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BHC--Lead Behavioral Health Clinic Measures - Part 1 of 2

Peggy O'Brien: Welcome to the fourth 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 BHC-Lead Behavioral Health Clinic Measures, and this is part 1 of 2. I'm Peggy O'Brien, a Senior Research Leader at Truven Health Analytics, presenting on behalf of SAMHSA.

There is 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 about parts about what I've covered that may be confusing or about related matters that I haven't 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 of them in this webinar. A PDF of the slides for each webinar is posted as a resource on the webinar site. The webinars themselves will be downloadable for a year or actually, viewable on demand for a year, after the event on the webinar site where you are listening to this presentation, as well as available through the SAMHSA website.

This is the webinar schedule with the intended audience identified in red. All are on Tuesday from 2:00 to 2:30 Eastern Time. Slides like these are available to use as a resource that you can refer to later as you wish. The webinar next week also relates to the Behavioral Health Clinic reported measures that are required as part of the CCBHC demonstration program and are generally intended for BHCs and states to help with their reporting of these measures.

The main focus today will be four BHC-lead measures. I also am integrated into the webinar responses to questions asked about certain measures that are being covered today. I will address those questions when I get to the specific measures.

These are the four BHC-lead measures that I will cover today. The rest of the BHC-lead measures that are required as part of the demonstration program will be covered next week. I will cover some of these measures in a lot of detail and others less so. The measures for discussion this week are--time to initial evaluation, the body mass index or BM I screening and follow-up measure for adults, tobacco use screening and cessation intervention, and unhealthy alcohol use screening and brief counseling.

This slide provides the age coverage and stratification requirements for each of the four measures we are discussing today. Other than time to evaluation, which is for ages 12 and older, each of these measures covers ages 18 and older. All of stratified by payer, and time to initial evaluation is stratified by age to capture differences between adults and those who are younger. By way of reminder, payer is Medicaid, dually eligible, and other. There was a question a couple of weeks ago during one of the webinars about the status of qualified Medicaid beneficiaries and where they fit in these three categories. We are checking with CMS to get input on this, and we'll let you know as soon as possible what the answer is.

The first measure we're going to discuss today is time to initial evaluation. For those who may be looking at the specs, it begins on page 30. This is one of the new measures that was developed by

SAMHSA. Most of the other BHC measures are derived from existing measures. Section A of the specifications is the description section and includes general information. For this spec, it begins by providing the typical simplified narrative describing the measure. In this instance, there are two metrics involved in the measure. The first is the percent of new consumers with initial evaluation provided within 10 days of first contact. The second is the mean or average number of days until the initial evaluation for new consumers. I will discuss both of these in more detail. The data collection method for this measure is medical records.

The next part of Section A contains guidance for reporting. It notes the two different metrics or calculations and it provides information about stratification. As a reminder, as we discussed in the first webinar, Medicaid includes Title 19 eligible CHIP beneficiaries but not Title 21, which are included in the other category for stratification purposes. There is more information about this distinction in the front matter to the specs in volume one.

Also discussed in the front matter of volume one is how to handle measures without continuous enrollment requirements. Continuous enrollment requirements are most often seen in state measures using administrative data. Specifically, 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. That is what you do for this measure.

Section A also provides information on types of medical record sources that may apply. This list is a very broad definition of medical records, and only some record sources apply to specific measures. For this measure, you might rely on your ERH, on paper records, on scheduling software, or as a remote possibility, something akin to the spreadsheets made available by NIATx. You are always reminded in the guidance for reporting to reference the data reporting templates and the appendices.

For each measure, I will explain both the denominator and the numerator, as well as the measurement periods that apply to both. For those who are new to quality measurement, the denominator is the entire eligible population you are measuring. In this case, it is the number of new consumers who are age 12 and older. The numerator is the number that falls within the entire eligible population--so it's a subset of the denominator--who are provided an initial evaluation within ten days of contact for the first metric, or for the second metric--the total number of days until that evaluation for all new consumers. That's because metric two is an average rather than a true performance measure in the sense that that term is typically used.

As you can see in the chart on this slide, the measurement period or the period of time for which data are collected differ for the denominator and numerator. For the denominator it's the measurement year and the six months before, less the last 30 days of the measurement year. This allows a half year look-back period to see if the person is a new consumer. For instance, if they came in on January 2nd, you would look back six months to see if they had been in during that period of time and, if not, they would be a new consumer. For the numerator, the measurement period is the measurement year. Again, the measurement year for CCBHCs is either demonstration year one or demonstration year two.

