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State-Lead Behavioral Health Clinic Measures -- Part 2 of 2

Peggy O'Brien: Welcome to the third webinar in the behavioral health clinic data collection and quality reporting webinar series, presented by the Substance Abuse and Mental Health Services Administration. Today's topic is State-Lead Behavioral Health Clinic Measures -- Part 2 of 2.

I'm Peggy O'Brien, a Senior Research Leader at Truven Health Analytics presenting on behalf of SAMHSA. Today, we also have representatives of SAMHSA and ASPE present.

There's a chat function where you can ask questions and we encourage you to do so. I will pause at several points in the webinar to respond to questions that people have asked about things I've 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. There are two poll questions in this webinar.

A PDF of the slides for each webinar is posted as a resource on the webinar site and webinars themselves will be available on demand for a year after the event on the webinar site as well as available on the SAMHSA website once they are posted.

This is the webinar schedule with the intended audience identified in red. All are on 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 webinar, next Tuesday, relates to the BHC-reported required measures for CCBHCs and are generally intended for State and BHCs to help with reporting of those measures. There will be two webinars related to BHC-reported measures specifically.

I will begin today by answering a few questions that came in after webinar 2 and clarify a couple of answers that I gave in webinar 2.

The main focus today, though, will be on the remaining seven state-lead measures that are required as part of the CCBHC demonstration program. Please ask any questions via chat and I will stop frequently to answer questions.

I want to start by clarifying answers to two of the questions that were asked in the webinar last week. For the SSD measure, the diabetes screening measure, the first one we discussed, someone asked if the diagnoses of schizophrenia and bipolar disorder that are required as part of the measure included schizoaffective disorder. I checked the value set afterwards and it does. And I encourage anyone who has questions about specific diagnoses that are included in the more general descriptions within the measures, to check the value sets to get the precise diagnoses that are required or other precise codes.

Someone also asked how to determine diagnoses, and I replied that you need an ICD-10 code. In general, that is correct, but for a few measures, you may be instructed also to

look at other things. For example in the SSD diabetes measure, diabetes also may be inferred from the dispensing of certain medications in the pharmacy data. So that is one example of where you may go beyond the simple use of ICD-10 codes.

There were several questions that came in after the last webinar. The vast majority of them relate to specific measures that are going to be discussed and I'm going to answer those when we get to the specific measures. They're all in the future or today. There was however one general question that I do want to address.

The question was, could you please tell me if the state-lead measures using administrative data are the same as the standard measures, aside from the reporting level? I know the notes state this measure is modified to require clinic level recording and to be consistent in format with other measures in the set of BHC measures but is not tested at the clinic level. That's the end of the quote, however I am not sure what is meant by the, and to be consistent in format.

My response to this is that there are really three potential differences between the state-lead measures using administrative data and the source measure. One is the reporting level that the question acknowledges. They are reported at the BHC level and not the state or plan level. The second is format. The measures are formatted for general consistency as much as possible, and the third is some other changes. So I want to go into the formatting changes and the other changes so that you have a better sense of what they are.

The formatting changes include things such as in section A of the spec, there is general additional information that's included such as links to value sets, information on the measurement period and things like that. There are sometimes additional definitions in section B, such as the definition of provider entity that we use to bring the measure to the BHC level. There is similarly an additional step in the definition of the eligible population in section C to bring the spec to the BHC level, as well as an attempt to more clearly provide the steps in determining the eligible population.

There are reminders about measurement periods in section D. There is additional general information in section E, such as information about the source measure and interpretation of the score. For some measures, this is added for some measures it was present in the source but in general, what you will find is that the actual specification, how you calculate the measure is the same.

There are however some non-level, non-formatting changes that are generally limited to measurement year, measurement period, stratification and age requirements. I'll go through each of those in turn.

Because the CCBHC demonstration programs will begin at different points between January 1 and July 1, 2017, the measurement year and periods that are identified in the source measures, are linked to a measurement year that's the calendar year, will differ from those that are identified in the BHC measures.

Also, each of the BHC state-lead measures require stratification by pair and for the states that means into Medicaid and dually eligible beneficiaries. The BHC state-lead measures by requiring reporting for both of those categories stratified also may cover different populations than those for which you presently report a measure because we're looking at the BHC population specifically.

