

**Behavioral Health Clinics**  
**Clarifications to Guidance about Quality Measures and Reporting**  
**Questions Related to Specific State-Lead and BHC-Lead Quality Measures for BHCs and CCBHCs**

*SAMHSA, CMS, and ASPE have provided the following clarifications to questions from states and clinics regarding the 32 quality measures published by HHS.*

**State Lead Measures**

**Patient Experience of Care Surveys (PEC and Y/FEC):**

**Question 1.a:** Regarding the two Patient Experience of Care consumer surveys, is the sample size of 300 the TOTAL of youth and adult, or 300 each: youth and adult?

**Clarification:** The sample size of 300 is for youth and adult separately, unless there are fewer than those numbers of individuals in the population of the BHC. See page 111 of Volume 1 of the Technical Specifications.

**Question 1.b:** Regarding the two Patient Experience of Care consumer surveys, does the survey need to cover all populations served?

**Clarification:** The goal of the survey is to be representative of the population served but the measure is written to allow the states to continue to collect as they do now, with the exception of oversampling (300) and requiring that the results be reported separately for the BHCs.

**Question 1.c:** Regarding the two Patient Experience of Care consumer surveys, do the sample sizes need to be representative of the relative size of the populations?

**Clarification:** There is no requirement that the states change what they are doing now, other than oversampling (300) and reporting the results separately by BHCs. The goal is that it be as representative as possible, given that caveat.

**Question 1.d:** For patient experience of care surveys, are there any stratification requirements?

**Clarification:** There are no explicit stratification requirements in the two existing surveys referenced in the BHC measures. Some states do incorporate more stratification than do others in part to get a more representative sample. These BHC measures incorporating the two patient experience of care measures were very deliberately created to allow states to continue to conduct the surveys just as they are doing presently. So there is nothing specific here related to stratification. The only change for these surveys is that you must report at the BHC level and reach out to 300 consumers per BHC per survey for reporting within the BHC quality measures.

**Question 1.e:** Regarding the patient experience of care surveys, we do not use mixed surveys for substance use clients. Is there an appropriate survey to use on substance use clients?

**Clarification:** The measures are intended to apply to everybody served by the BHC. The CCBHC demonstration program is designed to integrate care and to break down distinctions within behavioral health. The same surveys should, for the CCBHC demonstration program, be used for all CCBHC consumers. For non-CCBHC states or BHCs that are not CCBHCs or comparison sites, the state has the option of using another survey if they wish.

**Question 1.f:** Regarding the patient experience of care surveys, the state currently selects a blind sample across the entire system with no provider- specific identifiers. The departmental IRB exercises oversight of the process. Surveying within the particular agency will be a significant departure from the current practice. How do we handle this?

**Clarification:** Yes. It may be a departure for some states and should be raised with state departmental internal review boards.

### **Plan All Cause Readmission (PCR-BH):**

**Question 2:** Regarding risk adjustment for all-cause readmission, are there standardized tools for risk-adjustment? Can unadjusted rates be used for the measure?

**Clarification:** Unadjusted rates should be used. The Technical Specifications Manual is clear (Section A, Guidance for Reporting) that the table for risk adjustment that is included with the measure need not be completed. No risk adjustment has been developed and it is not required. The Technical Specifications Manual includes a risk adjustment table because the BHC measure is derived from a Medicaid Adult Core Measure, and we could not deviate from the source by removing the table.

### **Initiation and Engagement in AOD Treatment (IET-BH):**

**Question 3.a:** What if the client is 17 when he or she is admitted, but turns 18 within a week. How is that client counted in the Initiation and Engagement measure?

**Clarification:** For each measure, the Technical Specification Manual tells you how to ascertain age (e.g., the first day of the measurement year, the last day of the measurement year, the day that a specific service is provided). For the IET-BH measure, age is determined as of the last day of the measurement year. The measure stratifies age as 13–17, 18–64, and 65 years and older. So if the measurement year is January 1 through December 31 and the person is 17 on July 15 and 18 on July 23, then he or she is 18 for purposes of IET-BH.

**Question 3.b:** In the Value Set for NQF 0004, the allowed codes for ‘alcohol and drug dependence treatment’ and ‘detoxification visit’ only include SNOMED codes. Our center provides these services but doesn’t use SNOMED codes. Are we allowed to interpret the SNOMED codes into codes that we actually use?

**Clarification:** For purposes of the CCBHC demonstration, because this is a measure that is calculated and reported by the state, if the CCBHCs are going to use other codes, the state will want to make sure it has a mechanism to capture them. In situations such as this, the state should identify these codes and make them available to all CCBHCs so that reporting is consistent. Ideally, the codes also would be used by the non-CCBHCs as well to allow meaningful comparison. We ask for consistency and transparency and that the state provide this information to SAMHSA so that the evaluators have accurate information.

### **Follow-up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA):**

**Question 4.a:** Measures assume that BHCs will monitor customer use of emergency departments (EDs) and follow up as needed. Does SAMHSA have examples of formal agreements that BHCs enter into with EDs about shared data for care coordination purposes, for example, client ID and diagnosis related to ED client visits?

**Clarification:** SAMHSA does not have examples of such agreements. BHCs will need to enter into such agreements with facilities most likely to be their care coordination partners. Such agreements related to ED use might call for some or all of: 1) designation of individuals on both sides who will be responsible for alerting and receiving information related to ED use; 2) provision for inquiry of individuals seen in EDs for psychiatric or substance use purposes if they

are BHC consumers; 3) provision for releases of information that allow information sharing regarding the ED visit; and 4) provision for care coordination meetings to advance the processes and systems of care coordination. Other provisions might be included as well. Many hospitals will already be in a position of needing to better coordinate after-care and overtures and agreements such as this may actually be welcomed by hospitals as a way to facilitate that.

**Question 4.b:** With regard to Follow-up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA), does the diagnosis at follow-up need to be a perfect match? For example, one entity might give a diagnosis of severe and another diagnosis of mild or different entities might emphasize different substances, so that the diagnoses might have different codes.

**Clarification:** No, the diagnosis does not need to be a perfect match. The measure does require a substance use diagnosis in the primary diagnosis position for it to count in the numerator as follow-up. For example, if a person has an ED visit and is given a primary diagnosis of opioid dependence, and then there is follow-up at the BHC and a primary diagnosis of opioid misuse (or even some non-opioid-related substance use diagnosis listed as the primary follow-up diagnosis), it still would count as long as it is a substance use code and it is in the primary position.

**Question 4.c:** Regarding Follow-up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA), clinicians were very concerned about changing diagnosis to match the primary diagnoses given by the ED. Is this necessary?