Section B of the specs contains definitions for terms used in the measures. In general, these are derived from the CCBHC criteria for this measure, including business days which is defined as

Monday through Friday, excluding holidays, regardless of days of operation. If you had a BHC that operated seven days a week and was open on holidays, the only days that count are Monday through Friday--non-holidays.

Initial evaluation is defined, and it's based on the defined initial evaluation and the CCBHC criteria. Criterion 2B1 specifics when it must be done, and Criterion 4D3 specifies the content. A new consumer is defined as an individual who is not seen at the clinic in the past six months, provided as defined as received. The clinic is to record the number of business days from initial contact until the initial evaluation was received or completed for the consumer. That comes from the spec definition. Then provider entity is defined. It's defined for all of the measures. It's the entity that's being measured. It's the BHC or CCBHC for purposes of the demonstration program.

Section C defines the eligible population which is, in other words, the denominator. The age tells you the age group covered and when to measure age. Here it is at the end of the measurement year. The event diagnosis defines the eligible population step-by-step. Here that is a two-step process. First, you include new consumers seeking services during the first 11 months of the measurement year. Then, from those individuals, you count those who are age 12 and older at the end of the measurement year.

Section D provides the actual specification for the first metric--the percentage of new consumers within initial evaluation provided within ten business days of first contact. Remember to refer to the definition section, so you only capture new consumers and accurately capture the meaning of provided. The denominator and numerator are defined. The denominator is the number of consumers in the eligible population. It refers back to Section C, which we just talked about--so it's new consumers ages 12 and older. The numerator is the number receiving the initial evaluation within ten business days of first contact during the measurement year. That is metric one. The spec in Section D also contains reminders about the measurement periods--there are no exclusions--and a reminder to look at the appendix where there is an example.

Section E for this measure contains the second metric--the metric that is for the mean or average number of days until initial evaluation for new consumers. The denominator and numerator are reiterated, as are the measurement periods and the note regarding the appendix. Simply put, for this metric, you divide the total number of days between first contact and the initial evaluation for the entire eligible population--that means everybody who is a new consumer, 12 or older--by the number of people in the eligible population.

Section F contains additional notes. It indicates that this is specified at the BHC level. That means that it is aggregated, recorded, calculated at the BHC level. It recognizes that there is a limitation to this measure. Specifically it's likely that some new consumers will not receive an appointment within ten days because of their own schedules, because their need is not urgent, or simply because they do not show up for an appointment. This is a recognized limitation that will affect all clinics, and it was decided that trying to adjust for consumers who are offered but don't accept an appointment within ten business days complicates the calculation unnecessarily.

The last section of the measure always explains what the results of the measure mean. For the first metric, the percent getting an initial evaluation within ten days--higher is better because more new consumers are seen within ten days. For the second metric, the mean number of days

to initial evaluation or the average number of days--lower is better. The overall number of days to initial evaluation is lower, and that is better. I do want to point out one typo in the second paragraph of Section F, just to be clear. The third sentence says non-consumers, and it should be new consumers.

Volume 2 of the specs contains supplemental information in the form of appendences. This particular measure has an appendix, and this is a screenshot of the beginning of the appendix, which is an example working through the calculations for the measures. This is designed for people like me who may like examples where they can follow along the steps to help make sense of it.

As I said, I'm going to stop frequently for questions. If you don't have questions now, feel free to ask them later, but I want to see if there are any questions on what I've covered so far. I do promise I won't review all of the measures in this degree of detail. This one, however, is different from most, so I wanted to cover it in detail and also give you a chance to see the spec components in the context of the major that you will be calculating. Ame, do we have any questions so far?

Ame: The first question is from the Monique (Monod). If the consumer has private insurance and Medicaid, will we consider this consumer as Medicaid or as other?

Peggy O'Brien: That's a good question, and that is something I think I should defer rather than trying to answer. The question is, if they have both Medicaid and private insurance. Let me table that one and try and find out an answer.

Ame: The next question is from Margaret Morris. Can initial contact be by phone?

Peggy O'Brien: Yes. Initial contact can be by phone.

Ame: Next question is from Monique Monod. What is the definition of first contact?

Peggy O'Brien: First contact usually--and again, we're looking back six months, so it's possible somebody could've been seen at this clinic more than six months ago, but let's assume that this is a fresh face that we've never seen before. Initial contact is often a call looking for an appointment. That would be the most typical probably. I suppose it could be a walk-in looking for an appointment. It also could be, I think, a crisis service that is provided by the CCBHC.

Ame: The next question is from Margaret Morris. If no evaluation occurs, how is that handled in the average?

Peggy O'Brien: That is a good question. Actually, I would prefer not to try and figure out how to explain the answer on the webinar, but I will put that into the questions that will be answered as follow-up to the webinar.

