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Data Reporting and Quality Measurement -- An Introduction

Peggy O'Brien: Welcome to the behavioral health clinic data collection and quality reporting webinar series presented by the Substance Abuse and Mental Health Services Administration. This is the first of the eight webinars, and today's topic is Data Reporting and Quality Measurement -- An Introduction.

I am Peggy O'Brien, a senior research leader at Truven Health Analytics, presenting on behalf of SAMHSA. In general, I will be the speaker on the webinars, although representatives at SAMHSA and sometimes CMS or ASPE may also be present. As we move into the special issues webinars, we may also have guest speakers. Today, we have representatives of SAMHSA and ASPE available.

The focus today will be on introducing you to the webinars as a series. Talking about data and quality measure reporting generally, including the context of this reporting, the level of reporting, attribution of consumers, who is responsible for reporting and to whom, and when and how reporting occurs. We also will cover the measure specification or spec components or structure and the data reporting template components or structure.

As a starter, I should introduce some of the webinar logistics. There is a chat function where you can ask questions and we encourage you to do so. I will pause for questions at several points in the webinar to respond to any questions that you have about parts of what I have covered that may be confusing or about related matters that I have not addressed. Most webinars will have at least one poll question which listeners will have time to answer and which we can discuss. This webinar does not have a poll question. A PDF of the slides for each webinar will be posted as a resource on the webinar site for registrants and the webinars themselves will be downloadable for a year after the event on the webinar site as well as being available on the SAMHSA website.

This is the webinar schedule with the intended audience identified in red. All around Tuesday from 2:00 to 3:30 Eastern Time. These webinars will be available to you as a resource and this slide and others are provided so you can refer to them later as you wish.

The next two webinars relate to the state reported required measures for CCBHCs and are generally intended for states to help with their reporting of those measures. Although BHCs, CCBHCs are welcome to attend. The four webinars after that are addressed to both BHCs and states while the last webinar is probably primarily of interest to states although BHCs certainly can also attend. And I will provide you with more information about each of these webinars later.

The objectives of this series are to provide tools for dissemination to all states and behavioral health clinics that are using the measures. All webinars will be posted so states and BHCs can share content if needed. Because all states are different and are at different stages in implementation, the goal is to ensure that all states have the necessary information to develop their processes for collecting, analysing and reporting the quality measures.

The subject matter covered by the webinars includes background on data collection and reporting requirements, quality measure specifications, data reporting templates used for quality measure reporting, special issues related to quality measure reporting, lessons learned from state visits and I will try to answer questions and clear up confusion. I will begin by discussing quality measure reporting generally in the context of the BH --

The source of the measures that we're going to be discussing in this series is Appendix A of the CCBHC Certification Criteria, which included 32 measures, 17 of which were originally BHC-lead and 15 of which were originally state-lead. As drafted however, the BHC measures now include 14 BHC-lead and 18 state-lead because some of the ones that were originally designed to be led by the BHC have been shifted from the BHC to the States. From those, the measures that are now required of CCBHCs as part of the demonstration program include 21 measures, nine of these are CCBHC-lead, 12 of them are state-lead. The required number was reduced after the criteria were published.

The measures that are no longer required as part of the demonstration program are included, however, because states may wish to use some of them for the CCBHCs or states may wish to use some of them for other purposes. That is why I generally will refer to BHCs in these webinars and to CCBHCs when that is specifically relevant.

The changes that occurred included shifting three measures from BHCs to the states. That includes the two patient experience of care survey measures and initiation and engagement of alcohol and other drug treatment or IET. One measure was dropped as inconsistent with current treatment guidelines, that's the cardiovascular health screening measure. And one measure was replaced with two measures that essentially split the original into two although there were a few other changes that happened in the process and that is the follow-up after hospitalization measure.

This is the list of measures that were originally required of the CCBHCs but that no longer are required, they are however included in the BHC measures for those who may wish to use them and they are discussed in webinar 8, the last webinar in the series.