Some of the BHC state-lead administrative measures require stratification by age and those include for the state measures the plan for-all-cause readmission, APM, the Follow-Up -- two Follow-Up measures or the Follow-Up measure for adults, AMM and the initiation and engagement measure.

And you really need to check the age coverage and stratifications for these against what you report now because there may have been modifications. There are distinctions between the HEDIS measures and the Medicaid core measures. And in general, these BHC measures tend to follow the Medicaid core measures more closely in terms of age and age stratification, than they do the HEDIS measures. That is both the long and short answer to that question and that question like other questions that come in, will be responded to in writing as well.

These are the seven state-lead measures that I will cover today. Some will be covered in detail and others much less so because four of them are very similar to one another. The first four are the Follow-Up measures, two for emergency department and two for Hospitalization use. I will also address the Housing measure and the Patient Experience of Care Survey measure.

This and the next slide provide the age coverage and stratification requirements for each of the seven measures we're discussing today. The four Follow-Up measures which are shown on this slide, each cover different age groups. All are stratified by pair, and the adult Follow-Up After Hospitalization is also stratified by age.

These are the other three measures that we'll be talking about today. No stratification is required for these measures, except to the extent you may already report by group. For example, the Housing Status measure is generally reported by race, ethnicity, but that is not something that is a specific requirement of these measures. In general, these were designed to continue what you're doing now and I'll talk in more detail about that when I get to them.

The Housing Status measure does apply to all ages and the Experience of Care is split by age with one for those 18 and older and one for those 17 and younger because different surveys are used.

The first measure we'll cover today is Follow-Up After Discharge from the Emergency Department for Mental Health Treatment. If you're interested, this begins on page 113 of the measure specs. As a reminder, this measure and the related one on Discharge from the ED for Alcohol and Other Drug Dependents Treatment came out of the division of an earlier measure that had not been maintained by the measure steward. These will both be

2017 HEDIS measures and they are not among the 2016 HEDIS measures because they are new. I will go through this one in detail.

The Other ED Follow-Up measure and the two Follow-up post Hospitalization measures have a lot in common with this one. Though for those, I will address anything that is unusual but not go into great detail.

For this measure, the denominator is the number of ED visits for mental health treatment by consumers who are age six and older. The numerator has two rates, was there a follow-up visit with a primary diagnosis of mental health disorder within seven days after the ED visit, and was there a 30-day follow-up visit with the primary diagnosis of mental health disorder? The measurement period start with the discharge because you're measuring what happens after the discharge and the denominator measurement period covers the measurement year less the last 30 days, which allows you time to capture the 30-day follow-up rate without having to collect data that goes into the next year.

The numerator measurement period is the measurement year. And as a reminder for the CCBHCs, the measurement year is the demonstration year. This measure is based on ED discharges so there can be multiple discharges per consumer. It's not the number of consumers but the number of discharges for eligible consumers that you will be looking at.

Section A of the spec includes the typical simplified narrative describing the measure in this instance with the two rates related to follow-up at 7 and 30 days. All of the follow-up measures rely on administrative data, and all of them contain the 7- and 30-day follow-up rate. The guidance for reporting restates the history with how this and the following measure came to be in the BHC set because it differs from the measure that was identified in the CCBHC criteria.

Stratifications are discussed, these are by pair, and a link to the value set is included. Although this link is going to be only an approximation for this and the one following because this is a 2017 HEDIS value set that is not available in the 2016 value sets.

The definitions for this measure are minimal. Only the definition of provider entity is included as it is with all of these measures to make it clear they're specified at the BHC level.

The eligible population section includes consumers six or older when they have the ED visit. There's a requirement of continuous enrollment that spans the date of the ED visit to the point 30 days after. You should note that, because there may be multiple ED visits, there will be accompanying multiple continuous enrollment requirements. There can be no gaps in enrollment during the 30-day continuous enrollment period or periods, hence there is no anchor date and the benefits are medical and mental health.

And as a reminder, the requirements for continuous enrollment and any applicable enrollment cap or anchor date requirements are there for purposes of helping you determine whether somebody falls into the Medicaid population, the dually eligible population or some other population for purposes of stratification.