Ame: The next question is from Leslie Carve. Just to confirm this--if a family seeking services for a child under 12, we will not report this data. Why isn't time to initial evaluation being measured for children?

Peggy O'Brien: I think that time to initial evaluation for consumers younger than 12 is still very important, and it's clearly required as part of the criteria that the initial evaluation occur within a certain period of time. I think that the reason that it was stopped at 12 was to try and reduce the burden on the clinics, but clearly the criteria do have the same standards for initial evaluation for children as they do for adults.

Ame: The next question is from Allen Nay. Will a program that has open access and the clients can come in whenever they want during certain hours, but they happen to call to determine what your hours are--is that call considered first contact?

Peggy O'Brien: I'm going to say no, and I want to restate it to make sure that it's clear what I'm understanding the question to be. If a person calls just to find out what hours you're open, that is not an initial contact. That is an attempt to find out when they can come in and have an initial contact, if you have open hours and they can come in during those hours.

Ame: The question is from Lori Richardson. If someone receives an inpatient prescreen and there's a call later for services, would this be considered a new consumer?

Peggy O'Brien: I think that it would, but I want to defer that and think about it and possibly see.

Ame: The next question is from Jeff McKinsey. Please define initial assessment by prescriber.

Peggy O'Brien: Initial assessment by prescriber? I don't think that initial assessment by prescriber is used in this particular measure, but the initial evaluation is defined in the criteria for certification. I refer you to that, if that's what you're asking about.

Ame: The next question is from (Kenta) Jet. Does the PCP referral considered the first point of contact?

Peggy O'Brien: These are really good questions, and people are asking about details that I think are very important. My instinct is to say no to that, but it has to be a contact by the person who's seeking services or by their family if they're a child, but I also want to make sure that I confer with others about that one to be sure of that.

Ame: The next question is from Ty Nuygen. What are the compliance targets for these measures?

Peggy O'Brien: There are no set compliance targets for these measures. The states are going to be determining what they think is an appropriate rate, and SAMHSA does not set the targets for that. It's state by state.

Ame: The next question is from Carrie Walker. Does the other category include the uninsured?

Peggy O'Brien: Yes, it does.

Ame: We have a comment from Grace White. I don't think crisis counts, according to what I'm reading on page 31--due within ten business days of first contact or those who present within

routine non-emergency or non-urgent aids. However, you just said a crisis in reference to initial contact.

Peggy O'Brien: Right. Yes, and so that's something that I probably need to think harder about and talk to other people about before I respond.

Ame: The next question is from Emily (Dosh). Can you first contact the entering into level three detox and then they enter into follow-up outpatient care within ten days?

Peggy O'Brien: Again, I think that that's a particular situation I'd want to think about. I think it depends on whether the detox is a part of the CCBHC. If it's not, I would say no. If it is, it might be. That's something that I want to talk to people about and give the appropriate answer.

Ame: There are no more questions, Peggy.

Peggy O'Brien: Thank you, Ame. Okay, so I'll move on, and there will be many more opportunities to ask questions. For this measure, I'm going to also briefly go through the data reporting template, because I want to cover that once in this webinar just to kind of refresh people's memory and put it in context. Section A of the template pertains to the measurement year. Row five of the worksheet that you see on this screenshot is where you enter the measurement year. For CCBHCs, this will be DY1 or DY2. You'll see on the screenshot that I included part of the validation text which tells you what to do to complete that part of the data reporting template.

Section B is where you provide data source. This measure is the medical records data source specification. In row seven you're asked if it's medical records data that you used or other. Hopefully, it will be medical records data, and that's what I entered in this example. Then also in row seven further to the right, you're asked, if you select this medical records data what the source is. The choices are first, EHR which can include registry, practice management--in other words, electronic sources. The second option is paper, and the third option is both. For this example, I selected the HR option, so you see that filled in already. You might be using paper, or you might be using both. In row eight, if you selected other--you didn't use medical records data--then you need to specify what that other is and what you did use.

Section C is where you put in the date range for the data covered. This is the start and end date for the denominator and numerator. You're restricted in the formatting you can use to a two-digit month, two-digit date, and four-digit year. The date of validation message that I selected for this screenshot will remind you of that.

Section D contains the narrative descriptive for the measure and then information about stratification requirements. There is then a table for data entry which should auto calculate. You can see that I entered some hypothetical numbers for the numerator and denominator and that it calculated the rates or percentages. There also is an automatic rollup to the back of the templates. I'll show you that on the next slide. You also can see here that there is a table for each of the two metrics, as well as for each stratification. Ideally, scheduling software or your EHR will be the source for these numbers.