This slide and the two slides that follow are lists of the BHC measures identified by abbreviation, state versus BHC-lead, whether they are required as part of the demonstration program and on which webinar they are addressed. This is provided as a reference for your use. These slides are included for you to refer to back to so you can easily find the webinar that addresses a particular measure of interest. The ones you see

here are all state-lead and CCBHC-required. These are all BHC-lead and CCBHC-required. And these are all non-required for purposes of the demonstration program.

The BHC data collection and quality reporting requirements fit into an existing landscape with which the states are already very familiar. Examples include existing quality measures such as the HEDIS measures reported by states, or managed care organizations. Data reporting that may be required by state or federal agencies such as the TEDS or URS or NOMs data, and now the CCBHC data and quality measure reporting.

This idea of collecting data is certainly not new to the states, however, the data specifically being collected here may differ from what you are currently doing. We also acknowledge that for many providers, this may be a new undertaking. We want to try and de-mystify it for you.

Why is quality measurement important? There are several reasons. Internal quality improvement processes can help providers and others see the degree of progress they have achieved or help to determine whether new or additional improvement is needed. Incentive programs such as the quality bonus payments that are part of the CCBHC prospective payment system or PPS, rely on quality measures. Evaluation of the CCBHC demonstration program can be informed by the quality measures. And the evaluation will in turn inform the annual reports to Congress on whether the demonstration program should be continued, expanded, modified or terminated.

In sum, the quality measures provide a mechanism of accountability to the state, to SAMHSA and CMS and ultimately to Congress and the public. Most importantly however, they provide the states and clinics, with what we hope is actionable information.

There are a lot of stakeholders involved in the CCBHC demonstration and lots of different responsibilities. This includes the BHCs that hope to become CCBHCs, the states and the three agencies, SAMHSA, CMS and ASPE, that are involved. And very briefly I wanted to acknowledge some of the things that people are doing.

States are working with prospective CCBHCs during the planning grant period to apply for the demonstration program. Part of the preparation is setting up systems to collect data on each required measure, as well as anything else that may be required to satisfy the criteria and develop the PPS. Clinics are no doubt wondering how they're going to collect data and report it, while also meeting the expectations for service delivery that are required of a CCBHC. Clinics may be developing reporting systems in anticipation of the demonstration program. SAMHSA's technical assistance, including these webinars, is designed to help states and clinics to be able to collect the data for each measure.

With that out of the way, I want to move on to some of the basics that everyone should understand so we are all on the same page. The first is the level of reporting. This is

always the behavioral health clinic. No matter who is doing the reporting, the measures are calculated at the behavioral health clinic level.

In general, quality measures can be reported at the provider level, the BHC or CCBHC level or at the health plan or state level. For the measures we are discussing no matter who's reporting it, the BHC or the state, the measures are all collected, aggregated and reported at the BHC level. This level of reporting will be a different experience for many states as many state or health plan-reported measures are at a higher level of aggregation rather than at the clinic level.

Attribution as a BHC consumer for data reporting requires identification or flagging of data to specific BHCs. This means linking the person to the BHC. For safety BHCs, these generally means at least one service that falls within the CCBHC's scope of services during the demonstration year, whether it's provided within the four walls of the clinic or not. Unlike most reporting, there is no minimum population size for reporting under this demonstration program.

If the population for a particular rate is less than 30, however, that information will not be publicly reported or used for the evaluation because of concerns about confidentiality and statistical integrity.

In the broadest sense, the eligible population for these measures includes all BHC consumers served by a BHC provider. This will vary by measure, though. For CCBHCs, the measurement year is the demonstration year. CCBHC-lead measures are to be submitted within nine months after the end of the demonstration year and state-lead measures within 12 months. For non-CCBHCs using these measures, the measurement year will be whatever the state requiring the reporting says it should be. Most often this will be a fiscal year or a calendar year.

This slide shows the flow of reporting for the demonstration program. The CCBHC-reported data and measures are collected by the CCBHCs and reported to the state agency, whatever state agency has been elected to collect the data in your state. The state-reported data and measures, including those that have come from the CCBHCs to the state, are then sent on to SAMHSA using a SAMHSA CCBHC measure submission mailbox. The address is both here on the slide and in the front matter to the specs.