**Clarification:** The concern related to both FUA and FUM, is that the denominator includes those with a primary ED diagnosis that is mental health (MH)-related or substance use disorder (SUD)-related and that, in order to count in the numerator, the primary follow-up diagnosis must be MH-related or SUD-related respectively. An example would be if someone is seen at the BHC primarily for a SUD but goes to the ED with what looks like a MH diagnosis as the primary complaint (possibly not even mentioning a SUD and with a SUD not identified by the ED). If they then return to the BHC and the standing primary diagnosis of SUD remains, they would not be counted in the numerator. That is a problem and diagnoses provided by the BHC should be reflective of reality, which most often will be what the BHC has previously identified. It is possible, however, that an ED visit might surface a problem not previously identified or diagnosed by the BHC. There is no apparent solution to this. The measure will indicate some people did not have follow-up who did (because of the primary diagnosis requirement). The FUM and FUA measures are HEDIS measures, as written, and we must conform to that source. BHCs should not be changing their diagnosis simply to satisfy the measures, but the purpose of the measure is to make BHCs aware that there is an ED visit and assure follow-up. Every state and every clinic will face this problem with the two measures.

**Question 4.d:** With regard to Follow-up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA), what if the person is a Medicaid enrollee but is seen in a residential treatment program or some other substance use disorder program that is not paid for by Medicaid in our state? The data will not be available as Medicaid claims data.

**Clarification:** If the Medicaid enrollee is seen somewhere that is not captured in the claims data, the BHC or state should indicate that the data are not available and why (use the data reporting templates sections E and F).

## BHC-Lead Measures

## **Housing Status (HOU):**

**Question 5.a:** Regarding the Housing Status (HOU) measure, we do not collect URS information on substance use clients; we collect TEDS information and use those categories. How will that be handled?

**Clarification:** The measure calls for specific housing status categories to be used and it was designed to include both the mental health and substance use populations that are served. For that reason, you should, as much as possible, use the same housing status categories for everybody. If, for some reason, a state cannot do so, please develop a crosswalk to assure that the state has a method for attributing to the URS categories in a consistent way that can also be tracked for evaluation purposes if this is collected as part of the CCBHC demonstration program.

## **Initial Evaluation (I-EVAL):**

**Question 6.a:** Why is time to initial evaluation not being measured for children?

**Clarification:** Time to initial evaluation for consumers younger than 12 is very important, and, for CCBHCs in particular, it is clearly required as part of the certification criteria that the initial evaluation occur within a certain period of time regardless of age. The reason that reporting begins with those aged 12 or older was to help reduce BHC reporting obligations. States or the BHCs themselves may elect to report for those younger than age 12. If you do that, this information should be included in the additional notes in the bottom of the pertinent data reporting template, because the template cannot be modified.

**Question 6.b:** For the measure related to timing of initial evaluation, how is first contact defined? What are the elements that are required to meet the definition of contact?

**Clarification:** First contact represents the first time that the person (or family or guardian if the person is a child or has a guardian) contacts the BHC to obtain services. As stated in the Technical Specification for the I-EVAL measure, first contact also applies to a person who has not received services from the BHC during the previous 6 months. For BHCs that are part of the CCBHC demonstration program, the CCBHC certification criteria (2.b.1) require that the first contact include a preliminary screening and risk assessment to ascertain acuity of needs. Depending on the results, the first service and initial evaluation is required within 10 business days if needs are routine and within 1 business day if needs are urgent. If needs constitute an emergency, “appropriate action must be taken at once.” An initial evaluation, as defined in criterion 4.d.3, should be incorporated into the emergency evaluation process conducted by the BHC.

**Question 6.c:** For the measure related to timing of initial evaluation, can first contact be by phone?

**Clarification:** Yes. First contact can be by phone.

**Question 6.d:** For the measure related to timing of initial evaluation, if a consumer calls and both a preliminary screening and risk assessment and an initial evaluation are done over the phone, does that count as zero days? Similarly, if the consumer calls and asks to come into the office for an evaluation, does that time also count as zero days?

**Clarification:** For a BHC that is participating in the CCBHC demonstration program, if a new consumer calls for an appointment, the preliminary screening and risk assessment should be performed during that call. If they come into the office the same day and receive an initial evaluation, that evaluation occurred within zero days. Similarly, if they receive the initial evaluation (which builds on the preliminary screening) during the first call, that initial evaluation also was performed in zero days. But as a further reminder, the CCBHC criteria encourage the initial evaluation to be performed in person. Criterion 2.b.1 states that, “for those presenting with emergency or urgent needs, the initial evaluation may be conducted telephonically or by telehealth/telemedicine but an in-

person evaluation is preferred. If the initial evaluation is conducted telephonically, once the emergency is resolved the consumer must be seen in person at the next subsequent encounter and the initial evaluation reviewed.”

**Question 6.e:** For the measure related to timing of initial evaluation, if a consumer calls seeking an evaluation and we provide them with our own open access and then s/he never appears, is that counted in the denominator?

**Clarification:** Yes, assuming you performed the preliminary screening and risk assessment to ascertain level of acuity when the consumer called.

**Question 6.f:** For the measure related to timing of initial evaluation, if a program that has open access where clients can come in whenever they want during certain hours, but they happen to call first to determine what the open-access hours are, is that call considered first contact?

**Clarification:** No, a call to determine when open-access hours are held is not considered first contact unless that call is accompanied by the preliminary screening and risk assessment and collection of basic data about the person that includes insurance information. So a person calling to find out what hours the BHC is open is generally not an initial contact but rather an attempt to find out when they can come in and have an initial contact.

**Question 6.g:** For the measure related to timing of initial evaluation, is a PCP referral considered the first point of contact?

**Clarification:** No, the contact has to be made by the person who is seeking services or by his or her family if the person is a child. For those participating in the CCBHC demonstration, the first point of contact must include a determination of the person’s acuity of needs using the preliminary screening and risk assessment that is supposed to occur at first contact.

**Question 6.h:** For the measure related to timing of initial evaluation, can the first contact be when people are entering into Level III detox that is part of the BHC if they enter into follow-up outpatient care within 10 days?

**Clarification:** For purposes of the CCBHC demonstration program, Level III detox that is either inpatient or residential cannot be a CCBHC demonstration service. If there is a prescreen at the detox that satisfies the requirements of making someone a CCBHC consumer (preliminary screening and risk assessment by the CCBHC), then the results of the prescreen regarding acuity of need would govern when the initial evaluation must be performed, although payment could not be through the PPS given that the screening was done in an inpatient setting.

**Question 6.i:** For the measure related to timing of initial evaluation, if a person contacts a clinic more than once to initiate services, does the first contact count as initiation or does the last contact count as initiation? Or does each contact count separately?

**Clarification:** Only one contact in a 6-month period will count (with 6 months being used to determine if the person is a new consumer). The first contact seeking services is initiation and the time to initial evaluation counts from that point.

**Question 6.j:** For the measure related to timing of initial evaluation, if a person was being seen but had stopped coming in for 6 or more months before re-engaging, would that person be considered a new consumer?

**Clarification:** Yes. Within the definition used in the Technical Specification, that person would be considered a new consumer. He or she would be required to have the initial evaluation. This makes sense because the initial evaluation is designed to determine the person’s status on critical matters, and that status may have changed since he or she was last seen.