The guidance in section C for the eligible population continues here with step-by-step requirements for the eligible population or denominator.

Step 1 requires that you identify all consumers seen at the BHC during the measurement year. Step 2, from those, you identify those ages 6 or older on the date of the relevant ED visits. Step 3, from those, you identify those with an ED visit using codes that are in the ED value set with a primary diagnosis of mental illness -- and the codes for that are in the mental illness value set -- on or between the first day of the measurement year and the last day of the measurement year, less 30 days.

You include all ED visits during that time, and if there is more than one ED visit during a 30-day period, you use the last ED visit in that 30 days. And again, all of this is coming directly from the spec. I'm just trying to point out the most significant parts of it.

I am going to stop here and make a suggestion. Or at least put the idea in front of you. It will apply to the next measure as well. You might want to consider when programming this whether it makes sense to reverse steps 2 and 3.

They are included in the BHC measures in the same order in which they were included in the source measure. It may make more sense however to check first if the person is a CCBHC consumer, then if they had an eligible ED visit. And then if they were 6 or older on the date of the visit. Simply because there may be many fewer ED visits than there are people aged 6 or older.

Section D provides the administrative specification for the measure. The denominator is the number of ED visits as measured in section C, which we just talked about.

The numerator is provided for both rates and requires either an outpatient visit, an intensive outpatient encounter, or a partial hospitalization encounter with any kind of practitioner as long as there is a primary diagnosis of mental health within 7 and 30 days respectively, of the ED visit. And these can include visits that occur on the same day as the ED visit.

So, if someone goes from the emergency department, not to the hospital, but to the CCBHC or to partial hospitalization, those encounters count as follow-up. Last week someone asked if the diagnosis in these measures in general, the measures generally, had to be the primary diagnosis or not. My answer was, it depends on the measure. For this measure, the mental health diagnosis must be a primary diagnosis.

The spec identifies the value sets to use for each possible setting with value sets for mental health diagnosis included as well. A note is provided that explains how to handle different billing methods for intensive outpatient and partial hospitalization. Excluded from the initial ED visits are those that are followed by admission or direct transfer to an acute or non-acute inpatient setting during the 30-day follow up period. And instructions are provided for identifying those admissions or transfers. These events are excluded because the admission may interfere with the outpatient follow-up visit from the ED especially for the 7-day follow-up.

Finally, section E provides information on the source measure. It was designed for the commercial, Medicaid and Medicare populations, doesn't require risk adjustment and was specified and tested at the health plan level.

We modified it to be specified at the behavioral health clinic level and for consistency of formatting.

Regarding risk adjustment, according to the measures stewards, only one of the BHC measures requires risk adjustment and that is the plan all cause- readmission one which we discussed at the end of the webinar last week. And risk adjustment has not been developed for that measure so you need not worry about risk adjustment for any of the BHC measures.

For this measure, a higher score, which indicates consistent follow-up after an ED visit, is considered to represent better quality. Now, I'll briefly go on and go through the data reporting template for this measure as a refresher from last week, and this is the only template that I will go through today.

In section A of the template, the measurement year will, for CCBHCs, be demonstration year one or demonstration year two. If it's a non-CCBHC that is reporting, it is the pertinent fiscal year or calendar year.

For section B, the data source section requires in row 7, if it's administrative or other, it should be administrative because these are administrative measures we're talking about. In row 8, if it is administrative, is MMIS or some other source, the source of the data, if it's other, you specify.

And in row 9, if it's non-administrative data that you're using you need to specify what you used instead. The assumption is that it is administrative. In section C, the date range section, it calls for the denominator and numerator start and end dates for the data that are used.

Section D of the template provides some measure description and information on the stratification as well as the table for insertion of the numerator and denominator from which the rate will be calculated automatically.

As you can see, for the 7-day rate and the 30-day rate, you are to insert that information for the Medicaid and duals population. Because this is a state-reported measure, you can ignore the other category because the states do not have access to information on that group of people. These rates that are put in here, will auto-populate in the roll out sheets at the back of the data reporting templates.