SAMHSA then sends the data on, as appropriate, to CMS and ASPE for the purposes of the quality bonus payments or evaluation.

So how do you know what to report and how to report it? You know what to report by relying on the major specifications. You know how to report it by using the data reporting templates and the instructions for those templates.

The specifications are contained in two volumes. Volume 1 has introductory material and measure specifications. Volume 2 has appendices, and then there are the data

reporting templates. A lot of what I'm covering today is found in the introductory material to Volume 1.

So I'm going to pause now and see if there are questions on what we have covered so far, and there will be additional opportunities for questions later in the webinar

Ame, do we have any questions?

Ame: Alright, Peggy. We have three questions. One of the questions is from Wallowa Valley Center. The question is, is there a measure key?

Peggy O'Brien: Is there a measure key? I'm not exactly sure what you mean by a measure key. But there are the measure specifications which I'm going to be going through in excruciating detail over the next seven weeks.

So if you have additional questions beyond what the specifications are when you talk about a key, please let me know. But I will be going through the specs in great detail.

Ame: The next question is from [Ariel Coffman] and he's referring to slide 15 through 17, how do we decipher the abbreviations that are representing the required, non-required quality measures?

Peggy O'Brien: Okay. Let me go back here. Okay. The abbreviations are the abbreviations that you will find in the specs. And your state should have a copy of the specs and they should be able to make that available to you. Each of the measures has a title and it has an abbreviation just for ease of reference. And by looking in the specifications, actually in the table of contents, you'll be able to determine both the measure title and the measure abbreviation. I can give you an example from this slide that I have open here, which is slide 15. The fourth one down, IETBH is initiation and engagement of alcohol and other drug use or treatment, behavioral health. So each of these abbreviations applied to one of the measures and you can find that information and the specifications.

Ame: The next question is from NorthKey Community and it is, how will the reporting through to SAMHSA affect PQRS?

Peggy O'Brien: That is a good question. It's separate from PQRS. If you have PQRS reporting requirements and responsibilities, that is something that you will need to continue to provide. This reporting is separate and goes to SAMHSA for purposes of the demonstration program.

Ame: The next question is by Wallowa Valley Center and it is, where do you obtain Volumes 1 and 2?

Peggy O'Brien: Volumes 1 and 2 are available on the SAMHSA website, and they are available from your state. If your state is a member, is part of the planning grant, then

they have copies of the specifications, both volumes. They also have copies of the data reporting templates which I will be talking about. But you also can go to the SAMHSA website and I will get you the address of the SAMHSA website after this webinar in order to obtain the specifications.

Ame: The next question is by the Alaska Department of Health, and is, can you restate on reporting of measures with populations less than 30?

Peggy O'Brien: Yes. Typically when measures are reported, there is some minimum size to the eligible population. If you have a very small eligible population, there is a risk that if you report rates, the persons who are in the numerator of the measure, will be identifiable, which you don't want. You also need a certain critical mass for it to be statistically meaningful. And often, 30 is a number that is used for the denominator.

For purposes of this demonstration, in order to gather as much data as possible, we are asking that the states report regardless of size. However, if the eligible population or the denominator for the measure is less than 30, the rates will not be made public at all and it will be not used for purposes of the evaluation.

Ame: The next question is by [Jacob Blessy] and it's, is a BHC equal to a DCO?

Peggy O'Brien: Well I suppose it could be. But what I am referring to when I say BHC is, I'm referring to a behavioral health clinic generally. And the measures were designed to be used by any behavioral health clinic, whether they're part of the CCBHC program or not. Obviously, they stemmed from the CCBHC program but they can be used by other clinics or behavioral health centers. So while a BHC that's not a CCBHC might be DCO, that is not what they are generally intended to refer to. They are intended to refer to any behavioral health clinic, whether they're part of the demonstration program or not because SAMHSA would like them to be as widely used as possible.

Ame: The next question is by the State of Colorado. It was stated that annual cost reports are required. If a state elects to trend the year one PPS one rates by the MEI for year two rather than rebasing, a state would still be required to collect and submit a second round of cost reporting. Is that accurate?