**Question 6.k:** For the time to initial evaluation measure, I understand why we look back 6 months to determine if the consumer is a new consumer or not. However, why do we count those under 6 months past in the denominator? It seems like that would skew the data, given that we could not see these consumers prior to the beginning of the measurement year.

**Clarification:** Actually, the data are not skewed, because you are looking back 6 months only to see whether consumers came in during that time frame (i.e., to determine whether they are new consumers). If consumers were seen in the past 6 months, they are not included in the denominator or the numerator because they are not new consumers. However, if they were seen as new consumers during the MY, then you include them in the denominator; for the numerator, you look only at data for those new consumers in the current MY to see if they received an initial evaluation within 10 business days. If somebody made first contact on January 1 seeking services, you would look at the data for the past 6 months to determine if they are new. Were they here 1 week ago, 1 month ago, or 8 months ago? If it was 8 months ago (i.e., not within 6 months), they are considered a new consumer and are part of the denominator. Then you want to make sure that they had an initial evaluation within 10 days of that first encounter in the current MY; if they did, they are part of the numerator. For this measure, the denominator (all new consumers) and numerator (the subset of new consumers who received an appropriately timed initial evaluation) only include people seen during the MY; data from the previous year are used only to determine who is eligible for inclusion on the basis of being a new consumer.

**Question 6.l:** For the measure related to timing of initial evaluation, are we using the determined number of people scheduled during a specific timeframe (e.g., January 1, 2016, through February 29, 2016)?

**Clarification:** For this measure, you are looking at first contacts that occurred during the MY. For instance, if the MY begins on January 1, 2017 and ends on December 31, 2017, during that 12-month time frame, your denominator will be all new consumers (i.e., people who were not seen in the 6 months prior to their first contact) who are 12 years of age or older. For data purposes, however, you might be looking at data prior to the date that the MY began to ensure that you capture people who were not seen 6 months prior to their first contact. For example, if a person comes in for the first time on March 1, 2017, you will look back as far as September 1, 2016 only to determine if they are new.

**Question 6.m:** For the measure related to timing of initial evaluation, if no evaluation occurs, how is that handled in the average?

**Clarification:** For metric 2 (the mean or average number of days until initial evaluation), if no evaluation occurs, exclude those individuals from the denominator for the second metric and indicate in the data reporting template the number of new consumers excluded because no initial evaluation occurred.

**Question 6.n:** For the measure related to timing of initial evaluation, are people who contact the BHC to request services (schedule an initial visit) counted if they never receive an initial evaluation (e.g., they move away, they never show). Or are only people who receive an initial evaluation counted as part of the metric? If they are counted as consumers, how are they counted for the second part of the metric? Is the average number of days 31 for consumers who never received an initial evaluation, like it is for consumers who received an initial evaluation after the last day of the MY?

**Clarification:** For the first metric, people who contact the BHC seeking services are counted. At that point, they should have the preliminary screening and risk assessment to ascertain acuity of needs, with the timing for the initial evaluation based on the results. For the second metric, people who never receive an initial evaluation should be excluded and the number reported in the Additional Notes section of the data reporting template. You should count them in the first metric.

**Question 6.o:** I-EVAL is defined as the number of business days from initial contact until initial evaluation was received by or completed for the consumer. “Business Days” is defined as Monday through Friday. What if the clinic is open from Monday through Saturday and the initial evaluation was conducted on the Saturday following the initial contact?

**Clarification:** Only standard business days count. The measure captures consumers who were evaluated within 10 business days. For the first metric, if the initial contact was Friday and the evaluation was performed on Saturday, it would be 1 day because it was completed by Monday (the next business day). For the second metric, just count the actual number of days.

**Question 6.p:** For the measure related to timing of initial evaluation, how do you report consumers’ choosing not to be seen within 10 days? Do you still count that exception in your counts?

**Clarification:** We know there will be people who do not want to be seen as soon as 10 business days for a variety of reasons (e.g., they do not see it as urgent, their schedule does not allow them to be seen within 10 days, they made an appointment but did not keep it). It does not matter why they did not have their initial evaluation within 10 days. These people are counted as not receiving the initial evaluation within 10 business days, so they are excluded from the numerator. But they are included as new consumers in the denominator and they are counted as part of the eligible population because they are new consumers who are 12 years of age or older. We know that this is going to happen, but we also know that this is going to happen across the board to all BHCs.

**Question 6.q:** For the I-EVAL measure’s 12–17 and 18+ age ranges, do individuals fall into the 18+ on their 18<sup>th</sup> birthday, whereas 17.5-year-old individuals are in the 12–17 age bracket?

**Clarification:** Yes, people fall into the 18+ age bracket on their 18th birthday. On the day prior to their birthday, they fall into the 12–17 age bracket.

### **Tobacco Screening and Cessation Intervention (TSC):**

**Question 7.a:** For the Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention (TSC) measure, does e-cigarette use fall under tobacco use?

**Clarification:** Yes. The tobacco use measure includes “any type of tobacco,” and the U.S. Food and Drug Administration regulates e-cigarettes as “deemed tobacco products.” <https://www.federalregister.gov/articles/2016/05/10/2016-10685/deeming-tobacco-products-to-be-subject-to-the-federal-food-drug-and-cosmetic-act-as-amended-by-the> ; <http://blogs.fda.gov/fdavoices/index.php/2016/08/protecting-the-public-and-especially-kids-from-the-dangers-of-tobacco-products-including-e-cigarettes-cigars-and-hookah-tobacco/> ; <http://www.fda.gov/TobaccoProducts/Labeling/ProductsIngredientsComponents/default.htm>

**Question 7.b:** For the measure of screening and cessation intervention for tobacco use, how is cessation intervention defined? What if this person accepts having a phone call with the state quit line?

**Clarification:** According to the Technical Specification, a tobacco cessation intervention “includes brief counseling (3 minutes or less) and/or pharmacotherapy.” To be in the denominator, however, the eligible encounters must be provided by the “provider entity,” which is the BHC. This does not preclude use of a quit line, but there should be a brief intervention by the BHC as well.

**Question 7.c:** For the measure of screening and cessation intervention for tobacco use, does the tobacco screening and cessation intervention have to occur during the same encounter?

**Clarification:** The screening and intervention should be performed during the same encounter although the measure is silent on this point.

**Question 7.d:** For the measure of screening and cessation intervention for tobacco use, if the screening is positive, who should provide the counseling or intervention?

**Clarification:** This measure does not specify which staff should do the counseling. The center should follow any state or other requirements for licensure and training that would otherwise apply.

**Question 7.e:** For the measure of screening and cessation intervention for tobacco use, is use of the physician office codes required? Can nonphysicians report the CPT-II codes? Our state trains our Peer Recovery Support Specialists and our Wellness Coaches on the 5 A's, so they would more likely be working with the clients on this subject.

**Clarification:** BHCs may use staff who can provide these services within their state licensure. If operating under supervision of a physician, they can use the physician codes. If you are a BHC participating in the CCBHC demonstration program, you also may compile a list of comparable codes; but the list should be clear and be provided to all CCBHCs in the state, and the deviation should be indicated on the reporting template.

