic health record data previous to the current screening (to understand the history of specific clients in using your system of care)?**
   Yes ☐ No ☐ Not Sure ☐

4. **Are you able to link access log data from callers to their electronic health record data after the current screening (to track timeliness to first appointment)?**
   Yes ☐ No ☐ Not Sure ☐

5. **What resources and processes do you use to facilitate access for your threshold languages?**

6. **If your call center is not operated by the same organization 24/7, what service/contractor do you use for after-hours requests for services?**

7. **If you use another vendor or contractor for after hour call services, do they enter the client requests into your database for services?** Yes ☐ No ☐

8. **How do they link to your core database for service requests so you can track access and timeliness to first session? When the request is for residential treatment, is that specified in the core database?**

This second set of items refers to the processes and data for how you manage the incoming calls to the access call center.

9. **What is the average monthly volume of calls received in the last 12 months (or since you began your DMC-ODS if less than 12 months)?** ____ **from to**

   Does your access log track the number of calls by source type? Yes ☐ No ☐

   If yes, check all that apply below:

☐ Prospective Clients	☐ After hours Call Center	☐ Other County Agencies
☐ Family Members/ Friends	☐ Network Providers	☐ Other- Explain Below
Other:		

10. **How many rings or seconds before callers are put on hold and wait for a live person?**

    ____ Rings **or** ____ seconds

11. **Are callers "on hold" given the option of leaving a message to receive a call back?**

    If so, what % do so? ____ %**OR** ☐ that option is not available

12. **What is the average percentage of dropped/abandoned calls before speaking to live person out of your total calls per month? For example, if you got an average of 300 calls and the average dropped/abandoned calls was 60, you would have a 20% average rate of dropped/abandoned calls.**

    Average percent of dropped/abandoned calls per month= ____ %
    From To

13. What is the average wait time until a live person answers and discusses treatment needs or other issues with the prospective client/caller?

☐ don't know, software does not track this. **OR**

☐Wait times on average for last 12 months or since we started

were ____ minutes

14. Does the access call center track *disposition of calls by type* (for example: a. referrals to various levels of treatment, b. provided information but no referral, c. wrong number, etc.?)

☐ Yes, dispositions of calls are tracked in an access log

☐ Yes, dispositions of calls are tracked in the electronic health record system

☐ Yes, another mechanism is used for tracking disposition of calls (Please explain below)

☐ No, disposition of calls are not tracked

15. Does your access call center provide authorizations for residential treatment after completed screenings and/or assessments?

Yes ☐ No ☐

If yes, how many average monthly authorizations are there for residential treatment?

____ average authorizations average per month **from to**

16. What percentage of answered calls were referred to a treatment/program site for care (including the residential authorizations) monthly? ____ **%** -average percentage of callers linked to treatment within the DMC-ODS through the Access Call Center.

17. Are you able to link clients into three-way calls with your call center staff and the program you are referring them to? Yes ☐ No ☐

18. What tools are you using for ASAM screenings or ASAM assessments in the Access Call Center?

☐County Developed Tool

☐Triage/Continuum Software Tool

☐UCLA tool

☐Other ____

19. Are there other important facts and indicators you use to track the effectiveness and efficiency and customer service capacity of the Call Center?

☐Yes, we have developed additional indicators

☐Yes, we conduct periodic "secret shopper" calls to test the system

☐Yes, we have done customer service surveys

☐No, not at this time

20. Do you have any process for checking during or after the calls for client satisfaction with the process and outcomes?

☐Yes ☐No

Most DMC-ODS counties offer additional access points for clients through direct contact with contract providers, and some also offer walk in assessments at the access Center. This third set of questions address some aspects of these alternative access points. Many systems describe this model as "no wrong door."

21. What are the access points that clients can use other than the call center to directly enter your DMC-ODS? Also please indicate if the client's time of first contact is recorded.

Access Points to DMC-ODS Services	# of Sites (If applicable)	Track time of first contact?
Access center walk-in assessments if available		Yes ☐ No ☐
Outpatient clinics		Yes ☐ No ☐
Intensive outpatient treatment program		Yes ☐ No ☐
NTP		Yes ☐ No ☐
MAT (Other than NTP)		Yes ☐ No ☐
Residential treatment		Yes ☐ No ☐
Residential withdrawal management		Yes ☐ No ☐
Partial hospital		Yes ☐ No ☐
Other		Yes ☐ No ☐

22. How do providers at these other access points transfer their client first-contact data to a centralized DMC-ODS database for timeliness tracking?

23. **How does the DMC-ODS link the first contact data to access data in their electronic health record system for analyzing and reporting on timeliness metrics?**

24. **How frequently does the DMC-ODS produce comprehensive reports on timeliness metrics from all entry points and use them for quality improvement?**

This last set of questions provides an opportunity for you to include any other relevant information that you deem important for us to know, and also helps us maintain a user-friendly form that can provide clear and meaningful data.

25. **Any other important information to consider related to your access systems.**

26. **Problems or challenges with completion of the form**

County **Person Completing Form** **Date**

Contact information – Email/Phone number

PERFORMANCE IMPROVEMENT PROJECT (PIP) DEVELOPMENT & IMPLEMENTATION TOOL

BACKGROUND

All MHPs/DMC-ODSs are required to conduct performance improvement projects (PIPs) that focus on both clinical and nonclinical areas each year as a part of the plan's quality assessment and performance improvement (QAPI) program, per 42 C.F.R. §§ 438.330 and 457.1240(b).

A PIP is a project that is designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction. It may be designed to change behavior at a member, provider, and/or MHP/DMC-ODS/system level.

Each PIP will be evaluated every year by CalEQRO. Although topic selection and explanation may cover more than one PIP year, every section will be reviewed and updated as needed to ensure continued relevance and to address changes to the study, including new interventions.

Annual updates to these documents by the MHP/DMC-ODS should be identified by a change in font color or use of track changes.

The CalEQRO PIP Development and Implementation Tool is comprised of the following nine steps:

Step 1: Identifying the PIP Topic

Step 2: Developing the Aim Statement

Step 3: Identifying the PIP Population

Step 4: Describing the Sampling Method

Step 5: Selecting the PIP Variables and Performance Measures

Step 6: Describing the Improvement Strategy (Intervention) and Implementation Plan

Step 7: Describing the Data Collection Procedures

Step 8: Describing the Data Analysis and Interpretation of PIP Results

Step 9: Address the Likelihood of Significant and Sustained Improvement Through the PIP

INSTRUCTIONS

This tool provides a structure for development and submission of PIPs. It is based on **EQR Protocol 1: Validation of Performance Improvement Projects (PIPs)**, as a mandatory protocol delivered by the Centers for Medicare & Medicaid Services (CMS) in October of 2019. These can be found here:

CMS 2019 External Quality Review Protocols.

Following this tool will help ensure that the MHP/DMC-ODS addresses all of the required elements of a PIP, from planning to submission to implementation. If the MHP/DMC-ODS uses another format, they must ensure that all required elements of the PIP are addressed and included in their submission.

For each step, CalEQRO has indicated:

- The section of the CMS EQR Protocol 1: Validation of Performance Improvement Projects (PIPs) that this step addresses.
- Brief description of the step and key terms.
- Questions/prompts that will help complete the step.
- Worksheets to complete as part of each step.

Please define all acronyms at time of first use in these documents.

STEP 1: IDENTIFYING THE PIP TOPIC

Step 1 corresponds to CMS PROTOCOL STEP 1 – Review the Selected PIP Topic.

The PIP should target improvement in either a clinical service or non-clinical process that directly impacts beneficiary health and/or functional status.

The topics should reflect high-volume or high-risk conditions of the population served. High-risk conditions may occur for infrequent conditions or services. High risk also exists for populations with special health care needs, such as children in foster care, adults with disabilities, and the homeless. Although these individuals may be small in number, their special health care needs place them at high risk. If the PIP addresses a high-impact or high-risk condition, the importance of addressing this type of issue must be detailed in the study narrative.

PIP topics may be selected based on enrollee input. The topic should address a significant portion of the enrollees (or a specified sub-portion of enrollees) and have the potential to significantly impact enrollee health, functional status, or satisfaction.

Recommended benchmarks include those defined by:

CMS Priority areas CMS Quality of Care
Core Set of Children's Health Care Quality Measures for Medicaid and the Children's Health Insurance Program (CHIP)
Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid (Adult Core Set)

Complete Worksheet 1: Drafting the PIP Topic

STEP 2: DEVELOPING THE AIM STATEMENT

Step 2 corresponds to CMS PROTOCOL STEP 2 – Review the PIP AIM Statement

The PIP aim statement identifies the focus of the PIP and establishes the framework for data collection and analysis. The PIP aim statement should define the improvement strategy, population, and time period. It should be clear, concise, measurable, and answerable.

A PIP aim statement is clear, concise, measurable, and answerable if the statement specifies measurable variables and analytics for a defined improvement strategy, population, and time period. Potential sources of information to help form the PIP aim statement include:

- State data relevant to the topic being studied
- MHP/DMC-ODS data relevant to the topic being studied
- CMS Child and Adult Core Set performance measures
- Enrollee focus groups or surveys
- Clinical literatures on recommended care and external benchmarks.

CMS recommends that the aim of the PIP aligns with at least one of the *National Quality Strategies*, although others may be considered.

CRITIQUE OF EXAMPLE PIP AIM STATEMENTS

	Example PIP aim statements	Critique
Poor PIP Aim Statement	Does the MCP adequately address psychological problems in patients recovering from myocardial infarction?	• The PIP intervention is not specified • It is unclear how impact will be measured • The population and time period are not clearly defined
Good PIP Aim Statement	Will the use of cognitive behavioral therapy in patients with depression and obesity improve depressive symptoms over a six-month period during 2017?	• Specifies the PIP intervention (cognitive behavioral therapy) • Defines the population (patients with depression and obesity) and time period (six-month period during 2017) • Specifies the measurable impact (improve depressive symptoms)

Complete Worksheet 2: Drafting the Aim Statement

STEP 3: IDENTIFYING THE PIP POPULATION

Step 3 corresponds to CMS PROTOCOL STEP 3 – Review the Identified PIP Population.

In this step, the MHP/DMC-ODS identifies the population for the PIP in relation to the PIP aim statement (such as age, length of enrollment, frequency of service use, type of treatment, diagnoses, and/or other characteristics).

Depending on the nature of the PIP aim statement, PIP population, and available data, the PIP may include the entire population or a sample of the population. PIPs that rely on existing administrative data, such as claims and encounter data, registry data, or vital records, are typically based on the universe of the PIP population. PIPs that rely on either medical record review or the hybrid method (which uses a combination of administrative data and medical record review) typically include a representative sample of the identified population.

If a sample was used for the PIP, go to **Step 4**.

If the entire population was studied, skip Step 4 and go to **Step 5**.

If HEDIS® measures and sampling methodology are used, go to **Step 5**.

Complete Worksheet 3: Identifying the PIP Population

STEP 4: DESCRIBING THE SAMPLING METHOD

Step 4 corresponds to CMS PROTOCOL STEP 4 – Review the Sampling Method.

If the entire population of beneficiaries is being included in the PIP, there is no need to describe the sampling method.

General information about the use of sampling methods and the types of sampling methods to use to obtain valid and reliable information can be found in Appendix B (page 337) of the CMS EQR Protocols.

A sampling frame is the list from which the sample is drawn. It includes the universe of members of the target PIP population, such as individuals, caregivers, households, encounters, providers, or other population units that are eligible to be included in the PIP. The completeness, recency, and accuracy of the sampling frame are key to the representativeness of the sample

If sampling methods are used, the documentation presented must include the appropriateness and validity of the sampling method; the type of sampling method used and why; and what subset of the beneficiary population was used. General information about the use of sampling methods and the types of sampling methods to use to obtain valid and reliable information can be found in Appendix B of the CMS EQR Protocols. [1]

Complete Worksheet 4: Describing the Sampling Plan

[1] EQR Protocol: Appendix B: Sampling Approaches, October 2019, DHHS, Centers for Medicare & Medicaid Services (CMS), OMB Approval No. 0938-0786

STEP 5: SELECTING PIP VARIABLES AND PERFORMANCE MEASURES

Step 5 corresponds to CMS PROTOCOL STEP 5 – Review the Selected PIP Variables and Performance Measures.

A **variable** is a measurable characteristic, quality, trait, or behavior of an individual or process being studied. Variables in PIPs can take a variety of forms, as long as the selected variables identify the MHP/DMC-ODS performance on the PIP questions objectively and reliably and use clearly defined indicators of performance. When choosing variables, select ones that are best suited to the available data, resources, and PIP aim statement.

Consider variables for which there are existing performance measures. To the extent possible, CMS encourages MCPs to choose variables for PIPs that reflect health outcomes.

A **performance measure** is used to measure the outcomes. Performance measures monitor the performance of MHP/DMC-ODS at a point in time, to track performance over time and to inform the evaluation of quality improvement activities. For the purpose of the CMS protocol, outcomes are defined as changes in beneficiary health, functional status, satisfaction, or goal achievement that results from health care or supportive services. CMS encourages use of the Behavioral Health Core Set, the Certified Community Behavioral Health Clinics (CCBHC) measures, the Healthcare Effectiveness Data Information Set (HEDIS), as well as measures developed by the Agency for Health Research and Quality (AHRQ), and the National Quality Forum (NQF) for behavioral health or for SUD the American Society of Addiction Medicine (ASAM).

> Example 1: An MHP/DMC-ODS's goal is to decrease the use of acute behavioral health hospitalizations and ED visits. The intervention is use of preventive and primary care, and the independent variable used to measure the intervention is the number of preventive and primary care visits. The performance measure (dependent variable) is the number of hospitalizations and emergency department visits, which is used to measure the improvement rate. The required data are available monthly through the electronic health record.
>
> Example 2: An MHP/DMC-ODS's goal is to decrease use of antipsychotic medication by adolescents. The intervention is use of first-line psychosocial care for adolescents, and the independent variable used to monitor implementation of the intervention is the number of visits in which use of first-line psychosocial care for adolescents is documented. The performance measure (dependent variable) is a measure of antipsychotic medication prescribed (this could be the # of prescriptions, # of adolescents who have it prescribed or decrease in dosages, for example. The dependent variable would depend on the goal, which is the data used to measure the improvement rate. The required data are available every month through the electronic health record.

Example 3: A DMC-ODS's goal is to decrease readmissions to withdrawal management by adults with opioid use disorders. The intervention is use of intensive outpatient and Medication Assisted Treatment (MAT) services, and the independent variable used to monitor implementation of the intervention is the number of intensive outpatient and MAT visits. The performance measure (dependent variable) is the number of readmissions. Data are available quarterly through the electronic health record.

Data availability should also be considered when selecting variables for PIPs, as more frequent access to data, such as on a monthly or quarterly basis, supports continuous quality improvement (CQI) and Plan Do Study Act (PDSA) efforts and can allow an MHP/DMC-ODS to correct or revise course more quickly, if needed.

When selecting performance measures for a PIP, the MHP/DMC-ODS should first consider established measures (MHP/DMC-ODS, DHCS, CMS, etc.) because the specifications for these measures often have been refined over time, may reflect current clinical guidance, and may have benchmarks for assessing MHP/DMC-ODS performance.

Complete Worksheet 5: Selecting PIP Variables and Performance Measures

STEP 6: DESCRIBING THE IMPROVEMENT STRATEGY (INTERVENTION) & IMPLEMENTATION PLAN

Step 6 corresponds to CMS PROTOCOL STEP 8 – Assess the Improvement Strategies.

This step describes the improvement strategy (sometimes referred to as an intervention) and how it will be carried out. Selected strategies should be evidence-based; that is, there should be existing evidence (published or unpublished) suggesting that the test of change (performance measure) would likely lead to the desired improvement in processes or outcomes (as measured by the variables). The effectiveness of the improvement strategy is determined by measuring change in performance according to the predefined measures that were selected in Step 5.

Complete Worksheet 6: Describe Improvement Strategy (Intervention) & Implementation Plan

STEP 7: DESCRIBING DATA COLLECTION PROCEDURES

Step 7 corresponds to CMS PROTOCOL STEP 6 – Review the Data Collection Procedures.

In this step, the MHP/DMC-ODS identifies the data to be collected, including addressing the validity and reliability of the procedures used to collect the data that inform the PIP measurements.

Validity means that the data are measuring what is intended to be measured. Reliability means that the data are producing consistent results.

To ensure validity and reliability of the data collected as part of the PIP, the data collection plan should specify:

- The data sources for the PIP
- The data to be collected
- How and when the data are to be collected
- Frequency of data collection
- Who will collect the data
- Instruments used to collect the data

Data sources may include:

- Encounter and claims systems
- Medical records
- Case management or electronic visit verification systems
- Tracking logs
- Surveys
- Provider and/or enrollee interviews

This step may involve two main kinds of data collection: administrative data sources and medical record review. Procedures to collect data from administrative data systems will be different from procedures for visual inspection or abstraction of medical records or other primary source documents. However, both types of data collection require assurances that data are valid and reliable. CMS encourages the plans to utilize those data sources that they are able to collect data from on a regular basis (e.g., monthly, quarterly, and semi-annually):

Complete Worksheet 7: Describing The Data Collection Procedures

STEP 8: DESCRIBING THE DATA ANALYSIS AND INTERPRETATION OF PIP RESULTS

Step 8 corresponds to CMS PROTOCOL STEP 7 – Review the Data Analysis and Interpretation of PIP Results.

In this step, the MHP/DMC-ODS should describe the plan for data analysis and interpretation of PIP results. The data collection plan described in Step 7 should link to plan for data analysis.

The data analytic plan should be based on a CQI philosophy and reflect an understanding of lessons learned and opportunities for improvement. Interpretation of the PIP results should involve assessing the causes of less-than-optimal performance and collecting data to support the assessment.

The primary source for the assessment should be analytic reports of PIP results prepared by the MHP/DMC-ODS, including both baseline and repeat measurements of PIP outcomes. In addition, reasonable benchmarks should be included, where possible, such as state-level data, data from other counties, or industry benchmarks.

This protocol requires the analysis to assess the extent to which any change in performance is statistically significant; however, it does not specify a level of statistical significance that must be met. MHPs/DMC-ODS should indicate the level of statistical significance used in the analysis and which findings were statistically significant.

Complete Worksheet 8: Data Analysis and Interpretation of PIP Results

STEP 9: ADDRESS THE LIKELIHOOD OF SIGNIFICANT AND SUSTAINED IMPROVEMENT THROUGH THE PIP

Step 9 corresponds to CMS PROTOCOL STEP 9 – Assess The Likelihood that Significant and Sustained Improvement Occurred.

In this step, CalEQRO assesses the likelihood that significant and sustained improvement occurred as a result of the PIP. The assessment builds on findings from the previous steps. In this step, CalEQRO assess the overall validity and reliability of the PIP methods and findings to determine whether or not it has confidence in the results.

An important component of a PIP is to determine if the reported change is “real” change, or the result of an environmental or unintended consequence, or random chance. It is also essential to demonstrate sustained improvement.

To do so requires repeated measurements be conducted over the course of the PIP, and whether significant change in performance relative to baseline measurement was observed. The repeat measurement should use the same methodology as the baseline measurement. Any deviations in methodology (such as sampling, data source, or variable definition) must be thoroughly documented. If the PIP is in the early stages of implementation, and repeated measurements are not yet available, the analysis plan should describe the methodology for subsequent measurement. In assessing the likelihood that PIP results are sustainable, the analysis should include which findings were found to be significant either statistically, clinically, or programmatically over time.

PIP documentation should include the following

- Data that analyzes changes in processes or beneficiary outcomes based on the variables included and compared to baselines and benchmarks.
- Extent to which there was a quantitative improvement in process or outcomes.
- Extent to which statistical evidence supports that the improvement is true improvement.
- Results of statistical significance testing.
- Extent to which the improvements appear to be the result of the PIP improvement strategies.
- Issues associated with data analysis.

Potential sources of supporting information include:

- Statistical significance testing calculated on baseline and repeat indicator measurements (clarify that the appropriate test was used, such as a t-test for small samples)
- Benchmarks for quality specified by the state Medicaid agency or found in industry standards

- Interviews with staff and providers about the implementation and results of the PIP intervention

The EQRO will review the PIP methods and findings to assess whether there is evidence of statistically significant improvement that may be associated with the intervention implemented as part of the PIP. In addition, the EQRO may supplement the quantitative assessment with information gathered through interviews with staff and/or providers about the implementation and results of the PIP improvement strategies. Qualitative information may inform the assessment of whether observed changes were likely to be attributable to the PIP intervention, as opposed to a short-term event unrelated to the intervention or random chance.

Complete Worksheet 9: Likelihood Of Significant And Sustained Improvement Through The PIP

PIP PLANNING, SUBMISSION, AND IMPLEMENTATION WORKSHEETS

Worksheet 1: Drafting The PIP Topic

Worksheet 2: Drafting the Aim Statement

Worksheet 3: Identifying the PIP Population

Worksheet 4: Describing the Sampling Method

Worksheet 5: Selecting PIP Variables and Performance Measures

Worksheet 6: Describe Improvement Strategy (Intervention) and Implementation Plan

Worksheet 7: Describing the Data Collection Procedures

Worksheet 8: Data Analysis and Interpretation of PIP Results

Worksheet 9: Likelihood of Significant and Sustained Improvement Through the PIP

Please define all acronyms at time of first use in these documents.

WORKSHEET 1: DRAFTING THE PIP TOPIC

MHP/DMC-ODS Name	
Project Leader/Manager/Coordinator	
Contact email address	
Performance Improvement Title	
Type of PIP	☐ Clinical ☐ Non-clinical
PIP period (# months):	Start MM/YYYY to End MM/YYYY
Additional Information or comments	

Briefly describe the aim of the PIP, the problem the PIP is designed to address, and the improvement strategy.
What MHP/DMC-ODS data have been reviewed that suggest the issue is a problem?
What are the barrier(s) that the qualitative and/or quantitative data suggest might be the cause of the problem?
Who was involved in identifying the problem? (Roles, such as providers or enrollees, are sufficient; proper names are not needed.) Were beneficiaries or stakeholders who are affected by the issue or concerned with the issue/topic included?
Are there relevant benchmarks related to the problem? If so, what are they?

Step 1: Identifying the PIP Topic

WORKSHEET 2: DRAFTING THE AIM STATEMENT

What is the Aim Statement of this PIP? (The Aim statement should be concise, answerable, measurable and time bound.)
Briefly state the improvement strategy that this PIP will use. (Additional information regarding the improvement strategy/intervention should be supplied in Step 6.)
Who is the population on which this PIP focuses? Provide information on the study population such as age, length of enrollment, diagnosis, and other relevant characteristics of the affected population.
What is the timeframe for this PIP, from concept development to completion? Start MM/YYYY End MM/YYYY
Additional Information or comments

Step 2: Developing the Aim Statement

WORKSHEET 3: IDENTIFYING THE PIP POPULATION

Who is the population on which this PIP focuses? Provide information on the study population such as age, length of enrollment, diagnosis, and other relevant characteristics of the affected population. Please include data, sources of information and dates of sources.
Will all enrollees be included in the PIP? ☐ Yes ☐ No
If no, who will be included? How will the sample be selected?
Additional Information or comments

Step 3: Identifying the PIP Population

WORKSHEET 4: DESCRIBING THE SAMPLING PLAN

If the entire population is being included in the PIP, skip Step 4.

If the entire population is NOT being included in the PIP, complete the following:

Describe the sampling frame for the PIP. A sampling frame is the list from which the sample is drawn. It includes the universe of members of the target PIP population, such as individuals, caregivers, households, encounters, providers, or other population units that are eligible to be included in the PIP. The completeness, recency, and accuracy of the sampling frame are key to the representativeness of the sample
Specify the true or estimated frequency of the event.
Determine the required sample size to ensure that there are a sufficient number of enrollees taking into account non-response, dropout, etc.
State the confidence level to be used.
State the margin of error.
Additional Information or comments

Step 4: Describing the Sampling Plan

WORKSHEET 5: SELECTING PIP VARIABLES AND PERFORMANCE MEASURES

The questions below can be answered generally. Please complete the tables below for specific details.

What are the PIP variables used to track the intervention(s)? The outcome(s)? Refer to the tables 5.1 – 5.3 for details.
What are the performance measures? Describe how the Performance Measures assess an important aspect of care that will make a difference to beneficiary health or functional status?
What is the availability of the required data?
Additional Information or comments

TABLE 5.1 VARIABLE(S) AND INTERVENTION(S)

Goal	(Independent) Variable	Intervention	Performance Measure (Dependent Variable)	**Improvement Rate**
Example 1: Decrease use of emergency departments (EDs)	1) Documented count of reminder calls per outpatient appointment 2) Number of outpatient visits within 45 days of ED dx	1) Implement reminder calls 2) Outpatient services following dx from ED	Number of ED visits	
Example 2: Decrease antidepressant use by adolescents already using	1) Documented count of warm hand-offs from doc to CM 2) Documented count of visits for psychosocial services	1) Warm hand-off from doc to CM 2) Psychosocial services	1) # of youth on anti-depressants attending MH therapy at least 3 times in 1 month 2) # of youth who terminate use totally 3. # of youth whose dosages are decreased	

TABLE 5.2 SOURCES OF INDEPENDENT AND DEPENDENT VARIABLES

	Variable	Source of Data	Availability of Data
1			
2			
3			
4			
5			
6			

Step 5: Selecting the PIP Variables and Performance Measures

WORKSHEET 6: DESCRIBE IMPROVEMENT STRATEGY (INTERVENTION) AND IMPLEMENTATION PLAN

Answer the general questions below. Then provide details in the table below.

Describe the improvement strategy/intervention.
What was the quantitative or qualitative evidence (published or unpublished) suggesting that the strategy (intervention) would address the identified barriers and thereby lead to improvements in processes or outcomes?
Does the improvement strategy address cultural and linguistic needs? If so, in what way?
When and how often is the intervention applied?
Who is involved in applying the intervention?
How is competency/ability in applying the intervention verified?
How is the MHP/DMC-ODS ensuring consistency and/or fidelity during implementation of the intervention (i.e., what are the process indicators)?
Additional Information or comments

Complete this table and add (or attach) other tables/figures/charts as appropriate.

TABLE 6.1 IMPROVEMENT STRATEGY SUMMARY

	Intervention	Intervention Target Population	Date (MM/YYYY) Intervention Began	Frequency of Intervention Application	Corresponding Process Indicator(s)
1					
2					
3					
4					

Step 6: Describing the Improvement Strategy (Intervention) and Implementation Plan

WORKSHEET 7: DESCRIBING THE DATA COLLECTION PROCEDURES

Describe the methods for collecting valid and reliable data.
What are the data sources being used?
What are the data elements being collected?
What is the frequency of data collection (daily, weekly, monthly, annually, etc.)?
Who will be collecting the data?
What data collection instruments are being used? Please note if the MHP/DMC-ODS has created any instruments for this PIP.
Additional Information or comments

Step 7: Describing the Data Collection Procedures

WORKSHEET 8: DATA ANALYSIS AND INTERPRETATION OF PIP RESULTS

After carrying out the PIP, collecting, analyzing and interpreting the data, answer the following questions *with respect to the original aim of the PIP*:

What are the results of the study?
How often were the data analyzed?
Who conducted the data analysis, and how are they qualified to do so?
How was change/improvement assessed?
To what extent was the data collection plan adhered to—were complete and sufficient data available for analysis?
Were any statistical analyses conducted? If so, which ones? Provide level of significance.
Were factors considered that could threaten the internal or external validity of the findings examined?
Additional Information or comments

Present the objective results at each interval of data collection. Complete this table and add (or attach) other tables/figures/charts as appropriate.

TABLE 8.1 PIP RESULTS SUMMARY

Performance Measures	Baseline Measurement	Re-measurement 1	Re-measurement 2	Dates of Baseline and Re-measurements	FINAL Measurement

Step 8: Describing the Data Analysis and Interpretation of PIP Results

WORKSHEET 9: LIKELIHOOD OF SIGNIFICANT AND SUSTAINED IMPROVEMENT THROUGH THE PIP

What is the conclusion of the PIP?
Do improvements appear to be the results of the PIP interventions? Explain.
Does statistical evidence support that the improvement is true improvement?
Did any factors affect the methodology of the study or the validity of the results? If so, what were they?
What, if any, factors threatened the internal or external validity of the outcomes?
Was the improvement sustained through repeated measurements over comparable time periods? (If this is a new PIP, what is the plan for monitoring and sustaining improvement?)
Were there limitations to the study? How were untoward results addressed?
What is the MHP/DMC-ODS's plan for continuation or follow-up?
Additional Information or comments

Step 9: Address the Likelihood of Significant and Sustained Improvement Through the PIP

Behavioral Health Concepts, Inc – California EQRO | www.caleqro.com | info@bhceqro.com
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Information Systems Capabilities Assessment (ISCA)

FY 2020-21

Version 1.1

California Mental Health Plans & Drug Medi-Cal Organized Delivery Systems

MHP and DMC-ODS County Name: _____

Return an electronic copy of the completed assessment to CalEQRO for review by _____

Please note joint ISCA tool is to be used if MHP and DMC-ODS programs are using the same EHR system. If different EHR systems are being used, please use the separate MHP or DMC-ODS ISCA tool.

This document was produced by the California External Quality Review Organization (CalEQRO) in collaboration with the California Department of Health Care Services – Behavioral Health Division and California MHP and DMC-ODS stakeholders.

Information Systems Capabilities Assessment (ISCA)

Contact Information

Insert MHP and DMC-ODS identification information below. The contact name should be the person(s) completing or coordinating the completion of this assessment.

ISCA contact name and title:	
Mailing address:	
Phone number:	
Fax number:	
E-mail address:	
Identify primary persons who participated in completion of the ISCA (name, title):	
Date assessment completed:	

PURPOSE of the Information Systems Capabilities Assessment (ISCA)

Knowledge of the information systems (IS) capabilities of a Mental Health Plan (MHP) and Drug Medi-Cal Organized Delivery System (DMC-ODS) are essential to evaluate the MHP's capacity to manage the health care of its beneficiaries. The purpose of this assessment is to specify the desired capabilities of the MHP's and DMC-ODS' information systems and to pose standard questions to assess the strength of an MHP and DMC-ODS with respect to these capabilities. This will assist an External Quality Review Organization (EQRO) to assess the extent to which an MHP's and DMC-ODS' information systems can produce accurate data to measure encounters[1] and performance, support quality assessment and improvement, and inform the delivery and managing of care for its beneficiaries.

[1] "For the purposes of this protocol, an encounter refers to the electronic record of a service provided to a Managed Care Organization Pre-Paid Inpatient Health Plan [MHP and DMC-ODS] enrollee by both institutional and practitioner providers (regardless of how the provider was paid) when the service would traditionally be a billable service under fee-for-service (FFS) reimbursement systems. They contain substantially the same information included on claim forms (e.g., UB-04 or CMS 1500), although not necessarily in the same format as Protocol 5. Validation of encounter data reported by the Medicaid and CHIP managed care plan, CMS Protocol 199; October 2019.

OVERVIEW of the Assessment Process

Assessment of the MHP's and DMC-ODS' information systems is a process of four consecutive activities:

Step One involves the collection of standard information about each MHP's and DMC-ODS' information systems. This is accomplished by having the MHP and DMC-ODS complete an *Information Systems Capabilities Assessment (ISCA) for California Mental Health Plans.* CalEQRO developed the ISCA in cooperation with California stakeholders and the California Department of Health Care Services – Behavioral Health Division. It is provided to the MHP and DMC-ODS as part of the CalEQRO review notification packet. The California Department of Health Care Services – Behavioral Health Division defined the time frame in which it expects the MHP and DMC-ODS to complete and return the tool. The MHP and DMC-ODS will commonly require input from multiple areas of the organization such as IT/IS, Finance, Operations, and Quality Improvement in completing the ISCA. The MHP and DMC-ODS may also attach additional sheets as needed and clearly identify them as applicable to the numbered item on the tool (e.g., 1.4, or 2.2.3).