Peggy O'Brien: This particular webinar, in fact these webinars are not about the cost report. So I think I need clarification as to whether the question is actually about the cost report or if it is about quality measure report because they are two different things.

Ame: The next question is by [Aaron Reiner]. Are the reporting requirements only for Medicaid patients or all clinic patients?

Peggy O'Brien: That is going to vary by whether it is a state-reported measure or a clinic-reported measure. And I will get into that in a little bit in the discussion as we go forward. I have some slides on that.

Ame, is that all of the questions for right now?

Ame: We have one more question New Mexico CCBHC and they need some clarification on the difference between a BHC and a CCBHC.

Peggy O'Brien: Okay. I'm sure you all know what a CCBHC is. CCBHC is one of the behavioral health centers that's going to be participating in the demonstration program. CCBHCs are -- until they become CCBHCs, and are certified as such, and participate in the program, they are, what I'm calling, BHCs. They are behavioral health centers. They just are not certified. And the measures are created so that even behavioral health centers that are not part of the CCBHC demonstration program can use them.

Ame: And the last question from Tropical Texas Behavioral Center is, in case we need clarification on anything in the slides, whom do we contact and how?

Peggy O'Brien: There will be a mailbox on the very last slide and you will be able to address questions to that.

And having said that, I am going to move on to the next part of the presentation so that we can cover everything and I will stop for questions several times more during this webinar. So I'm going to go ahead.

So I'm going to start to provide information about the general structure of the specifications. Although a few of the specs were developed for SAMHSA and grew out of the CCBHC criteria, most of them were based on existing specifications. Those source specifications were written and developed by a variety of organizations and the BHC specs are designed to the extent possible to make them as consistent as possible in terms of organization and structure given the constraints of the existing measures.

The first section of each spec is the description, and this is section A. The description includes a narrative description of the measure. This is a plain language simplified statement of the population being measured, which is also known as the denominator, and the segment of the population that meets whatever standard is being measured, which is the numerator.

Part A also includes the data collection method, which I will talk about in a minute, in more detail. Part A also includes guidance for reporting, this varies, and I will go through measures in detail in later webinars. But it often includes information about stratification by payer or age, that is particular to the measure, information about multiple rates in a measure, if that is applicable, information on potential sources of data, information on value sets if the measure relies on administrative data, a reminder to refer to the data reporting template and miscellaneous other information.

Finally, in part A, there is an explanation of the measurement period which provides information on the time periods for data used to compute the denominator and

numerator respectively, information that also is available in a table in Appendix A in Volume 2 of the specs.

The three types of data that are generally relied on are administrative, medical records and hybrid data sources. Administrative data are transaction data; claims or encounters. Medical records are behavioral health clinic medical records or other clinic transaction data sources such as electronic health records, paper medical records, clinic registries or scheduling software. In some cases, we have stretched this a bit to include billing records.

Hybrid measure is the third kind, use both administrative data and medical records for the numerator. The denominator uses a sample of the major eligible population. This is designed to make the calculation based on medical records less burdensome.

Samples should be representative of the eligible population including, by age. And information about sampling can be found Appendix C to the specs in Volume 2. The sample size generally should be 411 unless the BHC has less than 411 eligible consumers.

This is a topic that will be discussed in greater detail in one of the special issues webinars as well as it may relate to specific measures when we cover those measures. And there are only three hybrid measures; one of which is not required.

Within the guidance for reporting in Part A, stratification is covered. There are two types of stratification in these measures. The age requirements for the measures vary greatly but only a minority of the measures require age stratification. The specifications will tell you what ages it's stratified by.

They are almost all stratified by payer, and the payer categories that have been used are Medicaid, dually eligible, which is Medicare and Medicaid beneficiaries, people who have both, and then all others.

Behavioural health clinics should report data on all the populations that they serve and stratify the data according to whether clinic users are Medicaid beneficiaries, dually eligible under Medicare and Medicaid, or others, who are enrolled in neither program.

There's a lot more detail on this in the introduction to the specs, but there is a distinction that should be made related to CHIP beneficiaries, and that is covered in the introduction but I'll just say briefly that Medicaid beneficiaries include Title 19-eligible CHIP beneficiaries. And those that are Title 21-eligible CHIP beneficiaries fall into the other category.