### **Alcohol Screening and Brief Counseling (ASC):**

**Question 8.a:** Regarding the measure of Unhealthy Alcohol Use: Screening and Brief Counseling (ASC), do all BHCs in a state have to use the same screening approach?

**Clarification:** No, all BHCs do not have to use the same screening approach. They should, however, all use an approach that is “systematic” as that is defined in the Technical Specification for the measure (i.e., AUDIT, AUDIT-C, single question screening).

**Question 8.b:** For the measure of screening and intervention for unhealthy alcohol use, is it the case that the AUDIT and AUDIT-C are the only tools to use for unhealthy alcohol use?

**Clarification:** No. There is one other option: the brief screening tool that is included in the Technical Specification definitions and which contains a single-question screen about number of drinks, which differs for men and women. Information also is available about what cut-off score a consumer needs to obtain on any of the 3 allowable screens to be considered as having unhealthy alcohol use. The options are limiting; there are only three possible ways to satisfy this measure in terms of screening.

**Question 8.c:** For the measure of screening and intervention for unhealthy alcohol use, if we have other screens already embedded in our EHR, can we use those instead of the AUDIT?

**Clarification:** The AUDIT, AUDIT-C, and the single-question screen specified in the ASC measure are permissible. Those are the only screens you can use to satisfy the numerator. The AUDIT has been validated across sex, age, and cultures.

[http://apps.who.int/iris/bitstream/10665/67205/1/WHO\\_MSD\\_MSB\\_01.6a.pdf](http://apps.who.int/iris/bitstream/10665/67205/1/WHO_MSD_MSB_01.6a.pdf)

**Question 8.d:** For the measure of screening and intervention for unhealthy alcohol use, is the CAGE appropriate given that we have that in our EHR?

**Clarification:** The CAGE is not one of the three allowed screening tools. It also is very important to note that the CAGE is only validated for adults, so it is not appropriate for use with adolescents. It also is less valid than alternative screening tools with some other consumer groups such as pregnant women. The

CAGE is often included as a default screen in EHRs, but that does not mean it is always appropriate for all ages or segments of the population. You should determine how to include other screens in the EHR to make sure you have both what you need to satisfy the measure and what you may need for a particular population segment.

**Question 8.e:** For the measure of screening and intervention for unhealthy alcohol use, is the AUDIT tool in the public domain?

**Clarification:** The AUDIT is freely available from a variety of sources, including the World Health Organization (WHO) that developed this tool. You can access it on the WHO website at: [http://apps.who.int/iris/bitstream/10665/67205/1/WHO\\_MSD\\_MSB\\_01.6a.pdf](http://apps.who.int/iris/bitstream/10665/67205/1/WHO_MSD_MSB_01.6a.pdf) The tool also is available from the WHO in Japanese, Spanish, and Slovenian. However, it may not be sold or used for commercial purposes.

**Question 8.f:** For the measure of screening and intervention for unhealthy alcohol use, do the screening and brief intervention need to happen in the same session/encounter?

**Clarification:** The measure Technical Specification does not indicate one way or the other. If you are screening someone for alcohol use, however, the time for a brief intervention is when they are screened. It should happen at the same encounter.

**Question 8.g:** For the measure of screening and intervention for unhealthy alcohol use, we have clinics that have not been using one of the three approved screening tools. Although it is recommended that these clinics re-screen everyone during the MY, is this necessary for individuals who have an active diagnosis of an alcohol use disorder? Or would these individuals fall under the “Exception” category in the numerator, given that they are already receiving treatment?

**Clarification:** Those with an active diagnosis of an alcohol use disorder would fall under the “Exception” (medical reasons for not screening).

**Question 8.h:** Regarding the measure of Unhealthy Alcohol Use: Screening and Brief Counseling (ASC), which staff is required to screen?

**Clarification:** The measure does not specify which staff should do the screening other than by inclusion of specific codes designating an eligible encounter. The BHC should follow any state or other requirements for licensure and training that would otherwise apply.

### **Screening for Clinical Depression and Follow-Up (CDF-BH):**

**Question 9.a:** With regard to the measure of Screening for Clinical Depression and Follow-up Plan, where is the list of standardized tools that are referred to?

**Clarification:** The Technical Specification for the measure includes a definition for standardized screening and lists a number of examples of standardized assessment tools used to screen for depression. The list is not exhaustive; there are other instruments that exist such as the PHQ-A that you can use. The measure, however, requires that the instrument be standardized.

**Question 9.b:** For the measure of screening for clinical depression and follow-up planning, the PHQ-9 is listed. Can the PHQ-A be used for children

**Clarification:** The PHQ-A is a standardized instrument designed for adolescents and was developed by those who developed the PHQ-9. It is always preferable to use an age-appropriate instrument, and the measure does not limit instruments that can satisfy the numerator to those examples listed in the definition of a standardized instrument; rather, it only requires that the screening tool be standardized.

**Question 9.c:** The measure of screening for clinical depression and follow-up planning excludes individuals with an active diagnosis of depression or bipolar disorder. What if you do not know when the diagnosis was made or what depression screening tool was used?

**Clarification:** The exclusion related to having an active diagnosis of depression or bipolar disorder means that the person has an existing diagnosis. In other words, that person presumably still satisfies the criteria for the diagnosis, and therefore you do not count him or her in either the numerator or the denominator because they are already diagnosed. It does not matter what tool was used to diagnose them in the past, and you do not need to screen them again for purposes of the measure. It is simply a way to eliminate those individuals, because you only want to count people who do not have a diagnosis to assure that they are screened.

**Question 9.d.:** For the measure of screening for clinical depression and follow-up planning, would it be viewed positively if all who scored positive on the scale were excluded because they had an active diagnosis of depression?

**Clarification:** During the webinars, we always try to explain how the rate achieved on the measure is related to quality. For this measure, a higher rate of screening and appropriate follow-up planning when needed is associated with higher quality, because the goal is to consistently screen recipients of services at the BHCs for depression and provide follow-up if the screen indicates it is needed. This measure is designed to improve identification of those in need and the provision of necessary services. The question seems to assume that the BHC can screen individuals and then, if they are found to have depression, exclude them from the denominator. That is not how the active diagnosis of depression comes into play and would defeat the purpose of the measure. Rather, because the purpose of the measure is to encourage the new identification of depression with resulting treatment, those who are already diagnosed with depression or bipolar disorder are excluded from the measure completely so you are only capturing those without an active diagnosis. You conduct screenings on those without an active diagnosis, and if depression is found, you provide follow-up planning. People counted in the numerator are the subset of those who are not excluded because of existing diagnosis or other exclusion criteria, who are screened and found not to have depression, or who are screened and found to have depression and then provided follow-up planning.