Step Two involves a review of the completed ISCA by the EQRO reviewers. Materials submitted by the MHP and DMC-ODS will be reviewed in advance of a site visit or virtual site review.

Step Three involves a series of onsite and/or telephone interviews, and discussion with key MHP and DMC-ODS staff members who completed the ISCA, as well as other knowledgeable MHP and DMC-ODS staff members. The purpose of the interviews is to gather additional information to assess the integrity of the MHP's and DMC-ODS' information systems.

Step Four produces an analysis of the findings from both the ISCA and the follow-up discussions with the MHP and DMC-ODS staff. A summary report of the interviews, as well as the completed ISCA document, is included in an information systems section of the EQRO report. The report discusses the ability of the MHP and DMC-ODS to use its information systems and analyze its data to conduct quality assessment and improvement initiatives. Further, the report considers the ability of the MHP's and DMC-ODS' information systems to support the management and delivery of mental health care and substance use disorders treatment services.

INSTRUCTIONS for completing the ISCA:

- Please complete this survey using Microsoft Word. Insert your response after each question.
- Label the ISCA submission with your county name and applicable fiscal year. For example, “Alameda ISCA FY 2020-21.xx/xx/xxxx.doc”.
- Be as concise as possible. If information is not available, write “N/A” in your response. If additional space is needed, please continue your response on a separate page.
- For any ISCA question, you may attach existing documents which provide an answer. For example, if you have current policy and procedure documents that address a question, attach and reference these materials.
- Do not create documents expressly for the CalEQRO review.
- Do not submit any documents with protected health information (PHI).
- Do not submit any documents with personally identifiable information (PII).
- This ISCA pertains to the collection and processing of data for Medi-Cal. In many situations, this may be no different from how a MHP and DMC-ODS collect and processes commercial insurance or Medicare data. However, if your MHP and DMC-ODS manage Medi-Cal data differently than commercial or other data, please answer the questions only as they relate to Medi-Cal beneficiaries and Medi-Cal data.

For clarification, certain terms used in this ISCA are defined below:

Beneficiary — The EQRO review focus is the Medi-Cal program, therefore individuals who are Medi-Cal eligible are referred to as beneficiary throughout the ISCA. We also recognize at times MHPs also refer to Medi-Cal eligible beneficiaries as consumers, clients, or patients.

Practice Management — Supports basic data collection and processing activities for common clinic/program operations such as new beneficiary registrations, beneficiary look-ups, admissions and discharges, diagnoses, services provided, billing, Client and Services Information (CSI) system and California Outcomes Measurement System (CalOMS) and American Society of Addiction Medicine (ASAM) reporting, and routine reporting for management needs such as caseload lists, productivity reports, and other day-to-day needs.

Medication Tracking — Includes history of medications prescribed by the MHP and/or DMC-ODS or externally prescribed medications, including over-the-counter drugs.

Managed Care — Supports the processes involved in authorizing services, receipt and adjudication of claims from network (formerly fee-for-service) providers, remittance advices, notices of action (NOAs), grievances and related reporting and provider notifications.

Electronic Health Records — Clinical records stored in electronic form as all or part of a beneficiary's file/chart and referenced by providers and others involved in direct treatment or related activities. This may include documentation such as assessments, treatment plans, progress notes, allergy information, lab results, and prescribed medications. It may also include electronic signatures.

Telehealth — Two-way, interactive treatment session between the beneficiary and their healthcare professionals at the distant site. This electronic communication means the use of interactive telecommunication equipment that includes, at a minimum, audio and video equipment. (Telehealth includes telemedicine and telepsychiatry).

Interoperability — The ability of health information systems to exchange electronic transactions within and across organizational boundaries to advance the effective delivery of healthcare data for beneficiaries.

Electronic Data Interchange — The electronic interchange of healthcare information using a standardized format; a process which allows one healthcare system to send information to another healthcare system electronically rather than with paper. Entities conducting business electronically are called trading partners.

Health Information Exchange — The exchange of health care information electronically across organizations within a region, community or hospital system. HIE provides the capability to electronically exchange standardized clinical information among different health care information systems.

Community Based Organizations — Treatment facilities and programs, many with long-standing contractual relationships with counties, that deliver services on behalf of an MHP or DMC-ODS and bill for their services through the MHP's Short-Doyle/Medi-Cal system or through the DMC-ODS. These are also known as contract providers. They are required to submit cost reports to the MHP or DMC-ODS and are subject to audits. They are not staffed with county employees, as county-run programs typically are. For the ISCA tool we interchangeably use the terms CBOs and contract providers. Contract providers do not include the former Medi-Cal fee-for-service

providers (often referred to as network providers) who receive authorizations to provide services and whose claims are paid or denied by the MHP's managed care division/unit.

Network Providers — This includes sole practice or small group practices who are contracted by the MHP to deliver behavioral health services for special populations, i.e., language, age groups, and diagnostic conditions.

Network Adequacy — The Final Rule requires the creation of network adequacy standards for behavioral health services in Medicaid managed care (mental health and substance use disorders). Three sections of the Final Rule comprise the majority of the network adequacy standards included in Title 42 of the Code of Federal Regulations:

- Timely access to service standards,
- Time and distance standards, and
- Assessment of the adequacy of the provider network.

If services cannot be provided within the provider network, services must be provided by an out of network provider.

The Final Rule allows for exceptions to time and distance or timely access standards with alternate access standards when the MHP has exhausted available options, including use of telemedicine and out of network providers.

SECTION A. *General Information*

A.1. List the top priorities for your MHP's and DMC-ODS' IS department:

Priority	MHP Status	DMC-ODS Status
	☐ Active ☐ Pending	☐ Active ☐ Pending
	☐ Active ☐ Pending	☐ Active ☐ Pending
	☐ Active ☐ Pending	☐ Active ☐ Pending
	☐ Active ☐ Pending	☐ Active ☐ Pending
	☐ Active ☐ Pending	☐ Active ☐ Pending

A.2. Describe significant IS-related achievements which were in-process or completed since the last CalEQRO review; indicate for each if it applies to MHP, DMC-ODS, or both MHP and DMC-ODS.

Priority	MHP Status	DMC-ODS Status
	☐ Completed ☐ In-process	☐ Completed ☐ In-process
	☐ Completed ☐ In-process	☐ Completed ☐ In-process
	☐ Completed ☐ In-process	☐ Completed ☐ In-process
	☐ Completed ☐ In-process	☐ Completed ☐ In-process
	☐ Completed ☐ In-process	☐ Completed ☐ In-process
	☐ Completed ☐ In-process	☐ Completed ☐ In-process

A.3. Do you have a current written business strategic plan for IS? If Yes, submit copy of the business plan with the ISCA.

☐ Yes ☐ No

A.4. How are mental health and substance use treatment services delivered?

Of the total number of services provided during the **prior calendar or fiscal year**, regardless of payment source, approximately what percentage were provided by:

	MHP	DMC-ODS
Type of Provider	Distribution	Distribution
County-operated/staffed clinics	%	%
Community Based Organizations (CBO)	%	%
Network providers	%	N/A
Total	100%	100%

A.5. Of the total number of services provided, approximately what percentage are claimed to Medi-Cal?

MHP	DMC-ODS
%	%

A.6. What percent of total annual or fiscal year MHP and DMC-ODS budgets are dedicated to support information systems (County IT overhead for operations, hardware, network, software license, ASP support, contractors, and IT staff salary/benefit costs)?

MHP	DMC-ODS
%	%

A.6.1 Identify basis used to determine budget percentage reported above.

☐ Fiscal Year ☐ Calendar Year ☐ Cost Report

A.7. Who controls the budget determination process for information system operations identified in A.6?

☐ Under MHP control
☐ Under DMC-ODS control
☐ Allocated to the MHP and DMC-ODS and managed by another County department
☐ Combination of MHP/DMC-ODS control and another County department or Agency

A.8. Estimate the number of people (named users) with log-on authority to or in your EHR information system:

Type of Staff	Estimated Number of Hands-on Users	
	MHP	**DMC-ODS**
Administrative and Clerical		
Clinical Healthcare Professional		
Clinical Peer Specialist		
Quality Improvement		
CBO/Contract Provider Administrative and Clerical		
CBO/Contract Provider Clinical Healthcare Professional		
CBO/Contract Provider Clinical Peer Specialist		
CBO/Contract Provider Quality Improvement		

A.9. **A.** Do contract provider users have access to directly enter data into MHP EHR?

☐ Yes ☐ No

B. Do contract provider users have access to directly enter data into DMC-ODS EHR?

☐ Yes ☐ No

Primary EHR Information Systems Used by the MHP and DMC-ODS

A.10. Describe the primary practice management and clinical systems currently in use:

System/ Application	Function	Version/ Build/ Promotion	Vendor/ Supplier	Years Used	Hosted By

A.10.1 What functions do these products perform or support?

(Check all that currently are used)

☐	Practice Management	☐	Appointment Scheduling	☐	Medication Tracking
☐	Managed Care	☐	e-Prescribing	☐	Data Warehouse/Mart
☐	Electronic Health Record (EHR)	☐	Document Imaging/ Storage	☐	Laboratory Results
☐	Outcomes	☐	Personal Health Record (PHR)	☐	Registry
☐	Referral Management	☐	Care Coordination	☐	Whole Person Care

A.11. Do you monitor EHR system percent of uptime and availability for clinical sites?
(If Yes, be prepared to provide information when CalEQRO is onsite.)

☐ Yes ☐ No

A.11.1 Do you have a standard or periodically measure end-user screen response time?

☐ Yes ☐ No

A.11.2 If Yes, what is your contract standard or recent end-user response test results?

(Select the one that most closely matches your policy or current standard)

☐	Under one second	☐	Between three to five seconds
☐	Between one to two seconds	☐	Do not track or monitor

A.12. Is your MHP or DMC-ODS a member/participant in Health Information Exchange?

☐ Yes ☐ No

A.12.1 If Yes, provide Health Information Exchange(s) name.

MHP	
DMC-ODS	

A.12.2 If No, does your healthcare professional staff do secure information exchange directly with service partners (e.g.: secure email, care coordination application/module, electronic consult)?

MHP	
DMC-ODS	

A.13. Are jail mental health or substance use disorder service transactions directly entered into the behavioral health EHR or entered into the behavioral health EHR electronically through a data exchange process from another EHR system?

☐ Yes ☐ No

A.13.1 If Yes, report total number of jail beneficiaries served in detention settings during last 12-month period:

MHP	DMC-ODS

A.13.2 If No, identify how jail mental health services or substance use disorders treatment service are provided.

Jail Mental Health/SUD System Operated By
☐ Another County Department (not MHP/SUD IS)
☐ Correctional Health-Care Service Provider

Secondary Information Systems Used by the MHP and/or DMC-ODS

A.14. List any other significant information systems used by your MHP and DMC-ODS in addition to your primary IS:

MHP	DMC-ODS	System/ Application	Function	Vendor/Supplier	Years Used	Hosted By
☐	☐					
☐	☐					
☐	☐					
☐	☐					
☐	☐					
☐	☐					
☐	☐					

A.15. A. Selection and implementation of a new Information System for **MHP**:

Mark one box that best describes your status today and respond to the associated questions:

☐ A) No plans to replace current system (in place more than five years).

☐ B) Considering a new system, but no formal project plan in place and no project team assigned to accomplish it.

☐ C) Actively searching for a new system, project plan in place and project team assigned and active.

☐ D) New system selected, not yet in implementation phase.

☐ E) Implementation in progress.

☐ F) New system in place (use this for systems installed in past five years).

B. Selection and implementation of a new Information System for **DMC-ODS**:

Mark one box that best describes your status today and respond to the associated questions:

☐	A) No plans to replace current system (in place more than five years).
☐	B) Considering a new system, but no formal project plan in place and no project team assigned to accomplish it.
☐	C) Actively searching for a new system, project plan in place and project team assigned and active.
☐	D) New system selected, not yet in implementation phase.
☐	E) Implementation in progress.
☐	F) New system in place (use this for systems installed in past five years).

A.16. Implementation of a new Information System
If you marked box D or E in A.15 A or B, complete the following questions. Otherwise skip to A.17.

A.16.1 Details of the new system:

Vendor:
Product(s):
Implementation start date:
Estimated go live date:
Estimated completion date:

A.16.2 Please identify staff directly responsible for system implementation:

Project Responsibility	Name and Title
Executive Sponsor	
Overall Project Director	
Project Manager	
Technology Project Manager	
Clinical Project Manager	

A.16.3 What departments/agencies, other than MHP and DMC-ODS county staff, will have direct access to the EHR system?

(Check all that apply)

☐	Mental Health Contract Providers (MHP)	☐	Federally Qualified Health Center (FQHC)
☐	Alcohol and Drug Contract Providers (SUD)	☐	Community/Rural Health Center (CHC-RHC)
☐	Whole Person Care (WPC)	☐	Primary Care Providers (PCP)
☐	Hospital(s)	☐	Indian Health Center (IHC)

A.17. Indicate status of the MHP's or DMC-ODS EHR deployment in the table below:

Function	MHP	DMC-ODS	Application/ Vendor	MHP Contract Provider Access	DMC-ODS Contract Provider Access
Alerts	☐	☐			
Assessments	☐	☐			
Care Coordination	☐	☐			
Document Imaging/ Storage	☐	☐			
Electronic Signature (Beneficiary)	☐	☐			
Laboratory Orders/ Results (eLab)	☐	☐			
Level of Care/ Level of Service	☐	☐			
Outcomes	☐	☐			
Prescriptions (eRx)	☐	☐			
Progress notes	☐	☐			
Referral Management	☐	☐			
Treatment plans	☐	☐			

A.17.1. A. Your official Chart of Record for county-operated **MHP** clinics/programs?

☐ Paper ☐ Electronic ☐ Combination

B. Your official Chart of Record for county-operated **DMC-ODS** programs?

☐ Paper ☐ Electronic ☐ Combination

A.17.2 A. If you checked Paper for A.17.1 A **(MHP**)., what remains on paper?

(Check all that apply)

☐	Medication Consent	☐	Release of Information
☐	Beneficiary Schedules	☐	Crisis Assessments
☐	Primary Care Coordination	☐	Laboratory Results
☐	Hospital Release Documents	☐	Medication History

B. If you checked Paper for A.17.1 B (**DMC-ODS**)., what remains on paper?

(Check all that apply)

☐	Medication Consent	☐	Release of Information
☐	Beneficiary Schedules	☐	Crisis Assessments
☐	Primary Care Coordination	☐	Laboratory Results
☐	Hospital Release Documents	☐	Medication History

A.18. A. How do MHP contract providers submit beneficiary practice management and service data to MHP IS?

Check all that apply – percentage estimates for submittal methods are acceptable but submittal method percentages must total 100%.

Submittal Method		Frequency	Submittal Method Percentage
☐	Health Information Exchange (HIE) between MHP IS	☐ Real Time ☐ Batch	%
☐	Electronic Data Interchange (EDI) to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	%
☐	Electronic batch file transfer to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	%
☐	Direct data entry into MHP IS by provider staff	☐ Daily ☐ Weekly ☐ Monthly	%
☐	Documents/files e-mailed to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	%
☐	Paper documents faxed to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	%
☐	Paper documents delivered to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	%
			100%

B. How do DMC-ODS contract providers submit beneficiary and service data to SUD IS?

Check all that apply – percentage estimates for submittal methods are acceptable but submittal method percentages must total 100%.

Submittal Method		Frequency	Submittal Method Percentage
☐	Health Information Exchange (HIE) between SUD IS	☐ Real Time ☐ Batch	%
☐	Electronic Data Interchange (EDI) to SUD IS	☐ Daily ☐ Weekly ☐ Monthly	%
☐	Electronic batch file transfer to SUD IS	☐ Daily ☐ Weekly ☐ Monthly	%
☐	Direct data entry into SUD IS by provider staff	☐ Daily ☐ Weekly ☐ Monthly	%
☐	Documents/files e-mailed to SUD IS	☐ Daily ☐ Weekly ☐ Monthly	%
☐	Paper documents faxed or delivered to SUD IS	☐ Daily ☐ Weekly ☐ Monthly	%
☒	Paper documents delivered to SUD IS	☐ Daily ☐ Weekly ☐ Monthly	%
			100%

A.18.1 For contract providers who have their own local EHR system or use ASP model EHR please complete the following information:

EHR Vendor Name	Name Contract Providers Using EHR

A.18.2 Briefly describe how you validate the integrity of claims data transfers from contract providers?

A.18.3 Are you, or, are you planning to implement interoperability to facilitate efficient data exchange with contract providers, primary care providers, and other partners?

If so, please provide:

Vendor	
Product Name	
Version installed or to be installed	

Telehealth Services – Use and Support

A.19. **A.** Does MHP currently use telehealth (telepsychiatry or telemedicine) services to augment service delivery capabilities?

☐ Yes ☐ No ☐ Implementing

A.19.1 A. If A.19. A. Yes or implementing; identify primary reason(s) for using telehealth as a service extender:

(Check all that apply)

☐ Hiring healthcare professional staff locally is difficult
☐ For linguistic capacity or expansion
☐ To serve outlying areas within the county
☐ To serve beneficiaries temporarily residing outside the county
☐ To serve special populations (i.e.: children/youth or older adult)
☐ To reduce travel time for healthcare professional staff
☐ To reduce travel time for beneficiaries
☐ To support Network Adequacy time and distance standards
☐ To address and support COVID 19 contact restrictions

A.19.1 B. Does DMC-ODS currently use, or is planning to implement, telehealth (telepsychiatry or telemedicine) services to augment service delivery capabilities?

☐ Yes ☐ No ☐ Implementing

If A.19.1. B. – Yes or in implementation status; identify primary reason(s) for using telehealth as a service extender:

(Check all that apply)

- ☐ Hiring healthcare professional staff locally is difficult
- ☐ For linguistic capacity or expansion
- ☐ To serve outlying areas within the county
- ☐ To serve beneficiaries temporarily residing outside the county
- ☐ To serve special populations (i.e.: children/youth or older adult)
- ☐ To reduce travel time for healthcare professional staff
- ☐ To reduce travel time for beneficiaries
- ☐ To support Network Adequacy time and distance standards
- ☐ To address and support COVID 19 contact restrictions

A.19.2 If A.19. A or A.19.1 B. – Yes; provide the following information:

	MHP	DMC-ODS
Telehealth Services	**Status**	**Status**
Medication support	☐ Yes ☐ No	☐ Yes ☐ No
Group therapy sessions	☐ Yes ☐ No	☐ Yes ☐ No
Group education and support sessions	☐ Yes ☐ No	☐ Yes ☐ No
Individual therapy session	☐ Yes ☐ No	☐ Yes ☐ No
Case management	☐ Yes ☐ No	☐ Yes ☐ No
New client intake and assessment	☐ Yes ☐ No	☐ Yes ☐ No

A.19.3 If A.19. A or A.19.1. B. – Yes; provide the following information:

Telehealth Information	MHP	DMC-ODS
Total number sites currently operational:		
Number county-operated sites:		
Number contract provider sites:		
Total number beneficiaries served during last 12 months:		
Adults:		
Children/Youth:		
Older Adults:		
Number telehealth encounters (services) provided last 12 months:		
Number telehealth encounters (services) provided in languages other than English provided last 12 months:		

A.19.4 If A.19 A. or A.19.1.B. – Yes; identify threshold languages directly supported by County or contract healthcare professional staff

during the past year. Do not include language line capacity or interpreter services.

(Check all that apply)

☐ Arabic	☐ Armenian	☐ Cambodian
☐ Cantonese	☐ Farsi	☐ Hmong
☐ Korean	☐ Mandarin	☐ Other Chinese
☐ Russian	☐ Spanish	☐ Tagalog
☐ Vietnamese		

A.20. Do any contract providers also use telehealth services as a service extender?

☐ Yes ☐ No

A.20.1 If A.20. – Yes identify contract providers who provide telehealth services using their own equipment. Complete the following information:

Name Contract Provider	Languages Supported	Number of Sites	Number of Beneficiaries Served	MHP, DMC-ODS or both

Beneficiary (Consumer) Personal Health Record

A.21. Do beneficiaries have on-line access to their health records, either through a personal health record (PHR) feature provided within the EHR, or a beneficiary portal, or through a third-party PHR such as those available through Network of Care, etc.?

☐ Yes ☐ No

If Yes, skip to A.22.

A.21.1 If No: Do you have future plans to implement a beneficiary personal health record?

☐ Yes ☐ No Plans to Implement

If No, skip to A.26.

A.21.2 If A.21.1 - Yes: Provide the expected implementation timeline.

(Select one timeline)

☐ Within six months	☐ Within the next two years
☐ Within the next year	☐ Longer than two years

A.22. Identify PHR services and support **currently** available to beneficiaries.

	MHP	DMC-ODS
Personal Health Services	**Status**	**Status**
View current, future, and prior appointments	☐ Yes ☐ No	☐ Yes ☐ No
Schedule or request new appointment	☐ Yes ☐ No	☐ Yes ☐ No
Receive appointment reminders	☐ Yes ☐ No	☐ Yes ☐ No
View active medication prescriptions	☐ Yes ☐ No	☐ Yes ☐ No
Capability to send and receive secure text messages	☐ Yes ☐ No	☐ Yes ☐ No

A.23. How many county-operated or contract provider sites are currently available for beneficiaries to access their personal health record?

A.24. Report the number of beneficiaries with access to their personal health records.

A.25. Are classroom or individual trainings available for beneficiaries to learn how to access and navigate the product or application?

☐ Yes ☐ No

A.25.1 If Yes, briefly outline the type of training and support provided.

Public Information Sharing /Communications

A.26. Does your MHP or DMC-ODS maintain an online provider directory for public access?

☐ Yes ☐ No

A26.1 If Yes, describe what provider information is maintained in the provider directory profile.

(Check all that apply)

- ☐ Providers' NPI
- ☐ Providers' License Number
- ☐ Providers' cultural trainings
- ☐ Languages spoken
- ☐ Gender-specific care
- ☐ Age-specific care
- ☐ Specialty health care
- ☐ Specialty therapy
- ☐ Accessibility (open to serve new clients)
- ☐ After hours or weekend appointments

A.26.2 If Yes, please provide link to online provider directory below.

MHP	
DMC-ODS	

A.26.3. A. Who is responsible to maintain and update MHP Provider Directory?

B. Who is responsible to maintain and update DMC-ODS Provider Directory?

A.27. Does the MHP and/or DMC-ODS and/or county public website URLs display content and information relevant to access/ engagement in languages other than English?

☐ Yes ☐ No

A.27.1 If Yes, provide URL address:

MHP	
DMC-ODS	

A.28. Who is responsible to maintain and update MHP and DMC-ODS web site(s)?

MHP	
DMC-ODS	

A.29. Do your MHP and DMC-ODS have a Social Media policy? If so, please provide a copy.

☐ Yes ☐ No

SECTION B. *Data Collection and Processing*

Data Timeliness, Accuracy and Completeness

B.1. **A.** Please specify what the expectation is for timely entry of MHP service/progress notes.

(Select only one that most closely matches the MHP timely policy)

☐	Same day	☐	Within five days
☐	Within 24 hours	☐	Within seven days
☐	Within two days	☐	More than seven days

B. Please specify what the expectation is for timely entry of DMC-ODS service/progress notes.

(Select only one that most closely matches the DMC-ODS timely policy)

☐	Same day	☐	Within five days
☐	Within 24 hours	☐	Within seven days
☐	Within two days	☐	More than seven days

B.1.1 Describe how you audit compliance with this policy. Include an example of any available summary data and the period of time this represents.

MHP	
DMC-ODS	

B.2. Do you review the following MHP or DMC-ODS data items for accuracy and completeness at time data is entered into EHR?

A. MHP data review:

(Check Yes/No box that applies)

Item	Yes/No	
Service date	☐ Yes	☐ No
Service time	☐ Yes	☐ No
Progress Note	☐ Yes	☐ No
Treatment Plan	☐ Yes	☐ No
Rendering Provider NPI	☐ Yes	☐ No
Rendering Provider Taxonomy	☐ Yes	☐ No

B. DMC-ODS data review:

(Check Yes/No box that applies)

Item	Yes/No	
Service date	☐ Yes	☐ No
Service time	☐ Yes	☐ No
Progress Note	☐ Yes	☐ No
Treatment Plan	☐ Yes	☐ No
Rendering Provider NPI	☐ Yes	☐ No
Rendering Provider Taxonomy	☐ Yes	☐ No

B.2.1 Identify the staff or the unit responsible to monitor for accuracy and completeness.

MHP	
DMC-ODS	

B.3. Describe how data errors discovered during back-end validations/processing are reported out and corrected.

B.3.1 Written protocols and/or procedures to identify and correct data errors.

Have documented procedures for handling data errors?	☐ Yes ☐ No
Does protocol/procedures apply to contract providers?	☐ Yes ☐ No

B.4. Describe any recent audit findings and recommendations. This may include EPSDT audits, Medi-Cal audits, DMC audits, independent county-initiated IS audits, OIG audits, and others.

MHP	
DMC-ODS	

Staff Credentialing – Network Adequacy (supported by policy)

B.5. Describe your process to validate new-hire providers' credentials; this includes license status and rendering provider NPI number?

MHP	
DMC-ODS	

B.5.1 Describe your process to validate providers' taxonomy code?

MHP	
DMC-ODS	

B.6. Briefly describe your workflow processes to capture MHP and DMC-ODS Network Adequacy rendering providers' data and information?

MHP	
DMC-ODS	

EHR Training and Ongoing User Support

B.7. For county-operated MHP or DMC-ODS staff - new user's initial network sign-on and initial EHR orientation.

A. For county-operated clinics and programs.

Training Activity	MHP IT	MHP QI	MHP Super Users	DMC-IT	DMC QI	DMC Super Users
Initial network logon access	☐	☐	☐	☐	☐	☐
EHR – User profile and access setup	☐	☐	☐	☐	☐	☐
EHR – Screen navigation	☐	☐	☐	☐	☐	☐
EHR – Reports, dashboard, alerts	☐	☐	☐	☐	☐	☐
Cultural Competency	☐	☐	☐	☐	☐	☐

B. For contract provider clinics and programs.

Training Activity	MHP IT	MHP QI	CBO Super Users	DMC-IT	DMC QI	CBO Super Users
Initial network logon access	☐	☐	☐	☐	☐	☐
EHR – User profile and access setup	☐	☐	☐	☐	☐	☐
EHR – Screen navigation	☐	☐	☐	☐	☐	☐
EHR – Reports, dashboard, alerts	☐	☐	☐	☐	☐	☐
Cultural Competency	☐	☐	☐	☐	☐	☐

B.8. List regular IS training offerings and frequency of trainings for Business and Billing staff, or, provide a list of classes conducted over the past year.

MHP	
DMC-ODS	

B.9. Do you routinely administer competency tests for IS users to evaluate training effectiveness?

☐ Yes ☐ No

B.10. Do you maintain a formal record or log of IS/computer training activities?

☐ Yes ☐ No

B.11. How frequently are HIPAA and 42 CFR Security and Privacy trainings conducted?

(Check all that apply)

☐	New Employee Orientation	☐	Once Annually
☐	Monthly	☐	Available - On Demand
☐	Quarterly	☐	Periodically

B.11.1 Do you monitor or review your contract providers HIPAA and 42 CFR Security and Privacy trainings and attendance log?

☐ Yes ☐ No

B.12. How many IS technology full time equivalent (FTE) positions are currently authorized for the MHP and DMC-ODS and describe changes since the previous CalEQRO review.

Program	IS FTEs (Include Employees and Contractors)	Number of New FTEs	Number of FTEs (Including Contractors) Retired, Transferred, Terminated)	Current Number of Unfilled FTEs
MHP				
DMC-ODS				

B.12.1 Has the number of authorized, approved or budgeted FTE positions increased or decreased during the past year?

☐ Increased ☐ Decreased ☐ No Change

B.12.2 Briefly explain purpose for increase or decrease of FTE positions.

MHP	
DMC-ODS	

B.12.3 Do you use an Application Service Provider to maintain and support the EHR?

☐ Yes ☐ No

B.13. How many data analytical FTEs do you currently have for the MHP and DMC-ODS and what are the changes since the previous CalEQRO review.

(Only report the number of FTEs that are not already included in the count provided in B.12. above).

Program	Data Analytical FTEs (Include Employees and Contractors)	Number of New FTEs	Number of FTEs (Including Contractors) Retired, Transferred, Terminated	Current Number of Unfilled FTEs
MHP				
DMC-ODS				

B.13.1 Has the number of authorized, approved or budgeted FTE positions increased or decreased during the past year?

☐ Increased ☐ Decreased ☐ No Change

B.13.2 Briefly explain the purpose for increase or decrease of FTE positions.

MHP	
DMC-ODS	

B.13.3 Do you use an outside company or organization to analyze data and produce reports?

☐ Yes ☐ No

Staff/Contract Provider Communications

B.14. A. Does your MHP have User Groups or other forums for both the contract and county providers to discuss information system issues and share knowledge, tips, and concerns?

Type of Group	Meeting Frequency (Weekly, monthly, quarterly, as needed)	Job Title for person who chairs meetings.	Do contract provider staff participate? (Yes/No)
Administrative Support User Group			
Clinical User Group			
Financial User Group			
Reports User Group			
IS Vendor Group			

B. Does your DMC-ODS have User Groups or other forums for both the contract and county providers to discuss information system issues and share knowledge, tips, and concerns?

Type of Group	Meeting Frequency (Weekly, monthly, quarterly, as needed)	Job Title for person who chairs meetings.	Do contract provider staff participate? (Yes/No)
Clerical User Group			
Clinical User Group			
Financial User Group			
Reports User Group			
IS Vendor Group			

B.15. What means and methods do you use to communicate policy, procedures, and information among MHP and DMC-ODS providers?

(Check all that apply)

☐ Web server	☐ Intranet server
☐ Shared network folders/files	☐ Content management software

☐ E-mail	☐ SharePoint

SECTION C. *Medi-Cal Claims Processing*

C.1. Indicate the normal cycle for submitting current fiscal year Medi-Cal and Drug Medi-Cal claim files to DHCS.

☐ Monthly ☐ More than 1x month ☐ Weekly ☐ More than 1x weekly

C.2. Do you have an internal operations manual or other documentation that describes activities to produce claims?

SD/MC Claims?	☐ Yes ☐ No
DMC Claims?	☐ Yes ☐ No

(Be prepared to present and discuss these during the CalEQRO review.)

C.3. Indicate the current method for submitting Medicare Part B claims to a fiscal intermediary.

☐ Clearinghouse ☐ Electronic ☐ Paper ☐ Not Medicare Certified

C.4. What Medi-Cal eligibility sources does your MHP and DMC-ODS use to determine eligibility?

(Check all that apply)

☐ IS Inquiry/retrieval from MEDS	☐ Eligibility verification using 270/271
☐ MEDS terminal (standalone)	☐ AEVS
☐ MEDS terminal (integrated with IS)	☐ Web-based search
☐ MMEF	☐ Other

C.4.1 Do you have procedures in place that monitor or review retroactive eligibility?

☐ Yes ☐ No

C.5. Do you have an Operations Manual or other documentation that describes how the Medi-Cal Remittance Advice (835) is analyzed for accuracy and/or completeness? (Be prepared to present and discuss this during the CalEQRO review.)

MHP	DMC-ODS
☐ Yes ☐ No	☐ Yes ☐ No

C.6. Do you have the capability to perform end-to-end (837/835) claims reconciliation to validate the adjudication of submitted claims?

☐ Yes ☐ No

C.6.1. If Yes, identify the type of product or application used:

☐ Dimension Reports application

☐ Web-based application, including your EHR system, supported by Vendor or ASP Staff

☐ Web-based application, supported by MHP or DMC staff

☐ Local SQL Database, supported by MHP/Health/County staff

☐ Local Excel Worksheet or Access Database

C.6.2 For voided claims tracking; does your product or application have the capability to record reason or purpose to void a previously paid claim?