Dates are required to report data stratified for Medicaid beneficiaries, including Title 19 CHIP beneficiaries and to the extent possible, clinic users who are dually eligible for

Medicare and Medicaid. We know that states are not able to report on the other category and some states may not be able to report on dually eligible.

The requirement to report data stratified by insurance payer, does not apply to reporting of data on housing status or the two patient experience of care measures. Part A of the specs also includes information about code sources for administrative data that is used for a lot of the state measures in particular, codes, billing codes and counter codes, are either included in the specification, they're including in the appendix or they're included by reference in the specs and there is a hyperlink to where they can be accessed.

In some cases, administrative measures will use value sets, and those value sets also are identified in the relevant specification, and there is a hyperlink to their source.

As I mentioned, stratification by payer is the norm. How to determine payer is important. And the material on this slide comes from the front matter to the specs in Volume 1. In general, however, you first must apply continuous enrollment requirements if they exist, which is generally only for administrative claims-based measures which tend to the state reported measures.

If a person does not meet continuous enrollment requirement as a Medicaid or dually eligible enrollee, they are considered, an other for stratification purposes. And I will go into greater detail about what continuous enrollment requirements are in a little bit.

If a measure specification does not include requirements for continuous enrollment, the insurance status at the time of the first visit during the measurement year, will be applied for the entire year.

This slide draws a distinction between measurement years and measurement periods. They are two different things. The measurement year is the period of interest. For the CCBHC, that is the demonstration year. You have demonstration year one and demonstration year two.

For other entities that may be using the measures, it could be a fiscal or calendar year. The measurement period is the time covered by the data used to calculate the measures. It may or may not be the same as the measurement year. Sometimes, there will be a look back or a look forward in the data or it may be a partial year. It also may be different for the numerator and the denominator. This information is included in the specifications as well as in Appendix A in volume two, and there is table of measurement periods in the templates which I will discuss later. The idea of measurement periods for some of these measures, is very complex, and we have done what we can to make it a little easier.

Moving on to specifications, part B contains definition for key terms that are used in the measure. So if there is a term that is used in a measure spec, go to the definitions, and find the definition that is applicable.

Part C of the specifications defines the eligible population. The eligible population is the basis for the denominator. Although there can be exclusions. This section usually includes; age, insurance requirements, which I'll talk about, and the event diagnosis that identifies the eligible population.

For insurance purposes, for claims-based data, there often is a requirement of continuous enrollment. This refers to the timeframe during which a consumer must be enrolled with Medicaid benefits, or dually eligible, to be included in the eligible population. The technical specifications for each measure provide the continuous enrollment requirement for each measure if there is one. Often, this will just be the measurement year.

There may be a provision for an allowable gap in enrollment. This specifies an allowable gap that can occur during continuous enrollment. This is often no more than 45 contiguous days. Some measures don't have allowable gaps and then there is an anchor date. If a measure requires a Medicaid beneficiary or dually eligible beneficiary to be enrolled in Medicaid or as a dual, the beneficiary must have the benefit on the anchor date. The allowable gap cannot include the date of the anchor date so if the anchor date is the last day of the measurement year for example, the gap cannot include the last day of the measurement year.

The last part of part C, the event diagnosis explains step by step, what is required to determine the eligible population or denominator.

Part D of the specifications is the actual specification itself. The denominator, most commonly refers to section C where the eligible population is defined, and then exclusions are applied. The numerator is also defined in part D along with any relevant exclusions. Again, the denominator is the eligible population and the numerator is the part of the population that satisfies the criteria that are being measured. The numerator is always a subset of the denominator.

Finally, part E of the specs contains additional notes which is potentially useful information such as information about the source measure or information on how to interpret the performance measure rate.

Many state-reported measures use value sets to identify billing or diagnostic codes for calculation. Value set information comes from different sources, depending on the measure. The location of the value sets are referenced in the specs and Appendix B contains a value set directory user manual to guide their use.

