Behavioral Health is Essential To Health

Prevention Works

Treatment is Effective

People Recover
Webinar 4: BHC-Lead Behavioral Health Clinic Measures – Part 1 of 2

Presented by the Substance Abuse and Mental Health Services Administration
August 2, 2016
Logistics

• Chat function for questions
• Poll questions
• Slide and webinar availability
1: July 12: Introduction and Background – States and BHCs
2: July 19: State-Reported Measures – States Only
3: July 26: State-Reported Measures – States Only
4: August 2: Clinic-Reported Measures – States and BHCs
5: August 9: Clinic-Reported Measures – States and BHCs
6: August 16: Special Issues – States and BHCs
7: August 23: Special Issues – States and BHCs
8: September 6: Non-Required Measures – States Only

All scheduled for Tuesdays 2:00 to 3:30 pm ET
Focus Today

Outstanding questions from Webinar 3
Examination of 4 BHC-lead measures
Outstanding Questions from Webinar 3
• Time to Initial Evaluation (I-EVAL)
• Preventive Care & Screening: Body Mass Index (BMI) Screening & Follow-Up (BMI-SF)
• Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention (TSC)
• Preventive Care & Screening: Unhealthy Alcohol Use: Screening & Brief Counseling (ASC)
### Age and Stratification

<table>
<thead>
<tr>
<th>Measure</th>
<th>Age Coverage</th>
<th>Stratification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time to Initial Evaluation (I-EVAL)</td>
<td>Ages 12 and older</td>
<td>Medicaid, Dual Medicare &amp; Medicaid, Other</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ages 12-17 years, 18 years+</td>
</tr>
<tr>
<td>Preventive Care &amp; Screening: Body Mass Index (BMI) Screening &amp; Follow-Up (BMI-SF)</td>
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<td>Ages 18 and older</td>
<td>Medicaid, Dual Medicare &amp; Medicaid, Other</td>
</tr>
</tbody>
</table>
Section A. Description

- Two metrics
  - % new consumers with initial evaluation provided within 10 business days of 1st contact
  - Mean (average) # days until initial evaluation for new consumers

- Data Collection Method
  - Medical Records
  - Continued next slide
Guidance for Reporting:

- This is a two-part measure and requires two different calculations.
- This metric is stratified by age (12-17 years, 18 years and older) and by whether the consumer is a Medicaid beneficiary, eligible for both Medicare and Medicaid, and other.
- Provider entities will rely on medical records to compile this information. There are several potential sources of information that may be used individually or together:
  - Electronic health records (including billing records)
  - Paper health records
  - A registry
  - An electronic scheduling system that is separate from the medical record and that is used to schedule and monitor appointments and critical time frames
  - A system similar to one developed by NIATS (the NIATx Outpatient Spreadsheet)
- Refer to the specific data-reporting template for the reporting requirements applicable to each measure and to the Appendices in Volume 2 of this manual.

Measurement Period: For both metrics, the measurement period for the denominator is the measurement year excluding the last 30 days of the measurement year and

Section A. Description (cont’d)

- Guidance for Reporting
  - 2 parts
  - Stratified (12-17, 18+, Payer)

Reminder regarding Payers:
- Medicaid: Medicaid beneficiaries including Title 19-eligible CHIP beneficiaries
- Dually eligible (Medicare & Medicaid): Dually eligible under Medicare and Medicaid
- Other: Enrolled in neither program, including Title 21-eligible CHIP beneficiaries

Note: If a 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.
Section A. Description (cont’d)

- **Guidance for Reporting**
  - Medical record sources:
    - EHR (including billing)
    - Paper records
    - Registry
    - Scheduling
    - NIATx Outpatient Spreadsheet
  - Data reporting templates and appendices

- **Measurement Period**
  - Denominator
  - Numerator

<table>
<thead>
<tr>
<th>Year before MY1</th>
<th>MY1</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Numerator MP</td>
</tr>
<tr>
<td></td>
<td>Denominator MP</td>
</tr>
</tbody>
</table>
**Section B. Definitions**

- **Business Days**
- **Initial Evaluation**
- **New Consumer**
- **Provided**
- **Provider Entity**