Section E, which deals with adherence to measure specification, begins with rows that require you to identify the population included. As this is a state-lead measure, you only need to provide this for the Medicaid population, the Title-XIX Eligible CHIP population which is part of Medicaid and the dually Eligible population.

You then need to answer the questions in row 41 regarding whether the calculation of the measure deviated from the spec and if so, how? In row 42 is the denominator represents the total eligible population, and if not, how it differed? And in row 43, specify the size of the denominator population and the measure-eligible population. These are all checks on the data.

Section E continues with, for the 7-day follow-up, a series of questions by pair. And again states can skip the other on neither section and those questions relate to numerator, denominator, and calculation generally. Section E of the data reporting template also has sections addressing the 30-day follow-up rate. And there is room for additional notes in Section F at the bottom of the worksheet. Now, I'm going to stop for a moment to see if there are any questions on what I covered so far.

Ame: Hi, Peggy, you don't have any questions at the moment.

Peggy O'Brien: Okay. There will be plenty of other opportunities. So, I will continue.

This is the companion measure to the one I just discussed, this one relates to follow-up after discharge from the ED for alcohol or other drug dependence treatment and it begins on page 118 of the specs.

This measure is constructed similarly to the one I just discussed, so the measurement period for the denominator also excludes less 30 days of the measurement year. And the measurement period for the numerator is the entire measurement year. It has two rates for 7- and 30-day follow-up, and it captures the number of eligible ED visits by eligible consumers not simply the number of consumers.

There is something that you might want to consider about this measure, the one that was on the slide previous to this. It is possible that a behavioral health clinic consumer might visit the ED and be given a substance-related diagnosis in the ED.

The person likely also will have other diagnoses as well. And in fact, substance use diagnosis may not even be in the person's chart prior to the ED visit. Then the person is seen at the BHC hopefully within 7 days, but there is no substance-related diagnosis quoted during that visit, or it's not quoted as the primary diagnosis which is what is required to satisfy the numerator for this measure.

So, think about what this does to the follow-up rate. It's counted as a failure of follow-up, either because there is no substance related diagnosis quoted on the follow-up visit, or it is not indicated as the primary diagnosis. And think about how you might want to address this in training BHC personnel who are involved in coding.

We have here our first poll question today and I am asking, do you have concerns about BHCs not including sufficient codes indicating alcohol and other drug dependence diagnoses or treatment resulting in under counting?

And you simply select yes or no. I'm concerned about it, no I'm not concerned about it. And then if you have any specific concerns, please indicate them in the chat box.

Okay, I'm going to move on and see what results we got. 78% indicated that they are concerned about it, 22% indicated that they are not.

Okay. So it sounds like for many people, this is a concern and something that bears thinking about how to address it with the BHCs to assure that coding actually captures what's happening. If you're having follow-up after an alcohol or drug dependence ED visit that the follow-up is follow-up to that, and that it is recognized because you want to make sure that the substance use diagnosis is there, and that it is the primary diagnosis in the follow-up visit in order to count. Otherwise, your numerator will be smaller than it should be and your rate will be lower than it should be.

There are two follow-up after hospitalization for mental illness measures. This one is for ages 21 and older, and another is for children and adolescents. This adult measure begins on page 165 of the specs.

The denominator is the number of eligible discharges for consumers aged 21 and older who are hospitalized for treatment of selected mental illness diagnoses. The numerator has two rates for 30-day and 7-day follow-up with a mental health practitioner.

The measurement period for the denominator is the measurement year, less the last 30 days of the measurement year in order to capture the 30-day follow-up. And the measurement period for the numerator is the measurement year. So, the way that this measure is structured is the same as it is for the ED follow-up measures that we just talked about.

I will not go through this one in detail because there are so many similarities, but did want to note that volume 2 in appendix D of the specs identifies mental health practitioners for purposes of follow-up and this measure does require that the follow-up be done by a mental health practitioner.

And I also wanted to note that the measure is based on hospitalizations and discharges, rather than the number of consumers. So there can be multiple hospitalizations and discharges per consumer during the measurement period.

It is kind of an interesting difference between this and the ED follow-ups, the ED follow-ups require either a mental health or substance use diagnosis as the primary diagnosis, depending on whether it's mental health or substance use measure. While these hospitalization measures focus more on the follow-ups being provided by a mental health practitioner rather than on the location of the diagnosis.