**Question 9.e:** Concerning “Screening for Clinical Depression and Follow-Up Plan (CDF-BH),” we are re-screening clients aged 12–17 years every 90 days. If the result of the first screening in the MY of a new adolescent client with no active diagnosis of depression at the time results in a PHQ score of 10 or higher and a new diagnosis of depression, are we to understand that since clients are only included in the measure based on their most recent encounter in the MY, clients screened for and diagnosed with depression earlier in the MY must be excluded from the measure data set?

**Clarification:** No. If adolescents are new clients and are screened on their first visit and found to have a PHQ-9 of 10, with a diagnosis of MDD being applied as a result of the standardized screening, they go into the denominator; given the screening score, they also go into the numerator if a follow-up plan is documented. As far as the measure goes, you have then satisfied the numerator for the MY. The following year, if they still have a depression diagnosis, you can exclude them from the denominator and numerator.

**Question 9.f:** Does the measure of screening for clinical depression and follow-up planning require us to screen every consumer that is either new or currently open, who does not have an active diagnosis of depression or bipolar disorder?

**Clarification:** If they are 12 or older and have an encounter that gets them into the eligible population, they become part of the denominator. Those people do need to be screened unless they have one of those active diagnoses or satisfy one of the other exclusions (refusal, urgent or emergent situation that precludes it, or their functional capacity or motivation to improve may influence the accuracy of results).

**Question 9.g:** Regarding the measure of screening for clinical depression and follow-up planning, in Webinar 5, the speaker indicated that the screening should be done at all visits. In some cases, individuals may be seen multiple times in a week (e.g., once for an injection, once to see a therapist, and once to see the doctor). Would we therefore have to screen for depression three times? Is it the intent that these screenings be conducted at that frequency?

**Clarification:** For CDF-BH, the numerator measures the “most recent” eligible service during the MY. The only way to assure screening occurs on the last visit during the MY is to perform a screening at every eligible visit. If the BHC is confident that the person will be seen again during the MY, it is possible to wait in the anticipation that the last visit during the MY will actually include a screen. BHCs may decide to use a tracking system to make sure consumers are screened. Of course, people who are already diagnosed with depression or bipolar disorder are excluded.

**Question 9.h:** Regarding Screening for Clinical Depression and Follow-up Plan (CDF-BH), in calculating this measure, BHCs will gather information on (a) whether a screening occurred, (b) whether the screen was positive, and (c) whether there was a follow-up plan if the screen was positive. By including only 1 numerator (was screened and, if positive, had follow-up plan), it will be difficult to tell if low rates are the result of patients not being screened or if the issue is with follow-up. Could this measure be modified to include the following breakout?

- Screening
  - Denominator: All eligible
  - Numerator: Encounters where screening occurred
- Follow-up
  - Denominator: Positive screenings
  - Numerator: Follow-up plan was made

**Clarification:** This information would be useful, and BHCs can elect to modify it in that way for their own use. We, however, cannot modify it from the existing structure that parallels the source measure and request that BHCs report it on the data reporting template as it is written. BHCs also have the option of reporting the suggested alternative approach in the Additional Notes section at the bottom of the data reporting template.

**Question 9.i:** For the measure of screening for clinical depression and follow-up planning, is sampling used? If so, is there a defined methodology?

**Clarification:** Sampling can be used. BHCs have a choice of using a sample or using the entire eligible population if codes were used that allow the BHC to capture measure components in their EHR. None of the BHC hybrid measures that rely on sampling or that have the option of sampling provide a definite methodology for the sampling. More information about this may be found in Webinar 6 on the SAMHSA 223 website at: <http://www.samhsa.gov/section-223/webinars>.

**Question 9.k:** For the BHC measures that have hybrid data sources such as CDF-BH, are the BHCs required to use sampling? If the BHCs have systems in place that are able to report on all consumers in the measure, can they simply report on all consumers or must they pick a subset?

**Clarification:** Sampling is not required. Reporting on all consumers is completely acceptable. Sampling would likely be harder for you if you already have this information.

**Question 9.l:** For the measure of screening for clinical depression and follow-up planning, how do you define an encounter? Is it any provider—therapist, MD, nurse practitioner, physician assistant?

**Clarification:** The codes that indicate whether there is an eligible encounter that will get the person into the denominator are provided in the source measure. These codes include ones for services that a psychiatrist, Master’s-level clinician, psychologist, PCPs, or others might utilize. You should review the source

measure link in Section A of the Technical Specification to ascertain precise codes and who, within the licensure and other requirements applicable, can provide the “eligible encounter.” Note that 42 CFR §440.50(a)(2)) allows those working under the supervision of a physician to perform services a physician would perform as long as it is within the licensure scope of services. For purposes of the CCBHC demonstration, if neither of these approaches work and other codes are available, the state should consider having a list of all such codes and they should be used uniformly across all CCBHCs.

**Question 9.m:** For the measure of screening for clinical depression and follow-up planning, if we incorporate codes going forward, can we use sampling from the baseline year since the codes are not currently being used?

**Clarification:** First, BHCs will use billing (encounter) data from the MY to develop the eligible population for the denominator. Second, BHCs also use data from the MY for the numerator, whether it is calculated via sample or by using the entire eligible population. If the BHC did not use the G codes prior to the MY but begins using them in the first MY, the BHC should have all the information it needs. If, however, the BHC does not have the G codes in place, it will need to do a more detailed record review. For BHCs seeking to establish a baseline against which to measure progress, one possibility would be to use the first 3–6 months of the first MY to establish a baseline for comparison.

### **Depression Remission at Twelve Months (DEP-REM-12):**

**Question 10.a:** For Depression Remission at Twelve Months (DEP-REM-12), would it count in the numerator as remission if the PHQ-9 score of less than five was achieved and measured after 5 months of treatment instead at 12 months, plus or minus 30 days?

**Clarification:** There are two versions of this measure. There is one that measures remission at 6 months and there is this one that measures remission at 12 months. The 12-month remission measure was selected for the BHC measures to ascertain long-term remission and follow-up. Therefore, the answer would be no; it has to be at 12 months, and it has to fall within that 30-day window on each side of 12 months.

**Question 10.b:** Regarding DEP-REM-12, if a client has finished treatment prior to 12 months and is no longer being seen by the clinic because they are in remission, this would currently not count as part of the numerator based on how the measure is set up even though the client is no longer in need of service. How do you recommend clinics to handle this issue? Should a follow-up appointment around 12 months be scheduled, even though the clients are finished with treatment? Should the clinics note the number of people who achieved remission prior to 12 months?

**Clarification:** The measure does require such an appointment. We know it may be difficult to get people in if they do not otherwise need service. We ask that BHCs try, however, and, if they do not succeed, to treat failure to do so as not satisfying the numerator. BHCs also are free to indicate in additional notes those clients who do not appear in the “12-month” window but who are known to have achieved remission prior to that point.

**Question 10.c:** Concerning Depression Remission at Twelve Months (DEP-REM-12), the measure indicates that the numerator should span across MY1 and MY2 and 1 month into MY3 and the denominator would encompass MY1 only. Is this measure not required to be reported annually? If not, when will we be required to report on this measure?