☐ Yes ☐ No

C.6.3 What is the name of the product or application?

SECTION D. ***Incoming Claims Processing (MHP - Network Providers)***

(DMC-ODS Programs - skip Section D)

Note: "Network providers" (commonly known as fee-for-service providers or managed care network providers) may submit claims to the MHP with the expectation of payment. Network providers do not submit a cost report to the MHP.

D.1. Provide the approximate monthly volume of claims received from network providers:

Average number of claims per month	
Average claims in dollars per month	$

If average claims per month is less than $10,000 for Mental Health ***network providers****, skip the rest of Section D.*

D.2. Do you have any documentation, such as policies and procedures, for processing the items below for network providers? Be prepared to discuss during the CalEQRO review, if requested.

Item	Yes/No	
Processing incoming claims	☐ Yes	☐ No
Payment to network providers	☐ Yes	☐ No
Billing Short-Doyle/Medi-Cal	☐ Yes	☐ No
Other:	☐ Yes	☐ No

D.3. What is the average length of time between receipt of an initial claim and payment to network provider, in days?

D.4. Estimate the percentage of your network providers' claims that were disallowed for payment during the prior calendar year.

%

D.5. Estimate what percentage of your network providers claims were denied for the following reasons.

%	No prior authorization found or authorization expired.
%	Number of services (or service time) exceeds prior authorization.
%	Beneficiary not eligible for services.

SECTION E. *Information Systems Security and Controls*

E1. Indicate the frequency of back-ups that are required to protect your primary information systems and data. (Check all that apply)

Back-up Frequency	
☐ Daily full back-up	☐ Daily incremental back-up
☐ Weekly full back-up	☐ Weekly incremental back-up
☐ Other:	

E.1.1 Where is the back-up media stored?

(Check all that apply)

Back-up Location	
☐ MHP/ DMC-ODS site	☐ County site
☐ Health Department site	☐ IS Vendor site
☐ Data Security Vendor	☐ Other:

E.1.2 How often do you require passwords to be changed?

Password Change Frequency	
☐ ≤ 60 days	☐ 61-90 days
☐ 91-180 days	☐ 181-365 days
☐ > 365 days	☐ Never

E.1.3 Have you adopted guidelines or a local policy for password management?

☐ Yes ☐ No

E.1.4 Do you require passwords to contain a combination of alphabetic characters, numbers, and/or special characters?

☐ Yes ☐ No

E.2. Do you have policies and procedures that describe the provisions in place for the following? Be prepared to discuss during the CalEQRO interview, if requested.

Item	Yes/No	
Physical security of the computer system(s) and hardcopy files	☐ Yes	☐ No
Security of laptops and other portable storage devices	☐ Yes	☐ No
Management of user access	☐ Yes	☐ No
Termination of user access	☐ Yes	☐ No

E.3. Do you have policies and procedures that describe the privacy provisions for release of information in 42 CFR, Part 2?

☐ Yes ☐ No

E.3.1 Do you track "break-the-glass" instances in your EHR system to document reason or purpose for accessing a beneficiary medical record when this task is not normally done by the provider?

☐ Yes ☐ No

E.4. Do you require encryption for laptops or other portable storage devices that contain Protected Health Information (PHI)?

☐ Yes ☐ No

E.5. Does your network employ intrusion detections methodologies to protect beneficiary data?

☐ Yes ☐ No

E.6. Does the MHP have a designated System Security Officer position in the organization chart who reports to MHP Executive team?

☐ Yes ☐ No

E.6.1 If your response to E.6 was No. Does the Health Agency or County IT have the responsibility to perform and monitor IS security duties?

☐ Yes ☐ No

E.7. Does the County or MHP and DMC-ODS have a security Continuity Plan for critical business functions that is compiled and maintained in readiness for use in the event of a cyber-attack, emergency or disaster? If so, be prepared to discuss while CalEQRO is onsite.

☐ Yes ☐ No

E.7.1 Does the County or MHP and DMC-ODS have an exercise and testing program to ensure staff have good understanding of their roles and responsibilities to effectively implement the business continuity plan?

☐ Yes ☐ No

SECTION F. ***Data Access, Usage and Analysis***

F.1. Who are the people most responsible for analyzing data from your information system?

Title	Organization or Department/Division	MHP, DMC-ODS or both

F.2. Describe two examples of data analyses performed in the last year – one for the MHP and one for the DMC-ODS – that were used in quality improvement or business process improvement activities. Be prepared to discuss during the CalEQRO review, if requested.

MHP	
DMC-ODS	

F.3. Indicate the reporting tools used by your staff to create reports from the IS.

☐ Microsoft Excel	☐ Microsoft Access
☐ Crystal Reports	☐ SPSS
☐ SAS	☐ Cognos
☐ Dashboard Software	☐ Vendor-supplied Report Writer

F.4. A. Does the MHP system capture Level of Care recommendations, referrals, and admissions for beneficiaries?

☐ Yes ☐ No

B. Does the DMH-ODS system capture ASAM Level of Care recommendations, referrals, and admissions for beneficiaries?

☐ Yes ☐ No

F.4.1. A. What percentage of MHP beneficiaries who request treatment are screened for referrals using Level of Care criteria?

%

F.4.1. B. What percentage of DMC-ODS beneficiaries who request treatment are screened for referrals using ASAM criteria?

%

F.5. A. Does the MHP system track reason for referrals that do not match Level of Care criteria-based recommendation for placement?

☐ Yes ☐ No

B. Does the DMC-ODS system track reason for referrals that do not match the ASAM Criteria-based recommendation for Level of Care placement?

☐ Yes ☐ No

F.5.1. Does the EHR system track whether the person requesting treatment was eventually admitted into a treatment program?

☐ Yes ☐ No

F.6. Which of the below tools or instruments do you use to measure beneficiary outcomes:

(Check all that apply)

☐	ANSA	☐	ASQ	☐	BASIS 24
☐	CAFAS	☐	CALOCUS	☐	CANS or CANS-50
☐	CalOMS	☐	DERS	☐	ECBI
☐	CBCL	☐	GAD-7	☐	LOCUS
☐	FAD	☐	IMR	☐	PCL-5
☐	MORS	☐	OHIO SCALES	☐	PHQ-9
☐	PDS	☐	PHQ	☐	RBPC
☐	PSC-35	☐	PTSD-RI	☐	YOQ
☐	SESBI-R	☐	TSYC	☐	ASI

F.6.1 Describe how these outcomes are communicated and used within the organization.

MHP	
DMC-ODS	

F.7. Do you have a direct service clinical staff productivity standard for treatment & documentation time for county-operated programs?

☐ Yes ☐ No

F.8. How frequently do you calculate Medi-Cal beneficiary penetration rates? (Note: Please coordinate with QI in responding to this question, as this may be separately tracked.)

☐	Monthly	☐	Quarterly
☐	Annually	☐	Rely on CalEQRO data

F.8.1 What are the data sources for the numerator and denominator of your MHP's and DMC-ODS penetration rates?

MHP	
DMC-ODS	

F.8.2 For what specific purposes are the penetration rate data used?

MHP	
DMC-ODS	

F.9. Do you use prevalence data to measure your potential unmet service needs? (Note: Please coordinate with QI in responding to this question as this may be separately tracked.)

☐ Yes ☐ No

F.9.1 If Yes, what are the data sources for estimating the potential unmet service needs?

☐ CHIS	☐ Special Study
☐ NSDUH	☐ If other, specify

F.9.2 For what specific purposes are the unmet needs data used?

MHP	
DMC-ODS	

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DMC-ODS Network Adequacy

External Quality Review Form
Version 3.0

County: **Person Completing Form:**
Contact Info:

If county has no zip codes with alternate access standards, skip questions 1-3.

1. **List all zip codes with the approved alternate access standards (AAS). For each zip code, identify the closest youth ODF provider, adult ODF provider, and NTP provider for each zip code. Add additional rows to the table if needed.**

Zip Code	Youth Outpatient Provider		Adult Outpatient Provider		NTP Provider	
	(a) Name	(b) Address	(c) Name	(d) Address	(e) Name	(f) Address
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						

2. **Out of Network Provider Access to youth and adults for Outpt, IOP and NTP service options for clients.**

List all out of network providers used by the DMC-ODS to insure access based on time & distance requirements or capacity needs

Provider Name & Address	Outpatient Treatment /IOP		NTP/OTP
	(a) Youth	(b) Adult	(c) NTP
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

3. **List all activities to improve access in AAS areas. Address these activities by area/zip codes and for youth and adults addressing outpatient and NTP/OTP and residential treatment access efforts. <u>Add additional pages of paper if needed</u>**

a.
b.
c.
d.

4. **How do you address disabled population access needs (deaf, blind, physical mobility access) in AAS areas and in general?**

5. **What has been your experience with using health plan transportation supports for MAT/NTP, outpatient, residential treatment and other Medi-Cal required services throughout the county?**

6. **Please describe your tele health services provided to persons living in any of your zip codes that do not meet time and distance standards or to persons with mobility issues who need treatment but cannot get to clinic- based services below:**

7. **Please describe your mobile services provided to clients by type and to what populations and what areas of your county:**

8. **Please describe your work coordinating care with Native American Indian Health services if there are any tribes or clinics in your county:**

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<DMC-ODS> Assessment of Timely Access

FY20-21 CalEQRO Site Reviews

County/ DMC-ODS: Name of person completing form:

FY 20-21 DMC-ODS Assessment of Timely Access contains two sections. CalEQRO will review both sections with you on-site.

Section 1 asks about the DMC-ODS's tracking capacity for timeliness metrics. The items included in this section are based on state network adequacy standards and standard term and conditions for the waiver.

Section 2 is a timeliness assessment questionnaire. The items included in this section assess the DMC-ODS's own findings on timeliness metrics. The DMC-ODS SHOULD complete both sections and upload as part of the pre-review process.

SECTION I – TIMELINESS TRACKING CAPACITY

1. Initial Access to DMC-ODS Treatment Services:

Please check the appropriate boxes:

New Beneficiaries Only	**Contract Providers should be included**	☐ **Yes**	☐ **No**
1.1. The DMC-ODS is able to record the time of initial requests by new beneficiaries at access center and provider sites:		☐ **Yes**	☐ **No**
If yes:			
a. By Phone:		☐ **Yes**	☐ **No**
b. Walk-in:		☐ **Yes**	☐ **No**
c. External Referrals (specify sources tracked):		☐ **Yes**	☐ **No**
1.2. The DMC-ODS is able to match initial requests to *any* follow-up appointments (including ASAM assessments):		☐ **Yes**	☐ **No**
1.3. The DMC-ODS tracks the length of time from initial request to *first offered* appointment (including assessment):		☐ **Yes**	☐ **No**
1.4. The DMC-ODS tracks the length of time from initial request to *first accepted* appointment:		☐ **Yes**	☐ **No**
1.5. The DMC-ODS tracks the length of time from initial request to *first face to face visit (including assessments)*:		☐ **Yes**	☐ **No**
1.6. The DMC-ODS tracks timeliness of first dose for patients on an opioid requesting methadone.		☐ **Yes**	☐ **No**
1.7. The DMC-ODS tracks timeliness data for clients living in zip codes with Alternate Access Standards who request services.		☐ **Yes**	☐ **No**

2. Ongoing Timeliness and Related Issues:

Please check the appropriate boxes:

All Beneficiaries	Contract Providers must be Included in DMC-ODS tracking	☐ Yes	☐ No
2.1. The DMC-ODS has a documented operational definition for an urgent appointment - Describe below:		☐ Yes	☐ No
2.2. The DMC-ODS is able to record the time of *urgent* appointment requests:		☐ Yes	☐ No
If yes:			
a. By Phone:		☐ Yes	☐ No
b. Walk-in to network provider sites:		☐ Yes	☐ No
c. External Referrals (specify sources tracked):		☐ Yes	☐ No
2.3 The DMC-ODS tracks the length of time between the *request for urgent appointment to initial face to face contact*:		☐ Yes	☐ No
2.4. The DMC-ODS tracks the *percentage* of residential discharged clients *who* receive a *follow-up care encounter within 7 days*:		☐ Yes	☐ No
2.5. The DMC-ODS tracks the *percentage* of withdrawal management discharged clients *who* get *readmitted to WM within 30 days*:		☐ Yes	☐ No
2.6. The DMC-ODS tracks it's *No Show rates for outpatient* appointments:		☐ Yes	☐ No

SECTION II – TIMELINESS FINDINGS

Please identify the time frame you are referencing (e.g. FY20-21, CY20, CY21, etc.):

- In this section, please provide the timeliness findings for key timeliness metrics that were marked YES in Section I.
- Leave blank for items that the DMC-ODS does not collect or calculate.

1. The length of time from initial request to first offered routine appointment (if tracked):

Use this text box to provide any specific methodological issues:

Data: ☐ **Entire System** ☐ **County Operated Only** ☐ **Contract Providers Only**

Routine Appointments Offered	All Services	Adult Services	Youth services
Average length of time from first request for service to first offered routine appointment	days (mean)	days (mean)	days (mean)
DHCS standard (10 business days) for offered appointment	10 days	10 days	10 days
Percent of appointments that meet DHCS standard	%	%	%
Range (minimum – maximum)	days	days	days

2. The length of time from initial request to first routine visit/service:

Use this text box to provide how this data is tracked:

Data: ☐ **Entire System** ☐ **County Operated Only** ☐ **Contract Providers Only**

Routine Visits/Services	All Services	Adult Services	Children's Services
Average length of time from first request for service to first visit/service	days (mean)	days (mean)	days (mean)
DHCS standard (10 business days) for first routine visit/service	10 days	10 days	10 days
Percent of first routine visits/services that meet this standard	%	%	%
Range (minimum – maximum)	days	days	days

3. The length of time from initial routine MAT request to NTP appointment/contact:
Describe how you calculate this percentage (only include MAT at NTP sites):

Data: ☐ **Entire System** ☐ **County Operated Only** ☐ **Contract Providers Only**

	All Services	Adult Services	Children's Services
Average length of time from assessment/ screening for MAT service to first MAT appointment at NTP sites	days (mean)	days (mean)	days (mean)
DHCS standard (3 business days) for routine NTP appointment	3 days	3 days	3 days
Percent of appointments that meet this standard	%	%	%
Range (minimum – maximum)	days	days	days

4. The length of time from service request for urgent appointment to actual visit/service encounter:

Describe how you calculate this percentage:

Data: ☐ **Entire System** ☐ **County Operated Only** ☐ **Contract Providers Only**
Unit of Measurement: ☐ **Hours**

	All Services	Adult Services	Youth Services
Average length of time for first urgent visit/service	hours (mean)	hours (mean)	hours (mean)
DHCS standard (48 hours) for urgent appointments	48 hours	48 hours	48 hours
Percent of appointments that meet this standard	%	%	%
Range (minimum – maximum)	hours	hours	hours

5. Timeliness of follow-up services post-residential treatment (3.1, 3.3, 3.5) discharge:

Use this text box to provide a description of how this is calculated:

	All Age Groups	Adult Residential Treatment	Children's Residential Treatment
Total number of residential discharges			
Number of clients who had a follow-up session within 7 days after discharge			
Average length of time for the first follow-up session after residential discharge	days range	days range	average range
DMC-ODS standard or goal	days	days	days
Percent of first follow-up services/visits that meet this standard	%	%	%

6. Withdrawal Management (WM) readmission rates within 30 days:

Use this text box to provide a description of how this is calculated:

☐ **All Providers Withdrawal Management** ☐ **Residential/WM Only** ☐ **OP WM Only**

	All Services	Adult Services	Children's Services
Total number of withdrawal management admissions			
Total number of clients with readmissions within 30 days of previous discharge			
Readmission rate (30 days)	%	%	%

7. No show rates for initial visit/service

How are no shows for first visit/service tracked?

☐	Anyone who did not make their first scheduled appointment
☐	Anyone who did not make their first scheduled appointment except for those who called in advance to cancel
☐	Anyone who did not make their first scheduled appointment except those who called in advance to reschedule
☐	Not tracked
☐	Other

8. **What was the <u>average monthly no show rate for first scheduled visit/service</u> (please indicate "NA" if not tracked)?**

Program Type and Overall	Average Monthly Scheduled First Visits/Services	Average Monthly No Shows	Average Monthly Percent No Shows
Outpatient			%
Intensive outpatient			%
Partial Hospital			%
NTP			%
Residential treatment (combine 3.1, 3.3, 3.5)			%
Residential withdrawal Management (3.2WM)			%
Total across all programs			%

9. **<u>Frequency of Timeliness Report Production (please upload to BOX at least one example report):</u>**

☐ **Monthly**	☐ **Quarterly**	☐ **Semi-Annually**	☐ **Annually**	☐ **Other (Please describe:)**

10. **<u>Frequency of Timeliness Report Review in ☐ QIC or ☐ Leadership Meetings ☐ Other:</u>**

☐ **Monthly**	☐ **Quarterly**	☐ **Semi-Annually**	☐ **Annually**	☐ **Other (Please describe:)**

Please include the de-identified source data used for the calculations included in this survey. These may be reports from your IS, Excel spreadsheets, or handwritten calculations. Please do not submit PHI.

If your DMC-ODS conducts any timeliness analyses by ethnic group or preferred language, please submit those as well.

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<DMC-ODS> Significant Changes and Initiatives

FY20-21 Site Reviews

Please outline key issues that the DMC-ODS has faced over the past year and plans to deal with over the coming year.

(If the DMC-ODS has a formal Strategic Plan, please submit that in addition to this document. The Strategic Plan can substitute for the "Current Initiatives" section.)

Changes to the environment impacting the DMC-ODS

1.
2.
3.
4.
5.

DMC-ODS list of significant initiatives and accomplishments since the last CAEQRO review (or during the past year if this is a first CalEQRO review)

1.
2.
3.
4.
5.

DMC-ODS List of Current Initiatives

1.
2.
3.
4.
5.

Information on Pending PED DMC Certifications

Legal Entity Org	Program Name	Type 2 NPI	Address	Service Type Waiting Approval	Number of Beds/Services *	Date of Application	Impact of Delay on Org & Capacity

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Please complete this roster for attendees and list participant names in alphabetical order by last name. **Please only list each name once**, no matter how many sessions they attend.

DMC-ODS - CalEQRO FY20-21 Review Attendance Log				
PARTICIPANTS				
LAST NAME	**FIRST NAME**	**POSITION**	**AGENCY**	**INITIALS**

BHC | Behavioral Health Concepts, Inc

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

<table>
<tr><td colspan="4">Policy/Procedure Number: MCCP2028</td><td colspan="3">Lead Department: Health Services</td></tr>
<tr><td colspan="4">Policy/Procedure Title: Residential Substance Use Disorder Treatment Authorization</td><td colspan="3">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="4">Original Date: 11/13/2019
Effective Date: TBD</td><td colspan="3">Next Review Date: <s>04/08/2021</s>04/14/2022
Last Review Date: <s>04/08/2020</s>04/14/2021</td></tr>
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<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: <s>04/08/2020</s>04/14/2021</td></tr>
</table>

I. RELATED POLICIES:

A. MCCP2022 – Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services
B. MCUP3037 – Appeals of Utilization Management/Pharmacy Decisions
C. MPUD3001 – Utilization Management Program Description
D. CGA024 – Medi-Cal Member Grievance System
E. MPQP1016 – Potential Quality Issue Investigation and Resolution
F. MCUP3113 – Telehealth Services
G. CMP41 – Wellness and Recovery Records

II. IMPACTED DEPTS:

A. Administration
B. Claims
C. Health Services
D. Member Services
E. Provider Relations

III. DEFINITIONS

A. Adolescents – As defined for Drug Medi-Cal (DMC) purposes, adolescents are eligible beneficiaries from the twelfth (12th) birthday up to the twenty-first (21st) birthday.
B. American Society of Addiction Medicine (ASAM) Criteria - As defined in the Department of Health Care Services (DHCS) Drug Medi-Cal Organized Delivery System Intergovernmental Agreement, pertains to necessary care for biopsychosocial severity and is defined by the extent and severity of problems in all six multidimensional assessment areas of the patient.
C. Discharge – The process to prepare the program beneficiary for referral into another level of care, post treatment return or re-entry into the community, and/or the linkage of the individual to essential community treatment, housing, and human services.
D. Behavioral Health Clinical Director – The Partnership HealthPlan of California (PHC) Behavioral Health Clinical Director is a Doctor of Medicine (MD), Doctor of Osteopathic Medicine (DO), clinical Doctor of Philosophy (PhD), or Doctor of Psychology (PsyD) who is actively involved in the behavioral health aspects of the Utilization Management (UM) program. This Director provides clinical oversight of PHC's behavioral health activities including substance use services and the activities of PHC's delegated managed behavioral health organization(s). The Behavioral Health Clinical Director has the authority to make decisions based on medical necessity which result in the approval or denial of coverage for behavioral health or substance use disorder treatment related services.
E. Licensed Practitioner of the Healing Arts (LPHA): Physicians, Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacist, Licensed Clinical Psychologist, Licensed Clinical Social

Worker (LCSW), Licensed Professional Clinical Counselor, Licensed Marriage and Family Therapist (LMFT), and licensed-eligible practitioners working under the ~~supervisor~~ supervision of licensed clinicians.

F. Medical Necessity – Medical Necessity means those treatment services that are reasonable and necessary to protect life, prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness or injury consistent with 42 Code of Federal Regulations (CFR) 438.210 (a) (4) or, in the case of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT), services that meet the criteria specified in Title 22, Sections 51303 and 51340.1

G. Non-Urgent Request – A request for medical care or services for which application of the time periods for making a decision does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

H. Program Beneficiary – A person who: (1) has been determined eligible for full scope Medi-Cal; (2) is not institutionalized; (3) meets criteria for authorization as described in section VI. A. below; (4) meets the admission criteria to receive Drug Medi-Cal (DMC) covered services; and (5) resides in Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, or Solano County.

I. Residential Treatment – As defined for DMC purposes, Residential Treatment means a non-institutional, 24-hour non-medical, short-term residential program of any size that provides rehabilitation services to beneficiaries. Each program beneficiary shall live on the premises and shall be supported in their efforts to restore, maintain, and apply interpersonal and independent living skills and access community support systems. Programs shall provide a range of activities and services. Residential treatment shall include 24-hour structure with available trained personnel, seven days a week, including a minimum of five hours of clinical service a week to prepare beneficiary for outpatient treatment.

J. Urgent Request – A request for medical care or services where application of the timeframe for making routine or non-life threatening care determinations:
   1. Could seriously jeopardize the life, health or safety of the member or others, due to the member's psychological state, or
   2. In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

The purpose of this policy is to describe the procedures used by Partnership HealthPlan of California (PHC) to process Treatment Authorization Requests (TARs) for residential substance use disorder treatment services.

VI. POLICY / PROCEDURE:

A. Criteria for Authorization of Residential Treatment Services for Substance Use Disorders (SUD)
   1. Partnership HealthPlan of California (PHC) authorizes residential treatment services for substance use disorders according to the specific terms of the contract with the provider and in accordance with the medical necessity requirements specified in Title 22, Section 51303 and the coverage provisions of the approved State Medi-Cal Plan for Medi-Cal eligible beneficiaries as described below:
      a. Adults (Age 21 or older)
         1) Must have at least one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) for Substance-Related and Addictive Disorders (with the exception of Tobacco Related Disorders and Non-Substance Related Disorders).
         2) Must meet the ASAM criteria definition of medical necessity for services based on the

ASAM Criteria. An LPHA at the residential facility (provider) will assess the Medi-Cal eligible beneficiary using a multi-dimensional assessment based on the ASAM criteria. A summary of the assessment findings must be submitted with the Treatment Authorization Request (TAR) to PHC.

b. Adolescents (From the twelfth [12th] birthday up to the twenty-first [21st] birthday)
   1) These Medi-Cal eligible beneficiaries are also eligible to receive Medicaid services under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program. Under the EPSDT mandate, they are eligible to receive all appropriate and medically necessary services needed to correct and ameliorate health conditions that are coverable under section 1905(a) Medicaid authority.
   2) Must meet the ASAM criteria definition of medical necessity for services based on the ASAM adolescent criteria. An LPHA at the residential facility (provider) will assess the Medi-Cal eligible beneficiary using a multi-dimensional assessment based on the ASAM adolescent criteria. A summary of the assessment findings must be submitted with the TAR to PHC.

2. PHC utilizes InterQual® Behavioral Health Criteria to ensure that the services are medically necessary and provided in sufficient amount, duration, or scope to reasonably achieve the purpose for which the services are furnished.
3. PHC shall not arbitrarily deny or reduce the amount, duration, or scope of a medically necessary service solely because of the diagnosis, type of illness, or condition of the beneficiary. This does not exclude use of industry standard utilization management practices.

B. Initial Authorization Process Overview
1. When the Medi-Cal eligible beneficiary presents to the residential substance use disorder treatment facility (provider), an LPHA will conduct an assessment to determine if the Medi-Cal eligible beneficiary meets medical necessity criteria for admission.
2. Within one business day of the intake, the residential provider shall submit a TAR with a summary of the assessment findings and a treatment plan to the PHC Health Services Department for review.
   a. TAR determinations cannot be made by PHC until all required documents and information are received.
   b. TARs should be submitted electronically via PHC's Online Services portal as electronic submission will allow for more expedient processing. If online submission is not possible, the TAR may be submitted via fax number (707) 863-4118 to PHC's Health Services Department for review.
3. PHC's LPHA staff reviews the documentation submitted with the TAR using the non-urgent preservice review time frame and notifies the provider of the determination within 5 business days of receipt of the request.
   a. PHC's LPHA staff includes LCSWs and LMFT's who can approve and defer (pend) the TAR, or deny the TAR for non-medical necessity determinations. The LCSW or LMFT reviews the information received from the residential treatment provider utilizing the approved review guidelines as described in section VI.A above.
   b. Requests that do not meet review guidelines are referred to the Behavioral Health Clinical Director (described in section III.E above) or Physician Designee for further evaluation. When a TAR requires clinician review, the LCSW or LMFT attaches all relevant documentation, InterQual® criteria and the Medical Director Worksheet.
   c. Notification of approved TARs will be provided to the provider at the time of decision, but no later than 24 hours from the date of decision.
4. A TAR submission may be initially approved from date of intake up to 30 days for adults and up to 15 days for adolescents.

C. Continued Stay/Reauthorization Process
   1. PHC will review the program beneficiary's progress periodically throughout their length of stay as appropriate.
   2. The provider submits a summary of the updated assessment findings, an updated treatment plan and a TAR or discharge plan to PHC no later than five business days prior to the expiration of the previous authorization.
      a. Continued stay residential SUD treatment authorizations do not meet the definition of "urgent care." These requests are classified as non-urgent preservice review, and PHC will review and notify the provider of the determination (approved, modified, deferred/pended, denied) within 5 business days of receipt of the request.
   2. Adults (Age 21 or older)
      a. The duration of stay in a residential treatment center is not expected to exceed 90 days. Any length of stay beyond 90 days requires prior approval from PHC.
      b. Adults, age 21 and over, may receive up to two non-continuous short-term residential regimens per 365-day period. A short-term residential regimen is defined as one residential stay in a DHCS licensed facility for a maximum of 90 days.
      c. After completing 90 days of treatment, an adult program beneficiary may receive one 30-day extension, if that extension is medically necessary and approved by PHC, per 365-day period.
   3. Adolescents (From the twelfth [12th] birthday up to the twenty-first [21st] birthday)
      a. Adolescent program beneficiaries will be discharged by day 30 unless extenuating circumstances exist.
      b. Adolescents, under the age of 21, may receive up to two 30-day non-continuous regimens per 365-day period for residential treatment. Adolescent beneficiaries receiving residential treatment shall be stabilized as soon as possible and moved down to a less intensive level of treatment.
      c. After completing 30 days of treatment, adolescents may receive one 30 day-extension if that extension is medically necessary, per 365-day period.
      d. EPSDT beneficiaries may receive a longer length of stay based on medical necessity.
   4. Pregnant/Post-Partum Beneficiaries
      a. Pregnant beneficiaries may receive residential treatment services during pregnancy and up to 60 days during the post-partum period (which begins on the last day of pregnancy).
      b. Providers will be required to provide proof of pregnancy or delivery date for each new TAR submitted to PHC.

D. Notification of Denials/Modifications/Appeals Process
   1. Only the Behavioral Health Clinical Director or Physician Designee can deny for reasons of medical necessity.
   2. For any decision to deny a TAR or to authorize a service in an amount, duration, or scope that is less than requested, electronic or written notification of the decision and how to initiate an appeal, if applicable, will be provided to the provider and Medi-Cal eligible beneficiary at the time of decision, but no later than 24 hours from the date of decision. Please refer to policy MCUP3037 Appeals of Utilization Management/ Pharmacy Decisions for further information on the appeals process.

VII. REFERENCES:

A. Department of Health Care Services (DHCS) Intergovernmental Agreement for Drug Medi-Cal Organized Delivery System (DMC-ODS) Services
B. Drug Medi-Cal Organized Delivery System (DMC-ODS) Quality Assurance-C Toolkit (Revision 3 dated 06-12-19)
C. Title 42 Code of Federal Regulations (CFR) Section 438.210 (a)(4)

D. Title 22 California Code of Regulations (CCR) Sections 51303 and 51340.1
E. InterQual® Behavioral Health Criteria
F. National Committee for Quality Assurance (NCQA) Guidelines (Effective July 1, ~~2020~~2021) UM 1 Program Structure Element A, UM 2 Clinical Criteria for UM Decisions Element A and UM 4 Appropriate Professionals Element A

VIII. DISTRIBUTION:
A. PHC Department Directors
B. PHC Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Behavioral Health Clinical Director

X. REVISION DATES:
04/08/20, ~~04/08/21~~04/14/21

PREVIOUSLY APPLIED TO:
N/A

****

In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

- Consistent with sound clinical principles and processes
- Evaluated and updated at least annually
- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

The materials provided are guidelines used by PHC to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under PHC.

PHC's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

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<tr><td colspan="5">Policy/Procedure Number: MCQP1025 (previously MPQP1025, QP100125)</td><td colspan="3">Lead Department: Health Services</td></tr>
<tr><td colspan="5">Policy/Procedure Title: Substance Use Disorder (SUD) Site Review and Medical Record Review (previously Behavioral Health/ Substance Abuse Facility Site Review)</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 02/18/2004</td><td colspan="6">Next Review Date: ~~04/08/2021~~04/13/2022
Last Review Date: ~~04/08/2020~~04/14/2021</td></tr>
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I. RELATED POLICIES:

A. MPQP1022 – Site Review Requirements and Guidelines
B. MPQP1016 – Potential Quality Issue Investigation & Resolution
C. MPQP1053 – Peer Review Committee
D. CMP36 – Delegation Oversight and Monitoring

II. IMPACTED DEPTS:

A. Health Services
B. Provider Relations
C. External and Regulatory Affairs

III. DEFINITIONS:

Substance Use Disorder Treatment Provider: Person or entity that provides direct alcohol and other drug treatment services and has been certified by the State as meeting the certification requirements for participation in the Drug Medi-Cal (DMC) program set forth in the DMC certification Standards for Substance Abuse Clinics and Standards for Drug Treatment Programs in California.