This is a screenshot of the rollup worksheet that's at the back of the data template reporting workbook where the results auto-populate from the major worksheet. You do not need to do anything with the rollup worksheet. It just magically appears filled in after you enter the information in the individual measure worksheet.

Section E asks about your adherence to the measure specs--rows 47 through 57 of this particular worksheet--you can't really see the 47 through 57. I think you see the last digits of the two digits--asks you to identify yes or no whether certain groups are contained in the calculation. Here I selected yes for the Medicaid population. Then I clicked on the data validation instruction to show you what the next question is--specifically, did your denominator also include the Title 19 CHIP population?

After the list of groups, it goes on to ask if your calculation deviated from the spec. The denominator represents the entire eligible population and the size of the population included. Section E continues on the next few slides. It's rather long. It's the longest part of the data reporting template. This shows for metric one--the part of Section E that asks about specifics--for specifics about adherence to the numerator, denominator, and overall calculation for each stratification by age and payer. These components are the same for each stratification. I won't show you the whole thing.

Section F is where you put additional notes, if any. As reminder, the front matter of the specs in volume one, as well as the instructions page of the templates, offer you guidance on completion of the different template sections, including when you might use additional notes. I promise not to go through the templates on any of the other measures today. I think probably once is sufficient in a webinar. Okay, so I'm going to pause again and see if there are additional questions on what I've covered so far, whether it's the templates or the specs so far.

Ame: The first question is from Ashley Fur. If a person was being seen that had stopped coming in for six plus months, but then re-engaged, would they be considered a new consumer?

Peggy O'Brien: Yes. Within the definition used for the specification they would be considered a new consumer, and they would be required to have the initial evaluation.

Ame: The next question is from Alex Hale. Regarding where the mail referenced on the left side of the slides can be access--so where is the manual and the data reporting template? Where can you find the copy?

Peggy O'Brien: Okay. The manual and the data reporting template are available on the SAMHSA website. You can go to SAMHSA Section 223, I think, and find them. The second webinar in this series--that was a question that was often asked in the first webinar--so in the second webinar that information is available on one of the early slides in webinar two. Even if you didn't register for webinar two, you can register for it on the same place that you registered for this one, and you can go back in and, if you need to, you can find the link to it there as well.

Ame: The next question is from (Catty) Garland. The age definition--is this determined by the age at data service or the age at beginning or end of reporting year?

Peggy O'Brien: The age--like age 12 or older--I believe at the end of the reporting year, but let me make sure I'm right about that. Bear with me while I--I don't want to say the wrong thing. Yes. For this measure, age is measured at the end of the measurement year. If you're a CCBHC, it would be the end of DY1 or the end of DY2. That information is always found in section C of the specification where they define the eligible population.

Ame: The next question is Ty Nuygen regarding data submission. Will a portal be available for data input reporting or electronic forms be made available to fill out?

Peggy O'Brien: No. There is an Excel worksheet which is the data reporting template that I just went over. This is also something that was addressed in much greater detail in the first webinar, so again the very general questions like this, the first webinar is a great place to look to find answers to most of them. The submission is via email. You send the data reporting template to SAMHSA.

Ame: The next question is from Eric (Fashee). In the data range for I eval, are we using the determined number of people scheduled during a specific timeframe, for example, January 1, 2016 through February 29, 2016?

Peggy O'Brien: You are using the measurement year, so if you're a CCBHC, for instance, and you're in demonstration year one--and let's just pretend your demonstration year begins on January 1st--it will go from January 1st of 2017 to December 31st of 2017. You're going to capture all of the new consumers for this measure. You're going to capture all of the new consumers--people who weren't seen in the six months prior to when they come in and make that first contact. Those are the new consumers who, as long as they're 12 or older, will be the denominator. You're capturing everybody in that demonstration year.

Ame: The next question is from Lori Richardson. How do you report exceptions--consumer choice that they did not want to be seen within ten days? Do you still count that exception in your counts?

Peggy O'Brien: That kind of goes to the limitation that I mentioned. We know that there will be people who don't want to be seen or they're not presenting as an urgent needs, they don't want to necessarily come in or their schedule won't fit coming in within ten business days. We know that there will be those people, and those people are counted as--they are not counted in the numerator. They are included as new consumers in the denominator, so they're part of the eligible population because they're a new consumer age 12 or older.

They don't get counted in the numerator because they didn't get evaluated within ten days, no matter who's fault it is. If they just don't show up we know that's going to happen, but that's going to happen across the board to all clinics, and this is kind of a crude measure of how many people are evaluated within ten days. We know it's not perfect because there are good reasons that people may not be, but it's a very kind of dry kind of measure.