**Clarification:** For purposes of the CCBHC demonstration program, this measure is to be reported annually and, because it is a BHC-lead measure, it is reported by CCBHCs within 9 months of the end of the demonstration year (DY). Realistically, this means that CCBHCs will need to stop including people at a certain point. Please exclude from the denominator and numerator those for whom the 12 month ( $\pm$  30 days) has not lapsed when the data must be reported. Using an example of a DY lasting from January 1 to December 31, 2017, the data would have to be reported by September 30, 2018. The latest index date that could be counted in that DY would be August 31, 2017. This is obtained by counting back 13 months from the reporting date.

**Question 10.d:** Concerning the DEP-REM-12 metric, some of our clinics have not used the PHQ-9 in the past, so consumers currently being seen by the clinics for major depressive disorder/dysthymia do not have PHQ-9 scores. Do these clinics need to screen all of their current clients using the PHQ-9 at the first visit during the DY?

**Clarification:** The measure requires that BHC include in the denominator consumers who (1) were seen at the BHC during the MY; (2) had a diagnosis of major depressive disorder/dysthymia in the proper diagnostic position, depending on the provider seeing them; (3) were 18 or older, and (4) had a PHQ-9 score greater than 9 on the day they present. Careful examination of the metric indicates that the measure does not require a PHQ-9 screening; however, once a PHQ-9 screening results in a score greater than 9, the procedures in the numerator to assess remission at 12 months must be satisfied. The short answer is that BHCs do not need to screen these consumers again, but do need to start using the PHQ-9 going forward.

**Question 10.e:** Concerning “Depression Remission at Twelve Months (DEP-REM-12),” is the Index Date for the measure the date of the first PHQ screening that resulted in a diagnosis of depression in the MY?

**Clarification:** Yes, as long as the consumer was not already in an index period from the year before.

### **Adult Suicide Risk Assessment (SRA-A) and Child Suicide Risk Assessment (SRA-BH-C):**

**Question 11.a:** The Value Set Authority Center (VSAC) requires a license to obtain the value sets for the two measures “Adult major depressive disorder (MDD): Suicide Risk Assessment” and “Child and adolescent major depressive disorder (MDD): Suicide Risk Assessment.” Are there applicable value sets that can be downloaded without a license?

**Clarification:** The VSAC is part of NIH and the VSAC license is free. The link is in the measures and is: <https://uts.nlm.nih.gov/license.html>. The Technical Specifications also refer to the CMS website for more information at [https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/eCQM\\_Library.html](https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/eCQM_Library.html). On that page you will go to eCQM Specifications for Eligible Professionals Update July 2014. Within the zip folder are subfolders for each measure. The child measure is CMS177v3 and the adult measure is CMS161v3. All of this information is in the BHC Technical Specifications. In each of those folders you will find several documents with additional information about the Technical Specifications. This last information may be helpful as a supplement to the BHC Technical Specifications but generally what the user needs is to obtain the free VSAC license and the value sets from that VSAC site and to use those in conjunction with the BHC Technical Specifications.

**Question 11.b:** Can you give us more clarification on VSAC for suicide risk assessment for children and for adults? Are BHCs and the state required to use these value sets? Slide 43 in Webinar 5 indicates that the type and magnitude of SRA is at the discretion of the clinician.

**Clarification:** You are required to use the value set. That provides the diagnosis and encounter codes you need to calculate the measure (for example, with the child measure, it includes the codes for encounter “Office Visit Grouping Value Set” and “Major Depressive Disorder-Active Grouping Value Set”). The type and magnitude of the SRA relates to the type of suicide risk assessment you use. That is different and is a clinical decision.

**Question 11.c:** The suicide risk assessment measure Technical Specification for adolescents says it includes anyone who is aged 6 to 17 years at the beginning of the measurement year, and the adult suicide risk assessment says it includes anyone aged 18 years on the date of encounter. Could a client be counted in both measures?

**Clarification:** Actually, the adult measure looks at age at the beginning of the measurement year as well. The two measures are mutually exclusive.

**Question 11.d:** Do the two suicide risk assessment measures align with the 2016 PQRS quality measures?

**Clarification:** Aside from payer mix and minor formatting differences, the two SRA measures align with the 2014 PQRS quality measures (as indicated by the Technical Specification in Section A).

**Question 11.e:** Does the SRA-A capture the number of people, whereas the SRA-BH-C captures the number of visits?

**Clarification:** No, they are both encounter-based rather than people-based, and they both capture the number of visits.

**Question 11.f:** For the two suicide risk assessment measures, what if the child, adolescent, or adult has depression and a co-occurring substance use disorder? Is their primary diagnosis both mental health and substance use disorder?

**Clarification:** Neither the adult measure nor the child and adolescent measure require that the depression be a primary diagnosis. The primary diagnosis should be that which is the diagnosis of greatest concern.

**Question 11.g:** In the “Adult Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-A)” measure, how is “recurrent episode” defined?

**Clarification:** The adult measure refers to a “new or recurrent episode identified by the clinic during the measurement year.” It would seem to indicate a new diagnosis or, if someone had depression in the past but it remitted, a new resurfacing of depression in the MY.

**Question 11.h:** With regard to the measure of child suicide risk assessment, a risk assessment is required to be completed at each visit where there is a MDD diagnosis. Some clinicians are concerned that this is too much to ask of the clients and that if they keep asking youth these questions, they may eventually decide that this is expected of them. Is it really necessary to assess youth with MDD for suicide risk each time they are seen?

**Clarification:** For youth, the measure does expect that the SRA will be conducted at each visit where there is a MDD diagnosis. The type and magnitude of the assessment is left to the discretion of the clinician but it should be standardized and the Technical Specification notes that low burden tools can be used. There are no exclusions. Clinical judgment also should be exercised in determining what is best for the client.

**Question 11.i:** For SRA-BH-C, the Technical Specifications Manual states that “a minimum of two encounters are required...to establish that an eligible professional has an existing relationship with the consumer.” We are assuming this means that that the two encounters must be with the same clinician. Is this correct?

**Clarification:** No, the encounters do not need to be with the same clinician, just the same BHC.

**Question 11.j:** For the SRA BH-C measure, the Technical Specification says we need to use a standard assessment tool, but it does not define one to use. What do you recommend?

**Clarification:** The SRA-BH-C measure does not identify specific standard assessment tools, but it does include types of information or inquiries that might be included in one. BHCs should follow that definition. If the state wants to select a specific tool to use, that is up to the state and nothing precludes it.

**Question 11.k:** For children, sessions are often performed with the parents without the child present. What is the expectation in those cases if children are included in the eligible population of the measure?

**Clarification:** This is most likely to be an issue with SRA-BH-C. If this presents a problem in measurement for a particular measure such as SRA-BH-C, we suggest that the BHC indicate in the Additional Notes on the data reporting template that it does not and cannot conduct a SRA for a child when only parents are in the session and that the BHC is excluding those visits from the denominator and numerator.