<table>
<thead>
<tr>
<th>TERM</th>
<th>DEFINITION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Business Days</td>
<td>Monday through Friday, excluding state and federal holidays (regardless of days of operation)</td>
</tr>
<tr>
<td>Initial Evaluation</td>
<td>Some certification standards, such as the CCBHC certification criteria, require that an initial evaluation be carried out for new consumers within a specified time frame based on the acuity of needs. In the case of a CCBHC, the initial evaluation is due within 10 business days of first contact for those who present with “routine” non-emergency or non-urgent needs. That standard is used in this specification. Other standards may exist for other entities and this specification can be adapted accordingly.</td>
</tr>
<tr>
<td>New Consumer</td>
<td>An individual not seen at the clinic in the past 6 months</td>
</tr>
<tr>
<td>Provided</td>
<td>As used in the context of the initial evaluation being “provided” by the clinic, the word “provided” means “received.” The clinic is to record the number of business days from initial contact until the initial evaluation was received by or completed for the consumer.</td>
</tr>
<tr>
<td>Provider Entity</td>
<td>The provider entity that is being measured (i.e., BHC)</td>
</tr>
</tbody>
</table>
Section C. Eligible Population

• Age stratification

• Event/Diagnosis
  • Step 1: All new consumers seeking services during the first 11 months of the measurement year (MY)
  • Step 2: Aged 12 years and older as of the end of the MY
### Section D. Medical Record Metric Specification #1

**Percentage of new consumers with initial evaluation (IE) provided within 10 business days of 1st contact**

- **Denominator:** Number in eligible population (section C)
- **Numerator:** Number receiving IE within 10 business days of the first contact with the provider entity during the measurement year.
- **Exclusions:** None
- **Notes re MPs**
- **Example:** Appendix

**Metric Calculation**

<table>
<thead>
<tr>
<th>Event/ Diagnosis</th>
<th>Step 1: Identify consumers who initially seek services during the measurement year.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Step 2: Identify consumers from step 1 aged 12 years and older as of the end of the measurement year.</td>
</tr>
</tbody>
</table>
Section E. Medical Record Metric Specification #2

Mean (average) number of days until IE for new consumers

- Denominator: Number in eligible population (section C)
- Numerator: Total number of days between 1st contact and IE for all in eligible population seen at provider entity in MY
- Notes re MPs
- Exclusions: None
- Example: Appendix
Section F. Additional Notes

- BHC-level reporting
- Recognized limitation
- Interpretation of scores
  - % with IE within 10 days: Higher = Better
  - Mean number of days to IE: Lower = Better
Appendix I-EVAL: Time to Initial Evaluation

- Volume 2
- Examples for both metrics
Questions so far?
A. Measurement Year

Row 5

- For CCBHCs, enter DY1 or DY2, as appropriate.
- For other entities, enter the appropriate Fiscal Year or Calendar Year
B. Data Source

- **A7-B7**: Medical Records Data or Other
- **C7-D7**: If Medical Records Data, select source
  - **EHR and/or registry and/or practice management data**
  - **Paper**
  - **Both**
- **A8-B8**: If “Other” in B7, specify.
### C. Date Range

- **Denominator Start Date** (mm/dd/yyyy)
- **Denominator End Date** (mm/dd/yyyy)
- **Numerator Start Date** (mm/dd/yyyy)
- **Numerator End Date** (mm/dd/yyyy)
D. Performance Measure

- **Metric 1**
- **Metric 2**
- **Stratifications**
- **Table for data entry**
  - Auto-calculates
  - Auto-populates roll-up table (next slide)
# Time to Initial Evaluation (I-EVAL) (14)