Ame: The next question is from Bob (Baloo). Are DY1 and DY2 defined as calendar year 2017 and 2018, regardless of when a state certifies a CCBHC? For example, states have until June 30, 2017 to certify their CCBHCs. Does that mean that DY1 data may actually be less than one year?

Peggy O'Brien: No. DY1 will be the first full year for the state. If the state certifies on February 1st, it will begin on February 1, 2017 and go to the end of January 2018, and then the second year will begin. You always have 12 months of data. It's just that it's going to be staggered, depending on when the state certifies and when the program starts in the state.

Ame: The next question is from Susan Kessman. Can you clarify what is meant by the numerator differ from the 12-to-17-year age range? Differ from what?

Peggy O'Brien: I think what the questioner is asking is--I think I said something about the numerator measurement period differing from the denominator measurement period. One of them is the measurement year, and one of them is not.

Ame: The next question is from Kim Sensor.

Peggy O'Brien: Ame, let me just finish here, because I found it. I think what the person is asking is what I meant when I said the numerator and denominator differ. That's the measurement period. I could be misinterpreting things, but this is how I'm going to answer, and if there's a different question please follow up with me. The numerator measurement period is the measurement year. The denominator measurement period is different. It's six months back and it ends 30 days before the measurement year end. Sorry, Ame. Go ahead.

Ame: Sorry, Peggy. We have questions from Kim Sensor. Is the individual who calls but never comes in for an appointment--are they to be included in the denominator?

Peggy O'Brien: Yes. If they call and are seeking an appointment they are somebody who should receive an initial evaluation, and they may not come in but they are counted in the denominator.

Ame: The next question is from (Malig Manog). If a consumer calls and then is transferred to a clinician and an initial evaluation is done over the phone, does that count as time as zero? Similarly, if the consumer calls and then the consumer asks to come into office for evaluation, does that time also be considered as zero?

Peggy O'Brien: If the person is evaluated over the phone by a clinician on the same day that they call. They had--I would say--I don't know if it said zero or one, but it's a very brief period of time. If they come in that same day, the same would be true.

Ame: The next question is from Bob Baloo. Are the CCBHCs reporting directly with the state?

Peggy O'Brien: The CCBHCs, for the measures that we're talking about today and next week--these are what we're calling the BHC lead measures. They're calculated by the BHCs, and they are reported on the data reporting template to the state. The state is also reporting the measures that are state lead measures that we talked about in the last two webinars. Altogether those go up to SAMHSA.

Ame: The next question is from Heidi Garwin. If a consumer calls seeking an evaluation and we provide them with our own open access and they never show, is that counted in the denominator?

Peggy O'Brien: Yes.

Ame: The next question is from Ty Union. How frequent is reporting required--annually or quarterly?

Peggy O'Brien: The reporting is required in the criteria annually. There is a certain amount of time after the demonstration year ends that the reporting has to be submitted. States have certain leeway as to whether they might like to see things more frequently. Sometimes it's a good idea to have data more frequently so that you know if there are problems and so you can actually respond to the data and make adjustments to the services. The requirements and the criteria are annually.

Ame: The next question is from (Lanig Wanatta). I understand why we check back six months to find out if the consumer is a first consumer or not. However, why do we count those under six months past in the denominator? Doesn't that skew the data, since we could not see these consumers prior to the start of DY1?

Peggy O'Brien: Actually, no because you're just looking back six months to see if they came in. You just need data. You need some kind of data to be able to look back six months just to determine if there are new consumers. That's the only reason that it goes back six months. The numerator is the measurement year, and so it's during the measurement year that you want to measure them and make sure that the evaluation occurred.

If somebody came in January 1st, or they called January 1st seeking services, you would look at the data for the past six months to determine are they new. Were they here a week ago, a month ago, or eight months ago? If it was eight months ago, they're a new consumer. Then you want to make sure that you have an initial evaluation within ten days, if that's what applies to that particular person. That's the numerator and that is data that is from measurement--the measurement year--the demonstration year. Your numerator in this measure is always looking at data from the demonstration year.

Ame, let me stop for just a second. I want to move on because we have three more measures that I want to try and cover today. The questions that I haven't gotten to yet, if there's time at the end I do want to address them, but I also do want to move on. Any question that's in the chat box will be answered, though, whether it's answered today or in the near future. I'm going to move on at this point, because I want to make sure that we get into the other measures as well.

The second measure that I'm going to cover is preventive care and screening--BMI screening and follow-up. This is the adult BMI measure. I'm going to go through this one in some detail because this is a more standard measure, unlike the time to evaluation measure. This measure begins on page 44 of the specs. The denominator for this measure is consumers aged 18 and older who are seen during the measurement year. Remember the measurement year will be demonstration year if you're a CCBHC.