**Adult BMI (BMI-SF):**

**Question 12.a:** Coming at the quality measures from a person-centered perspective, can the state design or define the population on whom we will collect measures? For example, collecting BMI from some individuals may have the unintended consequence of creating a barrier to getting the services that those people are seeking.

**Clarification:** There is no provision for selective application of the measures beyond the criteria for measurement in the Technical Specifications Manual. We understand that some behavioral health clients might not want to receive certain physical health services at the BHC and that trying to provide these services could hamper their acceptance of the behavioral health services they need. It also is possible that some of the hesitation may be on the part of providers who have not tried to collect this information. However, these screenings would be conducted by a nurse or medical assistant rather than by a therapist, which will allow for boundaries with regard to these services. There also are some measures that have exclusions or exceptions that excuse inclusion in the measures. Looking at the adult BMI measure in particular, at least two of the following documented exclusions might apply:

- Consumer is receiving palliative care
- Consumer is pregnant
- Consumer refuses BMI measurement (i.e., refuses height and/or weight)
- Any other reason documented in the medical record by the provider as to why a BMI measurement was not appropriate
- Consumer is in an urgent or emergent medical situation where time is of the essence, and to delay treatment would jeopardize the consumer's health status

**Question 12.b:** Can the measures be adapted by states? For instance, the BMI measure that was put out by SAMHSA states that a person with a BMI of 25 or greater requires a substantial amount of follow-up. However, in our state, that level of follow-up is required only if the person has a BMI of 30 or greater.

**Clarification:** Most of the measures were not created for the compilation of BHC quality measures; rather, most were adapted from current measures and cannot be changed. The requirements for the measure BMI should remain the same for each state.

**Question 12.c:** For the adult BMI measure, is the expectation for the BHC to generate the BMI or obtain it from other practitioners? If the latter, how?

**Clarification:** BMI can be generated at the BHC, which is the way that you can assure you actually get the information. Also, if you are working with a DCO as a CCBHC and the DCO is doing physical health screening, it should be able to provide you with those data. Part of the requirement for being a DCO is that they will provide you with the data that are needed to calculate these measures. If you have to obtain this information from a non-DCO provider (for example, a PCP that is not associated with the BHC or DCO), you will need a care coordination agreement with the pertinent PCP or whoever else may be doing the screening. Because obtaining this required agreement with a non-DCO provider is more difficult, your best options probably involve doing it yourself or having a DCO that will do it.

**Question 12.d:** For the adult BMI measure, if consumers choose to keep their own PCPs who are not within the BHC, will we need to contact those PCPs for the consumers' BMI information?

**Clarification:** Yes, although BHCs also have the option of conducting the BMI screening and follow-up planning internally.

**Question 12.e:** For the adult BMI measure, if the documentation is from another provider and not the BHC, does the patient record at the BHC have to include a copy of the screening? Is the BHC required to address follow-up plans or can this be done by the original screening provider?

**Clarification:** The original screening provider can develop and perform the follow-up plan. This measure is fairly open in terms of who can do what, but the BHC does need to have access to the data indicating that the follow-up happened. There has to be some mechanism for the BHC to obtain the data. Ideally, the mechanism would be an electronic data exchange. If not, it would need to be in the paper record.

**Question 12.f:** For the adult BMI measure, the Technical Specification states that self-reporting of height and weight is not permitted. What if it is obtained by the PCP?

**Clarification:** If a PCP has recorded height and weight, it is most likely going to be an actual measurement.

**Question 12.g:** For the adult BMI measure, can we build a clinical decision support rule in the EHR to satisfy the documentation requirement for the follow-up plan?

**Clarification:** This may depend on the EHR and the BHC's ability to adjust it. But yes, it would be optimal to build screenings or guidance into the EHR for decision support if that is possible.

**Question 12.h:** For the adult BMI measure, is it sufficient to pull data documenting the follow-up plan by simply clicking on a box in the EHR stating that follow-up was initiated or the other items billeted on page 45 of the Technical Specifications in the Follow-Up box? Or will a chart audit or review of documentation be required to demonstrate the measure?

**Clarification:** Success on the measure requires documented BMI screening and, if the BMI is outside normal limits, a documented follow-up plan. It seems the question is asking about documentation of the follow-up plan in particular. This measure uses medical records, and BHCs can rely on paper (chart review) or EHR to document this. If the BHC can format the EHR so that the clinician doing the screening and arranging a follow-up plan can indicate that in the EHR, that would no doubt be easiest. Use of the G codes in that way would be most desirable.

**Question 12.i:** For the adult BMI measure, if a consumer has multiple services during the MY, are we only collecting data from the most recent or earliest service during the MY?

**Clarification:** BHCs are not required to measure BMI every time there is a service. The consumers could have multiple services that have absolutely nothing to do with BMI, or they could have just one BMI screening during the year. If by chance they had their BMI measured multiple times, the BHC should only count the last occurrence.

**Question 12.j:** For the adult BMI measure, if a consumer's BMI was taken and a plan to address the issue was documented, do we have to have another plan if that consumer is seen again within a week or so, even though we already have one documented and it is being implemented?

**Clarification:** No, you do not. The measure is designed to ensure the BMI screening is done at least once a year.

**Question 12.k:** For the adult BMI measure, the measure relates to a BMI during the encounter or within 6 months prior. This appears to be encounter-based rather than a member-based measure. If a member has multiple encounters during the MY, are all encounters evaluated?

**Clarification:** Only one BMI screening is counted, and that is the most recent. This is a consumer-based rather than an encounter-based measure. The denominator includes consumers of the pertinent age who were seen at the BHC at least once in the MY and who have at least one of the eligible encounters. This measure, which looks at data for the MY only to identify the eligible population, is designed to capture those seen during the MY. The numerator looks at the subset of the eligible population who have a documented BMI and, if needed, a follow-up plan. The data used to see if the BMI and follow-up were documented reflect encounters during the MY, but the BHC can look back 6 months from the encounter to see if BMI was documented earlier. (This may involve looking at data in the prior year if the consumer's encounter is early in the MY.) This gives the reporter a 6-month grace period in which to have performed the screening.

**Question 12.l:** For the measure of adult BMI (BMI-SF), if there were a series of eligible encounters with normal BMI, then there was a BMI that was abnormal but no follow-up plan was documented until the next eligible encounter, would that consumer be counted in the numerator?

**Clarification:** No, the follow-up plan must be documented during the same encounter as the BMI screening or have been documented at some point in the previous six months.

**Question 12.m:** For the adult BMI measure, our state does not have a billable code for medical assistants to take BMI vitals in behavioral health settings. Would medical assistants be allowed to take vital signs for BMIs?

**Clarification:** There is nothing in this measure that specifies what kind of provider it has to be beyond the required use of encounter codes to establish the eligible population visits for the denominator. CCBHCs must follow the state's licensing, credentialing, and scope of practice regulations.

#### **Child and Adolescent BMI (WCC-BH):**

**Question 13.a:** For Weight Assessment for Children/Adolescents: Body Mass Index Assessment for Children/Adolescents (WCC-BH),” if BMI percentile is present, why are height and weight required?