IV. ATTACHMENTS:

A. Substance Use Disorder (SUD) Site Review Tool & Guidelines
B. Substance Use Disorder (SUD) Medical Record Review Tool & Guidelines

V. PURPOSE:

A. To provide SUD practice sites a comprehensive guideline for Site Review (SR) and Medical Record Review (MRR) requirements and processes. This policy will apply to DMC-certified providers contracted with Partnership HealthPlan of California (PHC).
   The purpose of the Site Review is to ensure that practice sites have sufficient capacity to:
   1. Provide appropriate SUD services
   2. Carry out processes that support continuity and coordination of care
   3. Maintain patient safety standards and practices, and

B. Operate in compliance with applicable federal, state, and local laws and regulations
   Findings of the Site Review are used to:
   1. Provide information for credentialing/re-credentialing decisions
   2. Identify areas where education and technical assistance is needed
   3. Identify and share best practices in patient safety, medical error prevention, and provision of quality care

Policy/Procedure Number: MCQP1025 (previously MPQP1025, QP100125)		**Lead Department: Health Services**
Policy/Procedure Title: Substance Use Disorder (SUD) Site Review and Medical Record Review (previously Behavioral Health/ Substance Abuse Facility Site Review)		☒**External Policy** ☐**Internal Policy**
Original Date: 02/18/2004	**Next Review Date:** ~~04/08/2021~~04/13/2022 **Last Review Date:** ~~04/08/2020~~04/14/2021	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

VI. POLICY / PROCEDURE:

A. Requirements
   1. PHC will conduct **annual** onsite monitoring reviews of services and subcontracted services for programmatic and fiscal requirements, and submit a copy of their monitoring and audit reports to the Department of Health Care Services (DHCS) within two weeks of issuance.

B. Review Personnel
   1. The Partnership HealthPlan of California (PHC) Chief Medical Officer (CMO) is ultimately responsible for Site Review activities completed by PHC personnel. At a minimum, PHC review teams will consist of a Registered Nurse (RN), Licensed Practitioner of the Healing Arts (LPHA), Physician Assistant (PA), certified counselor or Physician.
   2. Partnership HealthPlan of California will assure that reviewers collect data that is appropriate to their level of education, expertise, training and professional licensing scope of practice as determined by California statute. Only RNs, PAs, LPHAs or physicians may review survey elements labeled "RN/MD/LPHA Review only or RN/MD Review only". The Reviewer must sign the completed Site Review tool.

C. Site Review
   1. Site Review is an on-site review of the office site, processes, and covers the following areas:
      a. Access/Safety
      b. Personnel
      c. Office Management
      d. Pharmaceutical
   2. A Site Review is required to be completed prior to final credentialing of the site's SUD practitioners.
      a. PHC's Credentialing Department assesses the accreditation status of Substance Use Disorder Treatment Providers as part of the credentialing process. If any SUD providers are not accredited and have not had State or Centers for Medicare and Medicaid Services (CMS) reviews conducted within the last 36 months, PHC will conduct annual Site Reviews using the review tools in attachments B and C. Subsequently, PHC conducts Site Reviews regardless of accreditation status.
   3. In the review tool, there is a specific section that aids the reviewer in assessing the extent to which the site is accessible and useable by individuals with physical disabilities. The site provides access to, or has written policy to provide alternative access for members.

D. Medical Records Review
   1. In addition to the standard review tool, the following elements will be reviewed in the Medical Record Review
      a. Format Criteria
      b. Intake Services
      c. Treatment Services
      d. Discharge Services
      e. Recovery Services
      f. Residential (if applicable)

E. Out of Network Providers
   1. For providers outside of PHC's network, PHC will determine whether to conduct a Site Review or accept review findings from an outside entity that performed the most recent review. A copy of the annual reviews will be provided by the entity or PHC will conduct the review.

F. Focused Review
   1. Focused reviews are targeted audits consisting of review of problem areas identified through Site Review monitoring activities, to follow up on Corrective Action Plans (CAPs), from patient grievances, from potential quality issue reports or from observations of PHC staff. All deficiencies

found during a focused review will require the completion and verification of corrective actions according to the CAP timelines.

G. Requirements for New Practitioners at a Site
   1. A Site Review will not be repeated if a new provider is added to a provider site that has a current passing Site Review score. If a Substance Use Services provider moves to a site that has not undergone a previous Site Review, PHC performs a Site Review at this site.

H. Compliance Levels
   1. The Site Review has a total of 62 points possible. Possible points are adjusted to subtract "not applicable" items. The reviewer will advise the practice site of any deficiencies in critical elements during the Site Review. Compliance level categories include:

Compliance Category	Site Review Score	MRR Score
Exempted Pass	90% or above	90% or above
Conditional Pass	80-89%	80-89%
Not Pass	Below 80%	Below 80%

I. Corrective Action Plan (CAP) Requirements and Timelines
   1. Conditional Pass
      a. PHC will provide the practice site with a review findings report and a formal written request for corrections of all deficiencies within 10 ~~business~~ calendar days after the site visit. The practice site must submit a CAP to PHC addressing deficiencies within ~~45~~ 30 calendar days of the written initial CAP request date. PHC will then review/revise/approve the CAP. Under extenuating circumstances, an additional 30 day extension to complete deficiencies that have not been addressed may be granted. However, the total number of days to complete the CAP process may not exceed 120 days from the initial CAP request. PHC will follow the process and timeline outlined in Section VI. A8. CAP Timeline Table ~~Attachment G~~ of policy MPQP1022.
   2. Not Pass
      a. Pre-contractual Provider – Cannot be credentialed as a network provider. Prior to being approved as a network provider, a Site Review re-survey must be completed with a passing score. A CAP will be required as addressed in F1.
      b. Contracted Network Provider – Survey deficiencies must be corrected by the provider and verified by PHC within the CAP timelines. PHC reserves the right to remove any provider with a not pass score from the provider network. Members will be given a 30-day notice of provider termination. Refer to Member Notification of Primary Care or Specialist Termination – policy # 300 for the specific procedures.
   3. CAP Documentation
      a. CAPs will be completed using a standard format and form. The minimum elements to be included on a CAP:
         1) Specific deficiency(ies)
         2) Corrective Action(s) needed
         3) Projected date(s) of correction
         4) Actual date(s) of correction
         5) Re-evaluation timelines/dates
         6) Responsible person(s) for each corrective action
         7) Problems in completing corrective action, if any
         8) Education and/or technical assistance provided by PHC
         9) Evidence of the correction(s)

10) Completion and closure date
11) Name and title of reviewer

J. Non-Compliance with Corrective Action Process
1. Providers who do not correct survey deficiencies, or do not cooperate with the CAP process within the established CAP timelines will be referred to the PHC Chief Medical Officer; Provider Relations Staff and/or Credentialing Committee. Actions taken by the Credentialing Committee may include termination of the site from the provider network.
2. Actions taken will be effective until corrections are verified and the CAP is closed. If PHC chooses to remove the site from the network, members will be given a 30-day notice of termination. Refer to Member Notification of Primary Care or Specialist Termination – policy # 300 for the specific procedures.

K. Organizational Provider Appeals
1. See PHC Policy MPCR 9 "Fair Hearings Process for Adverse Credentialing Decisions" for appeal procedures
2. If verified evidence of correction of deficiencies is submitted and the decision to terminate the provider from the network is reversed, PHC will repeat the Site Review in 12 months.
3. If the decision is not reversed, and the provider is terminated from the network, the practice may reapply to become a network provider and PHC will complete a new site review.

L. Systematic Monitoring
1. Monitoring following the Site Review will include, but is not limited to, data gathered through the following sources:
   a. Member grievances and appeals (reviewed daily)
   b. Potential Quality Issue information (reviewed when identified)
   c. Focused review or other on-site visit (based on Site Review findings, track and trend quarterly reports)-
   d. Request CAP when problem verified and follow the above CAP process in Section F1.
      1) Critical Elements and other targeted areas of concern.
2. The CMO or Site Reviewer will determine and specify follow up action after the Site Review. Follow up activities may include an additional site visit to review continued compliance.

M. Delegation of Site Reviews
1. Delegation Agreement
   a. Prior to delegating Site Review to a provider, PHC will establish a formal, mutually agreed upon Delegation Agreement that will:
      1) Identify specific delegated functions
      2) Specify policies/procedures to be used for delegated functions
      3) Specify reporting requirements of the delegate
      4) Specify PHC training, communication, and oversight activities
2. Potential Quality of Care Issues
   a. Potential quality of care issues identified during the course of the Site Review will be conducted in accordance with the PHC policy for Peer Review Process. The clinical reviewer will complete a PQI Report Form, submit it to the Quality Department for follow up, and review.
3. Local Collaboration
   a. In an effort to streamline the regulatory process and reduce redundant Site Reviews at SUD sites, PHC will collaborate with other health plans having contracts with mutual providers. PHC will accept the Site Review score assigned by other health plans if the collaboration processes are defined in detail and meet and/or exceed the standards addressed in MPQP1025. PHC may choose to repeat the Site Review of a site that had passed a Site Review by another health plan's reviewers.

Policy/Procedure Number: MCQP1025 (previously MPQP1025, QP100125)		**Lead Department: Health Services**
Policy/Procedure Title: Substance Use Disorder (SUD) Site Review and Medical Record Review (previously Behavioral Health/ Substance Abuse Facility Site Review)		☒**External Policy** ☐**Internal Policy**
Original Date: 02/18/2004	**Next Review Date:** ~~**04/08/2021**~~**04/13/2022** **Last Review Date:** ~~**04/08/2020**~~**04/14/2021**	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

VII. REFERENCES:

A. MMCD Policy Letter (PL) 12-006 Revised Facility Site Review Tool
B. MMCD Policy Letter (PL) 14-004 Facility Site Reviews and Medical Record Review
C. DHCS All Plan Letter (APL) 15-023 Facility Site Review Tools for Ancillary Services and Community-Based Adult Services Providers
D. 3 CCR §504; 24 CCR (CA Building Standards Code); 28 CFR §35 (American Disabilities Act of 1990, Title II, Title III)
E. Department of Health Care Services (DHCS) Intergovernmental Agreement for Drug Medi-Cal Organized Delivery System (DMC-ODS) Services

VIII. DISTRIBUTION:

A. PHC Provider Manual
B. PHC Department Directors

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Medical Officer

X. REVISION DATES:

Medi-Cal
05/18/05; 04/19/06; 06/20/07; 06/18/08; 07/15/09; 09/15/10; 02/20/13; 05/15/13; 05/21/14; 09/20/17; *10/10/18; 11/13/19; 04/08/20; 4/14/21

*Through 2017, Approval Date reflective of the Quality Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

PREVIOUSLY APPLIED TO:

Partnership*Advantage*:
MPQP1025 - 06/20/2007 to 02/20/2013
Healthy Families:
MPQP1025 - 10/01/2010 to 02/20/2013
Healthy Kids
MPQP1025 - 06/20/2007 to 02/20/2013

Facility Site Review Survey
Substance Use Disorder (SUD) Treatment Services

Site ID	**Phone:**	**Fax:**	**Review Date**
Facility Name:	**Contact Name/Title:**		
Full Address:			
Reviewer Name/Title: Michelle Gazzigli LCSW			
Staff on site: ___CADC I/II/III ___ LAADC ___ SUDCC ___LCSW ___LMFT ___ASW ___MFTI ___RADT ___RADT II ___MD ___NP ___RN ___LVN ___Clerical Other_____			

Visit Purpose	**Certifications**	**Clinic type**	
_____ Initial Full Scope _____ Monitoring _____ Periodic Full Scope _____ Follow-up _____ Focused Review _____ Ed/TA _____Other _____	DMC Certification issue date _____	___ Outpatient (1) ___ Perinatal Outpatient (1) ___ Intensive Outpatient (2.1) ___ Intensive Perinatal Outpatient (2.1)	___ Residential (3.1) ___ Residential (3.5) ___ Withdrawal Management. (3.2) ___ Perinatal Residential (3.1) ___ Perinatal Residential (3.5) ___ OTP/NTP

Site Review Scores

	Points possible	Yes Pts. Given	No's	N/A's	Section Score %
I. Access/Safety	**13**				
II. Personnel	**10**				
III. Office Management	**53**				
IV. Pharmaceutical	**4**				
	80 Total Points Possible	**Yes Pts. Given**	**No's**	**N/A's**	

Scoring Procedure

1) Add points given in each section.
2) Add total points given for all four sections.
3) Adjust score for "N/A" criteria (if needed). Subtract "N/A" points from total points possible.
4) Divide total points given by "adjusted" total points.
5) Multiply by 100 to get the compliance (percent) rate.

_____ (Points given) ÷ _____ (Total/ Adjusted points) = _____ (Decimal Score) X 100 = _____% (Compliance Rate)

Compliance Rate

Note: Any section score of < 80% requires a CAP for the entire MRR, regardless of the Total MRR score.

_____**Exempted Pass: 90% or above:** (Total score is ≥ 90% *and* all section scores are 80% or above)

_____**Conditional Pass: 80-89%:** (Total MRR is 80-89% *OR any* section(s) score is < 80%)

_____**Not Pass: Below 80%**

_____CAP Required

_____Other follow-up

Next Review Due: _____

Facility Site Review Guidelines for Substance Use Disorder (SUD) Treatment Services

California Department of Health Services
Medi-Cal Managed Care Division

Purpose: Site Review Guidelines provide the standards, directions, instructions, rules, regulations, perimeters, or indicators for the site review survey. These Guidelines shall be used as a gauge or touchstone for measuring, evaluating, assessing, and making decisions."

Scoring: Site survey includes on-site inspection and interviews with site personnel. Reviewers are expected to use reasonable evidence available during the review process to determine if practices and systems on site meet survey criteria. Compliance levels include: 1) Exempted Pass: 90% or above, 2) Conditional Pass: 80-89%, and 3) Not Pass: below 80%. Compliance rates are based on total possible points, or on the total "adjusted" for Not Applicable (N/A) items. "N/A" applies to any scored item that does not apply to a specific site as determined by the reviewer. Survey criteria to be reviewed *only* by a R.N. or physician or LPHA are labeled "**RN/MD/LPHA Review only".**

Directions: Score full point(s) if survey item is met. Score zero (0) points if item is not met. Do not score partial points for any item. Explain all "N/A" and "No" (0 point) items in the comment section. Provide assistance/consultation as needed for corrective action plans, and establish follow-up/verification timeline.

1) Add the points given in each section.
2) Add points given for all four (4) sections to determine total points given for the site.
3) Subtract all "N/A" items from total possible points to determine the "adjusted" total possible points. If there are no "N/A" items, calculation of site score will be based on the total points possible.
4) Divide the total points given by the total points possible or by the "adjusted" total. Multiply by 100 to calculate percentage rate.

Scoring Example:

Step 1: Add the points given in each section.	**Step 2**: Add points given for all four (4) sections. 13 (Access/safety) 10 (Personnel) 53 (Office Management) 04 (Pharmaceutical) **80 (POINTS)**
Step 3: Subtract "N/A" points from 80 total points possible. 80 (Total points possible) – 5 (N/A points) 75 ("Adjusted" total points possible)	**Step 4**: Divide total points given by 79 or by the "adjusted" points, then multiply by 100 to calculate percentage rate. $\frac{\text{Points given}}{\text{75 or "adjusted" total}}$ or $\frac{75}{80}$ =. 949 = 95%

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Criteria	Access/Safety Reviewer Guidelines
A. Site is accessible and useable by individuals with physical disabilities.	• **ADA Regulations**: Site must meet city, county and state building structure and access ordinances for persons with physical disabilities. A site/facility includes the building structure, walkways, parking lots, and equipment. All facilities designed, constructed; or altered by, on behalf of, or for the use of a public entity must be readily accessible and usable by individuals with disabilities, if the construction or alteration was begun after January 26, 1992 (28 CFR 35.151). Any alteration to a place of public accommodation or a commercial facility, after January 26, 1992, must be made to ensure that, to the maximum extent feasible, the altered portions of the facility are readily accessible to and useable by individuals with disabilities, including individuals who use wheelchairs (28 CFR 36.402). • **Parking**: Parking spaces for persons with physical disabilities are located in close proximity to handicap-accessible building entrances. Each parking space reserved for the disabled is identified by a permanently affixed reflectorized sign posted in a conspicuous place. If provider has no control over availability of disabled parking lot or nearby street spaces, provider must have a plan in place for making program services available to persons with physical disabilities. • **Ramps**: A clear and level landing is at the top and bottom of all ramps and on each side of an exit door. Any path of travel is considered a ramp if its slope is greater than a 1-foot rise in 20 feet of horizontal run. • **Exit doors**: The width of exit doorways (at least 32-in.) allows for passage clearance of a wheelchair. Exit doors include all doors required for access, circulation and use of the building and facilities, such as primary entrances and passageway doors. Furniture and other items do not obstruct exit doorways or interfere with door swing pathway. • **Elevators**: If there is no passenger elevator, a freight elevator may be used to achieve program accessibility if it is upgraded for general passenger use and if passageways leading to and from the elevator are well-lit, neat and clean. • **Clear Floor Space**: Clear space in waiting/exam areas is sufficient (at least 30-in. x 48-in.) to accommodate a single, stationary adult wheelchair and occupant. A minimum clear space of 60-in. diameter or square area is needed to turn a wheelchair. • **Sanitary Facilities**: Restroom and hand washing facilities are accessible to able-bodied and physically disabled persons. A wheel-chair accessible restroom stall allows sufficient space for a wheelchair to enter and permits the door to close. If wheelchair accessible restrooms are not available within the office site, reasonable alternative accommodations are provided. Alternatives may include: grab bars located behind and/or along the sides of toilet with assistance provided as needed by site personnel; provision of urinal, bedpan, or bedside commode placed in a private area; wheelchair accessible restroom located in a nearby office or shared within a building. Sufficient knee clearance space underneath the sink allows for wheelchair users to safely use a lavatory sink for hand washing. A reasonable alternative may include, but is not limited to, hand washing items provided as needed by site personnel. **AOD 12000,** "Each program shall comply with all applicable local, state and federal laws and regulations. The program shall develop written procedures to ensure that the program is maintained in a clean, safe, sanitary, and alcohol and drug-free environment." **Note:** A public entity may not deny the benefits of its program, activities, and services to individuals with disabilities because its facilities are inaccessible (28 CFR 35.149-35.150). Every feature need not be accessible, if a reasonable portion of the facilities and accommodations provided is accessible (Title 24, Section 2-419, California Administrative Code, the State Building Code). Reasonable Portion and/or Reasonable Alternatives are acceptable to achieve program accessibility. Reasonable Portion applies to multi-storied structures and provides exceptions to the regulations requiring accessibility to all portions of a facility/site. Reasonable Alternatives are methods other than site structural changes to achieve program accessibility, such as acquisition or redesign of equipment, assignment of assistants/aides to beneficiaries, provision of services at alternate accessible sites, and/or other site specific alternatives to provide services (ADA, Title II, 5.2000). Points shall not be deducted if Reasonable Portion or Reasonable Alternative is made available on site. **Specific measurements are provided strictly for "*reference only*" for the reviewer. Site reviewers are *NOT* expected to measure parking areas, pedestrian path of travel walkways and/or building structures on site.**

I. Access/Safety

RN/MD/LPHA Review only

Site Access/Safety Survey Criteria	Wt	Yes	No	NA	Score
A. Site is accessible and useable by individuals with physical disabilities CCR §504; 24 CCR (CA Building Standards Code); 28 CFR §35 (American Disabilities Act of 1990, Title II, Title III)					
1) Site is accessible and useable by individual with physical disabilities	**1**	1)____	1)____	1)____	
2) If the site is NOT accessible, are reasonable alternatives available?	**1**	2)____	2)____	2)____	

Criteria	I. Access/Safety Reviewer Guidelines (Continued)
B. Site environment is maintained in a clean and sanitary condition.	The physical appearance of floors/carpets, walls, furniture, patient areas and restrooms are clean and well maintained. Appropriate sanitary supplies, such as toilet tissue, hand washing soap, cloth/paper towels or antiseptic towelettes are made available for restroom use. Environmental safety includes the "housekeeping" or hygienic condition of the site. Clean means unsoiled, neat, tidy, and uncluttered. Well maintained means being in good repair or condition. **AOD 12000, "**Each program shall comply with all applicable local, state and federal laws and regulations. The program shall develop written procedures to ensure that the program is maintained in a clean, safe, sanitary, and alcohol and drug-free environment."
C. Site environment is safe for all patients, visitors and personnel.	• **Ordinances**: Sites must meet city, county and state fire safety and prevention ordinances. Reviewers should be aware of applicable city and county ordinances in the areas in which they conduct reviews. • **Evacuation Routes**: Clearly marked, easy-to-follow escape routes are posted in visible areas, such as hallways, exam rooms and patient waiting areas. The minimum clear passage needed for a single wheelchair is 36 inches along an accessible route, but may be reduced to a minimum of 32 inches at a doorway. • **Site Specific Emergency procedures:** Staff is able to describe site-specific actions or procedures for handling medical emergencies until the individual is stable or under care of local emergency medical services (EMS). • **Illumination**: Lighting is adequate in patient flow working and walking areas such as corridors, walkways, waiting and exam rooms, and restrooms to allow for a safe path of travel. • **Access Aisle**: Accessible pedestrian paths of travel (ramps, corridors, walkways, lobbies, elevators, etc.) between elements (seats, tables, displays, equipment, parking spaces, etc.) provide a clear circulation path. Means of egress (escape routes) are maintained free of obstructions or impediments to full instant use of the path of travel in case of fire or other emergency. Building escape routes provide an accessible, unobstructed path of travel for pedestrians and/or wheelchair users at all times when the site is occupied. Cords (including taped cords) or other items are not placed on or across walkway areas. • **Exits**: Exit doorways are unobstructed and clearly marked by a readily visible "Exit" sign. • **Electrical Safety**: Electrical cords are in good working condition with no exposed wires, or frayed or cracked areas. Cords are not affixed to structures, placed in or across walkways, extended through walls, floors, and ceiling or under doors or floor coverings. Extension cords are not used as a substitute for permanent wiring. All electrical outlets have an intact wall faceplate. Sufficient clearance is maintained around lights and heating units to prevent combustible ignition. • **Fire Fighting/Protection Equipment**: There is firefighting/protection equipment in an accessible location on site at all times. An accessible location is reachable by personnel standing on the floor, or other permanent working area, without the need to locate/retrieve step stool, ladder or other assistive devises. At least one of the following types of fire safety equipment is on site: 1) Smoke Detector with intact, working batteries 2) Fire Alarm Device with code and reporting instructions posted conspicuously at phones and employee entrances 3) Automatic Sprinkler System with sufficient clearance (10-in.) between sprinkler heads and stored materials. 4) Fire Extinguisher in an accessible location that displays readiness indicators or has an attached current dated inspection tag. **Note: Specific measurements are provided strictly for "*reference only*" for the reviewer. Site reviewers are *NOT* expected to measure parking areas, pedestrian path of travel walkways and/or building structures on site.**

I. Access/Safety

RN/MD/LPHA Review only

Site Access/Safety Survey Criteria (Continued)	Wt	Yes	No	NA	Score
B. Site environment is maintained in a clean and sanitary condition. 8 CCR §5193; 28 CCR §1300.80					
1) All patient areas including floor/carpet, walls, and furniture are neat, clean and well maintained.	**1**	1)____	1)____	1)____	
2) Restrooms are clean and contain appropriate sanitary supplies	**1**	2)____	2)____	2)____	
3) The program is maintained in a clean, safe and sanitary and alcohol/drug-free environment.	**1**	3)____	3)____	3)____	
C. Site environment is safe for all patients, visitors and personnel. 8 CCR §3220; 22 CCR §53230; 24 CCR, §2, §3, §9; 28 CCR §1300.80; 29 CFR §1910.301, §1926.34 **There is evidence that staff has received safety training and/or has safety information available in the following**:					
1) Fire safety and prevention	**1**	1)____	1)____	1)____	
2) Emergency non-medical procedures (e.g. site evacuation, workplace violence)	**1**	2)____	2)____	2)____	
3) Lighting is adequate in all areas to ensure safety.	**1**	3)____	3)____	3)____	
4) Exit doors and aisles are unobstructed and egress (escape) accessible.	**1**	4)____	4)____	4)____	
5) Exit doors are clearly marked with "Exit" signs.	**1**	5)____	5)____	5)____	
6) Clearly diagramed "Evacuation Routes" for emergencies are posted in a visible location.	**1**	6)____	6)____	6)____	
7) Electrical cords and outlets are in good working condition.	**1**	7)____	7)____	7)____	
8) At least one type of firefighting/protection equipment is accessible at all times.	**1**	8)____	8)____	8)____	

Comments: Write comments for all "No" (0 points) and "N/A" scores.

Totals

Total Points Possible: 13

Criteria	II. Personnel Reviewer Guidelines		
A.	**Medical Professional**	**License/Certification**	**Issuing Agency**
1) Professional health care personnel have current California licenses and certifications.			
	Doctor of Medicine	Physician's & Surgeon's Certificate DEA Registration	Medical Board of CA Drug Enforcement Administration
	Psychiatrist/Psychologist	Physician's & Surgeon's Certificate with specialty training	Medical Board of California
	Nurse Practitioner (NP)	RN License w/NP Certification and Furnishing Number	CA Board of Registered Nursing
	Registered Nurse (RN)	RN License	CA Board of Registered Nursing
	Registered Pharmacist	Pharmacist License	CA State Board of Pharmacy
	Physicians' Assistant (PA)	PA License. DEA Registration	Medical Board of CA DEA
	Licensed Practitioner Healing Arts	LPHA	Board of Behavioral Sciences
	Marriage and Family Therapist	MFT	Board of Behavioral Sciences
	Licensed Clinical Social Worker	LCSW	Board of Behavioral Sciences
	Licensed Professional Clinical Counselor	LPCC	Board of Behavioral science
	Psychiatric Technician	Psychiatric Technician	CA Board of Vocational Nursing and Psychiatric Technicians
	Licensed Vocational Nurse (LVN):	LVN License	CA Board of Vocational Nursing and Psychiatric Technicians
	Note: All medical professional licenses and certifications must be current and issued from the appropriate agency for practice in California. Any license/certification that has been approved during the current re/credentialing process need not be re-checked during the site review. Any licenses/certifications not included in the re/credentialing process must be checked for current status as part of the site review process. Although sites with centralized personnel departments are not required to keep documents or copies on site, copies and/or lists of currently certified or credentialed personnel must be readily available when requested by reviewers.		
2) The Substance Abuse Clinic has a Licensed Physician designated as Medical Director.	Per **Title 22, E.IV.A,** it is mandatory to have a Licensed Physician designated as Medical Director of the Substance Abuse Clinic.		

II. Personnel

RN/MD/LPHA Review only

Site Personnel Survey Criteria	Wt	Yes	No	NA	Score
A. Professional health care personnel have current California Licenses and Certifications. CA Business & Professional (B&P) Code §2050, §2585, §2725, §2746, §2834, §3500, §4110					
1. All required Professional Licenses and Certifications, issued from the appropriate licensing/certification agency, are current.	**1**	1)____	1)____	1)____	
2. The Substance Abuse Clinic has a Licensed Physician designated as Medical Director.	**1**	2)____	2)____	2)____	

This page = 2 points

Criteria	II. Personnel Reviewer Guidelines
3) The program has a written plan for training staff that is updated annually.	**Title 22, C-19020**- The program must have a written plan that is updated annually for the training needs of staff. • Professional staff (LPHA's) receive a minimum of **5 hours** continuing education related to addiction medicine each year. Site personnel have received information and/or training about member rights. Evidence is verifiable for any occurrences of staff training which may include informal in-services, new staff orientation, external training courses, educational curriculum and participant lists, etc. If there is no verifiable evidence of staff training, staff is able to locate written member rights information on site and explain how to use information.
4) There is at least 30% of staff who provide counseling that are licensed or certified as Drug & Alcohol Counselors.5.	**Title 22, D-13010**- There has to be at minimum 30% of staff who are certified or licensed to be providing Drug/Alcohol Counseling.
5) All new providers and staff conducting ASAM assessments have completed the two e-Trainings.	Intergovernmental Agreement Exhibit A, Attachment I, III, GG, 3,ii, a The Contractor shall ensure that, at minimum, providers and staff conducting assessments are required to complete the two e-Training modules entitled "ASAM Multidimensional Assessment" and "From Assessment to Service Planning and Level of Care". A third module entitled, "Introduction to The ASAM Criteria" is recommended for all county and provider staff participating in the Waiver.
6) Tuberculosis (TB) Testing is offered and performed for all staff.	Tuberculosis testing must be offered to all staff and performed and documented.
7) For Residential Detoxification there is adequate staff on duty at all times with CPR certificate and current first aid training.	**AOD 11040**- During the provision of detoxification services, the minimum staffing or volunteer ratios and health-related requirements shall be as follows: a. In a program with 15 or fewer clients who are receiving detoxification services, there shall be at least one staff member or volunteer on duty and awake at all times with a current cardiopulmonary resuscitation certificate and current first aid training. b. In a program with more than 15 clients who are receiving detoxification services, there shall be at least two staff members or volunteers, per every 15 clients, on duty and awake at all times, one of whom shall have a current cardiopulmonary resuscitation certificate and current first aid training. c. Clients shall not be used to fulfill the requirements of this section.
8) Staff will receive Cultural and Linguistic training. Annually	The program shall promote the delivery of services in a culturally competent manner to all clients, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity.