## Roll-up worksheet

### Metric #1: Percentage of New Clients with Initial Evaluation within 10 Business Days

<table>
<thead>
<tr>
<th>Measure</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 12-17 years</td>
<td>9</td>
<td>33</td>
<td>27.27%</td>
</tr>
<tr>
<td>Medicaid</td>
<td>2</td>
<td>10</td>
<td>20.00%</td>
</tr>
<tr>
<td>Medicare &amp; Medicaid</td>
<td>3</td>
<td>11</td>
<td>27.27%</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td>11</td>
<td>33.33%</td>
</tr>
<tr>
<td>Age 18+ years</td>
<td>18</td>
<td>42</td>
<td>42.86%</td>
</tr>
<tr>
<td>Medicaid</td>
<td>5</td>
<td>13</td>
<td>38.46%</td>
</tr>
<tr>
<td>Medicare &amp; Medicaid</td>
<td>6</td>
<td>14</td>
<td>42.86%</td>
</tr>
<tr>
<td>Other</td>
<td>7</td>
<td>21</td>
<td>46.67%</td>
</tr>
<tr>
<td>Total (all age groups)</td>
<td>27</td>
<td>75</td>
<td>36.00%</td>
</tr>
<tr>
<td>Medicaid</td>
<td>7</td>
<td>23</td>
<td>30.43%</td>
</tr>
<tr>
<td>Medicare &amp; Medicaid</td>
<td>9</td>
<td>25</td>
<td>36.00%</td>
</tr>
<tr>
<td>Other</td>
<td>11</td>
<td>27</td>
<td>40.74%</td>
</tr>
</tbody>
</table>

### Metric #2: Mean Number of Days until Initial Evaluation

<table>
<thead>
<tr>
<th>Measure</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 12-17 years</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
E. Adherence to Measure Specifications:

- **Population included (Rows 47-57)**
  - Did your calculation of the measure deviate from the specification (Row 58)
  - Does the denominator represent the total eligible population (row 59)
  - Specify the size of the population included in the denominator (Row 60)
- **Continued**
### E. Adherence to Measure Specifications: (continued)

- **Metric #1**
  - Age Range 12-17
  - Age Range 18+
  - Medicaid
  - Medicare & Medicaid
  - Other

- **Same for Metric #2**
### Time to Initial Evaluation (I-EVAL) (17)

#### F. Additional Notes

<table>
<thead>
<tr>
<th>Question</th>
<th>Additional Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did the denominator differ for neither Medicaid nor Medicare &amp; Medicaid population?</td>
<td>If denominator differs, explain the deviation in the next cell.</td>
</tr>
<tr>
<td>If denominator differs, explain the deviation in the next cell.</td>
<td></td>
</tr>
<tr>
<td>Did the calculation differ in some other way for the neither Medicaid nor Medicare &amp; Medicaid population?</td>
<td>If other, explain the deviation in the next cell.</td>
</tr>
<tr>
<td>If other, explain the deviation in the next cell.</td>
<td></td>
</tr>
<tr>
<td><strong>Total Eligible Population:</strong></td>
<td></td>
</tr>
<tr>
<td>Did the numerator differ for the Total Eligible population?</td>
<td>If numerator differs, explain the deviation in the next cell.</td>
</tr>
<tr>
<td>If numerator differs, explain the deviation in the next cell.</td>
<td></td>
</tr>
<tr>
<td>Did the calculation differ in some other way for the Total Eligible population?</td>
<td>If other, explain the deviation in the next cell.</td>
</tr>
<tr>
<td>If other, explain the deviation in the next cell.</td>
<td></td>
</tr>
</tbody>
</table>

*F. Additional Notes:*

There are some things you would like to tell us about the reporting process.

End of Worksheet
Questions so far?
Preventive Care & Screening: Body Mass Index (BMI) Screening & Follow-Up (BMI-SF)(1)

- **Denominator**: Number of consumers aged 18 years and older seen during measurement year (MY)
- **Denominator Measurement Period (MP)**: The MY
- **Why?** To look at everyone seen during the MY
- **Numerator**: Number of denominator-eligible consumers with a BMI documented during the current encounter or during the previous six months AND with a BMI outside of normal parameters with a follow-up plan documented during the encounter or during the previous six months of the encounter
- **Numerator Measurement Period**: The MY and the previous six months
- **Why?** To capture BMI documentation and follow-up plan for BMI outside normal parameters going back, if necessary, up to 6 months before the MY.