The measurement period for the denominator is just the measurement year. The numerator is the subset of those individuals who have a documented BMI during the current encounter or in the prior six months, and if the BMI is not in the normal range, a documented follow-up plan. The numerator asks both was it a BMI documented and two--was a follow-up plan documented if the BMI was not in normal range?

The measurement period for the numerator is the measurement year plus the six months before. That allows you to go back and see if there were earlier BMI screenings and follow-up plans that were done. We have a little grace period there.

The plain language of this measure and the measurement period is, you start with those who are seen at the clinic in the measurement year who are 18 and older. Among those, for the numerator you look back up to six months from when they were seen during the measurement year to see if there is a documented BMI and, if needed, a documented follow-up plan.

The narrative description of this measure includes guidance on a number of things, including what is a normal parameter which depends on age, that this measure uses medical records as its data source, that stratification is by payer, that there is no diagnosis involved in this measure, that it's designed to assure that BMI is measured annually for all consumers seen during the measurement year and that the documentation can be from the CCBHC or from another source such as a PCP and that you need to look at the most recent BMI.

Guidance is provided on medical records, and they're broadly defined here to include billing records. You are referred to the source measure. There is a link provided in the spec for the codes that you'll need here, and I'll talk more about this in a little bit. The measurement periods are explained.

The definitions provided include body mass index--you likely will have a means to calculate this more automatic than this--and what constitutes a follow-up plan. This definition includes examples but is not exclusive to those. You can have other kinds of follow-up plans if somebody has a BMI outside of the normal range.

The definitions also provide who's not eligible to be in the measure. This is an exclusion that keeps these people completely out of the measure. They're not in the denominator. They're not in the numerator. That includes people who are receiving palliative care, people who are pregnant, people who refuse to have their height or weight taken, any other documented reason that indicates that obtaining BMI is not appropriate, or if there's an urgent or emergent medical situation where time is of the essence and delaying treatment would jeopardize their health status and, in addition, the definitions that provider entity has defined.

Section C of this measure refers to the age range. Here it is age18 or older on the date of service during the measurement year. Though the question somebody had about the last measure about how do you determine how old they are, what date do you use--it's always in this location whatever the measure.

The event diagnosis which is how you determine the eligible population that comprises the denominator--were they seen there once during the year. That means that links them to the BHC, so that has to happen. Step two--were they 18 or older on the date of service? For step two, in order to determine if you have an eligible encounter, you're referred to the source measure for the relevant CPT or HCPCS codes. There is a link in the spec to that source in Section A. The encounter does not need to be at the BHC, so if you have a DCO doing physical health screening, that counts, as would a PCP or other provider with which you have a care coordination agreement. The simplest way to make sure this happens, though, is to do it yourself.

Section D of the spec is the specification. For the eligible population or denominator, as usual, it refers back to Section C, so you make sure you're getting those at the correct ages, seen at CCBHC with an eligible encounter--the things we talked about on the last slide. For the numerator, it restates the description, and then it provides three codes where the numerator is satisfied and two where it is not. This is if you're using billing records and you have automated this, so that you can code and collect these easily.

There are five codes that are important here in the numerator. The numerator is met if you have a BMI that's documented as normal, if you have a BMI that's above normal and there's a follow-up plan that's documented, and if you have a BMI that's below normal and you have a follow-up plan that's documented. All of those people get counted in the numerator. The numerator is not met and these are not included if there is no BMI documented and no reason is provided or if a BMI is documented as outside normal parameters and no follow-up plan is documented and no reason is provided.

There are five separate HCPCS codes for these numerator possibilities. Ideally, your EHR billing system will allow you to use these codes to automate the calculation of this measure so you can simply pull it out of your EHR.

Also included in this section are instructions for obtaining both height and weight. Self-reported is not sufficient. There is more information on the follow-up planning and more information on when the numerator is met.

Information is then provided on exclusions, and I already went through those exclusions a couple of slides back. It was palliative care, pregnancy, refusal, and a few other things. There are codes for documenting ineligibility, and the BHCs are encouraged to incorporate those codes into their systems as well. These are two of the five codes that I mentioned a minute ago.

For this measure, failure to record quality data codes means that the consumer is excluded from the denominator and, of course, also from the numerator. Not all measures operate this way. This is a carryover from the source measure. I want to stop and comment on this. Ideally, a measure will not excuse inclusion in the measure for individuals where the provider doesn't use the codes that are needed to record the measure, but that’s how the original measure was written. There is a positive way to look at this.