II. Personnel

RN/MD/LPHA Review only

Site Personnel Survey Criteria	Wt	Yes	No	NA	Score
A. Professional health care personnel have current California Licenses and Certifications. CA Business & Professional (B&P) Code §2050, §2585, §2725, §2746, §2834, §3500, §4110					
3. The program has a written plan for training staff that is updated annually. Professional staff (LPHA's) receive a minimum of 5 hours continuing education related to addiction medicine each year	**1**	3)____	3)____	3)____	
4. There is at least 30% of staff who provide counseling that are licensed or certified as Drug & Alcohol Counselors.	**1**	4)____	4)____	4)____	
5. Providers and staff conducting ASAM assessments have completed the two e-Trainings.	**1**	5)____	5)____	5)____	
6. Tuberculosis (TB) Testing is offered and performed for all staff.	**1**	6)____	6)____	6)____	
7. For Residential Detoxification there is adequate staff on duty at all times with CPR certificate and current first aid training.	**1**	7)____	7)____	7)____	
8. There is evidence the staff have completed Cultural and linguistic Training annually.	**1**	8)____	8)____	8)____	

This page = 6 points

Criteria	II. Personnel Reviewer Guidelines
B. Counseling services are only provided by registered or certified individuals.	• According to **AOD 8000 b.,** "Counseling services may only be provided by individuals registered or certified pursuant to California Code of Regulations, Title 9, Division 4, and Chapter 8 or by a licensed professional acting within their scope of practice." Obtain copies of licences8 Hour class at hire should be done on **day one**
C. Compliance with the following Minimum Quality Treatment Standards is required for all SUD treatment programs either partially or fully funded by Substance Abuse and Prevention Treatment Block Grant (SABG).	Personnel Policies: a.) Personnel files shall be maintained on all employees and volunteers/interns and shall contain the following: Application for employment and/or resume; Signed employment confirmation statement/duty statement; Job description; Performance evaluations; Health records/status as required by program or Title 9; Other personnel actions (eg. Commendations, disciplines, status change, employment incidents and/or injuries); Training documentation relative to substance use disorders and treatment; Current registration, certification, intern status, or licensure; Proof of continuing education required by licensing or certifying agency and program; Program Code of Conduct and for registered, certified, and licensed staff, a copy of the certifying body's code of conduct as well. b.) Job descriptions shall be developed, revised as needed, and approved by the program's governing body. The job descriptions shall include: Position title and classification; Duties and responsibilities; Lines of supervision; Education, training, work experience, and other qualifications for the position. c) Written code of conduct for employees and volunteers/Inters shall be established which address at least the following: Use of drugs and/or alcohol; Prohibition of social/business relationship with clients or their family members for personal gain; Prohibition of sexual contact with clients; Conflict of interest; Providing services beyond scope; Discrimination against clients or staff; Verbally, physically, or sexually harassing, threatening, or abusing clients, family members or other staff; Protection of client confidentiality; The element found in the code of conduct(s)for the certifying organization(s) the program's counselors are certified under; Cooperation with compliant investigations. d) If a program utilizes the services of volunteers and or interns, procedures shall be implemented which address: Recruitment; Screening; Selection; Training and orientation; Duties and assignments; Scope of practice; Supervision; Evaluation; Protection of client confidentiality. e) Written roles and responsibilities and a code of conduct for the medical director (if applicable) shall be clearly documented, signed and dated by an authorized program representative and the medical director. • Obtain copy

II. Personnel

RN/MD/LPHA Review only

Personnel Survey Criteria	Wt	Yes	No	NA	Score
B. Counseling services are only provided by registered or certified individuals.	**1**	1)____	1)____	1)____	
C. Compliance with the following Minimum Quality Treatment Standards is required for all SUD treatment programs either partially or fully funded by Substance Abuse and Prevention Treatment Block Grant (SABG). 1) Personnel Policies meet the minimum quality drug treatment standards for SABG	**1**	1)____	1)____	1)____	
Comments: Write comments for all "No" (0 points) and "N/A" scores. Totals					

10 pts total points possible

Criteria	III. Office Management Reviewer Guidelines
A. Medical records are available for the Provider at each scheduled patient encounter.	The process/system established on site provides for the availability of medical records, including outpatient, inpatient, referral services, and significant telephone consultations for patient encounters. Medical records are filed that allows for ease of accessibility within the facility, or in an approved health record storage facility off the facility premises (22 CCR, § 75055).
B. Medical record confidentiality is maintained according to State and Federal guidelines.	• **Privacy**: Patients have the right to privacy for dressing/undressing, physical examination and medical consultation. Practices are in place to safeguard patient privacy. Because dressing areas and examination room configurations vary greatly, reviewers will make site-specific determinations. • **Confidentiality**: Personnel follow site policy/procedures for maintaining confidentiality of individual patient information. Individual patient conditions or information is not discussed in front of other patients or visitors, displayed or left unattended in reception and/or patient flow areas. • **Electronic records**: Electronic record-keeping system procedures have been established to ensure patient confidentiality, prevent unauthorized access, authenticate electronic signatures, and maintain upkeep of computer systems. Security protection includes an off-site backup storage system, an image mechanism with the ability to copy documents, a mechanism to ensure that recorded input is unalterable, and file recovery procedures. Confidentiality protection may also include use of encryption, detailed user access controls, transaction logs, and blinded files. • **Record release**: Medical records are not released without written, signed consent from the patient or patient's representative, identifying the specific medical information to be released. The release terms, such as to whom records are released and for what purposes, should also be described. This does not prevent release of statistical or summary data, or exchange of individual identifiable medical information between individuals or institutions providing care, fiscal intermediaries, research entities and State or local official agencies. • **Record retention:** Hospitals, acute psychiatric hospitals, skilled nursing facilities, *primary care clinics*, psychology and psychiatric clinics must maintain medical records and exposed x-rays for a minimum of 10 years following patient discharge, except for minors (Title 22, CCR, and Section 75055). Records of minors must be maintained for at least one year after a minor has reached age 18, but in no event for less than 7 years (Title 22, CCR, and Section 75055). Each Plan must maintain all records and documentation (including medical records) necessary to verify information and reports required by statute, regulation or contractual obligation for 5 years from the end of the fiscal year in which the Plan contract expires or is terminated (Title 22, CCR, Section 53861). PER THE **INTERGOVERNMENTAL AGREEMENT**, **DHCS** AND **CMS** MAY AUDIT **10 YEARS** FROM THE DATE THE STATE PREPAID HEALTH INSURANCE PROGRAM (PHIP) INTERGOVERNMENTAL AGREEMENT EXPIRES, OR FROM THE DATE OF THE COMPLETION OF ANY AUDIT, WHICHEVER IS LATER. • **Adequacy of Medical Record/treatment record keeping:** The reviewers must discuss office documentation practices with the practitioner or practitioner staff. This discussion must include the forms and methods used to keep the information in a consistent manner. It must also include how the practice insures the confidentiality of records. The reviewers must assess the record for orderliness of the record and documentation practices. To ensure member confidentiality the reviewer may review "blinded" medical/treatment records or a model instead of an actual record.

III. Office Management

RN/MD/LPHA Review only

Office Management Survey Criteria	Wt	Yes	No	NA	Score
A. Medical records are available for the Provider at each scheduled patient encounter. 22 CCR §75055; 28 CCR §1300.80					
1) Medical records are readily retrievable for scheduled patient encounters.	**1**	1)____	1)____	1)____	
2) Medical documents are filed in a timely manner to ensure availability for patient encounters.	**1**	2)____	2)____	2)____	
B. Confidentiality of personal medical information is protected according to State and federal guidelines. 22 CCR §51009, §53861, §75055; §28 CCR §1300.80; CA Civil Code §56.10 (Confidentiality of Medical Information Act) 42CFR					
1) Substance Use Disorder consult and therapy rooms safeguard patients' right to privacy.	**1**	1)____	1)____	1)____	
2) Procedures are followed to maintain the confidentiality of personal patient information.	**1**	2)____	2)____	2)____	
3) Medical record release procedures are compliant with State and federal guidelines.	**1**	3)____	3)____	3)____	
4) Storage and transmittal of medical records preserves confidentiality and security.	**1**	4)____	4)____	4)____	
5) All patient's health service records must be retained for a minimum of ten (10) years from the patient's discharge date or seven years after a minor patient reaches the age of eighteen.	**1**	5)____	5)____	5)____	
6) There is a system in place that ensures medical records are maintained in a consistent manner.	**1**	6)____	6)____	6)____	

This page = 8pts

Criteria	III. Office Management Reviewer Guidelines (Continued)
C. All program policies and procedures shall be contained in a manual that is located at each certified site and that shall be available to staff and volunteers.	**AOD 12010** Program Policies All program policies and procedures shall be contained in a manual that is located at each certified site and that shall be available to staff and volunteers. The policies and procedures shall contain, but not be limited to, the following: 1. Program mission and philosophy statement(s). 2. Program description, objectives, and evaluation plan 3. Admission and readmission; including client assignment to counselor and contact information 4. Intake and discharge; including recovery services 5. Individual and group sessions; 6. Alumni involvement and use of volunteers 7. Recreational activities; 8. Detoxification services, if applicable; 9. Program administration and personnel practices 10. Client grievances/complaints 11. Fiscal practices 12. Continuous quality improvement; 13. Client rights 14. Medical Policies 15. Nondiscrimination in provision of employment and services; 16. Community relations; 17. Confidentiality; 18. Maintenance of program in a clean, safe and sanitary physical environment; 19. Maintenance and disposal of client files; 20. Drug screening; 21. Staff code of conduct as specified in section 13020 of these Standards; 22. Client code of conduct 23. Care Coordination/Case Management **CCR Title 9, Division 4** NTP/OTP Policies 24. All NTP/OTP medical policies shall conform with CCR, Title 9, Division 4 with regard to medication practices.

III. Office Management

RN/MD/LPHA Review only

Office Management Survey Criteria	Wt	Yes	No	NA	Score
C. All program policies and procedures shall be contained in a manual that is located at each certified site and that shall be available to staff and volunteers. The policies and procedures shall contain, but not be limited to, the following:					
1) Program Mission and Philosophy Statement	**1**	1)____	1)____	1)____	
2) Program Description, objectives and evaluation plan.	**1**	2)____	2)____	2)____	
3) Admission and Re-admission	**1**	3)____	3)____	3)____	
4) Intake and Discharge recovery services	**1**	4)____	4)____	4)____	
5) Individual and Group Sessions	**1**	5)____	5)____	5)____	
6) Alumni involvement and Use of volunteers	**1**	6)____	6)____	6)____	
7) Recreational activities	**1**	7)____	7)____	7)____	
8) Detoxification Services (if applicable)	**1**	8)____	8)____	8)____	
9) Program administration and personnel practices	**1**	9)____	9)____	9)____	
10) Client grievances/complaints	**1**	10)____	10)____	10)____	
11) Evidence of Fiscal practices and budget mechanisms	**1**	11)____	11)____	11)____	
12) Continuous quality improvement	**1**	12)____	12)____	12)____	
13) Client rights and	**1**	13)____	13)____	13)____	
14) Medical policies	**1**	14)____	14)____	14)____	
15) Nondiscrimination in provision of employment and services;	**1**	15)____	15)____	15)____	
16) Community Relations	**1**	16)____	16)____	16)____	
17) Confidentiality	**1**	17)____	17)____	17)____	
18) Maintenance of program in a clean, safe, and sanitary physical environment;	**1**	18)____	18)____	18)____	
19) Maintenance and disposal of client files	**1**	19)____	19)____	19)____	
20) Drug screening	**1**	20)____	20)____	20)____	
21) Staff code of conduct as specified in section 13020 of these Standards and	**1**	21)____	21)____	21)____	
22) Client code of conduct	**1**	22)____	22)____	22)____	
23) Care Coordination/Case Management	**1**	23)____	23)____	23)____	
24) All NTP/OTP medical policies shall conform with CCR, Title 9, Division 4, Chapter 4 with regard to medication practices	**1**	24)____	24)____	24)____	

This page = 24pts

Criteria	III. Office Management Reviewer Guidelines (Continued)
D. Compliance with the following Minimum Quality Treatment Standards is required for all SUD treatment programs either partially or fully funded by Substance Abuse and Prevention Treatment Block Grant (SABG).	**1. Program Management-Admission or Readmission** a) Each program shall include in its policies and procedures written admission and readmission criteria for determining client's eligibility and suitability for treatment. b) Use of alcohol/drugs of abuse; Physical health status: Documentation of social and psychological problems. c) If a potential client does not meet the admission criteria, the client shall be referred to an appropriate service provider. d) If a client is admitted to treatment, a consent to treat shall be documented in the client record. e) All referrals made by the program shall be documented in the client record. f) Copies of the following documents shall be provided to the client upon admission: Clients rights, client fee policies, and consent to treatment. **2. Program Management** Copies of the following shall be provided to the client or posted in a prominent place accessible to all clients: a)A statement of nondiscrimination by race, religion, sex, gender identity, ethnicity, age, disability, sexual preference, and ability to pay; b) Grievance procedures; Appeal process for involuntary discharge; Program rules, expectations and regulations. c) Where drug screening by urinalysis is deemed appropriate the program shall: Establish procedures which protect against the falsification and/or contamination of any urine sample; Document urinalysis in the client's file. **3.Treatment** a)Assessment of all clients shall include: Drug/Alcohol use history; Medical history; Family history; Psychiatric history; Social/recreational history; Financial history; Educational history; Employment history; Criminal history, legal status; Previous SUD treatment history. b) Treatment plans shall be developed with the client within 30 days of admission and include: A problem statement for all problems identified through the assessment whether addressed or deferred; Goals to address each problem statement (except when deferred); Action steps to meet the goals that include who is responsible for the action and the target date for completion; Signature of primary counselor and client. c) All treatment plans shall be reviewed periodically and updated to accurately reflect the client's progress or lack of progress in treatment. d) Progress notes shall document the client's progress toward completion of activities and achievement of goals on the treatment plan. e)Discharge documentation shall be developed with the client, if possible and include: A description of the episode; Prognosis; Client's plan for continued recovery including support systems and plans for relapse prevention; Reason and type of discharge; Signature of primary counselor and client; A copy of the discharge documentation shall be given to the client.

III. Office Management

RN/MD/LPHA Review only

Office Management Survey Criteria	Wt	Yes	No	NA	Score
D. Compliance with the following Minimum quality Treatment Standards is required for all SUD treatment programs either partially or fully funded by Substance Abuse and Prevention Treatment Block Grant (SABG).					
1. **Program Management –** Admission or Readmission					
a) Program policies and procedures include written admission and readmission criteria for determining client's eligibility and suitability for treatment.	**1**	1a)____	1a)____	1a)____	
b) Use of alcohol/drugs of abuse; Physical health status: Documentation of social and psychological problems.	**1**	1b)____	1b)____	1b)____	
c) If a potential client does not meet the admission criteria, the client shall be referred to an appropriate service provider.	**1**	1c)____	1c)____	1c)____	
d) If a client is admitted to treatment, a consent to treat shall be documented in the client record.	**1**	1d)____	1d)____	1d)____	
e) All referrals made by the program shall be documented in the client record.	**1**	1e)____	1e)____	1e)____	
f) Copies of the following documents shall be provided to the client upon admission: Clients rights, client fee policies, and consent to treatment.	**1**	1f)____	1f)____	1f)____	
2. **Program Management –** Copies of the following shall be provided to the client or posted in a prominent place accessible to all clients:					
a) A statement of nondiscrimination by race, religion, sex, gender identity, ethnicity, age, disability, sexual preference, and ability to pay;	**1**	2a)____	2a)____	2a)____	
b) Grievance procedures; Appeal process for involuntary discharge; Program rules, expectations and regulations.	**1**	2b)____	2b)____	2b)____	
c) Where drug screening by urinalysis is deemed appropriate the program shall: Establish procedures which protect against the falsification and/or contamination of any urine sample; Document urinalysis in the client's file.	**1**	2c)____	2c)____	2c)____	
3. **Program Management** – Treatment – Assessment of all clients shall include:					
a) Drug/Alcohol use history; Medical history; Family history; Psychiatric history; Social/recreational history; Financial history; Educational history; Employment history; Criminal history, legal status; Previous SUD treatment history.	**1**	3a)____	3a)____	3a)____	
b) Treatment plans shall be developed with the client within 30 days of admission and include: A problem statement for all problems identified through the assessment whether addressed or deferred; Goals to address each problem statement (except when deferred); Action steps to meet the goals that include who is responsible for the action and the target date for completion; Signature of primary counselor and client.	**1**	3b)____	3b)____	3b)____	
c) All treatment plans shall be reviewed periodically and updated to accurately reflect the client's progress or lack of progress in treatment.	**1**	3c)____	3c)____	3c)____	
d) Progress notes shall document the client's progress toward completion of activities and achievement of goals on the treatment plan.	**1**	3d)____	3d)____	3d)____	
e) Discharge documentation shall be developed with the client, if possible and include: Description of the episode; Prognosis; Client's plan for continued recovery including support systems and plans for relapse prevention; Reason and type of discharge; Signature of primary counselor and client; A copy of the discharge documentation shall be given to the client.	**1**	3e)____	3e)____	3e)____	

Comments: Write comments for all "No" (0 points) and "N/A" scores.

This page = 14pts

Criteria	III. Office Management Reviewer Guidelines (Continued)
E. There is 24-hour access to interpreter services for non-or limited-English proficient (LEP) members.	All sites must provide 24-hour interpreter services for all members either through telephone language services or interpreters on site. Site personnel used as interpreters have been assessed for their medical interpretation performance skills/capabilities. ***Note:*** https://www.lep.gov/faqs/faqs.html#OneQ11 • If bilingual staff are asked to interpret or translate, they should be qualified to do so. Assessment of ability, training on interpreter ethics and standards, and clear policies that delineate appropriate use of bilingual staff, staff or contract interpreters and translators, will help ensure quality and effective use of resources. • Those utilizing the services of interpreters and translators should request information about certification, assessments taken, qualifications, experience, and training. Quality of interpretation should be a focus of concern for all recipients. • Family or friends should not be used as interpreters, unless specifically requested by the member. • ACA 2010 § 1557: prohibits from using low-quality video remote interpreting services or relying on unqualified staff, translators when providing language assistance services. • A request for or refusal of language/interpreter services must be documented in the member's medical record.
F. Copies of the following shall be provided to the beneficiary or posted in a prominent place accessible to all beneficiaries.	Copies of the following should be available to beneficiaries: Statement of nondiscrimination, PHC grievance phone number and packet, Appeal process for involuntary discharge, Program rules and expectations
G. Evidence Based Practices are used	Intergovernmental Agreement Exhibit A, Attachment I, III, AA, 3, iii Providers will implement at least two of the following EBPs. The two EBPs are per provider per service modality. a. Motivational Interviewing: b. Cognitive-Behavioral Therapy: c. Relapse Prevention: d. Trauma-Informed Treatment: e. Psycho-Education

III. Office Management

RN/MD/LPHA Review only

Office Management Survey Criteria	Wt	Yes	No	NA	Score
E. There is 24-hour access to interpreter services for non- or limited-English proficient (LEP) members. 22 CCR §53851; 28 CCR 1300.67.04					
1) Interpreter services are made available in identified threshold languages specified for location of site.	**1**	1)____	1)____	1)____	
2) Persons providing language interpreter services, including sign language on site, are trained in medical interpretation.	**1**	2)____	2)____	2)____	
F. Copies of the following shall be provided to the beneficiary or posted in a prominent place accessible to all beneficiaries.					
1) A statement of nondiscrimination by race, religion, sex, ethnicity, age, disability, sexual preference, and ability to pay	**1**	1)____	1)____	1)____	
2) Complaint process and grievance procedures	**1**	2)____	2)____	2)____	
3) Appeal process for involuntary discharge	**1**	3)____	3)____	3)____	
4) Program rules and expectations	**1**	4)____	4)____	4)____	
G. Evidenced Based Practices are used					
1) At least two types of evidence based practices are documented.	**1**	1)____	1)____	1)____	

Comments: Write comments for all "No" (0 points) and "N/A" scores. This page = 7pts

Total domain pts possible = 53

Criteria	IV. Pharmaceutical: Pharmaceutical Services Reviewer Guidelines
A. For Residential Facilities, Drugs and medication supplies are maintained secured to prevent unauthorized access.	• **Deficiencies:** All deficiencies related to Pharmaceutical Services (e.g. medication maintenance, storage, safety, distribution, etc.) must be addressed in a corrective action plan. • **Controlled substances**: Written records are maintained of controlled substances inventory list(s) that includes: provider's DEA number, name of medication, original quantity of drug, dose, date, name of patient receiving drug, name of authorized person dispensing drug, and number of remaining doses. Controlled substances are stored separately from other drugs in a securely locked, substantially constructed cabinet (Control Substances Act, CFR 1301.75). Control substances include all Schedule I, II, III, IV, and V substances listed in the CA Health and Safety Code, Sections 11053-11058, and do not need to be double locked. Personnel with authorized access to controlled substances include physicians, dentists, podiatrists, physician's assistants, licensed nurses and pharmacists. • **Security**: All drugs for dispensing are stored in an area that is secured at all times (CA B&P Code, §4051.3). Keys to locked storage area are available only to staff authorized by the physician to have access (16 CCR, Chapter 2, Division 3, Section 1356.32). The Medical Board of California interprets "all drugs" to also include both sample and over-the-counter drugs. The Medical Board defines "area that is secure" to mean a locked storage area within a physician's office. **Note**: During business hours, the drawer, cabinet or room containing drugs, medication supplies or hazardous substances may remain unlocked ***only*** if there is no access to area by unauthorized persons. Whenever drugs, medication supplies or hazardous substances are unlocked, authorized clinic personnel must remain in the immediate area ***at all times***. At all other times, drugs, medication supplies and hazardous substances must be securely locked. Controlled substances are locked at all times. There must not be any expired medications on site.

IV. Pharmaceutical

RN/MD Review only

Pharmaceutical Services Survey Criteria	Wt	Yes	No	NA	Score
A. Drugs and medication supplies are maintained securely to prevent unauthorized access. CA B&P Code §4051.3, §4071, §4172; 22 CCR §75037(a-g), §75039; 21 CFR §1301.75, §1301.76, §1302.22					
1) For Residential Facilities and Withdrawal management, drugs are stored in specifically designated cupboards, cabinets, closets or drawers.	**1**	1)____	1)____	1)____	
2) Controlled drugs are stored in a locked space accessible only to authorized personnel.	**1**	2)____	2)____	2)____	
3) A dose-by-dose controlled substance distribution log is maintained.	**1**	3)____	3)____	3)____	
4) There are no expired medications on site.	**1**	4)____	4)____	4)____	
Comments: Write comments for all "No" (0 points) and "N/A" scores. Totals					

4 total points possible

Reviewer Comments:

If more than one Reviewer, both must sign here.

Reviewer Signature: _____

Reviewer Name: Michelle Gazzigli LCSW_____

Reviewer Title: LCSW_____

Reviewer Signature: _____

Reviewer Name: _____

Reviewer Title: _____

Medical Record Review Survey
Substance Use Disorder (SUD) Treatment Services

No. of LPHA/MD_____

Facility Name:_____ Site ID:_____ Review Date _____ No. of Records_____

Provider _____ Phone _____ Fax _____

Address_____ Contact person/title _____

City/Zip Code_____ Reviewer/title _____ Reviewer/title _____

Visit Purpose	Site-Specific Certification(s)	Clinic type
_____ Initial Full Scope _____ Monitoring _____ Periodic Full Scope _____ Follow-up _____ Focused Review _____ Ed/TA _____Other _____ (type)	DMC Certification_____ ASAM Designation_____ (**For Residential Programs**)	___ Out Pt (1) ___ Withdrawal Mgmt. (3.2) ___ Residential (3.1) ___ Residential (3.5)* ___ Intensive Perinatal Out Pt (2.1) ___ Intensive Out Pt (2.1) ___ Perinatal Out Pt (1) ___ Perinatal Res. (3.5) ___ OTP _____ Other

Scoring Procedure

		Points possible	Yes Pts. Given	No's	N/A's	Section Score %
I.	**Format**	**(6) X 10 = 60**				
II.	**Intake Services**	**(16) x 10 = 160**				
III.	**Treatment Services**	**(20) x 10 = 200**				
IV.	**Discharge Services**	**(4) x 10 = 40**				
V.	**Recovery Services**	**(4) x 10 = 40**				
VI.	**Residential**	**(3) x 10= 30**				
		Total Points Possible	**Yes Pts. Given**	**No's**	**N/A's**	

Medical Record Scores

Scoring is based on **10** medical records.

1) Add points given in each section.
2) Add points given for all six (6) sections.
3) Subtract "N/A" points (if any) from total points possible to get "adjusted" total points possible.
4) Divide total points given by "adjusted" total points possible.
5) Multiply by 100 to determine compliance rate as a percentage.

_____ ÷ _____ = _____ **x 100** = _____%

Points Given / Total/ Adjusted Pts. Poss. / Decimal Score / Compliance Rate

Compliance Rate

Note: Any section score of < 80% requires a CAP for the entire MRR, regardless of the Total MRR score.

_____**Exempted Pass: 90% or above:** (Total score is ≥ 90% *and* all section scores are 80% or above)

_____**Conditional Pass: 80-89%:** (Total MRR is 80-89% *OR any* section(s) score is < 80%)

_____**Not Pass: Below 80%**

_____CAP Required

_____Other follow-up

Next Review Due: _____

Medical Record Review for Substance Use Disorder (SUD) Treatment Services

California Department of Health Care Services
Medi-Cal Managed Care Division

Purpose: Medical Record Review Guidelines provide standards, directions, instructions, rules, regulations, perimeters, or indicators for the medical record survey, and shall be used as a gauge or touchstone for measuring, evaluating, assessing, and making decisions.

Scoring: Survey score is based on a review standard of 10 records per Licensed Practitioner of the Healing Arts (LPHA). Documented evidence found in the hard copy (paper) medical records and/or electronic medical records are used for survey criteria determinations. An Exempted Pass is 90%. Conditional Pass is 80-89%. Not Pass is below 80%. The minimum passing score is 80%. A corrective action plan (CAP) is required for a total MRR score below 90%. Also, any section score of less than 80% requires a CAP for the entire MRR, regardless of the total MRR score. Not applicable ("N/A") applies to any criterion that does not apply to the medical record being reviewed, and must be explained in the comment section. Medical records shall be randomly selected using methodology decided upon by the reviewer. Ten (10) medical records are surveyed for each LPHA. Sites where documentation of patient care by all LPHA on site occurs in universally shared medical records shall be reviewed as a "shared" medical record system. Scores calculated on shared medical records apply to each LPHA sharing the records. A minimum of ten shared records shall be reviewed for 2-3 LPHA, twenty records for 4-6 LPHA, and thirty records for 7 or more LPHA. Survey criteria to be reviewed *only* by a R.N. or physician or LPHA are labeled "**RN/MD/LPHA Review only".**

Directions: Score one point if criterion is met. Score zero points if criterion is not met. Do not score partial points for any criterion. If 10 shared records are reviewed, score calculation shall be the same as for 10 records reviewed for a single LPHA. If 20 records are reviewed, divide total points given by the "adjusted" total points possible. If 30 records are reviewed, divide total points given by the "adjusted" total points possible. Multiply by 100 to calculate percentage rate. Reviewers have the option to request additional records to review, but must calculate scores accordingly. Reviewers are expected to determine the most appropriate method(s) on each site to ascertain information needed to complete the survey.

Scoring Example:

Step 1: Add the points given in each section.	**Step 2**: Add points given for all six (6) sections. (Format points given) (Intake Services points given) (Treatment Services points given) + (Discharge Services points given) (Recovery Services points given) (Residential points given) **= (Total points given)**
Step 3: Subtract the "N/A" points from total points possible. (Total points possible) – (N/A points) = ("Adjusted" total points possible)	**Step 4**: Divide total points given by the "adjusted" points possible, then multiply by 100 to calculate percentage rate. Total points given / "Adjusted" total points possible Example: 267 / 305 = 0.875 X 100 = **88%**

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Rationale: A well-organized medical record keeping system supports effective patient care, information confidentiality and quality review processes

Criteria	I. Format Reviewer Guidelines
A. An individual medical record is established for each member.	**AOD 12020**, "A separate, complete, and current record shall be maintained at the program for each client. Programs shall develop any necessary forms. All client files shall contain demographic information sufficient to identify the client and to satisfy data collection needs of the program and funding agencies."
B. Chart contents are securely fastened and consistently organized.	Printed chart contents are securely fastened, attached or bound to prevent record loss. Electronic record information is readily available. Charts are consistently organized. This is per Partnership requirements.
C. Chart records are maintained in a confidential manner and stored for no less than 10 years from the date of closing.	Chart records must be confidentially secured and kept for no less than 10 years. Per the **Intergovernmental Agreement, under 42 CFR 438,** DHCS and CMS may audit for ten (10) years. Subcontractors are required to agree to grant state and federal oversight agencies the right to inspect books, contracts, computer or other systems that pertain to the services performed and to make materials available for audit for ten years from the completion of any audit, whichever is later.
D. For Perinatal Services: **1. There is access to mother/child rehabilitative services.** **2. There is education provided on the harmful effects of drugs and alcohol on the mother and fetus or infant.** **3. There is evidence of coordination of ancillary services in the case management note.** **4. There is proof of pregnancy and/or delivery.**	Per **Title 22 (page 11-12 Documentation, Modalities and Services)** these services must be offered to perinatal patients under **DMC-ODS** services. There must be proof of pregnancy and if applicable, proof of delivery to receive perinatal DMC-ODS services
E. For Adolescent Services: **1. Clients age 12-21 years have received ASAM assessment and meet the adolescent treatment criteria for care that is being provided.**	ASAM – The 5 Levels of Addiction Treatment According to the widely used ASAM adolescent placement criteria, there are 5 basic levels of teen addiction treatment. **The 5 levels of care are:** Level 0.5 – Early intervention Level 1 – Outpatient Level 2 – Intensive outpatient treatment or partial hospitalization Level 3 – Residential or intensive inpatient treatment Level 4 – Medically managed intensive inpatient treatment To determine an appropriate level of care, professionals look at the situation across 6 assessment dimensions, which are: **Acute intoxication and withdrawal** – looking at how much medical management of withdrawal might be needed, for example. **Biomedical complications** – assessing for other health conditions that might complicate the recovery process. **Emotional, behavioral and cognitive conditions or complications** – looking for other mental health, developmental or behavioral conditions that might complicate the recovery process and lead to a higher level of care requirement. **Readiness to change** – the more ready and motivated for change the lower the treatment intensity that is required. **Relapse or continued use potential** – teens able to control use and maintain abstinence for moderate periods require less intensive treatment than teens unable to stop for even short periods of time. **Recovery environment** – Teens without a safe and stable recovery environment may require higher intensity care, such as residential treatment, to make lasting gains. • **The ASAM shall be completed within 14 days of the first face-to-face interaction for youth.**
F. Timely Access	The first face-to-face appointment shall occur within 15 calendrer days of initial contact at all Levels of Care.

I. Format Criteria

Note: A Format section score < 80% requires a CAP for the entire MRR, regardless of the Total MRR score.

RN/MD/LPHA Review only

Criteria met: Give one (1) point. **Criteria not met: 0 points** **Criteria not applicable: N/A** **Age/Gender**	**Wt**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	Score
A. An individual medical record is established for each member.	**1**											
B. Chart contents are securely fastened and consistently organized.	**1**											
C. Chart records are maintained in a confidential manner and stored for no less than 10 years from the date of closing.	**1**											
D. For Perinatal Services: **5. There is access to mother/child rehabilitative services.** **6. There is education provided on the harmful effects of drugs and alcohol on the mother and fetus or infant.** **7. There is evidence of coordination of ancillary services in the case management note.** **8. There is proof of pregnancy and/or delivery.**	**1**											
E. For Adolescent Services: **Clients age 12-21 years have received ASAM assessment and meet the adolescent treatment criteria for care that is being provided.**	**1**											
F. Timely access	**1**											
	Yes											
Comments:	No											
	N/A											

6 Pts. Possible

Criteria	II. Intake Services Reviewer Guidelines
A. The written admission/readmission criteria must include the following: At least one diagnosis from the DSM-V identified; Use of alcohol/drug abuse; Physical health status; and Documentation of social and psychological problems.	Each provider shall include in its policies, procedures and practice, written admission and readmission criteria for determining beneficiary's eligibility and the medical necessity for treatment. These criteria shall include, at minimum: • DSM diagnosis • Use of alcohol/drugs abuse • Physical health status • Documentation of social and psychological problems
B. Medical Necessity is determined through a face-to-face or telehealth review by a medical director or LPHA, or a *face-to-face review between the counselor and the LPHA/Medical Director must be conducted if a counselor conducts the client intake.	Medical necessity must be performed in a face-to-face or telehealth (video-conference) review by either a medical director or a LPHA. **Reference: Intergovernmental Agreement Exhibit A, Attachment I, III, B. 2. i.** *This is part of a DHCS decision to make this a mandatory step in Medical Necessity Determination for waiver beneficiaries (see waiver). The intake information is compared to the DSM-IV criteria. A diagnosis is made if enough criteria are met to support the diagnosis. The ASAM criteria is compared to the DSM diagnosing criteria, and the level of care is then determined. **The diagnosis and medical necessity determination shall be completed within 15 calendar days of the first face-to-face interaction.**
C. A Client's Rights document is signed and available in the client file.	There is evidence of a Client's Rights document available in the client file for review.
D. There is a Consent to Treatment form signed in the client file.	The beneficiary shall sign a consent for treatment form.
E. There is a Program Rules document signed and in the client file.	There is evidence of a Program Rules document signed and in the client file for review.
F. There is an Admission Agreement signed and in the client file.	There is evidence of an Admission Agreement and in the client file for review.
G. There is verification of Medi-Cal/ PHC eligibility in the client file.	There is evidence of PHC or Medi-Cal eligibility in the client file for review.
H. There is a signed Follow-Up Consent document in the client file.	There is evidence of a Follow-Up Consent signed and in the client file for review.
I. Physical exam must be in patient's chart.	A physical exam must be in the patient's chart. The SUDS Clinician Must either: a. Obtain a copy of the most recent physical exam (if one was completed in the last 12 months). The exam can only be reviewed by a Physician. **OR** b. Perform a new exam. The exam must be performed by a Physician, PA, or Nurse Practitioner (N.P.). c. Put in Treatment Plan goals. d. Contact Care Coordination (CC) in Partnership Health Plan to help set up unestablished member with a network PCP provider to perform a physical exam. 22 CCR § 51303, 42 CFR § 438.210(a)(4) **NOTE: This must be done within *30 days* of admission into program.** **PHC contract states if client has not been seen in longer than 6 months, client will be referred to PHC Care Coordination department aid in receiving medical care.**

II. Intake Services

Note: An Intake Services section score < 80% requires a CAP for the entire MRR, regardless of the Total MRR score.