<table>
<thead>
<tr>
<th>Year before MY1</th>
<th>MY1</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Numerator MP</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Denominator MP</strong></td>
<td></td>
</tr>
</tbody>
</table>

Slide 29
A. Description

- Narrative description of measure with normal parameters included
- Data Collection Method: Medical Records
- Guidance for Reporting:
  - Payer stratification
  - No diagnosis
  - Once per year for each consumer seen during the year
  - BMI may come from outside source
  - Use most recent BMI

(cont’d next slide)
Preventive Care & Screening: Body Mass Index (BMI) Screening & Follow-Up (BMI-SF)(3)

A. Description (cont’d)

• Guidance for Reporting:
  • Sources of medical records
  • Refer to source measure for codes that you will need
  • Measurement Period

- Measurement Period

Preventive Care & Screening: Adult Body Mass Index (BMI) Screening & Follow-Up (BMI-SF)

- Electronic health records (including billing records)
- Paper health records
- Registry

- Please refer to the most recent source measure PQRS #128 at PQRS Measures for encounter codes needed to calculate this measure.
- Refer to the specific data-reporting template for the reporting requirements applicable to each measure and to the Appendices in Volume 2 of this manual.

Measurement Period: The measurement period for the denominator is the measurement year. The measurement period for the numerator is the measurement year and the previous 6 months.
B. Definitions

- **Body Mass Index (BMI)**
- **Follow-up Plan**
- **Continued next slide**

### BMI

**Definition:** Body Mass Index (BMI) is a number calculated using the Quetelet index—weight divided by height squared (W/H²)—and is commonly used to classify weight categories. BMI can be calculated using:

- **Metric Units:** BMI = Weight (kg) / (Height [m] x Height [m])
- **English Units:** BMI = (Weight [lbs] x 703) / (Height [m] x Height [m])

### Follow-Up Plan

Proposed outline of treatment to be conducted as a result of a BMI out of normal parameters. A follow-up plan may include, but is not limited to:

- Documentation of education
- Referral (for example to registered dietitians, nutritionists, occupational therapist, physical therapist, primary care provider, exercise physiologist, mental health professions, or surgeon)
- Pharmacological interventions
- Dietary supplements
- Exercise counseling
- Nutrition counseling
B. Definitions (cont’d)

- Not eligible for BMI Calculation or Follow-up Plan
  - Palliative care
  - Pregnant
  - Refuses height &/or weight
  - Any other documented reason it is not appropriate
  - Urgent or emergent medical situation where time is of the essence and delay of treatment would jeopardize health status

- Provider Entity
Preventive Care & Screening: Body Mass Index (BMI) Screening & Follow-Up (BMI-SF)(6)

C. Eligible Population

- Age 18 or older on date of service this MY
- Event/Diagnosis:
  - Step 1: Seen at the BHC at least once during the MY
  - Step 2: 18 or older on date of service during the MY: Types of eligible encounters are limited to those identified by codes in the source measure

<table>
<thead>
<tr>
<th>Provider Entity</th>
<th>The provider entry that is being measured (i.e., BHC)</th>
</tr>
</thead>
<tbody>
<tr>
<td>C. ELIGIBLE POPULATION</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CRITERIA</th>
<th>REQUIREMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>Consumers aged 18 years and older on the date of service during the measurement year</td>
</tr>
</tbody>
</table>

Event/Diagnosis

Follow the steps below to identify the eligible population:

- **Step 1**
  - Identify consumers flagged as having been seen at the provider entity at least once during the measurement year

- **Step 2**
  - Identify consumers from step 1 who are aged 18 years or older on the date of service during the measurement year.

Relevant codes (Current Procedural Terminology [CPT®] or Healthcare Common Procedure Coding System [HCPCS]) are identified in the most recent source measure specification.

Note: The types of eligible encounters are limited to those listed.
D. Medical Records Specification

- **Denominator – Eligible Population**
- **Numerator:**
  - Restated
  - Numerator Quality Data Coding Options
    - Three codes where numerator is satisfied
    - Two codes where it is not
  - Continued next slide
Preventive Care & Screening: Body Mass Index (BMI) Screening & Follow-Up (BMI-SF)(8)

D. Medical Records Specification (cont’d)

- **Numerator:**
  - Numerator Instructions
    - How to obtain height and weight
    - Follow-Up Plan
    - Performance Met
  - Cont’d next slide
Preventive Care & Screening: Body Mass Index (BMI) Screening & Follow-Up (BMI-SF)

D. Medical Records Specification (cont’d)

- Exclusions FROM DENOMINATOR & NUMERATOR:
  - Relevant quality-data codes for non-eligibility
  - Incomplete Reporting Exclusion