And this is the follow-up after hospitalization for mental illness measure that applies to those who are ages 6 through 20. And it begins on page 172 of the specs. This measure tracks the adult measure closely.

One thing to note on all four of these follow-up measures is that the 30-day rate is always equal to or greater than the 7-day rate because the 7-day visits are included in the 30-day visits.

There are four follow-up measures that are calculated by the states. The state has claims data that allows it to measure follow-ups, so that should not be an issue. The practical concern though is how clinics are supposed to know that their consumer was seen at the ED or was hospitalized. Very often, clinics will be aware of this, sometimes, however, they will not know and certainly not time for the 7-day follow-up to occur.

So how can BHCs find out in a timely manner, and can the state do something to help that? Here are some thoughts about the second question, can the states help the BHCs know about ED visits or hospitalizations in time, to facilitate 7-day follow-up?

These are some ideas, there may be others that people can think of, that may help. Can the state get data or alerts to the BHCs, or perhaps based on Medicaid or managed care pre-approvals. Or is there some other way for the state to have that data in a more timely fashion, and pass it on to the BHCs so that they know somebody has been either admitted to the hospital or has been seen at the ED and can follow-up within 7 days.

Can the state somehow facilitate agreements with hospitals to encourage prompt care coordination? Is there a way for hospitals to alert BHCs or care coordination teams possible? Can EHRs and health information exchange play a role in this? From the standpoint of the BHCs themselves, can they educate high risk consumers to call the BHC? Can BHCs provide ID cards for their consumers so hospitals can notify the BHC? And how can this be done within HIPAA and 42 CFR Part 2?

These are just food for thought, some of these ideas are ones for state action, some are for BHC action and some such as those related to care coordination teams stem from the general requirements for care coordination that you see in the CCBHC certification criteria.

I'm going to move on to the housing status measure. This is the first of the state-lead metrics that are not administrative, specifically the housing status measure and the patient experience of care survey measures. The housing status measure derived from the reporting requirements, from the uniform reporting system or URS in the Mental Health Block Grant.

The housing measure divides the measurement year into two equal periods just as the URS or Mental Health Block Grant requires and determines the number or percent of consumers at the BHC who are living in each of 10 different categories of housing at each of those two time periods.

This measure is designed to parallel the existing reporting requirements from the URS and in Mental Health Block Grants. The timing of collection and the 10 categories are the same. The categories are defined in the specification, but they include private residence, foster home, residential care, crisis residence, children's residential treatment facility, institutional setting, jail or correctional facility, homeless, other, and unavailable, which means that information on the consumer's residence is not available.

Again the exact definitions are included in the specs and come directly from the URS definitions. These data are to be collected twice a year, always at admissions and

discharge and if otherwise, at the last assessment during the half year period. This is exactly the way it is done at present. The only thing that differs here is that the information is reported by BHC separately at the BHC level, just like everything else in the BHC measures.

And I want to mention again that because the URS covers all ages, this measure does as well. There also is information in the spec derived from the URS regarding what to do if there are multiple known living situations during a 6-month period, also if the person is only seen at the BHC during the first or second part of the year, the person is not included in the count for the portion where they are not seen.

As an aside, I think it's probable that most of the CCBHCs will already be collecting this data as part of the Mental Health Block Grant program. Some may not be. Each state will need to examine this and make sure that those CCBHCs that are not collecting this data, do so. And do so in the same twice a year schedule as the rest of the CCBHCs.

It also is possible that some CCBHCs will not be collecting this for all ages, even though the US calls for all ages, or may not be collecting it for substance use clients who are not included in the Mental Health Block Grant funded programs. States will need to work with their CCBHCs to assure that it is collected for all clients in all ages.

I'm going to move on to the patient experience of care surveys. I'm not going to spend much time on this. The first one uses the mental health statistics improvement program, adult consumer experience of care survey, or MHSIP. And it's identical to what is presently collected with two exceptions. Dates report by BHC, and if they are part of the CCBHC demonstration program by comparison clinic. Dates oversample the BHCs and comparison clinics reaching out to 300 consumers per BHC and comparison clinic, unless you normally do more, or unless the BHC has fewer consumers.