Most BHCs will never have reported this measure or even possibly screened for BMI, much less developed a follow-up plan. Some will have, but many will not. Many of you are starting from square one. If you can get on top of this early and begin using these codes and documenting the screening, the follow-up, and exclusions in your one, that will be progress in comparison to the past. Your ability to consistently make sure that the screening is done, follow-up is developed, and coding properly occurs will increase, resulting in even more improvement at a higher rate through year two. This is the sort of improvement in integrated care that is being promoted by the CCBHC demonstration program. The codes are merely a method of reporting it, but they're a necessary part of it.

Section E of the measure spec has additional notes, which tell us that the source measure was developed for the Medicare population. We're using it for the entire BHC population. It's not risk

adjusted. None of the BHC measures are risk adjusted. You don't need to worry about that, and is specified at both the provider and other levels, which is unusual. Many of the measures were not. We modified it here to be consistent with the other BHC measures in terms of format, but otherwise we adhere to the source measure.

The interpretation of scores states that a higher rate on this measure is an indicator of better quality. That means more people are being screened for BMI, and where that BMI is outside of the normal range, follow-up plans are being developed. There is also an example in the appendix--an example calculation--and this is a screenshot of that appendix.

I want to stop again and see if there are questions. I also do have two more measures to get through. I will take as many questions as I think I can and still try to cover the other measures. Ame, do we have questions on this?

Ame: The first question is from Bob Baloo. Is the expectation for the CCBHC to generate the BMI or obtain from other practitioners? If the latter, how?

Peggy O'Brien: Okay. It can be generated at the BHC, which is the most sure-fired way of you actually getting it. You also could have a DCO that you're working with as part of the CCBHC that is doing physical health screening, and they should provide you with that data that is necessary. That's part of the requirement for being a DCO--that they will provide you with the data that's necessary to be able to calculate these measures.

Now, if you're not using either of those avenues, then you're going to have to have a care coordination agreement with the pertinent PCP or whoever else may be doing the screening or hopefully doing the screening. That's more difficult, I grant that, but that is the approach that would have to be taken in that particular circumstance. That tells you that the best way is probably to do it yourself or to have a DCO that is doing it.

Ame: The next question is from Patty Garland. If they have multiple services during the measurement year, are we only collecting data from the most recent or earliest service during the measurement year?

Peggy O'Brien: They could have multiple services that have absolutely nothing to do with BMI. You're not required to measure the BMI every time there's a service. You just have to have--they have to have a service during the year, so that they're linked to you. If by some odd chance they had their BMI measured multiple times, I think that the spec probably will tell you which one to use. It's usually the last, but most people who are visiting CCBHC probably will not be getting their BMI measured frequently.

Ame: The next question is from Margaret Morris. If the documentation is from another provider and not the CCBHC, does the patient record at the CCBHC have to include a copy of the screening? Is the CCBHC required to address follow-up plans or can this be done by the original screening provider?

Peggy O'Brien: The original screening provider can develop the follow-up plan and do the follow-up. This measure is pretty open in terms of who can do what, but the CCBHC does need

to have access to the data indicating that it happened. Ame, did I miss the first part of that question?

Ame: No.

Peggy O'Brien: Okay.

Ame: Does the patient record at the CCBHC have to be included in the copy of the screening if the original documentation is not from the CCBHC

Peggy O'Brien: Okay. There has to be some mechanism for the CCBHC obtaining the data. Ideally, it would be an electronic data exchange. If not, it would be in the paper record.

Ame: The next question is from Emily Dutch. It states self reporting of height and weight is not permitted. What if it is obtained by the PCP?

Peggy O'Brien: As self-reported, it's going to be very hard, I suspect, for you to determine that, but generally, if a PCP has recorded height and weight, my guess is that it's going to be an actual measurement rather than relying on the person to tell them how much they weigh or how tall they are.

Ame: The next question is from Ashley Fur. Just to clarify, if a consumer chooses to keep their own PCP that is not within the CCBHC, will we need to contact that PCP for their BMI information?

Peggy O'Brien: Yes. The section of the CCBHC certification criteria that relates to care coordination requires that the CCBHC's attempt to have care coordination agreements of some sort with primary care providers. For some, that will be simpler than others. If you have a FQHC that's part of your organization or that's one of your DCOs and a lot of people go to that, then that's much easier, but you do need to have care coordination with primary care.

Ame: The next question is from Elizabeth Luciano. Can we build the clinical decision support rule in the EHR to satisfy the documentation requirement for the follow-up plan?

Peggy O'Brien: Can you build it--the clinical decision--into the EHR? I would think so. I think it depends on your EHR and your ability to adjust it, but yes. If it's possible to build things in--screenings or guidance--it's a great idea.

Ame: The next question is from Laura Larkin. A CCBHC can collect BMIs, even if a person gets their PCP services elsewhere--correct?