- Example Calculation: Appendix BMI-SF
E. Additional Notes

- Information on source measure
  - Medicare population
  - Not risk adjusted
  - Specified at provider and other levels
  - Modified here to be consistent with other BHC measures in format

- Interpretation of score: Better quality = higher score
Appendix BMI-SF

Example Calculation

Steps in calculation | Medicaid | Medicaid & Medicare | Neither | Total
---|---|---|---|---
BMI ≥ 25 and < 30 kg/m² | | | | 1
BMI ≥ 18.5 and < 25 kg/m² | | | | 2
Exclude BMI Not Documented, Consumer Not Eligible: 15
Exclude BMI Documented Outside of Normal Limits and Follow-Up Plan Not Documented in EMR, Consumer Not Eligible: 4
Exclude No quality-data codes reported: 1
Total: 100
Questions so far?
Poll Question 1

How will you obtain the most recent height and weight results?

Option 1: To the extent possible, we will have a care coordination agreement with each consumer’s primary care physician that will assure we have those data.

Option 2: We will make sure that we attempt to measure height and weight for all consumers at least annually as a routine matter.

Option 3: Both of the above.

Option 4: Other

If you wish, please briefly indicate your “other” approach in the chat box.
Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention (TSC)(1)

- **Denominator**: Number of consumers aged 18 years and older who were screened for tobacco use one or more times within 24 months
- **Denominator Measurement Period (MP)**: The Measurement Year (MY)
- **Why?** To assure screening at least every other year for all consumers seen in a MY
- **Numerator**: The number of consumers who were screened for tobacco use at least once within 24 months AND who received tobacco cessation intervention if identified as a tobacco user
- **Numerator MP**: The Measurement Year (MY) and the prior year
- **Why?** To capture intervention if past year or present year screening revealed need

<table>
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<tr>
<th>Year before MY 1</th>
<th>MY1</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Numerator MP</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Denominator MP</strong></td>
<td></td>
</tr>
</tbody>
</table>
Section A. Description

- Narrative of measure
- Data Collection Method: Medical Records
- Guidance for Reporting:
  - Stratified by payer
  - Report once per MY if seen that year
- Source of records
- Code sources
- Template and Appendices (example & codes)
- Measurement period
Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention (TSC)(3)

B. Definitions:
- Provider Entity
- Tobacco Cessation Intervention
- Tobacco Use

C. Eligible Population:
- Age: 18 and older on date of service during MY
- Event/Diagnosis:
  - Step 1: Seen at Provider Entity
  - Step 2: Age 18 or older
  - Step 3: Eligible encounter in MY (source measure)
D. Medical Record Specification

- **Denominator:**
  - Section C
  - Incomplete Reporting Exclusion

"Continued next slide"
Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention (TSC)(5)

D. Medical Record Specification

- Numerator
- Narrative description
- Numerator options:
  - Two codes numerator satisfaction
  - One code numerator failure
- Exception: Documented medical reasons for not screening
- Measurement Period Note
- Example Calculation: Appendix TSC

E. Additional Notes

1. The NACIQI specifications state “exceptions” in circumstances when many specifications would otherwise “satisfy.” We retain the NACIQI language for consistency with the original measure. The NACIQI measure also places exceptions in numerator calculations.
Questions so far?
Preventive Care & Screening: Unhealthy Alcohol Use: Screening & Brief Counseling (ASC)(1)

- **Denominator**: Number of consumers aged 18 years and older seen during the Measurement Year (MY)
- **Denominator Measurement Period (MP)**: The MY
- **Why?** To assure systematic screening at least every other year for all consumers seen in a MY
- **Numerator**: The number of consumers who were screened at least once within the last 24 months for unhealthy alcohol use using a systematic screening method **AND** who received brief counseling if identified as an unhealthy alcohol user
- **Numerator Measurement Period**: The Measurement Year (MY) and the prior year
- **Why?**

<table>
<thead>
<tr>
<th>Year before MY 1</th>
<th>MY1</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Numerator MP</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Denominator MP</strong></td>
<td></td>
</tr>
</tbody>
</table>
### B. Definitions

- **AUDIT and AUDIT-C**
- **Brief Counseling**
- **Provider Entity**
- **Systematic Screening Method**