RN/MD/LPHA Review only

Criteria met: Give one (1) point. **Criteria not met: 0 points** **Criteria not applicable: N/A** Age/Gender	**Wt**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
A. The written admission/readmission criteria must include the following: At least one diagnosis from the DSM-V identified; Use of alcohol/drug abuse; Physical health status; and Documentation of social and psychological problems.	**1**											
B. Medical Necessity is determined through a face-to-face or telehealth review by a medical director or LPHA, or a *face-to-face review between the counselor and the LPHA/Medical Director must be conducted if a counselor conducts the client intake.	**1**											
C. A Client's Rights document is signed and available in the client file.	**1**											
D. There is a Consent to Treatment form signed in the client file.	**1**											
E. There is a Program Rules document signed and in the client file.	**1**											
F. There is an Admission Agreement signed and in the client file.	**1**											
G. There is verification of Medi-Cal/ PHC eligibility in the client file.	**1**											
H. There is a signed Follow-Up Consent document in the client file.	**1**											
I. Physical exam must be in Patient's chart.	**1**											

Criteria	II. Intake Services Reviewer Guidelines (Continued)
J. There is a Consent to Release Information document signed and in the client file.	There is evidence of a Consent to Release Information document signed and in the client file for review. This is per **42 CFR.**
K. There is a HIPAA document signed and in the client chart.	There is evidence of a HIPAA (Health Information Portability and Accountability Act) signed and in the client file for review.
L. When establishing initial contact with the client, the treatment facility documents missed appointments and outreach efforts/follow-up contacts.	There must be documentation of at least 3 outreach efforts from the facility to the client for engagement in treatment.
M. The provider accepts proof of eligibility for DMC as payment in full for treatment services rendered upon intake and monthly.	**NOTE**: This is ***except*** when there is a share of cost (SOC).
N. Adult clients must meet the ASAM criteria definition of medical necessity for services based on the ASAM criteria.	American Society of Addiction Medicine (ASAM) Criteria shall be applied by the diagnosing individual (Medical Director or LPHA) to determine placement into the level of assessed services. **Reference: Intergovernmental Agreement Exhibit A, Attachment I, III, B. 2. i.** • **ASAM level of Care data shall be entered into the designated system for each assessment or re-assessment and within 7 days of the assessment/re-assessment. The ASAM assessment shall be completed within 7 days of the first face-to-face interaction for adults.** **THE MEDICAL DIRECTOR OR LPHA SHALL REVIEW EACH BENEFICIARY'S PERSONAL, MEDICAL AND SUBSTANCE USE HISTORY IF COMPLETED BY A COUNCELOR.**
O. Upon Intake, a Personal, Medical, and Substance Abuse History is completed.	The provider shall assure a counselor or LPHA completes a personal, medical, and substance use history for each beneficiary upon admission to treatment. The history shall be completed during the first face-to-face interaction. Assessment for all beneficiaries shall include at a minimum: Drug/alcohol use history; Medical history; Family history; Psychiatric/psychological history; Social/recreational history; Financial status/history; Educational history; Employment history; Criminal history, legal status, and previous SUD treatment history.
P. There is evidence of at least two Evidence Based Practices (EBPs) being used.	Providers will implement at least two of the following Evidence Based Practices (EBPs) in patient's treatment. They are as follows: • **Motivational Interviewing**: this approach frequently includes other problem solving or solution-focused strategies that build on clients' past successes. • **Cognitive- Behavioral Therapy**: Based on the theory that most emotional and behavioral reactions are learned and that new ways of reacting and behaving can be learned. • **Seeking Safety:** teaches present-focused coping skills to help clients attain safety in their lives. • **Trauma-Informed Treatment**: Services must take into account an understanding of trauma, and place priority on trauma survivor's safety, choice and control. • **Living in Balance:** helps address issues in lifestyle areas that may have been neglected during addiction.

II. Intake Services (Continued)

Note: An Intake Services section score < 80% requires a CAP for the entire MRR, regardless of the Total MRR score.

RN/MD/LPHA Review only

Criteria met: Give one (1) point. **Criteria not met: 0 points** **Criteria not applicable: N/A** **Age/Gender**	**Wt**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	Score
J. There is a Consent to Release Information document signed and in the client file.	**1**											
K. There is a HIPAA document signed and in the client chart.	**1**											
L. When establishing initial contact with the client, the treatment facility documents missed appointments and outreach efforts/follow-up contacts.	**1**											
M. The provider accepts proof of eligibility for DMC as payment in full for treatment services rendered upon intake and monthly.	**1**											
N. Adult clients must meet the ASAM criteria definition of medical necessity for services based on the ASAM criteria.	**1**											
O. Upon Intake, a Personal, Medical, and Substance Abuse History is completed.	**1**											
P. There is evidence of at least two Evidence Based Practices (EBPs) being used.	**1**											
	Yes											
Comments:	No											
	N/A											

16 Pts. Possible

Rationale: A well-organized medical record keeping system supports effective patient care, information confidentiality and quality review processes.

Criteria	III. Treatment Services Reviewer Guidelines
A. The most recent Treatment Plan **B.** **C.** **D. must be in the record.**	The most recent treatment plan must be in the file**.**
B. The Treatment Plan is signed in the designated time frame, dated and legible.	**Signature:** If the MD or LPHA deem the services in the initial treatment plan medically necessary, they must print their name, sign, and date the treatment plan within ***15 calendar days*** of being signed by the counselor. Withdrawal Management within one business day of admission. -It must be signed by the beneficiary (client) within ***30 days*** of admission to treatment. IF the beneficiary refuses to sign the treatment plan, the provider shall document the reason for refusal and the provider's strategy to engage the beneficiary to participate in treatment. -The treatment plan must be signed by the counselor within ***30 calendar days*** of admission to treatment. **Note: If ALL signatures are not within the total 30 day timeframe, Services rendered in that time will be ineligible for payment.** **Legibility:** means the record entry is readable by a person other than the writer. Handwritten documentation, signatures and initials are entered in ink that can be readily/clearly copied.
C. The Treatment Plan is consistent with issues per the client.	Per **Title 22**, the statement of problems should match the assessment. Goals to be reached need to address each problem the patient presents with. Action steps refer to activities and interventions which will be taken to accomplish the goal(s). Target dates are dates set in place for when the action steps are scheduled to be accomplished. - Statement of problems - Goals including goal of obtaining a physical exam if needed, and goal of obtaining treatment for an identified significant medical illness if needed - Action steps - Target dates - Type and frequency of counseling/services - Diagnosis as documented by the Medical Director or LPHA - Assignment of primary therapist or counselor - If the beneficiary has not had a physical examination within the 12-month period prior to the beneficiary's admission to treatment date, a goal that the beneficiary have a physical examination is required - If documentation of a beneficiary's physical examination, which was performed during the prior 12 months, indicates a beneficiary has a significant medical illness, a goal that the beneficiary obtain appropriate treatment for the illness. **Timeframe:** Within 30 calendar days from beneficiary's admission to treatment **NOTE: ALL elements need to be present in order to receive points for this criteria.**
D. There is documentation that the client actively participated in the initial Treatment Plan process.	There is evidence in the Treatment plan documentation that the client played an active role in creating the plan..

III. Treatment Services

Note: A Treatment Services section score < 80% requires a CAP for the entire MRR, regardless of the Total MRR score.

RN/MD/LPHA Review only

Criteria met: Give one (1) point. **Criteria not met: 0 points** **Criteria not applicable: N/A** Age/Gender	**Wt**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
A. The most recent Treatment Plan must be in the record.	**1**											
B. The Treatment Plan is signed in the designated time frame, dated and legible.	**1**											
C. The Treatment Plan is consistent with issues per the client.	**1**											
D. There is documentation that the client actively participated in the initial Treatment Plan process.	**1**											

Comments:

Rationale: A well-organized medical record keeping system supports effective patient care, information confidentiality and quality review processes.

Criteria	III. Treatment Services Reviewer Guidelines (Continued)
F. Documentation of Date and type of each session with signature of rendering counselor, and notes describing progress toward achieving the client's individual goals are in the client's chart.	According to **AOD 8000 c. 1-4,** "The following documentation of attendance at each individual counseling session and group counseling session shall be placed in the client's file: 1. Date of each session attended; 2. Type of session (i.e., individual or group); 3. Signature of counselor who conducted the session; and 4. Notes describing progress toward achieving the client's treatment plan or recovery plan goals". 1. Date of each session attended 2. Type of session (i.e., individual or group) 3. Signature of counselor who conducted the session 4. Notes describing progress toward achieving the client's treatment plan or recovery plan goals This is also illustrated in **§ 51341.1. Drug Medi-Cal Substance Use Disorder Services.**22 CA ADC § 51341.1
G. For Outpatient, Intensive Outpatient, Naltrexone Treatment, and Recovery Services, the Progress Note consists of all of the minimum components spelled out in the AOD 7100 b.	Per **Title 22 and AOD 7100 b**, LPHA or Counselor must have these elements in their progress notes for **all** patients enrolled in outpatient services: • Topic of the session • Description of beneficiary's progress toward treatment plan goals • Date of each treatment service • Start and end time of each treatment service • Typed or legibly printed name of LPHA or counselor, signature and date progress note was documented (printed and signed name adjacent to one another) **within 7 days of the session** • Identify if service was in-person, telephone or telehealth • Document location of service and how confidentiality was maintained if provided in the community ~ **If case management services are provided, additional criteria of: a description of how the services relates to the beneficiary's treatment plan problems, goals, action steps, objectives, and/or referral.** **NOTE: ALL elements need to be present in order to receive points for this criteria.**
H. For Outpatient Services, there is a minimum of two individual or group counseling sessions provided to the client every month.	Per **Title 22 and AOD standards,** there must be a minimum of two individual or group counseling sessions provided to the client every month in the Outpatient setting.
I. Progress notes contain an individual narrative summary describing client's progress on the treatment plan goals and action steps.	The progress note must contain this documentation in order to receive points on this criteria. This is crucial to insuring that the care and action steps taken are individualized to the client identified needs and consistent with the treatment plan goals.
J. In Residential Care and Intensive Outpatient Care, there is a minimum of one progress note per calendar week.	If applicable, the progress notes must contain dates and duration of group counseling sessions and have to be signed within the week following the calendar week when the counseling sessions were provided.

III. Treatment Services (Continued)

Note: A Treatment Services section score < 80% requires a CAP for the entire MRR, regardless of the Total MRR score.

RN/MD/LPHA Review only

Criteria met: Give one (1) point. **Criteria not met: 0 points** **Criteria not applicable: N/A** Age/Gender	**Wt**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
F. Documentation of Date and type of each session with signature of rendering counselor, and notes describing progress toward achieving the client's individual goals are in the client's chart.	**1**											
G. For Intensive Outpatient, Outpatient, Naltrexone Treatment, and Recovery Services, the Progress Note consists of all of the minimum components spelled out in the AOD 7100 b.	**1**											
H. For Outpatient Services, there is a minimum of two individual or group counseling sessions provided to the client every month.	**1**											
I. Progress notes contain an individual narrative summary describing client's progress on the treatment plan goals and action steps.	**1**											
J. In Residential Care and Intensive Outpatient Care, there is a minimum of one progress note per calendar week.	**1**											

Comments:

Rationale: A well-organized medical record keeping system supports effective patient care, information confidentiality and quality review processes.

Criteria	III. Treatment Services Reviewer Guidelines (Continued)
K. The program provides individual and group counseling directed toward concepts of withdrawal, recovery, an alcohol and drug-free lifestyle, relapse prevention and familiarization with related community recovery resources.	According to **AOD 8000 a**., "The program shall provide individual and group counseling sessions for clients. Family members and other persons who are significant in the client's treatment and recovery may also be included in sessions. Individual and group counseling sessions shall be directed toward concepts of withdrawal, recovery, an alcohol and drug-free lifestyle, relapse prevention and familiarization with related community recovery resources. Emphasis shall be placed on the recovery continuum appropriate to clients' needs."
L. Group sign in sheets include the printed names, signatures, dates, start and end times and topic of discussion.	Sign in sheets **MUST** include all of these components: • Printed name and signature of the client • Printed name, title and signature of the counselor • Date of session • Start and end times • Topic • List of the participants' names (printed or legibly written) and the signature of each participant that attended the counseling session.
M. Counseling Groups consist of between 2 and 12 clients.	The Counseling Group must consist of between 2 and 12 clients per **Title 22**: "(B) For day care habilitative services, group counseling shall be conducted with no less than two and no more than twelve clients at the same time, only one of whom needs to be a Medi-Cal beneficiary."
N. There are services provided, and documented directly by the treatment facility, or there are referrals made for the following services: educational, vocational, counseling, job referral, legal services, medical and dental services, social and recreational services.	Under **Title 22**, services must be provided or offered to the client receiving Substance Use Disorder Treatment Services for- education, vocation, counseling, job referral, legal, medical, and dental, social and recreational. Case management
O. Before conclusion of Treatment Services, and prior to rendering Recovery Services, counselor and client have met and collaborated on Treatment Goals and Recovery Plan.	According to **AOD 7110, "**Before active program participation is concluded and prior to program approved discharge, a counselor shall meet with each client to develop a continuing recovery plan that includes individual strategies to assist the client in sustaining long-term recovery. The continuing recovery or discharge planning process shall be inclusive of the goals identified in the treatment plan and the previous recovery plan and shall include referrals to appropriate resources."
P. Provider adheres to Practice Guidelines regarding Care Coordination and transitions between levels of care, including documentation of warm hand off.	Both the discharging and admitting PROVIDER agencies shall be responsible to facilitate the transition between levels of care, including assisting in scheduling an intake appointment, ensuring a minimal delay between discharge and admission at the next level of care, providing transportation as needed, and documenting all information in the beneficiary record. **Performance Standard: Transitions between levels of care shall occur within five (5) and no longer than ten (10) business days from the time of re-assessment indicating the need for a different level of care.** The PROVIDOR shall screen for and link clients with mental and physical health, as indicated. Also ensure that beneficiaries have access to recovery supports immediately after discharge or upon completion of an acute stay. A **warm hand** off is an interaction that happens in person between members of the transferring and receiving provider in front of the client and family (if present).

III. Treatment Services (Continued)

Note: A Treatment Services section score < 80% requires a CAP for the entire MRR, regardless of the Total MRR score.

RN/MD/LPHA Review only

Criteria met: Give one (1) point. **Criteria not met: 0 points** **Criteria not applicable: N/A** Age/Gender	**Wt**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
K. The program provides individual and group counseling directed toward concepts of withdrawal, recovery, an alcohol and drug-free lifestyle, relapse prevention and familiarization with related community recovery resources.	**1**											
L. Group sign in sheets include the printed names, signatures, dates, start and end times and topic of discussion.	**1**											
M. Counseling Groups consist of between 2 and 12 clients.	**1**											
N. There are services provided, and documented directly by the treatment facility, or there are referrals made for the following services: educational, vocational, counseling, job referral, legal services, medical and dental services, social and recreational services.	**1**											
O. Before conclusion of Treatment Services, and prior to rendering Recovery Services, counselor and client have met and collaborated on Treatment Goals and Recovery Plan.	**1**											
P. Provider adheres to Practice Guidelines regarding Care Coordination and transitions between levels of care, including documentation of warm hand off.	**1**											

Rationale: A well-organized medical record keeping system supports effective patient care, information confidentiality and quality review processes.

Criteria	III. Treatment Services Reviewer Guidelines (Continued)
P. The Program ensures that individuals infected with Tuberculosis who are seeking SUD Treatment Services receive a referral to other providers if they are denied admission to the program due to lack of capacity.	Per **DMC-ODS**, the program must ensure that individuals infected with Tuberculosis who are seeking SUD Treatment Services receive a referral to other providers if they are denied admission to the program due to lack of capacity.
Q. If client is in Treatment Services for time exceeding 6 months, justification for continuing services are documented in the chart.	Identifying the DSM diagnostic code and establishing the medical necessity for treatment and services, and justifying the need to continue services. Include documentation of the following: Beneficiary's personal, medical and substance abuse history; Documentation of most recent physical examination; Progress notes and treatment plan goals; LPHA's or counselor's recommendations; Beneficiary's prognosis. The continuing services justification must be completed ***no sooner than 5 months*** and ***no later than 6 months*** after the admission date. The physician must determine continuing medical necessity and justification must include prognosis and the counselor's recommendation for continuing treatment.
R. The Ongoing Treatment Plan meets the Criteria for completion and signing.	The Ongoing Treatment Plan must be: • Completed at MOST 90 days after the signing of the initial Treatment Plan. • Signed by the counselor within 90 days after the initial Treatment plan. • Signed by the client within 30 days of being signed by the counselor. The ongoing Treatment plan must have a signature from the LPHA/MD within 15 days of being signed by the client. Per **Title 22,** It is mandatory for the ongoing treatment plan to be completed no later than 90 days after the initial treatment plan and must be signed by the counselor within 90 days after the initial treatment plan, signed by the client within 30 days of the counselor's or LPHA's signature, and signed by the MD/LPHA within 15 days of being signed by the client. • **If beneficiary refuses to sign updated treatment plan, then document reason for refusal and document strategies to engage beneficiary to participate in treatment.** **Note: All Signatures must be present and within the appropriate timeframe in order to get the point for this criteria.**
S. The program ensures that Tuberculosis (TB) services are available and offered to clients receiving Substance Use Disorder (SUD) Treatment including counseling, testing, and referral.	It is mandatory for Tuberculosis services to be offered with a diagnosis of Tuberculosis (TB).
T. There has been Tuberculosis (TB) testing done and care received based on results.	A positive test and/or chest x-ray confirming Tuberculosis will be used to confirm the level of care that must be provided to the client.

III. Treatment Services (Continued)

Note: A Treatment Services section score < 80% requires a CAP for the entire MRR, regardless of the Total MRR score.

RN/MD/LPHA Review only

Criteria met: Give one (1) point. **Criteria not met: 0 points** **Criteria not applicable: N/A** Age/Gender	**Wt**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
P. The Program ensures that individuals infected with Tuberculosis who are seeking SUD Treatment Services receive a referral to other providers if they are denied admission to the program due to lack of capacity.	**1**											
Q. If client is in Treatment Services for time exceeding 6 months, justification for continuing services are documented in the chart.	**1**											
R. The Ongoing Treatment Plan meets the Criteria for completion and signing.	**1**											
S. The program ensures that Tuberculosis (TB) services are available and offered to clients receiving Substance Use Disorder (SUD) Treatment including counseling, testing, and referral.	**1**											
T. There has been Tuberculosis (TB) testing done and care received based on results.	**1**											
Comments:	Yes											
	No											
	N/A											

20 Points Possible

Rationale: Well-documented records facilitate communication and coordination, and promote efficiency and effectiveness of treatment.

Criteria	IV. Discharge Services Reviewer Criteria
A. A therapist or counselor shall complete a discharge plan for each client, except for a beneficiary with whom the provider loses contact.	Per **Title 22:** "A therapist or counselor shall complete a discharge plan for each beneficiary, except for a beneficiary with whom the provider loses contact." If the medical director or LPHA determines that continuing treatment services for the beneficiary is not medically necessary, the provider shall discharge the beneficiary from treatment and arrange for the beneficiary to go to an appropriate level of treatment services. Discharge plan should include the following: -A description of each of the beneficiary's relapse triggers. -A plan to assist the beneficiary to avoid relapse when confronted with a trigger -A support plan The discharge plan shall be prepared within 30 calendar days prior to the scheduled date of the last face-to-face treatment with the beneficiary. The discharge plan shall be completed by the time of transfer if moving to a different level of care.
B. The discharge plan is signed by both the client and the counselor	During the LPHA's or counselor's last face-to-face treatment with the beneficiary , the LPHA or counselor and the beneficiary shall type or legibly print their names, sign and date the discharge plan. A copy of the discharge plan shall be provided to the beneficiary and documented in the beneficiary record. **This is N/A if the provider loses contact with the client.**
C. If client was unavailable to complete a Discharge Plan, the *Discharge Summary* was completed within 30 days of the last face-to-face contact with the client.	This must be signed and dated by the counselor, and completed within 30 days from the last face-to-face with the client.
D. If client terminates services, the *Discharge Summary* must include: **1. Reason for discharge** **2. Description of treatment episodes** **3. Description of Recovery Services completed** **4. Current alcohol and/or other drug usage** **5. Vocational and educational achievements;** **6. Client's continuing recovery or discharge plan signed by counselor and client** **7. Transfers and referrals** **8. Client's comments.** **9. Beneficiary's prognosis** **10. Duration of Beneficiary's treatment as determined by the dates of admission and discharge from the treatment episode**	According to **AOD 7120 b. ,** A discharge summary that includes: 1. Reason for discharge, including whether the discharge was voluntary or involuntary and whether the client successfully completed the program; 2. Description of treatment episodes; 3. Description of recovery services completed 4. Current alcohol and/or other drug usage 5. Vocational and educational achievement 6. Client's continuing recovery or discharge plan signed by counselor and client 7. Transfers and referrals 8. Client's comments 9. Beneficiary's prognosis 10. Duration of Beneficiary's treatment as determined by the dates of admission and discharge from the treatment episode. **Note: Must meet all of this criteria in order to receive the point.**

IV. Discharge Services

Note: A Discharge Services section score < 80% requires a CAP for the entire MRR, regardless of the Total MRR score.

RN/MD/LPHA Review only

Criteria met: Give one (1) point. **Criteria not met: 0 points** **Criteria not applicable: N/A** Age/Gender	**Wt**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
A. A therapist or counselor shall complete a discharge plan for each beneficiary, except for a beneficiary with whom the provider loses contact.	**1**											
B. The discharge plan is signed by both the client and the counselor.	**1**											
C. If client was unavailable to complete a Discharge Plan, the Discharge Summary was completed within 30 days of the last face-to-face contact with the client.	**1**											
D. If client terminates services, the Discharge Summary must include: **1. Reason for discharge** **2. Description of treatment episodes** **3. Description of Recovery Services completed** **4. Current alcohol and/or other drug usage** **5. Vocational and educational achievements** **6. Client's continuing recovery or discharge plan signed by counselor and client** **7. Transfers and referrals** **8. Client's comments.**	**1**											
	Yes											
	No											
	N/A											

Comments:

4 Points Possible

Rationale: Medical records support coordination and continuity-of-care with documentation of past and present health status, medical treatment and future plans of care.

Criteria	V. Recovery Services Reviewer Criteria
A. Recovery Services provided are based on beneficiary directed concerns established in the Recovery Plan.	Beneficiary concerns are identified (triggers, relapse, preventative measures to prevent relapse). There needs to be clear evidence that there is a focus on coordination of care for the identified individual needs of the beneficiary.
B. Recovery Discharge is appropriately documented.	Recovery Discharge summary must be completed within 30 days of the last face-to-face client contact.
C. The Recovery Plan includes information on relapse triggers, proposed coping strategies, and a support plan.	**Per AOD 7100 a**, Support plan, proposed coping strategies and information on relapse triggers need to be included in the Recovery Plan. "a. If a program develops a recovery plan, it shall include the following: 1. A statement of challenges the client expects to encounter during recovery. 2. A statement detailing methods of handling the challenges of recovery. 3. A statement of actions that will be taken by the program and/or client to prepare for the challenges of recovery."
D. Adult beneficiaries in Residential treatment shall be re-assessed every 30 days, Youth every 30 days.	Adult beneficiaries in Residential treatment shall be re-assessed at a minimum every 30 days (since they will be assessed on day one). Youth beneficiaries in residential treatment shall be re-assessed at a minimum of every 30 days, unless there are significant changes warranting more frequent reassessments.

V. Recovery Services

Note: A Recovery Services section score < 80% requires a CAP for the entire MRR, regardless of the Total MRR score.

RN/MD/LPHA Review only

Criteria met: Give one (1) point. **Criteria not met: 0 points** **Criteria not applicable: N/A** Age/Gender	**Wt**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
A. Recovery Services provided are based on beneficiary directed concerns established in the Recovery Plan.	**1**											
B. Recovery Discharge is appropriately documented.	**1**											
C. The Recovery Plan includes information on relapse triggers, proposed coping strategies, and a support plan.	**1**											
D. Adult beneficiaries in Residential treatment shall be re-assessed every 30 days, Youth every 30 days	**1**											
	Yes											
Comments:	No											
	N/A											

4 Points Possible

Rationale: These guidelines are pulled from the DHCS website http://www.dhcs.ca.gov/provgovpart/Pages/Incidental-Medical- Services.aspx.

Criteria	VII. Residential Reviewer Criteria
A. There is evidence that there has been Prior Authorization obtained	Residential Treatment requires a Prior Authorization for services.
B. There is oversight of self-administered medications.	There is documentation present in the chart that illustrates oversight of patient's taking their medication.
C. The Residential Program provides the opportunity for the client to participate in planned recreational activities.	Per **AOD 10000,** "Residential programs shall provide the opportunity for clients to participate in planned recreational activities."

VII. Residential

Note: A Residential Treatment section score < 80% requires a CAP for the entire MRR, regardless of the Total MRR score.

RN/MD/LPHA Review only

Criteria met: Give one (1) point. **Criteria not met: 0 points** **Criteria not applicable: N/A** Age/Gender	**Wt**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
A. There is evidence that there has been Prior Authorization obtained	**1**											
B. There is oversight of self- administered medications.	**1**											
C. The Residential Program provides the opportunity for the client to participate in planned recreational activities.	**1**											

Comments:

Yes											
No											
N/A											

3 points possible

Reviewer Comments:

If more than one Reviewer, both must sign here.

Reviewer Signature: _____

Reviewer Name: _____

Reviewer Title: _____

Reviewer Signature: _____

Reviewer Name: _____

Reviewer Title: _____

Partnership HealthPlan of California

UTILIZATION MANAGEMENT PROGRAM DESCRIPTION

MPUD3001

April 2021

Table of Contents

PROGRAM PURPOSE

Partnership HealthPlan of California (PHC) is a County Organized Health System (COHS) contracted by the State of California to provide Medi-Cal Beneficiaries with a health care delivery system to meet their medical needs.

The mission of Partnership HealthPlan of California is "To help our Members, and the Communities we serve, be healthy." Our vision is to be "the most highly regarded health plan in California."

PHC has program descriptions and policies to describe the structures needed to provide high quality health care while being stewards of taxpayer resources. In the Utilization Management Program Description, PHC outlines the structure of our measurement and management of utilization of health care services within our system.

The PHC Utilization Management (UM) program serves to implement a comprehensive integrated process that actively evaluates and manages utilization of health care resources delivered to all members, and to actively pursue identified opportunities for improvement.

The utilization program is housed within the Health Services Department which consists of five teams including:

- Utilization Management
- Care Coordination
- Population Health
- Pharmacy
- Quality Improvement

The PHC UM program serves to accomplish the following:

- Ensure that members receive the appropriate quality and quantity of healthcare service
- Ensure that healthcare service is delivered at the appropriate time
- Ensure that the setting in which the service is delivered is consistent with the medical care needs of the individual

The UM program provides a reliable mechanism to review, monitor, evaluate, recommend and implement actions on identification and correction of potential and actual utilization and resource allocation issues.

PHC recognizes the potential for under-utilization and takes appropriate steps and actions to monitor for this. The processes for UM decision making are based solely on the appropriateness of care and services and existence of coverage. PHC does not reward practitioners or other individuals for issuing denials of coverage. Financial incentives for UM decision makers do not encourage decisions that result in under-utilization and PHC does not use incentives to encourage barriers to care and service. This does not preclude the use of appropriate incentives for fostering efficient, appropriate care.

PROGRAM OBJECTIVES

UM Program Objectives

The PHC UM program serves to ensure that appropriate, high quality cost-effective utilization of health care resources is available to all members. This is accomplished through the systematic and consistent application of utilization management processes based on current, relevant medical review criteria and expert clinical opinion when needed. The utilization management process provides a system that ensures equitable access to high quality health care across the network of providers for all eligible members as follows:

- Ensures authorized services are covered under contract with the State of California Department of Health Services (DHCS) California Code of Regulations (CCR) Title 22 - For Medi-Cal Members (Title 22).

- Coordinates thorough and timely investigations and responses to member and provider reconsideration and appeals associated with utilization issues
- Initiates needed operational revisions to prevent problematic issues from reoccurring
- Ensures that services which are delivered are medically needed and consistent with diagnosis and level of care required for each individual, taking into account any co-morbid condition that exists and the ability of the local delivery system to meet the need
- Educates members, practitioners, providers and internal staff about PHC's goals for providing quality, cost-effective, managed health care
- Defines the methods by which utilization criteria and clinical practice guidelines are selected, developed, reviewed, and modified based upon appropriate and current standards of practice and professional review
- Promotes and ensures the integration of utilization management with quality monitoring and improvement, risk management, and case management activities
- Ensures a process for critical review and assessment of the UM program and plan on, at minimum, an annual basis, with updates occurring more frequently if needed. The process incorporates provider, practitioner and member input along with any regulatory changes, changes to current standards of care, and technological advances
- Evaluates the ability of delegates to perform UM activities and to monitor performance

Program Structure

This section outlines the individual program staff and the assigned activities, including approval authority and the involvement of the designated physician.

Assigned Responsibilities

Program Staff

Chief Medical Officer (CMO) – MD/DO

The Chief Medical Officer is responsible for the implementation, supervision, oversight and evaluation of the UM Program.

This position provides guidance and overall direction of UM activities and has the authority to make decisions based on medical necessity which result in the approval or denial of coverage. The assigned activities for this position include but are not limited to:

- Assuring that the UM program fulfills its purpose, works towards measurable goals, and remains in regulatory compliance
- In collaboration with the Senior Director of Health Services and the Associate Directors of Utilization Management; oversees UM program operations and assists in the development and coordination of UM policies and procedures.
- Reviews for the consistent application of UM decision criteria at least annually and implements corrective actions when needed

*Services related to substance use services as outlined in the Regional Drug Medi-Cal Model are placeholders for when DHCS releases the benefit. Activity is not anticipated to be effective until late Spring 2020.

- Serves as the Committee Chair for the Quality/Utilization Advisory Committee (Q/UAC) and the Pharmacy and Therapeutics (P&T) Committee and regularly attends the Physician Advisory Committee (PAC)
- Ensures timely medical necessity review and decisions are made by daily staffing physicians for medical review consultation
- Guides and assists in the development and revision of PHC medical policy, criteria, clinical practice guidelines, new technology assessments, and performance standards for Q/UAC review, adaptation and PAC approval
- As the chairman of the Q/UAC, presents UM activities on a regular basis to the Q/UAC and provides periodic updates on utilization management activities to the PAC and the Board of Commissioners
- Evaluates the overall effectiveness of the UM program
- Evaluates and uses provider and member experience data when evaluating the UM program in collaboration with the Senior Director of Health Services and appropriate committees

Regional Medical Director - MD/DO

The Regional Medical Director is a physician with the authority to make decisions based on medical necessity which result in the approval or denial of coverage.

The assigned activities for this position include but are not limited to:

- Evaluates the appropriateness and quality of medical care delivered through PHC in the designated regional area
- Participates in enterprise-wide projects that require Physician involvement
- Other duties as assigned by the Chief Medical Officer.