The youth and family experience of care survey is similar to the adult survey and the measure is treated the same. There was a question received about these two surveys in the measure, as to whether the requirement of 300 consumers is for both of them, combined or if it's separate.

And the requirement for 300 consumers is -- per survey, so 300 for the adult; 300 for the youth and families. It was also asked to what extent these surveys needed to be representative of the consumer population and what part of the consumer population.

It is desirable that the surveys be representative of this consumer population, but the measure was designed to have states continue doing what they are doing now. So that the only changes should be that you have extra sampling for the CCBHCs if it's a CCBHC, and that you have reporting by CCBHC, or by BHC so that in terms of how you sample and who you sample, beyond those requirements, nothing should change.

I will stop again for questions. And I also forgot to ask after the poll, if there are any comments in the chat box about that, so Ame, do we have any questions at this point or anything else in the chat box?

Ame: First question is from [Daniel Carlson], measures assume that CCBHCs will monitor customer use of EDs and follow up as needed. Does SAMHSA have examples of formal agreements that CCBHCs enter into with ED shared data, i.e., client ID diagnosis related to ED client visits?

Peggy O'Brien: Okay, Ame could you repeat that one more time please? There's a little echo.

Ame: Measures assume that CCBHCs will monitor consumer use of EDs and follow-up as needed. Does SAMHSA have examples of formal agreements that CCBHCs enter into with EDs to share data, client ID, diagnosis related to ED client visits?

Peggy O'Brien: So the question is, are there examples of the types of agreements that you might work out between local EDs or hospitals and the BHC to assure that there is care coordination and follow-up. That is something that I would want to take back to SAMHSA to discuss and see what there may be.

This I will say that, and I know that it's a different realm, that the Accountable Care organizations, the ACOs have been working on doing this for a couple of years now, and it's been something that has been a difficult process. But one thing that has helped is to have agreements with hospitals to assure that providers know that there's been an admission.

So that is something that is very important and criteria do call for some sort of agreement. So I would like to defer answering that, and see what we can find.

Ame: The next question is from [Ginger Bankeen], does the diagnosis need to be a perfect match? I can see issues of one entity giving a diagnosis of severe and another diagnosis of mild or emphasizing different substances, which are sometimes different codes.

Peggy O'Brien: Right. So if you, for instance, if you have an ED visit and the person is given a primary diagnosis of an opioid dependence, and then there is follow-up at the CCBHC and it's opioid misuse or something like that. As long as it is a substance use code, and it is in the primary position, then it should count in the numerator.

Ame: The next question is from [Tracy Lippert], for surveys, is there any stratification requirements?

Peggy O'Brien: There are no explicit stratification requirements in the existing surveys. And I believe that some states do more stratification than others. And in particular, in an attempt to get a more representative sample.

And these measures were very deliberately created to allow states to continue to process these, that they're doing presently. So there is nothing specific here related to stratification.

Ame: The next question is from [Susan Borris], we don't collect URS info on such clients, we collect TEDS info and use those categories. How will that be handled?

Peggy O'Brien: First of all, I think I would want to know if the TEDS category for housing status are the same. And my guess is, they're probably not, but I don't know.

The measure calls for specific categories to be used. So it is designed to incorporate and include both the mental health and substance use populations that are served, and should use the same category for everybody.

Ame: The next question is from [Adrian Ransoni] does the state select comparison clinics? If so, are there criteria for selecting comparison clinics?

Peggy O'Brien: In general, I'm not going to get in into the evaluation because that is what the comparison clinics are about. The ASPE is selecting or ASPE's contractor will be selecting the comparison clinics. The state does not do that.

Ame: The next question is from Susan Borris, we do not use mixed surveys for subs clients. Is there an appropriate surveys to use on subs clients?

Peggy O'Brien: For substance use clients?

Ame: Yes.

Peggy O'Brien: Okay. Yes, I know that there are other surveys that are designed for substance use clients. The way the measures are written, they're designed to apply to everybody and so this is an issue that I want to defer discussing and confer with SAMHSA and others about.