Sources of value sets may include the HEDIS 2016 or 2017 value sets. The US National Library of Medicine Value Set Authority Center, or for one measure, Minnesota Community Measurement. Each spec that relies on value sets tells you exactly where to find them. If a measure does not have value sets, codes are provided either in the spec, in the appendix or by reference to the source measure. Links are included in the measures to codes and source measures, or to value sets.

The specs also include introductory material, a lot of which I have been talking about, as well as other important matters. Volume 2 includes an appendix of measurement periods, a value set directory user manual, guidance for selecting sample sizes, definitions of practitioner types for one or two of the measures, and measure-specific appendices. The appendices include examples that were designed to help explain the measures that are reported by the BHCs and in a few cases, code tables.

I'm willing to pause again and see if there are any questions on what we've covered so far. And there will be further opportunities for questions a little bit later in the webinar as well. Ame, are there questions?

Ame: Yes. The first question is from Medi Columbia Center. Would Medicaid QMB beneficiaries be defined as Medicaid/Medicare dual eligible? QMBs equals Medicaid pays for their Medicare premiums, but does not cover service that's not covered by Medicare.

Peggy O'Brien: I think you have to look at it for purposes of stratification versus for purposes of payment.

And the way the specifications are written, there are the Medicaid beneficiaries, those who are just Medicaid, there are those that are both Medicare and Medicaid which are the duals, and then there's everybody else. And that is the simple stratification that's called for on the specifications.

For purposes of payment under the PPS, it's something that CMS is better equipped to answer, probably than I am, in terms of how the duals fit into the picture.

And that is a question that I am going to defer to CMS. However, we will make sure that that message, or that question is conveyed.

And if that doesn't address what you're getting at, please don't hesitate to ask again.

Ame: The next question is by Margaret Morris. When you say samples should be representative, does that mean they should be stratified by age/gender, for example? Or should they be randomized?

Peggy O'Brien: They should be randomized and stratified. And the one demographic that is specifically mentioned, is age. And I think that that's in part because a lot of the measures are stratified by age, and so if the measure that is a hybrid measure where

you're using a sample, is stratified by age, then you want to make sure it's representative of the age groups that are stratified.

I am going to go into a lot more detail on the sampling in -- it's either webinar 6 or 7 -- they are the special issues webinars that are not about specific measures, and can talk a little bit more about that.

I also would refer you to the front matter of the specs because there is some information in there about the sampling and the hybrid measures.

And I believe that there is also a link to a CMS technical assistance document that can also provide you with guidance, but there will be more discussion of this in either webinar 6 or 7.

Ame: The next question is from Community Counseling, Terry Bruiser, please redefined the anchor date.

Peggy O'Brien: Okay. The anchor date, this only applies if it's administrative data. So you will have a continuous enrollment requirement that says somebody has to be enrolled, say for the entire measurement year.

And there's an allowable gap of 45 days. You can have up to 45 days during that measurement year, when they are not covered by Medicaid.

The anchor date is a specific date during the year, when they have to have coverage. The gap and the anchor date cannot coincide. So if the last day of the measurement year, and this is just an example, is the anchor date, and it says, the anchor date is the last day of the measurement year, then the gap cannot cover that period of time, it cannot cover that last day of the year.

And this is because of how measures are calculated. Some of them require that somebody have service on a particular date, or have coverage on a particular date in order to be calculated.

So that is what the anchor is, it's a date that the gap can't include.

Ame: The next question is from LifeWorks NW, if an agency has four BHC/CCBHC sites, is the denominator combined, or is each site considered their own entity/BHC?

Peggy O'Brien: Okay. So I going to talk about CCBHCs here. If you have a CCBHC that is a community behavioral health center, and it has multiple sites that are part of the CCBHC, the measurement is for the entire CCBHC. So the denominator would include all four sites, it's not separated by clinic or by setting, it's the whole CCBHC.

Ame: The next question is from Daymark Recovery Service, how are private BHCs to obtain claims when claims are filed separately from the BHC such as to meet the reporting measures that would include pharmacy claims?

Peggy O'Brien: Okay. I think this is a question that is in part going to be state-specific in terms of how data are accessible.