Associate Medical Director - MD/DO

This Physician has the authority to make decisions based on medical necessity that result in the approval or denial of coverage. The assigned activities for this position include:

- Coverage in the UM Department for medical necessity reviews applying evidence-based UM decision criteria to the review process in determining medical appropriateness and necessity of services for PHC members
- Provides review of quality of care issues and serves on Q/UAC
- Other duties as assigned by the Chief Medical Officer

Behavioral Health Clinical Director - MD/DO/PhD/ PsyD

The PHC Behavioral Health Clinical Director is an MD, DO, clinical PhD, or PsyD who is actively involved in the behavioral health aspects of the UM program. This Director provides clinical oversight of PHC's behavioral health activities including substance use services and the activities of PHC's delegated managed behavioral health organization(s). The Behavioral Health Clinical Director has the authority to make decisions based on medical necessity which result in the approval or denial of coverage for behavioral health or substance use services. The assigned activities for this position include:

- Establishes UM policies and procedures in collaboration with PHCs delegated managed behavioral health organization(s)
- Oversees and monitors quality improvement activities
- Facilitates network adequacy
- Participates in the peer review process
- Evaluates behavioral health care and substance use disorder (SUD) treatment services requests in collaboration with PHC′s delegated managed behavioral health organization(s)
- Oversees and monitors functions of PHC's delegated managed behavioral health organizations
- Serves on Quality/Utilization Advisory Committee; Pharmacy and Therapeutics
- Committee; Credentials Committee and Internal Quality Improvement Committee including the Substance Use Internal Quality Improvement Subcommittee.

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Pharmacy Services Director – Pharm.D.

This position is responsible for overseeing all HealthPlan activities related to pharmacy services and supervising the PHC Pharmacy management team, PHC Clinical Pharmacists, and support staff. The assigned activities for this position include but are not limited to:

- Formulary management
- Development of applicable policies and guidelines
- Serves on the Pharmacy and Therapeutics (P&T) Committee, the Drug Utilization Review (DUR) Board and the Pediatric Quality Committee (PQC)
- Drug utilization review
- Drug prior authorization
- Implementation of cost effective pharmacy measures
- Serving as primary contact with the contracted Pharmacy Benefit Manager (PBM), pharmacy providers, and pharmacists
- Participation in provider education initiatives such as academic detailing with plan physicians
- Medical education meetings
- Assisting with development of Clinical Practice Guidelines
- Other duties as assigned by the Chief Medical Officer

Senior Director of Health Services - RN

Responsible for the day-to-day implementation of the PHC Utilization Management Program. This position has the authority to make decisions on coverage not relating to medical necessity. The assigned activities include:

- Provides oversight and guidance for the UM program across all regions
- Reports to the Q/UAC on UM activity
- Coordinates departmental UM and Quality Improvement efforts
- Collaborates with providers and facilities
- Monitors and analyses UM data to inform decision making
- Develops recommendations based on data analysis and strategic planning.
- Collaborates with the Chief Medical Officer and the Q/UAC on UM activities
- Evaluates and uses provider and member experience data when evaluating the UM program in collaboration with the Chief Medical Officer
- Prepares and presents the annual evaluation, program description to Q/UAC and PAC

Associate Director of Utilization Management Programs- RN

Under the direction of the Senior Director of Health Services, manages and provides direction to the Utilization Management department managers, supervisors and staff for all product lines ensuring consistent development, implementation, and maintenance of health services programs. This position has the authority to make decisions on coverage not relating to medical necessity. Assigned activities include:

- Implements the UM program within assigned region
- Provides day to day direction to UM Managers and Supervisors within assigned region to meet department goals and objectives and is available to staff on-site or by telephone
- Conducts annual performance evaluations for assigned UM staff
- Conducts monitoring activities
- Participates in staff trainings and on-site continuing education
- Audits medical records as appropriate and monitors for consistent application of UM criteria by UM staff, for each level and type of UM decision
- Collaborates with providers and facilities
- Develops recommendations for program improvements
- Coordinates activities with Quality Improvement, Member Services, Claims, and Provider Relations departments to identify, track, and monitor quality of care outcomes and trends
- Participates in establishing and maintaining reports which relay the efficacy of UM activities and summarizes, at least annually, the UM activity, quality improvement activities and utilization outcomes, with supporting statistical data at IQI and Q/UAC

Associate Director of Utilization Management Strategies- RN

Under the direction of the Senior Director of Health Services, plans, monitors and evaluates utilization management activities to identify strategic initiatives to enhance the efficacy of the UM program, while improving health outcomes, in a cost effective manner. This position has the authority to make decisions on coverage not relating to medical necessity. Assigned activities include:

- Collaborates with the provider relations contracting team to identify strategic opportunities and develops recommendations
- Participates in contract review and negotiations
- Attends regular meetings with hospitals, long-term care facilities and community agencies to facilitate cost effective and appropriate alternative placements
- In collaboration with the Senior Director of Health Services and Senior Director of Provider Relations, reviews and processes provider grievances in accordance with appropriate regulatory requirements and participates in provider grievance meetings
- Works collaboratively with claims and configuration department leaders and team members to identify systematic issues or opportunities for staff and/or provider education
- Attends claims configuration meetings and Benefit Review Evaluation Workgroup (BREW) as well as IQI, Q/UAC and PAC
- Works with providers and/or vendors to facilitate issue resolution and ensure a consistent UM process
- Develops, reviews, and/or revises PHC UM policies and procedures in collaboration with the Senior Director of health services as appropriate.

Associate Director of Utilization Management Regulations

Under the direction of the Senior Director of Health Services, provides oversight of the UM Program to ensure compliance with regulatory requirements including, but not limited to, requirements of DHCS and the National Committee for Quality Assurance (NCQA). Assigned activities include:

- Coordinates activities with External and Regulatory Affairs Compliance, Member Services, Claims, and Provider Relations departments to identify, track, and monitor quality of care issues and trends related to UM Department processes
- Prepares reports on departmental activities according to established schedules and format. Identifies patterns and trends, conducts retrospective review as needed and works with UM Leadership to develop corrective action plans.
- Participates in the grievance process
- Acts as primary contact and support to each UM Delegate, providing training and support as necessary
- Conducts delegation oversight through regular auditing of each UM Delegate, prepares audit reports for review by the Senior Director of Health Services and the Chief Medical Officer or physician designee, and prepares information for the Delegation Oversight Review Sub-Committee (DORS)
- Collaborates with the Associate Director of UM Programs to ensure that all policies and procedures related to regulatory requirements are updated at least annually, or as needed, and presented to appropriate committees for review. Assists PHC staff and providers with the interpretation of PHC policies, procedures, and regulatory requirements.
- Works with UM Leadership and Trainer to develop standardized training content and materials for new staff and ongoing education for existing staff
- Participates in the planning and development of new/ enhanced Health Services plan benefits or product lines as needed. Attends Benefits Review and Evaluation Workgroup meetings
- Participates in audits by various regulatory agencies as necessary

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Utilization Management Team Manager - RN

Responsible for the implementation, management and evaluation of an effective and systematic UM Program. Provides day-to-day guidance to UM staff and manages all aspects of utilization review activities and is available to staff on-site or by telephone. Working with the Chief Medical Officer, Senior Director of Health Services, Associate Directors of UM, utilization committees, and Health Plan Directors, promotes efficient resource utilization throughout the organization, providing leadership, teambuilding and direction needed to ensure attainment of UM goals. This position has the authority to make decisions on coverage not relating to medical necessity. The assigned activities include:

- Coordinates completion of activities
- Presents work plan status reports and updates to the Q/UAC
- Monitors for consistent application of UM criteria by UM staff for each level and type of UM decision
- Participates in staff trainings and on-site continuing education
- Provides recommendations for interventions designed to improve utilization management issues
- Coordinates implementation of interventions
- Develops UM policy and procedures for Q/UAC approval
- Develops, or coordinates development of, documentation of UM activities
- Conducts annual performance evaluations for assigned UM staff

Inpatient/Outpatient Nurse Supervisor UM - RN

This position is responsible for the daily mentorship and oversight of the staff assigned to inpatient or outpatient services. This position has the authority to make decisions on coverage not relating to medical necessity. The assigned activities include:

- Works collaboratively with all levels of leadership within the department to efficiently coordinate workflow and individual staff assignments
- Provides day to day supervision to the assigned team, overseeing daily operation of the inpatient or outpatient review process
- Participates in staff trainings and on-site continuing education. With UM Leadership, conducts annual performance evaluations for assigned UM staff
- Audits medical records as appropriate and monitors for consistent application of UM Criteria by UM staff, for each level and type of UM decision.
- This position, in addition to his/her own case load, may be assigned cases in the area of oversight as deemed necessary to provide coverage

Nurse Coordinator/ UM II - RN/ LVN

Work collaboratively with all levels of UM leadership and other PHC staff to develop, implement, and evaluate health outcomes, provider performance and other performance indicators pertinent to quality of care. This position has the authority to make decisions on coverage not relating to medical necessity. Assigned activities include:

- Assist in training and orientation of new staff to the department upon request
- Review and authorization of DME, Ancillary and Medical TARs based on established guidelines
- Review and authorization of Long Term Care TARs based on established guidelines
- Review and authorization of inpatient Hospital TARs based on established guidelines
- Retrospective review of services to determine medical necessity
- Refer cases to the Chief Medical Officer for requests that may not appear to meet evidence- based medical necessity criteria
- Determines if requested services are part of the member's benefit package
- Work collaboratively with the Care Coordination, Population Health, Pharmacy and Quality Improvement staff on UM issues

Nurse Coordinator/ UM I - RN/ LVN

Work collaboratively with all levels of UM leadership and other PHC staff to develop, implement, and evaluate health outcomes, provider performance and other performance indicators pertinent to quality of care. This position has the authority to make decisions on coverage not relating to medical necessity. Activities assigned include:

- Review and authorization of DME, Ancillary and Medical TARs based on established guidelines.
- Review and authorization of Long Term Care TARs based on established guidelines.
- Review and authorization of inpatient Hospital TARs based on established guidelines.
- Retrospective review of services to determine medical necessity
- Refer cases to the Chief Medical Officer for requests that may not meet medical necessity criteria
- Determine if requested services are part of the member's benefit plan
- Work collaboratively with the Care Coordination, Population Health, Pharmacy, and Quality Improvement staff on UM issues

Behavioral Health Clinical Specialist – LCSW or LMFT or other licensed behavioral health specialties

Licensed Practitioner of the Healing Arts (LPHA)[1] who develops, implements, and coordinates medically necessary treatment services within PHC's Health Services for adults and children with behavioral health and/or substance use service needs. Reviews residential placement authorization requests for residential treatment services according to the specific terms of the contract with the provider and in accordance with the medical necessity requirements for Medi-Cal eligible beneficiaries.

Data Coordinator/ Supervisor UM – Administrative

Works closely with UM Leadership to establish consistent evaluation of Data Coordinators' work performance. Responsible for oversight of Data Coordinators.

- Monitors day to day functions including coordination of assignments, monitoring of call volume and adherence to PHC workplace policy and is available to staff on-site or by telephone
- Assists in the refinement/improvement of the HS programs
- Provides performance feedback to the Data Coordinator staff and conducts staff trainings as needed.
- Monitors UM Data Coordinator activity for consistent application of desktop processes and procedures by UM Data Coordinator staff
- Provides leadership, direction, training, and support to the assigned staff
- Participates in staff trainings and on-site continuing education
- Conducts annual performance evaluations for assigned UM staff

Data Coordinator/ UM Lead - Administrative

Under the direction of the Data Coordinator Supervisor and UM Leadership:

- Monitors Data Coordinator documentation for accuracy
- Ensures Data Coordinator staff have the resources required for completing TAR entry and using good judgment and is available to staff on-site or by telephone
- Enters both manual and electronic submitted data into PHC systems for RAF and TAR authorizations
- Monitors UM Data Coordinator staff for consistent application of desktop processes and procedures
- Responsible for assisting with ongoing staff education in proper use of systems and PHC UM Departmental policies and procedures
- Participates in staff trainings and on-site continuing education

[1] Licensed Practitioner of the Healing Arts (LPHA): Physicians, Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacists, Licensed Clinical Psychologist, Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor, Licensed Marriage and Family Therapist (LMFT), and licensed-eligible practitioners working under the supervision of licensed clinicians.

Executive Assistant to CMO - Administrative
Provides administrative support to the Chief Medical Officer. Responsible for maintaining and updating online policy and procedure manuals and managing appointment calendars. Coordinates setup and executes minutes for designated meetings.

Continuing Education Program Coordinator - Administrative
Provides administrative support to the Chief Medical Officer. Responsible for coordinating the Continuing Education program, including planning meetings and trainings. Audits each CME/CE activity to ensure all elements required by organizations overseeing PHC's educational programs are documented. Maintains organized electronic versions of all continuing education records.

Health Services Administrative Assistant II - Administrative
Provides administrative support to the Senior Director and/or other UM Leadership. Responsible for maintaining and updating online policy and procedure manuals and managing appointment calendars. Coordinates setup and executes minutes for designated meetings.

Health Services Administrative Assistant I – UM - Administrative
Provides administrative support to UM Leadership. Responsible for maintaining and updating policy and procedure manuals, managing appointment calendars, and working closely with the Information Technology Department to ensure appropriate electronic functioning for the Health Services Department.

Health Services Administrative Assistant II – CMO - Administrative
Responsible for administrative support to the Associate and Regional Medical Directors. Responsible for managing appointment calendars, scheduling daily UM and pharmacy workload coverage for the MDs, developing weekly and monthly schedules for distribution to other departments, and coordinating Peer-to-Peer requests from providers. Coordinates setup and executes minutes for designated meetings.

Authorization Specialist/ UM Trainer – Administrative
Responsible for providing training on all appropriate software platforms for new hires. Creates and maintains current training materials for the UM department. In conjunction with UM leadership team, prepares and delivers retraining of identified topics as deemed necessary.

- Facilitates independent DME consultant evaluation visits to members for specialty equipment needs as needed or directed by UM Leadership.
- Acts as a resource regarding UM department software programs and special projects upon request and is available to staff on-site or by telephone
- Coordinates with Member Services Call Center system to place members into appropriate Direct Member status related to their care.

Coordinator II - Administrative
Under the direction of the UM Team Manager and/or the Data Coordinator Supervisor:

- Serves as a resource to other departments who have inquiries into the UM process
- Responsible for the input of data and information concerning UM Referrals and Authorizations
- Receives and responds to telephonic inquiries from providers regarding status of authorization requests and other questions or concerns
- Performs triage and transfers calls to appropriate professional staff when indicated

Coordinator I - Administrative
Under the direction of the UM Team Manager and/or the Data Coordinator Supervisor - responsible for the input of data and information concerning UM Referrals and Authorizations.

- Maintains departmental documents
- Receives and responds to telephonic inquiries from providers regarding status of authorization requests and other questions or concerns
- Performs triage and transfers calls to appropriate professional staff when indicated

Coordinator I - Appeals - Administrative
Under the direction of the Associate Director of UM Programs:

- Responsible for clerical processing of appeals in accordance with policy, procedures, timeframes and requirements of various regulatory bodies for all lines of business
- Acts as liaison to Claims Department in coordinating timely response to all claims inquiries
- Participates in special projects, tasks and assignments as directed

Delegation Program Coordinator I – Administrative
Under the direction of the Associate Director of UM Regulations

- Responsible for collecting and tracking required document submissions from delegated entities
- Coordinates and participates in both desktop and onsite audits of delegated entities
- Ensures efficient and appropriate collaboration between the Utilization Management staff and UM delegated entities

Project Coordinator II - Administrative
Under the direction of the Senior Director of Health Services or other designated leadership.

- Tracks project deliverables and resources using appropriate internal tools to ensure deadlines are met
- Works collaboratively with the HS analyst, IT and Finance to design and implement reports to accurately reflect the work completed and outcomes achieved within the Department and its programs
- Coordinates with the Regulatory Affairs Department to conduct research on regulations, statutes, laws, administrative policies and procedures

Committees

Board of Commissioners
The Board of Commissioners on Medical Care (the Commission) promotes, supports, and has ultimate accountability, authority and responsibility for a comprehensive and integrated UM program. The Commission is ultimately accountable for the efficient management of healthcare resources and services provided to members. The Commission has delegated direct supervision coordination, and oversight of the UM program to the Q/UAC which reports to the PAC, the committee with overall responsibility for the program. Members of the Commission are appointed by the county Boards of Supervisors for each geographic service area and include representation from the community, consumers, business, physicians, providers, hospitals, community clinics, HMOs, local government, and County Health Departments. The Commission meets six times a year.

Physician Advisory Committee (PAC)
The PAC monitors and evaluates all Health Services activities and is directly accountable to the Board of Commissioners for the oversight of the UM program. The PAC meets at least ten (10) times a year and may not convene in the months of July and December, with the option to add additional meetings if need. Voting membership includes external Primary Care Providers (PCPs), board certified high-volume specialists, and behavioral health practitioners. A voting provider member of the committee chairs the PAC. The PHC Chief Executive Officer, Chief Operating Officer, Chief Financial Officer, Chief Medical Officer, Associate Medical Director of Quality, Regional Medical Director(s), Clinical Director of Behavioral Health, Senior Director of Health Services and leadership from the Quality and Performance Improvement, Provider Relations, Utilization Management, and Pharmacy departments attend the PAC meetings regularly. Other PHC staff attend on an ad hoc basis to provide expertise on specific agenda items. The PAC oversees the activities of the Q/UAC and other quality-related committees and reports activities to the Board of Commissioners.

Quality/Utilization Advisory Committee (Q/UAC)

The Q/UAC is responsible to assure that quality, comprehensive health care, and services are provided to PHC members through an ongoing, systematic evaluation and monitoring process that facilitates continuous quality improvement. Q/UAC voting membership includes consumer representative(s) and external providers who are contracted primary care providers (PCPs) and board certified specialists in the areas of internal medicine, family medicine, pediatrics, OB/GYN, nephrology, neonatology, behavioral health, and representatives from other high volume specialties. The PHC Chief Medical Officer (CMO) (chair of the committee), Clinical Director of Behavioral Health, Associate Medical Director of Quality, Associate and Regional Medical Directors and leadership from the Quality and Performance Improvement, Provider Relations, Utilization Management, Care Coordination, Population Health, Pharmacy, and Grievance Departments attend the Q/UAC meetings regularly. Other PHC staff attend on an ad hoc basis to provide expertise on specific agenda items. The committee meets on a monthly at least ten (10) times per year, with the option to add additional meetings if needed. Q/UAC activities and recommendations are reported to the PAC and to the Commission at least quarterly. The Q/UAC provides guidance and direction to the UM program by coordinating activities and by functioning as the expert panel when needed. Coordination includes but is not limited to:

- Reviewing, making recommendations to, and approving the *UM Program Description* annually
- Assuring individual member needs are taken into consideration when determinations for care are rendered and in the development of medical policy and procedures.
- Analyzing summary data and making recommendations for action
- Reviewing action plans for quality improvements of UM activities and providing ongoing monitoring and evaluation
- Reviewing medical policy, protocol, criteria and clinical practice guidelines
- Providing oversight of delegated activities

Pharmacy and Therapeutics Committee (P&T)

The P&T Committee is chaired by PHC's Chief Medical Officer (CMO) and is comprised of PHC's Pharmacy Director, Associate and Regional Medical Directors, PHC staff and network practitioners including pharmacists, primary care physicians, behavioral health and other specialists. P&T makes decisions and recommendations on development and review of the prescription drug formulary*, pharmacy policy and procedures, and drug approval criteria. P&T Committee also serves as PHC's Drug Utilization Review (DUR) Board to review PHC's DUR program and activities and make recommendations where necessary to improve PHC's drug utilization. The P&T meets quarterly, providing regular activity reports and recommendations to the PAC, the approval authority for P&T related activities.
(**Note: PHC's formulary and medication coverage benefits shall continue as described in this policy until such time as the pharmacy benefit carve-out to Medi-Cal Fee-for-Service described in APL 20-020 and the Governor's Executive Order N-01-19 may take effect*.)

Provider Advisory Group (PAG)

The PAG is one of the Commission's advisory committees and acts as a liaison between practitioner offices and PHC. The committee meets quarterly and has representatives from physician groups and individual offices, community clinics, ancillary providers, long term care facilities, employees of county health departments, and community advisory groups. The PAG reports directly to the Board of Commissioners, providing feedback and making recommendations related to health care service issues, community health activities, and issues for special needs populations.

Substance Use Services Internal Quality Improvement Subcommittee (SUIQI)

A committee comprised of appropriate PHC and County staff tracks progress towards successful completion of quality initiatives, surveys, audits, and accreditation for the PHC's Substance Use Services oversight. The SUIQI meets at least quarterly. Activities and progress are reported to the IQI. This also includes

- Review of Utilization Management retroactive and appeals review
- Review of inter-rater reliability for peer review and utilization management
- Review of quality of service, quality of facility, and access complaints and grievances

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- Investigation of potential over-use, under-use, and misuse of services.
- Review of policies related to provision of SU services

Members of the committee include the Behavioral Health Clinical Director, the CMO, and representatives from the Provider Relations, Member Services, Claims, Compliance, Behavioral Health and Quality Improvement Departments.

Consumer Advisory Committee (CAC)

The CAC is composed of PHC health care consumers who represent the diversity and geographic areas of PHC's membership. There are two CAC committees – one in PHC's Northern seven counties and a second in PHC's Southern seven counties. Both groups meet quarterly. The CAC is a liaison group between members and PHC, advocating for members by ensuring that the health plan is responsive to the health care and information needs of all members. The CAC reviews and makes recommendations regarding Member Services' Quality Improvement Activities, provides feedback on Quality Initiatives and serves in the capacity of a focus group. A consumer from each region serves on the Board to provide consumer input and report back to their respective CAC.

UTILIZATION MANAGEMENT PROGRAM SCOPE

UM activities are developed, implemented and conducted by the PHC Health Services Department under the direction of the Chief Medical Officer and the Senior Director of Health Services. The UM staff performs specific activities.

Specific functions include:

- Prospective, concurrent and retrospective utilization review for medical necessity, appropriateness of hospital admission, level of care and continued inpatient confinement on a frequency consistent with evidence-based criteria and PHC guidelines, PHC criteria/ medical policy and the member's condition. This review is performed cooperatively with the facility care team which may consist of the attending physician(s) and any associated health care personnel who can provide information that will substantiate medical necessity and level of care.
- Discharge planning in collaboration with the facility care team
- Review inpatient and outpatient UM data to determine appropriateness of member and provider utilization patterns
- Use of most current edition of InterQual® Criteria for medical authorization, and other PHC UM guidelines and medical policy as developed and approved by the Quality / Utilization Advisory Committee (Q/UAC)
- Use of California Department of Health and Welfare Code of Regulations Title 22, Center for Medicare & Medicaid Services (CMS) Code of Federal Regulations (CFR) Title 42 and National and Local Coverage Determinations
- Review certification requests for skilled nursing care, home health care, durable medical equipment, ambulatory surgery, ambulatory diagnostic and treatment procedures such as physical, occupational and speech therapies.

The UM program incorporates the monitoring and evaluation for the subsequent services and reviews and updates policies and procedures as appropriate but at least annually.

- Acute hospital services
- Subacute care
- Ambulatory care
- Emergency and urgent care services
- Durable Medical Equipment and supplies
- Ancillary care services, including but not limited to home health care, skilled nursing care, subacute care, pharmacy, laboratory and radiology services

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- Long-term care including Skilled Nursing Facility (SNF) Care and Rehabilitation Facility Care
- Pharmacy drug formulary (*Note: PHC's formulary and medication coverage benefits shall continue as described in this policy until such time as the pharmacy benefit carve-out to Medi-Cal Fee-for-Service described in APL 20-020 and the Governor's Executive Order N-01-19 may take effect.*)

Mental Health

Members may self-refer for mental health services to mental health providers using the delegated Behavioral Health Organization's toll-free referral numbers or by contacting the preferred behavioral health provider directly. Members do not need a referral or prior authorization to receive mental health services.

In an effort to coordinate the member's overall health care, , mental health providers are instructed to ask members to sign a release of information so that the mental health provider can contact the member's PCP or other providers. However, the release of information is not a condition for the approval or provision of services.

Mental health services for Members with Medi-Cal as their primary insurance are provided as follows:

- Members determined to have mental health needs that require mild to moderate mental health treatment are served by PHC's delegated contractor, Beacon Health Options at (855) 765-9703.
- Members assigned to Kaiser are assessed by Kaiser and served or appropriately referred.
- Members determined to have moderate to severe mental health conditions are referred to the County Mental Health Plan in the Member's county of eligibility (Except for Solano County Kaiser
- members who will have their moderate to severe mental health conditions managed by Kaiser). The administration of such referrals is addressed in the respective Memorandum of Understanding (MOU) with each respective County Mental Health Plan, consistent with California statutes and regulations.
- An initial assessment may be performed by any of these entities described above to determine the most appropriate level of service for the Member, including appropriate referral.

Effective July 1, 2020, PHC provides substance use disorder treatment services as outlined in the Regional Drug Medi-Cal Model. PHC performs utilization management for residential treatment of substance use disorders. For more information, please see the Substance Use Disorder Treatment Services/ Wellness & Recovery Program section below.

County Mental Health Plans provide crisis assessments and authorizations for care. Immediate access to the crisis service remains an option throughout all phases of treatment by any provider. Each County operates crisis services which to address clients in crisis; crisis services also act as a backup after hours and on weekends as well as at other times of provider unavailability. Members may call the County crisis line directly, without a referral. Members eligible for mental health services from PHC delegated contractors will be re-directed to appropriate County crisis services as needed.

A certain level of mental health services is appropriately dealt with in a primary care practice, including screening and referrals to services. Primary Care Providers may contact each county's Mental Health Plan or PHC's delegated contractor, Beacon Health Options, for telephone consultation. For detailed referral and consultation procedures, PCPs can refer to PHC Policy MPCP2017 Scope of Primary Care—Behavioral Health and Indications for Referral Guidelines.

PHC is responsible for the delivery of non-specialty mental health services for children under age 21 and outpatient mental health services for adult beneficiaries with mild to moderate impairment of mental, emotional, or behavioral functioning resulting from a mental health disorder, as defined by the current

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Diagnostic and Statistical Manual of Mental Disorders (DSM). Outpatient mental health services are delivered as specified in policy MCUP3028 Mental Health Services whether they are provided by PCPs within their scope of practice or through PHC's provider network. PHC continues to be responsible for the arrangement and payment of all medically necessary, Medi-Cal-covered physical health care services, not otherwise excluded by contract, for PHC beneficiaries who require specialty mental health services.

In compliance with Mental Health Parity requirements on October 1, 2017, as required by Title 42, CFR Section 438.930, PHC ensures direct access to an initial mental health assessment by a licensed mental health provider within the PHC provider network. No referral from a PCP or prior authorization is required for an initial mental health assessment to be performed by a network mental health provider.

PHC meets the general parity requirement (Title 42, CFR, §438.910(b)) which stipulates that treatment limitations for mental health benefits may not be more restrictive than the predominant treatment limitations applied to medical or surgical benefits. Neither a referral from the PCP nor prior authorization is required for a beneficiary to seek any mental health service, including the initial mental health assessment from a network mental health provider.

If a dispute occurs between the local County Mental Health plan and Partnership HealthPlan of California (PHC) or its delegated contractors, Kaiser or Beacon Health Options, both parties will participate in a dispute resolution process as defined in PHC Policy MCUP3127 Dispute Resolution Between PHC and MHPs in Delivery of Behavioral Health Services. This is consistent with the dispute resolution process outlined by State regulations and the individual County/PHC Memoranda of Understanding.

Triage and Referral for Mental Health

PHC monitors the triage and referral protocols for the delegated behavioral health services provider(s) to assure they are appropriately implemented, monitored and professionally managed. Protocols employed by delegates must be clinical evidence-based and an accepted industry practice. Protocols shall outline the level of urgency and appropriateness of the care setting.

Triage and referral decisions are performed by the Care Coordination and UM teams of the delegated Behavioral Health Services Provider which are co-located in the PHC offices with oversight by PHC's Behavioral Health Clinical Director. Both work collaboratively with the designated County Mental Health Plans to ensure members receive care at the appropriate level in a timely manner.

Substance Use Disorder Treatment Services/ Wellness & Recovery Program

PHC works to ensure that members receive effective and appropriate behavioral health care services for both mental health and substance use disorders. Substance Use Disorder (SUD) treatment services are administered either by PHC or through individual counties.

The range of services in the Wellness & Recovery Program include:

- Outpatient treatment (licensed professional or certified counselor, up to nine hours per week for adults)
- Intensive outpatient treatment for individuals with greater treatment needs (licensed professional or certified counselor, structured programming, 9-19 hours per week for adults)
- Detoxification services (withdrawal management)
- Residential treatment (Prior authorization is required as per policy MCCP2028 Residential Substance Use Disorder Treatment Authorization)

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- Medication assisted treatment (methadone, buprenorphine, disulfiram, naloxone)
- Case management
- Recovery services (aftercare)

Behavioral Health Treatment (BHT) for Members Under 21 Years of Age

PHC has provided benefits for Behavioral Health Therapy for children diagnosed with Autism Spectrum Disorder (ASD) since September 2014.

Effective July 1, 2018, PHC expanded its benefit coverage to include Behavioral Health Treatment (BHT) for eligible Medi-Cal members under the age of 21 as required by the Early and Periodic Screening and Diagnostic Treatment (EPSDT) mandate.

Treatment services may include Applied Behavioral Analysis (ABA) and other services known as Behavioral Health Treatment (BHT).

BHT is the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the direct observation, measurement and functional analysis of the relations between environment and behavior.

BHT services teach skills through the use of behavioral observation and reinforcement, or through prompting to teach each step of targeted behavior. BHT services include a variety of behavioral interventions that have been identified as evidence-based by nationally recognized research reviews and/or other nationally recognized scientific and clinical evidence that are designed to be delivered primarily in the home and in other community settings.

PHC will provide BHT services for all members who meet the eligibility criteria for services as stated in 1905® of the Social Security Administration (SSA) and outlined in DHCS All Plan Letter (APL) 19-014.

- Additional detailed information regarding the BHT benefit can be found in the following PHC Policies and Procedures:
  - MPUP3126 Behavioral Health Treatment (BHT) for Members Under the Age of 21
  - MCCP2014 Continuity of Care

Quality Improvement Collaboration

The UM team works collaboratively with the Quality Improvement Department to enhance the care provided to our members through venues such as the Internal Quality Improvement Committee (IQI) , the Quality/ Utilization Advisory Committee (Q/UAC) and daily UM activities.

In the committee environment, the UM team takes an analytical, evaluative and strategic look at predetermined metrics to evaluate and offer recommendations which further enhance the UM program. Data is reviewed and discussed at least bi-annually during the IQI and Q/UAC meetings. The Q/UAC provides guidance and direction to the UM program by coordinating activities and by functioning as the expert panel when needed. Collaboration includes but is not limited to:

- Reviewing, making recommendations to, and approving the *UM Program Description* annually
- Assuring individual member needs are taken into consideration when determinations for care are rendered
- Analyzing summary data and making recommendations for action
- Reviewing the recommendations of Process Implementation Teams to develop UM improvement action plans, ongoing monitoring, and evaluation

- Recommending medical policy, protocol, and clinical practice guidelines based on provider and member experience information.

During daily activities, the UM team supports QI efforts in the identification of potential quality of care issues, reporting adverse occurrences identified while conducting UM case review, improvement of Healthcare Effectiveness Data and Information Set (HEDIS®) scoring by referrals to care coordination, and care coordination efforts to ensure members are seen by the appropriate provider for their condition.

UTILIZATION MANAGEMENT PROCESS

PHC applies written, objective, evidence-based criteria (InterQual®) and considers the individual member's circumstance and community resources when making medical appropriateness determinations for behavioral health and physical health care services.

On an annual basis, PHC distributes a statement to all its practitioners, providers, members and employees alerting them to the need for special concern about the risks of under-utilization. It requires employees who make utilization-related decisions and those who supervise them to sign a statement which affirms that UM decision making is based only on appropriateness of care and service.

Furthermore, PHC does not reward practitioners or other individuals conducting utilization review for issuing denials of coverage or service. Financial incentives for UM decision makers do not encourage decisions that result in under-utilization and PHC does not use incentives to encourage barriers to care and service. This does not preclude the use of appropriate incentives for fostering efficient, appropriate care.