#### Table: Definitions

<table>
<thead>
<tr>
<th>TERM</th>
<th>DEFINITION</th>
</tr>
</thead>
<tbody>
<tr>
<td>AUDIT and AUDIT-C</td>
<td>The AUDIT is the Alcohol Use Disorders Identification Test and the AUDIT-C is an abbreviated version of the AUDIT. Both were developed by the World Health Organization.</td>
</tr>
<tr>
<td>Brief Counseling</td>
<td>Brief counseling for unhealthy alcohol use refers to one or more counseling sessions, a minimum of 5-15 minutes, which may include feedback on alcohol use and harms, identification of high-risk situations for drinking and coping strategies, increased motivation, and the development of a personal plan to reduce drinking.</td>
</tr>
<tr>
<td>Provider Entity</td>
<td>The provider entity that is being measured (i.e., HHC)</td>
</tr>
<tr>
<td>Systematic Screening Method</td>
<td>For purposes of this measure, one of the following systematic methods to assess unhealthy alcohol use must be utilized. Systematic screening methods and thresholds for defining unhealthy alcohol use include:</td>
</tr>
</tbody>
</table>
  - AUDIT Screening Instrument (score ≥ 4)
  - AUDIT-C Screening Instrument (score ≥ 4 for men, score ≥ 3 for women)
  - Single-Question Screening: How many times in the past year have you had 5 (for men) or 4 (for women and all adults older than 65 years) or more drinks in a day? (response ≥ 1)
C. Eligible Population

**Event/Diagnosis:**

- **Step 1:** Seen at Provider Entity
- **Step 2:** Age 18 years and older on date of service during MY
- **Step 3:** Either:
  1. **At least 2 encounters at provider entity (relevant codes in source measure)** OR
  2. **One preventive care visit (relevant codes in source measure)**
Preventive Care & Screening: Unhealthy Alcohol Use: Screening & Brief Counseling (ASC)(4)

• Numerator
  • Performance met:
    • Unhealthy alcohol use screened for and identified and brief counseling provided
    • Unhealthy alcohol use screened for and not identified
  • Performance not met:
    • Not screened OR brief counseling not provided despite positive screen
Poll Question 2

The goal of including these last 3 measures is to assure screening and prevention related to BMI, tobacco and alcohol use. Each contain HCPCS codes designed to allow recording of whether the numerator requirements were satisfied (e.g., Was screening done? Was follow-up or intervention done?)

What possible impediments do you see to numerator satisfaction (select all that apply):

1. We will not have staff trained to carry out the procedures.
2. We do not have the codes in our EHRs.
3. We do not think we can modify our EHRs to include the codes.
4. We do not think staff will consistently carry out the procedures annually or as may otherwise be required.
5. We will have to get the data from our DCOs and they may not carry out the procedures or code properly.
6. Other (elaborate in chat box).
7. We do not expect this to be a problem.
Questions?
Upcoming Webinar Schedule

5: August 9: Clinic-Reported Measures – States and BHCs
6: August 16: Special Issues – States and BHCs
7: August 23: Special Issues – States and BHCs
8: September 6: Non-Required Measures – States Only

All scheduled for Tuesdays 2:00 to 3:30 pm ET
Five BHC-Lead Measures

- Weight Assessment for Children/Adolescents: Body Mass Index Assessment for Children/Adolescents (WCC-BH) –Administrative or Hybrid
- Screening for Clinical Depression and Follow-Up Plan (CDF-BH)
- Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-BH-C)
- Adult Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-A)
- Depression Remission at Twelve Months (DEP-REM-12)
Preview of Next Webinars
Webinars 6 & 7: August 16 & 23, 2016

Special Issues:

- Sampling and calculating hybrid measures
- Quality Bonus Measures
- Data from dually eligible enrollees
- Lessons learned in state visits
- Continuous Quality Improvement (CQI) and the role of data
- When is a person a CCBHC consumer
- Other issues/questions raised in earlier webinars
### BHC Measures (1)

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Contact Information

Please submit additional questions to CCBHC_Data_TA@samhsa.hhs.gov about:

• Material covered today
• BHC-lead measures that will be covered in the next webinar
• Ideas for special issues
• Other questions related to data collection, analysis, or reporting

We will attempt to respond to them in the appropriate webinars.