Ame: We have a comment from [Ted Saturni], many mental health providers are hesitant to include an SRD diagnosis even though they have been told that a claim will be paid so long as the primary diagnosis is mental health.

Peggy O'Brien: Yes, often, certain diagnoses including substance use are not applied to a person because of fear of stigma, and the same is often true of certain mental health diagnoses as well.

However, the measures, which is what we're talking about, do require certain diagnoses and follow-up, and in particular for the follow-up after ED, if somebody was seen at an emergency department and had a substance use diagnosis, that diagnosis has already been applied to them and if it is not applied at the follow-up visit as a primary diagnosis, it doesn't get counted. And they do already have that diagnosis in their record from the ED.

Ame: And our last comment is from [Ted Saturni], 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.

Peggy O'Brien: Yes. In preparing these measures, we looked into the extent to which states identify or can identify by clinic or by behavioral health center, and recognize that some states can already do this and do it, and some do not. And so in order to make this measure meaningful in terms of assessing the CCBHCs, it was decided to require that it be reported by BHC or CCBHC. So that will be a departure for some states.

Are there any other questions or comments right now?

Ame: We have no more questions.

Peggy O'Brien: Okay. Thank you. So I will move on. We're actually getting through this relatively quickly. This slide shows the upcoming webinar schedule.

As a reminder, we meet every Tuesday at 2 o'clock Eastern Time, and we will be skipping the last week of August, which is reflected in the schedule. And next week I will give you a better idea of what the special issues webinars will cover because they are evolving.

This is what will be covered next week and the first webinar that is specifically focused on BHC-Lead Measures. We will discuss five of them that includes Time to Initial Evaluation, the Body Mass Index Screening & Follow-Up Measure, Tobacco Use -- Screening and Cessation Intervention measure, Unhealthy Alcohol Use Screening & Brief Counselling measure and Depression Remission at Twelve Months.

That will be followed by the second of the two webinars dealing with BHC-lead measures and that will cover the remaining four BHC-lead measures that are required as part of the CCBHC program, including Body Mass Index Assessment for Children and Adolescents. Screening for Clinical Depression and Follow-Up Plan, Child and Adolescent major Depressive Disorder -- Suicide Risk Assessment, and Adult Major Depressive Disorder -- Suicide Risk Assessment.

So I'm going to pause here to ask you to consider the following two questions, what do you want to know about data collection analysis, or reporting for the state-lead measures that has not been covered? Because this webinar today is the last of the two state-lead measures that are required as part of the CCBHCs demonstration program.

And what do you want the BHCs to know about the measures that they report?

If you have ideas now and want to show them by chat, please do so, otherwise, please submit them to the mailbox for SAMHSA questions and that address will be provided in a few slides.

I'm going to pause and see if anybody has anything specific that they would like to ask about the state-lead measures that has been covered over the past two webinars, including this one, or things the BHCs in particular need to know about the measures that they report.

Ame: We have one comment from [Ted Saturni], there's a Block Grant meeting on August 9, in D.C. that many individuals may be required to attend.

Peggy O'Brien: On August 9?

Ame: Yes.

Peggy O'Brien: Okay. Okay. All right. Good to know. So that's the second of the clinic-reported measures, and I don't think that rescheduling it at this point is an option, however, I will say that, again, there's a PDF of the slides that is included as a resource on this webinar site where you're listening to the webinar right now, and you can download the webinar on demand.

So after the webinar, on August 9 is finished, anybody who's missed it that wants to listen to it, can go on as long as they're registered, and they can listen to it and see the slides, and eventually it will be also on the SAMHSA website. And I also wanted to mention that if somebody is not registered for any one of these, they can go in, and register, and if they're not registered for ones that have already passed, they can still register. In that way, they can look at the slides and listen to the webinar for the ones that have passed as well.

Are there any other questions or comments, Ame?

Ame: There are no other questions.

Peggy O'Brien: Okay. Okay, this slide and the next two slides are provided just for your reference. These are the measures included by abbreviation and whether they are state or BHC-lead, whether they're required as part of the demonstration program and in which webinar they are discussed. These are included so that you have a handy reference for where you can locate the information about a specific measure in the eight webinars.