**Clarification:** These are requirements from the source measure, most likely to ensure that whoever calculated the percentile actually captured the height and weight and did the calculation accurately.

**Question 13.b:** For WCC-BH, is it correct that we do not have to show evidence of Counseling for Nutrition Code or Counseling for Physical Activity Code during the measurement period, just that a BMI was conducted?

**Clarification:** That is correct.

**Question 13.c:** The only options for WCC-BH are administrative or hybrid, which includes administrative. Does this mean that, if we do not have access to the administrative data, we cannot use our EHR for these data.

**Clarification:** You can use your EHR for these data, as indicated in Section A of the Technical Specification.

**Question 13.d:** If sampling is used for WCC-BH, what size sample is considered reflective of the whole population? Is it 5 percent, 10 percent, or some other percentage?

**Clarification:** Sampling for hybrid measures was addressed in Webinar 6, including how to determine whether you have a sufficient sample to be considered representative. Please see webinar 6 on the SAMHSA 223 website at: <http://www.samhsa.gov/section-223/webinars>.

**Question 13.e:** Are BHCs required to use sampling for WCC-BH? If the BHCs have systems in place that are able to report on all consumers in the measure, can they simply report on all consumers or must they pick a subset?

**Clarification:** Sampling is not required. Reporting on all consumers is completely acceptable. Sampling would likely be harder for you if you already have this information.

**Question 13.f:** Does the “Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)” measure have to be completed by a PCP or an OB/GYN?

**Clarification:** To be compatible with the source measure, the BHC measure states that the assessment should be completed by a PCP or OB/GYN. We realize this will make it difficult in many cases to obtain data and assure that the BMI screening occurs. For this reason and in the context of the CCBHC demonstration, the BMI screening may be conducted by medical personnel at either the CCBHC or a DCO without regard to whether they are a PCP or OB/GYN for the consumer, as long as they are operating within the scope of practice for their licensure. Because this is a deviation from the measure Technical Specification, however, it should be so indicated in the section of the data reporting template where adherence or non-adherence to the Technical Specification is reported.

**Question 13.g:** For WCC-BH, the OB/GYN and PCP requirement has been relaxed for this measure for purposes of the CCBHC demonstration. Is the list of codes for the outpatient value set still going to be the same? If so, could this potentially be limiting to clinics that did not use a PCP or OB/GYN?

**Clarification:** This is a BHC-reported measure. The BHCs will be able to have any “medical personnel” (within the licensure or certification requirements of the state) undertake the BMI screening to satisfy the measure. This might include nurses, medical assistants, and others. If a BHC or state does not believe that the codes will allow this for all such staff at the BHCs, include the codes that are pertinent for eligible services with those other personnel and indicate this in the data reporting template as a deviation from the Technical Specifications. In circumstances such as this, the state should develop a list of such codes that is transparent and consistent across providers, especially across CCBHCs. Please note that federal regulations allow those (properly licensed) working under the supervision of a physician to use billing codes designed for physicians.

**Question 13.h:** Concerning WCC-BH, if the CCBHC demonstration does not include primary care services, why are CCBHCs required to report on the BMI percentile for children served by a PCP?

**Clarification:** One focus of the CCBHC initiative is to foster better integration of physical and behavioral health care, and part of the scope of services to be provided by CCBHCs is physical health screening and monitoring. The screenings such as BMI that are part of the quality measures are designed to promote this scope of services. If there is a PCP and you know that the screening already has been conducted and documented, then you can obtain and use that information.

#### **Questions Applicable to Multiple Specific Measures:**

**Question 14.a:** For the alcohol and the tobacco screening measures, what if there was screening for alcohol or tobacco within the previous year, but it was done using a different screening tool than the ones specified in the measure?

**Clarification:** The tobacco screening measure does not specify a particular screening tool. The alcohol screening measure gives you three options for screening tools that will satisfy the numerator. That does not mean that the screening tool that was used was necessarily inappropriate. But to count in the numerator, the tool should be one of those listed in the measurement. Numerous consumers might benefit from being screened again using the appropriate screen, as defined in the measure.

**Question 14.b:** Referring to the measure of screening and intervention for either unhealthy alcohol use or for tobacco use, one questioner mentioned that Volume 1 of the Technical Specifications Manual calls this "counseling intervention" whereas Volume 2 calls this "cessation intervention" and asked where terms are defined?

**Clarification:** There are two different measures: (1) Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention (TSC), and (2) Preventive Care & Screening: Unhealthy Alcohol Use: Screening & Brief Counseling (ASC). That is how they are titled in Volume 1, where the Technical Specifications are provided, and in Volume 2, which includes appendices for TSC and ASC. Both measures have definitions in Volume 1—TSC on page 67 and ASC on page 70.

**Question 14.c:** BMI screening and tobacco cessation screening and intervention are often done as part of a regular office visit with the PCP or mental health professional. Is the requirement that the code actually be reported, or is another method of documentation (e.g., a checkbox, clinical notes) permissible?

**Clarification:** The data reporting templates give you the option of indicating that you are using administrative or medical records, with the latter being electronic or paper. Yet the Technical Specifications for the tobacco screening and adult BMI screening measures specifically state that failure to use the quality data codes means that the person is excluded from the denominator and the numerator (i.e., that he or she is not counted). This is derived from the source measure and could not be changed. The preference, however, is that codes are used and the process is automated. Failing that, you could use some other form of documentation if you can ensure that the alternative is automated in the EHR and can be captured to allow you to automate the process. You should work toward use of the codes and, in the meantime, be sure to document the change as a deviation from the measure in the data reporting template.

**Question 14.d:** For the adult BMI measure as well as the alcohol and tobacco screening measures, does the screening have to occur at the BHC?

**Clarification:** The adult BMI screening can be performed by any provider as long as the provider who is seen in the encounter that helps establish the eligible population is a suitable one pursuant to state licensing requirements. For the alcohol and tobacco measures, the objective would be to have it be done at the BHC. It should be a routine part of screening and care at a BHC. Again, for both of those screenings, the quality measure allows the BHC to look back a year before the MY to see if the screening happened. If the BHC does not have that information, it will be beneficial to undertake the screening during the MY.

**Question 14.e:** Our clinics have expressed concerns that the SRA-BH-C and CDF-BH metrics would require screening for major depression disorder, dysthymia, and/or suicidality during group treatment sessions or family therapy sessions where this type of screening may be inappropriate because of the nature of these sessions. However, not screening during group or family therapy sessions would influence the numerator for both metrics. Is there a "work around" for this, or should clinics simply make a note that they do not do these screenings at group or family therapy sessions?

**Clarification:** Although it may be true that you typically will not want to undertake a suicide assessment in group sessions, there may be occasions in group or family therapy where it becomes clear that a suicide assessment or a depression screening is indicated and may be clinically appropriate during or after the

session. Given that, please calculate the measures as specified, but do note it in the data reporting template that you do not typically do these screenings in group or family therapy.