Working with practitioners and providers of care, the following factors are taken into consideration when applying guidelines to a particular case in review:

- Input from the treating practitioner
- Age of member
- Comorbidities in existence
- Complications
- Progress of treatment
- Psychosocial situation
- Home environment
- Consideration of the delivery system and availability of services to include but not be limited to:
  - Availability of inpatient, outpatient, transitional and residential treatment (SUD) facilities
  - Availability of outpatient services
  - Availability of highly specialized services, such as transplant facilities or cancer centers
  - Availability of skilled nursing facilities, subacute care facilities or home care in the organization's service area to support the patient after hospital discharge
  - Local hospitals' ability to provide all recommended services
- Benefit coverage

Referrals and requests for prior authorization of services are to be submitted by the provider of service to the PHC UM department by mail, fax or through PHC's Provider Portal which is a Secure Electronic Internet system. The following information must be provided on all requests.

- Member demographic information
- Provider demographic information
- Requested service/procedure to include specific CPT/HCPCS code(s)
- Member diagnosis (Using current ICD Code sets)
- Clinical indications necessitating service or referral
- Pertinent medical history, treatment or clinical data
- Location of service to be provided

*Services related to substance use services as outlined in the Regional Drug Medi-Cal Model are placeholders for when DHCS releases the benefit. Activity is not anticipated to be effective until late Spring 2020.

- Requested length of stay for all inpatient requests
- Proposed date of procedure for all outpatient surgical requests

Pertinent data and information is required to enable a thorough assessment of medical necessity. If information is missing or incomplete, the requestor will be notified and given an opportunity to submit additional information.

Elective Admission Precertification

The UM department evaluates every proposed treatment plan, and determines benefit eligibility, suitability of location and level of care prior to the approval of service delivery for select diagnoses and procedures.

Utilizing written criteria such as InterQual®, Medi-Cal Criteria and PHC medical policy approved by the Q/UAC, licensed and professional UM staff review and approve completed Treatment Authorization Requests (TARs).

Only the Chief Medical Officer or physician designee may make a medical necessity determination and have the authority to deny a service request based on lack of medical necessity. PHC offers the practitioner the opportunity to discuss any medical necessity denial determination with the physician reviewer rendering the decision.

Referral Management

Referrals are generated by the primary care provider and submitted to PHC either by mail, fax or secure Provider Portal. PHC monitors and analyzes requests to identify trends and assist in follow-up care. Requests for out-of-network referrals are reviewed to determine if the service is available and can be provided within the service area. Out-of-Network requests are also used to evaluate provider access and to determine if the local network requires enhancements to meet member needs.

Continued Stay/Concurrent Review

Acute care hospitalization reviews are performed by licensed professionals to ensure medical necessity of continued stay, the appropriateness of level of care, and care duration. This review is conducted either on site, by accessing the facility electronic medical record through a secure portal, or telephonically using written PHC medical policy, InterQual®, and/or Medi-Cal guidelines. PHC UM staff in conjunction with the use of written criteria consider the following:

- Patient age
- Patient comorbidities
- Complications
- Progress of treatment
- Psychosocial circumstance
- and Home environment where applicable

Requests for authorization are reviewed within 24 hours of notification of admission and concurrently throughout the stay. The UM team facilitates discharge planning in collaboration with the facility care team and makes referrals to PHC case management and social services as appropriate.

Consideration of available services in the local service area or delivery system and the ability to meet the member's specific health care needs are evaluated as part of application of criteria and the development of an ongoing plan of care and discharge plan.

Only the Chief Medical Officer or physician designee has the authority to deny a request for service based on lack of medical necessity. PHC offers the practitioner with clinical expertise in the area being reviewed the

opportunity to discuss the application of criteria in determining medical necessity or any determination based on lack of clinical justification with the physician reviewer.

In addition to individual conversations with practitioners on specific case reviews, PHC conducts several committees for the purpose of hearing and incorporating practitioner input in the development of medical policy. PHC, through the Physician Advisory Committee (PAC), the Pharmacy and Therapeutics Committee (P&T) and the Physician Advisory Group (PAG), provides practitioners with clinical expertise in several areas the opportunity to advise or comment on the development and/or adaptation of UM criteria and provide feedback or instruction on the application of that criteria. Within the previously stated committees, PHC evaluates UM criteria and procedures against current clinical and medical evidence and updates them accordingly.

Skilled Nursing/Sub acute/ Long- Term Acute/Rehabilitation Facility Review
Review of all Skilled Nursing and Rehabilitation Facility confinements are performed by licensed professionals to ensure medical necessity of continued stay and the appropriateness of level and duration of care. This review is conducted telephonically using written PHC medical policy, Title 22 criteria, and/or InterQual® criteria. PHC UM staff in conjunction with the use of written criteria consider the following:

- Age
- Comorbidities
- Complications
- Progress of treatment
- Psychosocial circumstance
- and Home environment where applicable

Requests for authorization are reviewed within 24 hours of notification of admission. The UM team facilitates discharge planning in collaboration with the facility care team and makes referrals to PHC case management and social services as appropriate.

Consideration of available services in the local service area or delivery system, and the ability to meet the member's specific health care needs are evaluated as part of applying criteria and the development of an ongoing plan of care and discharge plan.

Discharge Planning
Discharge planning is a critical component of the utilization management process and begins upon admission with an assessment of the patient's potential discharge needs. It includes preparation of the family and the patient for continuing care needs and initiation of arrangements for services or placement needed after acute care discharge.

PHC Nurse Coordinators work with hospital discharge planners, case managers, admitting/attending physicians and ancillary service providers to assist in making necessary arrangements for post-discharge needs.

Post-Service Retrospective Review
Post-service retrospective reviews may occur when a member is retroactively granted Medi-Cal benefits by the State of California, when a provider does not realize an authorization is required prior to rendering a service, when the rendered service code billed does not match the code authorized, or the service may have been rendered after the expiration of the authorization. TARs must be received by PHC within fifteen (15) business days of the date of service or within 60 calendar days of either a denial from the primary insurance carrier or retrospective eligibility. (TARs submitted beyond these timeframes are considered late but will still be reviewed for medical necessity.)

All retrospective reviews are completed within 30 calendar days of receipt of request. Electronic or written notification of the decision and how to initiate a routine or expedited appeal will be provided to the provider within 24 hours of decision, but no longer than 30 calendar days from the date of the receipt of the request. PHC is not required to notify members of post-service review decisions as the member is not at financial risk for the services being requested.

Services requiring an authorization can be retrospectively reviewed for medical necessity, appropriateness of setting, and length of stay up to one year after services are rendered and may result in an adverse determination.

Emergency Room Visits

Emergency room visits where a prudent layperson, acting reasonably, would believe an emergency condition exists, DO NOT require prior authorization.

Timeliness of UM Decisions

PHC makes UM decisions in a timely manner to accommodate the clinical urgency of the situation and to minimize any disruption in the provision of care. PHC measures the timeliness of decisions from the date when the organization receives the request from the member or PCP, even if the PHC does not have all the information necessary to make a decision. PHC documents the date when the request is received and the date a decision is rendered in the UM documentation system.

PHC has communicated to both providers and members the practice of processing non-urgent requests during the next business day if the request is received after business hours.

PHC Utilization Management abides by the following timeliness guidelines when processing health services requests.

Urgent Requests

A request for medical care or services where application of the time frame for making routine or non-life threatening care determinations could jeopardize the live, health or safety of the member or others due to the member's psychological state or, in the opinion of the practitioner with knowledge of the members medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment requested.

Concurrent Review Request:

A request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care.

Pre-Service Request

A request for medical care or services that PHC must approve in advance, in whole or in part.

Non-Urgent Request

A request for medical care or services for which application of the time periods for making a decision does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

Post-Service Request / Retrospective Review

A request for medical care or services that have been received.

Non-Behavioral Healthcare Decisions and Behavioral Healthcare Decisions

Type of Request	Decision Time Frame	Notification[1] Time Frame	Extended Time Frame
Urgent concurrent review	72 hours (3 calendar days) of receipt of request	72 hours (3 calendar days) of receipt of request	May be extended one time up to 14 calendar days

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Urgent pre-service	72 hours (3 calendar days) of receipt of request	72 hours (3 calendar days) of receipt of request	May be extended one time up to 14 calendar days
Non-urgent pre-service	5 business days of receipt of request	24 hours of determination date	May be extended *two* times up to 14 calendar days[2]
Post-service	30 calendar days of receipt of request	30 calendar days of receipt of request	N/A

[1] Notification: Give electronic or written notification of decision to practitioner (and member when required)
[2] Per DHCS regulations

Review Criteria
Current InterQual® criteria sets are used as the main review guidelines. Additional criteria are selected or developed using other resources as necessary to help in determining review decisions which include, but are not limited to, Medi-Cal (State of California) guidelines and State policy letters (see policy MCUP3139 Criteria and Guidelines for Utilization Management). InterQual® criteria are produced using a rigorous development process based on evidence-based medicine and reviewed at least annually, but as frequently as quarterly, by a panel of board-certified specialists. All UM policies are based on InterQual® criteria and are reviewed annually by the Quality/Utilization Committee (Q/UAC) and the Physician Advisory Committee (PAC) which also include board-certified specialists.

In the absence of applicable criteria, the PHC UM medical staff refers the case for review to a licensed, board-certified practitioner in the same or similar specialty as the requested service. The reviewing practitioners base their determinations on their training, experience, the current standards of practice in the community, published peer-reviewed literature, the needs of the individual patients (age, comorbidities, complications, progress of treatment, psychosocial situation, and home environment when applicable), and characteristics of the local delivery system. Board-certified consultants are available through our providers on our Quality/Utilization Advisory Committee (Q/UAC). PHC also contracts with a third-party independent medical review organization which provides objective, unbiased medical determinations to support effective decision making based only on medical evidence. (See policy MCUP3138 External Independent Medical Review.)

Criteria are selected, reviewed, updated or modified using feedback from the Q/UAC and PAC as well as member feedback identified in member survey results and the Consumer Advisory Committee (CAC), State policy letters, State Memorandums of Understanding and/or medical literature, among other sources. In collaboration with actively practicing practitioners, criteria are evaluated on at least an annual basis. Relevant clinical information is obtained when making a determination based on medical appropriateness and the treating practitioner is consulted as appropriate. All information obtained to support decision-making is documented in the utilization management documentation system.

Decisions are based on information derived from the following sources:

- Clinical records
- Medical care personnel
- Facility utilization management staff
- Attending physician (attending physician can be the primary care physician, hospitalist or the specialist physician (or all three as necessary)
- Board-certified specialists are consulted when medically necessary

The needs of individual patients and the characteristics of the local delivery system are taken into account when determining the medical necessity of an inpatient hospitalization.

Inter-Rater Reliability (IRR)
PHC assesses the consistency with which physician and non-physician reviewers apply UM criteria in decision making and evaluates Inter-Rater Reliability. The Inter-Rater Reliability mechanism uses live cases

to ensure medical management criteria are appropriately and consistently applied in making UM determinations. The methodology employed is designed to annually assess 50 cases or 5% of reviewer case load, whichever is less, over the course of a year period.

The following types of reviews/reviewers are audited:

- Nurse Coordinator Review of Inpatient Services
- Nurse Coordinator Review of Outpatient Services
- Nurse Coordinator Review of Long Term Care Services
- Physician Review of Medical Necessity Authorizations
- Pharmacist and Pharmacy Technician Review of Pharmacy TARs
- LCSW/LMFT Review of Residential Substance Use Disorder Treatment Authorizations

A performance target of 90% accuracy is set for inter-rater reliability. An audit summary is reported at least annually or more often as needed to the Internal Quality Improvement (IQI) Committee. If a reviewer falls below the targeted threshold, a corrective action plan is initiated and monitored and results are presented to the Quality/Utilization Advisory Committee (Q/UAC) for review and discussion. Please refer to policy MPUP3026 Inter-Rater Reliability Policy for a full description of the IRR process.

Availability of Criteria

All criteria used to review authorization request are available upon request. In the case of an adverse determination, the criteria used are made part of the determination file. Access to and copies of specific criteria utilized in the determination are also available to any requesting practitioner by mail, fax, email, or on our website: http://www.partnershiphp.org. To obtain a copy of the UM criteria, practitioners may call the PHC UM Department at (800) 863-4155.

Members may request criteria used in making an authorization determination by calling the member services department to request a copy of the criteria. The UM team will work with member services to provide the criteria used in the review decision.

PHC's Provider Relations Department notifies providers in writing through the New Provider Credentialing Packet and the provider's contract that UM criteria is available online at http://www.partnershiphp.org in the Provider Manual section. Providers are also notified quarterly in writing via the Quarterly Provider Newsletter about the on-line availability of UM criteria and policies at http://www.partnershiphp.org in the Medi-Cal Provider Manual section.

COMMUNICATION SERVICES

PHC provides access to staff for members and practitioners seeking information about the UM process and the authorization of care in the following ways:

- Calls from members are triaged through member services staff who are accessible to practitioners and members to discuss UM issues during normal working hours when the health plan is in operation (Monday - Friday 8 a.m. - 5 p.m.).
- Members and Providers may contact the PHC voice mail service to leave a message which is communicated to the appropriate person on the next business day. Calls received after normal business hours are returned on the next business day and calls received after midnight on Monday - Friday are returned on the same business day.
- After normal business hours, members may contact the advice nurse line for assistance
- Practitioners may contact UM staff directly either through secure email or voicemail. Each voice mailbox is confidential and will accept messages after normal business hours. Calls received after normal business hours are returned on the next business day and calls received after midnight on Monday - Friday are returned on the same business day.

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- PHC has a toll free number (800) 863-4155 that is available to either member or practitioners.
- UM staff identify themselves by name, title and organization name when initiating or returning calls regarding UM issues.
- Members can view information about PHC's language assistance services and disability services in the Member Handbook which is mailed to members upon enrollment and is always available online at http://www.partnershiphp.org/Members/Medi-Cal/Documents/MCMemberHandbook.pdf Additionally, PHC provides annual written notice to Members about our language assistance services and disability services in our Member Newsletter.

Linguistic services are provided by PHC to monolingual, non-English speaking or limited English proficiency (LEP) Medi-Cal beneficiaries for population groups as determined by contract. These services include the following:

No cost linguistic services:

- Oral interpreters, sign language interpreters or bilingual providers and provider staff at key points of contact available in all languages spoken by Medi-Cal beneficiaries
- Written informing materials (to include notice of action, grievance acknowledgement and resolution letters) fully translated into threshold languages, upon request
- Use of California Relay Services for hearing impaired [TTY/TDD: (800) 735- 2929 or 711]

PHC regularly assesses and documents member cultural and linguistic needs to determine and evaluate the cultural and linguistic appropriateness of its services. Assessments cover language preferences, reported ethnicity, use of interpreters, traditional health beliefs and beliefs about health and health care utilization.

Denial Determinations

Denial determinations may occur at any time in the course of the review process. Only the Chief Medical Officer, or a physician designee acting through the designated authority of the Chief Medical Officer, has the authority to render a denial determination based on medical necessity (see Program Structure section for details).

A denial determination may occur during continued stay/concurrent review in which case notification and/or discussion with the treating practitioner and the Health Plan physician adviser/Chief Medical Officer or physician designee is offered.

Denial determinations may occur at different times and for various reasons including but not limited to:

- At the time of prior authorization; when the requested service is not medically indicated or not a covered benefit.
- When timely notification was not received from a facility for an inpatient stay to foster transfer of a medically stable patient
- When an inpatient facility fails to notify the Health Plan of admission within one business day of the admission or appropriate clinical information is not received
- Or after services are rendered at claims review when the services were not authorized, or are medically unnecessary

A denial may also occur for inappropriate levels of care or inappropriate care. Notwithstanding previous authorization, payment for services may be denied if it is found that information previously given in support of the authorization was inaccurate.

PHC offers the practitioner the opportunity to discuss any denial or potential denial determination based on lack of medical necessity with the Health Plan Chief Medical Officer, or a physician designee.

The denial notification states the reason for the denial in terms specific to the member's condition or service request and in language that is easy to understand and references the criterion used in making the determination so the member and provider have a clear understanding of the Health Plan's rationale and enough information to file an appeal.

Partnership HealthPlan of California is aware of the need to be concerned about under-utilization of care and services for our members. PHC monitors over and under-utilization through the Over/Under Utilization Workgroup which reviews annual utilization patterns. Decisions made by PHC's Utilization Reviewers are solely based on the appropriateness of the care or service.

The Health Plan does not compensate any individual involved in the utilization process to deny care or services for our members nor do we encourage or offer incentives for denials.

Process for a Provider to Appeal an Adverse Benefit Determination on Behalf of a Member

Members and providers are provided fair and solution-oriented means to address perceived problems in exercising rights as a Medi-Cal beneficiary or provider, in accordance with requirements of PHC's contract with the Department of Health Care Services (DHCS). This process is entirely separate from that of State Fair Hearings, to which members retain their access. Please refer to PHC policy MCUP3037 Appeals of Utilization Management/ Pharmacy Decisions for a full description of the process.

Appeals of Adverse Benefit Determinations (ABDs)

A member, a member's authorized representative, or a provider acting on behalf of a member, has 60 calendar days from the date of determination to submit an appeal request in response to a Notice of Action (NOA) letter. A member or a member's authorized representative may initiate an appeal by contacting PHC's Member Services department. An appeal initiated in this way is considered a Member Appeal and will be referred to the PHC Grievance and Appeals department for processing. A provider may also request an appeal on behalf of a member, with written consent from that member, by faxing or writing PHC's UM or Pharmacy Department.

After receipt of the request for appeal, PHC will provide written acknowledgement to the member and provider that is dated and postmarked within five (5) business days of receipt of the appeal. PHC has 30 calendar days from the receipt of the appeal request to render a determination.

The Chief Medical Officer or physician designee reviews the request for appeal if the determination was based on medical necessity. The Chief Medical Officer or physician designee may request further information from the provider such as:

- Diagnostic information
- Previous treatment
- Clinical justification
- Opinions from specialists or other providers
- Evidence from the scientific literature prior to processing the request.

The provider is expected to respond to a request for further information within the 30 calendar day determination time frame. If the provider does not respond to the request for further information within that time frame, the appeal can be extended no more than 14 calendar days.

When a decision has been made, the provider and/or member, if applicable, are notified in writing within five (5) business days with a Notice of Appeal Resolution (NAR) letter. PHC is not required to notify the

member of a decision when the member is not at financial risk for the services being requested (e.g. concurrent or retroactive reviews).

Providers who disagree with the appeal decision may then file a grievance with PHC by the process described in the Provider Grievance policy MP PR-GR 210.

If PHC's determination specifies the requested service is not a covered benefit, PHC shall include in its written response the provision in the Contract, Evidence of Coverage, or Member Handbook that excludes the service.

The response shall either identify the document and page where the provision is found, direct the provider and member to the applicable section of the contract containing the provision, or provide a copy of the provision and explain in clear concise language how the exclusion applies to the specific health care service or benefit request.

Expedited Appeals of Adverse Benefit Determinations

Expedited appeals may be initiated by the member or the provider. A member may initiate an expedited appeal by calling the Member Services Department. A provider may initiate an expedited appeal on behalf of a member with written consent by faxing or writing the PHC UM or Pharmacy Department. If the request for expedited appeal is not accompanied by written consent from the member, the Plan will proceed with the request.

Expedited appeals are performed by PHC only when, in the judgment of the Chief Medical Director or Physician Designee, a delay in decision-making may seriously jeopardize the life or health of the member.

PHC refers the expedited appeal request to the Chief Medical Officer or Physician Designee for decision on the appeal. The Chief Medical Officer or Physician Designee is expected to make a decision as expeditiously as the medical condition requires, but no later than seventy-two (72) hours after the receipt of the request for an expedited appeal.

Expedited reviews are also granted to all requests concerning admissions, continued stay or other health care services for a member who has received emergency services but has not been discharged from a facility.

PHC provides verbal confirmation of its decisions concurrent with mailing of written notification no later than seventy-two (72) hours after receipt of an expedited appeal. If the expedited appeal involves a concurrent review determination, the member continues to receive services until a decision is made and written notification is sent to the provider. PHC is not required to notify the member of a concurrent decision as the member is not at financial risk for the services being requested.

Appeal Rights

A member may ask assistance from a patient advocate, provider, ombudsperson or any other person to represent them in their request.

A member may also request a State Hearing if a member has filed an appeal and received a "Notice of Appeal Resolution" letter upholding the initial denial of service. Information on how to obtain an expedited State Hearing is included as a part of the "Notice of Appeal Resolution" letter to the member.

Member grievance and appeal information is included in the member handbook, distributed annually in the member newsletter, and is posted on the PHC website.

It is the responsibility of the Member Services Director and the Member Services Department to ensure:

- Member Rights and Responsibilities are included in the member handbook which is mailed to all new members and posted on the PHC website
- Members are advised of their right to receive a copy of the Member Rights and Responsibility statement annually in the PHC's member newsletter.
- Members are notified of all revisions to the Member Rights and Responsibilities statement in the member newsletter following revisions.

It is the responsibility of the Provider Relations Director and the Provider Relations Department to ensure

- The Member's Rights and Responsibilities statement is included in the PHC provider manual issued to all contracted providers. The manual is issued to providers after their contract has been fully executed.
- Any revisions to the Member's Rights and Responsibilities statement are issued to all contracted providers within 90 days from the date these revisions are finalized.

Data Sources

Utilization Management supports the effective, efficient, and appropriate utilization of member benefits through ongoing review, evaluation and monitoring of the member's personal health information in making medical necessity determinations.

Data sources may include, but are not limited to:

- Medical records, from outpatient provider offices and hospital records (including accessing hospital Electronic Medical Records (EMR); for current and historical data
- Member handbook or Evidence of Coverage
- Consultations with treating physicians
- network adequacy information
- Local delivery system capacity information
- Specialist referrals
- Recent Physical exam results
- Diagnostic testing results
- Treatment plans and progress notes
- Operative and pathological reports
- Rehabilitation evaluations
- Patient characteristics and information
- Patient psychosocial history
- Information from family / social support network
- Prospective/concurrent/retrospective utilization management activities
- Claim/encounter (administrative) data

Data Collection, Analysis, and Reporting

Data collection activities for analysis and reporting are coordinated by the UM department. At the data gathering/performance measurement phase, participants in the process include programmers and analysts in the Finance and Health Services departments, staff nurses, and any other personnel required for the collection and validation of data. All data collection activities are documented and reported to the Q/UAC twice a year and more often if requested. Data collection activities may include, but are not limited to:

- Member satisfaction surveys
- Provider satisfaction surveys
- Readmission statistics
- Potential quality incident data

- Member appeal data
- Provider appeal data
- Internally developed databases
- Pharmacy utilization data
- Other administrative or clinical data

EVALUATION OF NEW MEDICAL TECHNOLOGY

PHC evaluates the inclusion of new medical technologies and the new application of existing technologies in its benefit packages. While the basic benefits are set by the State of California Department of Health Care Services (DHCS) and outlined in Title 22 of the Health and Welfare Code, PHC has the option of adding to this basic package of benefits for its members.

PHC's Policy MCUP3042 Technology Assessment outlines the steps taken during the determination process. The PHC Physician Advisory Committee will review all cases and make a final recommendation to the Board of Commissioners as to new benefits. The Commission is the only entity that can add benefits.
Once a new benefit is added, the information is disseminated to all Primary Care Providers and appropriate specialists in the form of a mail notification of benefit addition, and to all members in the next member newsletter.

New technologies are handled on a case-by-case basis which includes obtaining information regarding the safety, efficacy and indications that support the use of the intervention. There must be evidence that the proposed intervention will add to improved outcomes as compared to what is currently available. The service provider must have a record of safety and success with the intervention and cannot be part of a funded research protocol. The Chief Medical Officer works closely with the requesting physician and specialists as needed in researching these cases.

DELEGATION

UM activities that are delegated to contract providers are reviewed and approved on an annual basis by the Q/UAC. A delegation agreement, including a detailed list of activities delegated and reporting requirements is signed by both the delegate and PHC.

- Providers to whom UM activities have been delegated are responsible for reporting results and analyses to PHC on a quarterly or annual basis. Reports are summarized for review and evaluation by PHC's Delegation Oversight Review Sub-Committee (DORS) and Q/UAC.
- Audits are conducted no less than annually and evaluation includes a review of both the processes applied in carrying out delegated UM activities, and the outcome achieved in accordance with the respective policy(s) and agreement governing the delegated responsibility.
- The Q/UAC reviews evaluations and make recommendations regarding opportunities for improvement and continuation of delegated functions.

A pre-delegation evaluation is conducted when delegation of functions to providers is being considered.

Protected Health Information (PHI)

The Privacy Rule, described in 45 CFR Parts 160 and 165, applies to covered entities. The Privacy Rule allows covered providers, entities, and health plans to disclose PHI in order to carry out their health care functions.

Partnership HealthPlan of California is fully compliant with the general rules, regulations and implementation specified in The Privacy Rule. PHC also provides reasonable administrative, technical, and physical

safeguards to ensure PHI confidentiality, integrity and availability and to prevent unauthorized or inappropriate access, use or disclosure of PHI.

The PHC Director of Regulatory Affairs and Program Development also serves as the PHC Privacy Officer. PHC has implemented a comprehensive program that includes "Notice of Privacy Practices" (NPP) sent to all members, as well as implementation of a confidential toll-free complaint line available to members, providers and PHC staff. For non-covered entities, PHC requires Business Associate Agreements (BAA). Additionally, there is training on an annual basis for the PHC workforce and PHC providers/networks, and PHC maintains policies and procedures around documentation of complaints of violations or suspected privacy incidents.

STATEMENT OF CONFIDENTIALITY

Confidentiality of provider and member information is ensured at all times in the performance of UM activities through enforcement of the following:

- Members of the Q/UAC and PAC are required to sign a confidentiality statement that will be maintained in the QI files.
- UM documents are restricted solely to authorized Health Services Department staff, members of the PAC, Q/UAC, and Credentialing Committee, and reporting bodies as specifically authorized by the Q/UAC.
- Confidential documents may include, but are not limited to Q/UAC and Credentialing meeting minutes and agendas, QI and Peer Review reports and findings, UM reports, or any correspondence or memos relating to confidential issues where the name of a provider or member are included.
- Confidential documents are stored in locked file cabinets with access limited to authorized persons only, or they are electronically archived and stored on protected drives.
- Confidential paper documents are destroyed by shredding.

NON-DISCRIMINATION STATEMENT

PHC complies with applicable Federal civil rights laws and does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, age, disability, or sex.

PHC will not deny or limit coverage, deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, for any health services that are ordinarily or exclusively available to individuals of one sex, to a transgender individual based on the fact that an individual's sex assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such health services are ordinarily are exclusively available. Also, PHC will not otherwise deny or limit coverage, deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, for specific health services related to gender transition if such denial, limitation, or restriction results in discrimination against a transgender individual.

PHC provides free aids and services to people with disabilities to communicate with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

PHC provides free language services to people whose primary language is not English or those with limited English proficiency (LEP). These services include the following:

- Qualified sign language interpreters
- Information written in other languages
- Use of California Relay Services for hearing impaired

STATEMENT OF CONFLICT OF INTEREST

Any individual who has been personally involved in the care and/or service provided to a patient, an event or finding undergoing quality evaluation may not vote or render a decision regarding the appropriateness of such care. All members of the Q/UAC are required to review and sign a conflict of interest statement, agreeing to abide by its terms.

PROVIDER AND MEMBER SATISFACTION

PHC conducts satisfaction surveys on both members and providers. Included in the evaluation are questions that deal with both member and provider satisfaction with the UM program. The responses to the survey are reviewed by staff from Health Services, Member Services, and Provider Services. Thresholds are set and responses that fall below are considered for corrective action by the HealthPlan. The results, as well as plans for corrective action, are developed in conjunction with the Q/UAC. Corrective actions that were in place are evaluated at the time the follow-up annual survey is done unless the committee feels an expedited time frame needs to be implemented.

ANNUAL PROGRAM EVALUATION

The Utilization Management program undergoes a written evaluation of its overall effectiveness annually by the Q/UAC, which is reviewed and approved by the PAC.

At a minimum the evaluation considers UM department activities and outcomes, the review of Key Performance Indicator metrics such as Productivity, Timeliness, Bed-days, readmission rates and denial rates along with resource effectiveness and barriers to performance.

Preparation for the Annual Program Evaluation involves participation by all Utilization Management and Pharmacy leadership including but not limited to:

- Senior Health Services Director
- Director, Pharmacy Services
- Associate Directors of UM
- UM Team Manager

Elements of the program evaluation include an objective assessment of meeting targeted goals to ensure appropriate, efficient utilization of resources/services for PHC members across the continuum of care in compliance with requirements of state/federal and regulatory entities.

- Annual UM Program Description update
- Annual review and evaluation of UM processes (meeting goals and identifying opportunities for process improvements)
- Timely review and update of UM policies and procedures
- Obtain approval of UM policies and procedures at Q/UAC

Inter-Rater Reliability scoring, TAR timeliness, percentage of eRAFs vs. Manual RAFs, and Call Performance is compared with regulatory compliance standards and internal benchmarks.

To determine if the UM program remains current and appropriate, the organization annually evaluates:

- The program structure
- The program scope, processes, information sources used in the determination of benefit coverage and medical necessity

- The level of involvement of the senior-level physician and designated behavioral healthcare practitioner in the UM program
- Consideration of member and practitioner experience data when evaluating the UM program

The organization updates the UM program and its description annually based on the evaluation.

To ensure the provision of healthcare services at the appropriate level of care the evaluation considers:
- Inpatient bed day rate
- Inpatient average length of stay
- SNF admit rate
- SNF average length of stay
- Readmission rate
- Denial rate
- Timely completion of notifications of denial of care
- Timely completion of notifications of authorization of care
- Rate of referrals to Care Coordination
- Effectively integrating feedback - the program reflects on Member/Provider satisfaction results concerning the UM program looking at:
    - Daily Work Flow Monitoring
    - Call Abandonment rates
    - Call Volume
    - Average caller wait time

An assessment of Department resources is determined by looking at the impact of staffing changes, learning curves and system limitations which impede work effectiveness. There is a review of Inter-Rater Reliability scoring in relation to staff training/re-education, acclimation to new technology such as documentation software/ hardware based on evaluating user acceptance, and the assessment of appropriate staffing ratio to ensure adherence to regulatory and internal performance standards.

A summary of the program evaluation, including a description of the program, is provided to members or practitioners upon request. When the evaluation is complete, an announcement indicating the availability of UM information is published in the member and provider newsletter.

REFERENCES:
Department of Health Care Services (DHCS) standards
National Committee for Quality Assurance (NCQA) Guidelines (Effective July 1, 2020) UM Standards 1-5, 7

Original Date: QI/UM Program 04/22/1994 effective 05/01/1994
Revision Date(s): 08/16/95
Revision Date(s): UM Program Description - 04/17/97; Board Approval January 28, 1998; 06/10/98; 01/20/99; 05/2000; 05/01/01; (UD100301) 03/20/02; 08/20/03; 10/20/04; 10/13/05; 06/21/06; (MPUD3001) 04/16/08; 08/03/10; 11/19/14; 02/17/16; 04/19/17; *06/13/18; 04/10/19, 06/12/19 *(Amended)*, 10/09/19 *(Amended);* 04/08/20; 06/10/20 (*Amended*); 04/14/21

*Through 2017, Approval Date reflective of the Quality/Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

UM PROGRAM DESCRIPTION APPROVAL

Robert Moore, MD, MPH, MBA	***03/17/2021***
Quality/Utilization Advisory Committee Chairperson	*Date Approved*

Jeffrey Gaborko, MD	***04/14/2021***
Physician Advisory Committee Chairperson	*Date Approved*

Nancy Starck	***04/28/2021***
Board of Commissioners Chairperson	*Date Approved*

*Services related to substance use services as outlined in the Regional Drug Medi-Cal Model are placeholders for when DHCS releases the benefit. Activity is not anticipated to be effective until late Spring 2020.