I may be mistaken in this, and we'll find out as we go through each of the measures in detail, but in general, the pharmacy claims data is attached to or part of measures that are state-reported.

And I'm hoping that that's true across the board, but I can't swear to it without looking through all the measures right now. But I believe that pharmacy data is generally something that is required for state-reported measures. If not, when I get to specific measures, I'll address it there.

Ame: The next question is from Community Counseling. If the payer changes, their original payer should continue to be used, correct?

Peggy O'Brien: If it's an administrative claims data measure which is usually the state measures, you follow the instructions for the continuous enrollment. So if somebody is kicked out of being called a Medicaid enrollee because of continuous enrollment requirements, they become, an other, so they get counted as an other.

If there are not continuous enrollment requirements, and I think I haven't covered this yet, I think I will cover it in a little bit, they are counted on the insurance coverage the payer on the first day of the measurement year for the person, the first day that they are seen during the measurement year, will be the coverage that counts for them for purposes of the measure. And I will go into this in greater detail in a little bit.

Ame: The next question is from IPRO. If the MP is not necessarily the same for the denominator and numerator, how is the numerator a subset of the denominator? Do you mean the individuals in the numerator must be also in the denominator?

Peggy O'Brien: Yes. Anybody who is in the numerator, will also be in the denominator. So you start with the denominator, and that is the eligible population that's being measured, and then the numerator is the subset of that population that satisfies whatever the criteria of the measurement, are.

Ame: The next question is from People Incorporated. Those not identified as CCBHC-eligible, do not get included in the data reporting, correct?

Peggy O'Brien: That is correct. And there will be a mechanism that CMS establishes for purposes of claims data that will allow linkage of individuals to the CCBHC.

Ame: And then the last question is from [Carla McCaffree] with regard to consumer attribution, if someone is seen, for example in the CCBHC i.e., an assessment, are they counted as consumers for the CCBHC for data collection purposes?

Peggy O'Brien: Yes, they are. Yes. And there is going to be additional guidance coming out about identification as a CCBHC consumer from SAMHSA that will be coming out, hopefully pretty soon.

Ame: Those were all the questions for now.

Peggy O'Brien: Okay. Thank you. So I'll move on, and there will be time for more questions at the end.

I'm going to start talking about the data reporting templates just to get you acquainted with the structure of them.

When I explain specific measures in later webinars, I will go through these again, for a few of the measures, so you can see how they actually fit together.

So this won't be the only time that I review them.

As background, I should note that the data reporting templates are used to report the rates for the measures, and there will be one data reporting template workbook for each CCBHC, for each measurement year. All the data in an individual template will relate to only one BHC or CCBHC. So if a state has 20 CCBHCs, there will be 20 reporting templates.

And I see the slides are moving of their own volition here. I'm going to try to get the slides to move to where they belong. Be patient please.

Okay. So one of the first things in the templates is the caseload characteristics worksheet which is completed by the behavioral health clinic.

The behavioral health clinic only needs to include the numerator and the denominator. The denominator is the total population, which you can't see in the screenshot, but it's at the bottom of the worksheet. And the percentages will be automatically calculated for you. So as an example, you can see here, there are five consumers, ages 0 to 11, 10 who are ages 12 to 17, and so forth.

And you can't see it, but the total BHC population is at the bottom, and in this hypothetical, it's 200. So all you have to do is insert the number for each age group, or other demographic, and the total population, and the worksheet will calculate the percentages for you.

Section A of the template is a place where you put the measurement year, and this is not a date, it is the measurement year. So for CCBHCs, that would be DY1,

demonstration year 1, or DY2, demonstration year 2. And if you're not a CCBHC, it would probably be a fiscal year, or a calendar year.

And as you can see on the screenshot, there are directions that pop up when you click on a cell in the template, that give you instructions on what to do. There are also instructions at the beginning of the data reporting templates.

Section B is where you indicate the data source. For example, it could be administrative, or medical records, or hybrid. And for example with medical records, you would indicate if you relied on electronic records, paper records, etcetera.