So we have another poll here, and this revisiting the poll that we did last week because people were not able to respond to multiple choices, and there are a total of seven choices here, I added one, based on a comment that we got last time.

So this has to do with dually eligible data, and what do you think will be the biggest obstacles for you in obtaining claims data for dually eligible, that is Medicaid and Medicare dually eligible, consumers? And I ask that you select all that apply. The first is, and you may need to scroll down to see all of these.

The first is, we don't have any access to Medicare data. Two, our access to Medicare data is delayed enough to affect our ability to report quality measures when required. Three, we will have problems matching Medicare data with Medicaid identifiers. Four, we will not be able to obtain substance use claims in Medicare data. Five, we cannot obtain Medicare Part D data. Six, other. Seven, I do not predict this to be a challenge.

And again, please summarize any additional comments on why you will or will not have difficulty obtaining duals data in the chat box. And I'll wait for a minute while people respond to this.

Okay. I'm going to see what the results are this time. 46% report they do not have any access to Medicare data, 51% reported that that access is delayed enough to affect their ability to report quality measures when required, 38% we will have problems matching Medicare data with Medicaid identifiers, 32%, we will not be able to obtain substance use claims in Medicare data, 27%, we cannot obtain Medicare part D data, 13% other, and about 11% do not predict this to be a challenge.

Ame, are there any comments in the chat box in relation to this?

Ame: No, Peggy. There are no comments.

Peggy O'Brien: Okay. So as I mentioned last week, the information that you're providing in this poll will allow us to help prepare part of the special issues webinar where we will be discussing dually eligible data, and this is good information for us to have to know what the potential concerns, and challenges are going to be.

Okay. I went through, I believe, three or four questions last week out loud. I didn't have them on slides and it's difficult to get the questions that are asked between webinars actually into the slides in time to get the slides posted. So I'm always going to be running a little behind. And I think that probably the best way to handle the questions that come in between webinars will mainly be to rely on posting answers through SAMHSA. So that's likely what's going to happen in the future. All of the questions and answers will be compiled.

So these slides are the questions that I answered last week regarding the number of state-lead measures, regarding aggregation at the state level, which doesn't happen and regarding what other data might be required to be collected. And I'm not going to go through them again but they are here on the slides so that the people that asked the question, as well as anybody else that's interested can look at the slide and see the answers, questions or the responses to these questions.

On this slide, we provide you again the CCBHC data TA mailbox where you can write in any questions that you have. The address is on the screen. It can be about material that I covered today, questions about the BHC-lead measures that are coming up. And I will say, there were a number of questions or at least a few questions that came in over the past week that relate specifically to BHC-lead measure such as the suicide risk assessment measure, the BMI measure and some others that will be addressed -- the questions and answers will be addressed at the time that those measures are discussed.

If you have any ideas for the two special issues webinars, please share them and if you have any other questions related to data collection, analysis and reporting, please send them to the TA mailbox.

And to the extent you know an advance question related to the measures that are going to be discussed it is very helpful because I can try and deal with them in the context of the measure when I'm discussing it.

If you have any questions about material that I covered today or in the last webinar, I'll also try to address that at the beginning of the next webinar.

So as a special note, please do address your questions related to these webinars to the address on the slide and not to CMS. The CMS mailbox is for questions that are specific to the PPS cost reports and related matters. And I know SAMHSA also send out an email regarding the office hours times and the schedule for that, they will be starting next week. And we'll go through the very first part of September, the first week of September. And we will start scheduling those either this afternoon or tomorrow morning.

And as a reminder, we ask that you get us the questions in advance via email and hopefully three days in advance so that we can provide you with good solid answers and make maximum use of the limited time that's available. And we ask that the questions relate to these measures and to the data collection analysis and reporting that is required for these measures and not to the PPS or to the evaluation or to other questions that you may have about the demonstration program that aren't specific to these measures.

So that is all I have to cover for the prepared material. And I want to check one more time to see if there are any other questions.

Ame, do we have any other questions or comments?

I see a question here. It is a comment from Nevada; Medicaid data also may be delayed. So that's also something for us to keep in mind.

Okay. I think that is it. Thank you very much and we'll begin our discussion of BHC-lead measures next week. Thank you.