And if other sources than those specified are used, there is a space for you to explain what they are. The hope is that what you're using is what the specs tell you to use.

Section C of the data reporting template, is the date range for the measurement period. And this provides a place to indicate the starting the ending month day and year for the numerator and denominator. It tells you the time period covered by the data that's used. The template will only let you enter this information in one format.

Section D is the performance measure. It provides measure of the description, and stratification information, and then it includes a table to insert the numerator and denominator. The total and rates are calculated automatically.

The rates then get automatically transferred to the roll-up worksheet near the end of the data reporting templates. And I'll show that to you a little bit later.

Section E of the data reporting template is for information about adherence to measurement specifications. It allows you to indicate the population measured and ways in which data collection or reporting might differ from the specifications.

Although you are asked to adhere to the specs as much as humanly possible, we know it will not always be possible so there is a place for you to explain how it differed.

And the last thing on each worksheet for the templates is additional notes where you can put additional information. For example if non-adherence wasn't completely captured in Section E, you can put a note about it section F.

And I mentioned the roll-up table. The roll-up table is a separate worksheet near the end of the templates. It's automatically filled from the Section D entries for each measure, and once it is complete, it provides a nice summary of the rates for each CCBHC or BHC.

And then finally within the templates, there are the measurement period tables. It's the last set of worksheets in the workbook and it provides measurement periods for each measure for CCBHC calculation based on when the state's demonstration years begin and end. This was included specifically for the CCBHC demonstration program because

states have the option of starting their programs anytime between January 1 and July 1, 2017.

So because each measure has different measurement periods and each state may have a different starting point, it got very complicated and this is an effort to try and provide you with information that would help de-confuse it to a certain extent.

Hey, we are almost finished so I'm going to stop again and see if there are questions about anything that I've covered, related issues that I didn't address and I'm going to do my best to answer them.

Ame: The first question is by Tim McGuire. Is there are difference between an electronic health record and a patient registry?

Peggy O'Brien: That's a good question. A patient registry is typically related to a specific disorder or condition. Electronic health records are the records that you might consider it as encompassing a registry, but electronic health records are broader.

Ame: Next question is by Roddy Atkins. When will the template be made available?

Peggy O'Brien: The templates are available. They're with the specs on the SAMHSA website and they also should be available from your state.

Ame: That is all the questions for now.

Peggy O'Brien: Okay. I'm going to do a preview of the next two webinars so you know what will be covered.

Next week, on July 19, I will be talking about six of the state lead measures. They are all administrative data. Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications, adherence to antipsychotic medications for individuals with schizophrenia, follow-up care for children prescribed ADHD medication, anti-depressant medication management, initiation and engagement of alcohol and other drug-dependence treatment and plan all cause re-admission rate. And next week is going to be a very dense, dense webinar.

The following week, on the 26, I will be discussing the last seven state-lead measures that are still part of the required CCBHC demonstration program measures including the four followup measures. Two related to emergency department use and two related to hospitalization. I will include also the housing status measure and the two patient experience of care measures.

Okay, this slide contains contact information, please submit any additional questions you have to the CCBHC_Data_Ta mail box. The address is on the screen. It can be about material that was covered today, questions about the state-lead measures that will be covered in the next two weeks, ideas for the two special issues webinars that are

webinars 6 and 7, and any other questions related to data collection, analysis and reporting.

To the extent you know in advance questions related to specific measures, it would be great if you can ask them in advance so I can try and answer them in the webinar where the measure is discussed. I think that would be the most beneficial way to do it. It's to try and address questions that you know you have.

Any remaining questions about material covered today, I will try and cover or answer in the next webinar. I'll start the webinars with a response to questions to the extent that I can and any other questions that you have will be addressed in the appropriate upcoming webinars.

So we're finished with the prepared material and I'm going to check one more time to see if there are any other questions.

Ame: There's a question from [Jaime Olivers]. Please provide the link to the volume and workbooks mentioned during webinars. Those are the only questions at this time.

Peggy O'Brien: Okay. I will make sure that the link to the SAMHSA website where the specs and templates are located will be made available to people.

So if there are no other questions, thank you and we'll start on state-lead measures next week.