Peggy O'Brien: Yes.

Ame: The next question is from Ty Nugent. The state of Michigan does not have a billable code for medical assistants to take BMI vitals on the VH side of the CCBHC. Would MAs be allowed to take vital BMIs?

Peggy O'Brien: Medical assistants that are in--?

Ame: Yes.

Peggy O'Brien: Yes. There is nothing in this measure that specifies what kind of provider it has to be. Ame, I'm going to stop the questions again, just because we have only 30 minutes left, and I want to try and get through a couple more measures. Because we have this special issues webinar coming up--webinars six and seven--I had anticipated we might run out of time for all of these measures, because there are a lot of questions, so anything that's not covered thoroughly enough on these, I am going to revisit.

Let me move on to the next slide here, which is actually related to what we were just talking about. It's a poll. How will you obtain the most recent height and weight results? You can only pick one of these. Option one--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 two--we'll make sure that we attempt to measure height and weight for all consumers at least annually as a routine matter, option three--both of the above, option four--other. If you wish to indicate your other approach in the chat box, that would be appreciated and any other comments that you have. I'm going to pause for just a second and let you pick one of those as to what your approach is.

Okay. I'm going to move on so we can see what the results are. Okay, so very few of you are planning to have a care coordination agreement or to rely on that, anyway, for obtaining these data. Fifty percent will attempt to actually measure the height and weight for all consumers, at least annually as a routine matter. Forty-seven percent would use both approaches. Okay, so that's good. I think those are valid approaches.

I am going to move on to the next measure. The next two measures are related to each other. They're very similar. I'm not going to go into them in great detail. The first one is the tobacco use measure screening and cessation intervention. The only thing I want to point out about this slide is that the codes that you use for this measure and the fourth measure, to which there is a link--actually, I do want to go into more detail. Sorry. On this one, if you are following on your specs, it begins on page 66. This looks at the number of consumers who are 18 and older who are seen at the BHC during the measurement year. That's the denominator.

The numerator asks, out of those, how many were screened for tobacco use and if they screened positive that they have received a cessation intervention one or more times in the past year. The denominator measurement period is the measurement year. In other words, you only look at people who are seen at the BHC during the measurement year. The numerator goes back to the prior year to see if they were screened and intervention occurred, if necessary, in either year. You only look at people who come in during the demonstration year, but you can go back up to a year in your records to see if they were screened and, if they needed a cessation intervention, that they got it. Again, as I mentioned, the spec has a link to a place for the codes that you need for this measure.

The definitions--you see a definition of tobacco, and that is any tobacco. Tobacco cessation intervention--it's defined as including group counseling of three minutes or less and/or pharma therapy. The steps for determining the eligible population or denominator are--were they seen at

the provider during the measurement year or were they 18 or older on the date of service, and did they have an eligible encounter. Again, the codes for that are in the source measure.

Again, for this one, there is an incomplete reporting exclusion, whereby if the quality data codes are not used, the consumer is excluded from the denominator and the numerator. This, again, can have the unwanted effect of discouraging code use, which is not what SAMHSA is hoping for. It is an artifact of the source measure. This is an opportunity for BHCs to adopt and use these codes, which I'll talk more about on the next slide--increasing electronic documentation of screening and intervention with more room for improvement in year two. It also makes it more automated and easier to calculate.

I seem to have missed a slide here. Okay. Sorry. To calculate the numerator, you want to make sure both that the person was screened and it's called for that they received an intervention. There are two codes indicating numerator satisfaction--if they were screened for tobacco use and received tobacco cessation intervention, if they were identified as a tobacco user, or they were screened for tobacco use and were are non-user of tobacco. There's also a code indicating numerator failure. That is either the screening or the cessation intervention, if called for, was not performed and no reason is provided. Again, for these codes, you need to see the most recent source measure, and there's a link to that in this specification.

There's also an exception. The source measure calls it an exception--most of the stewards or measures call them exclusions--and if there is documentation of medical reasons for not screening, such as limited life expectancy, there is a code that allows you to document that, so that you're not counted.

The measurement period is noted. The BHC specs have a special note here for CCBHCs who may not have had access to this information for the year before the program began. That is that screening should be carried out in the first year of the demonstration to assure that it occurs. If you are a new CCBHC and you have somebody who comes in, in demonstration year one, and you don't have access to information about this from the prior year for whatever reason, the solution is to actually just make sure that you do a screening and, if necessary, an intervention in year one.

I am going to stop and respond to a question that was received in the SAMHSA mailbox about this measure. The question was, who should provide the counseling, the care measure? The guidance is not specific. The response to that is the measure does not specify which staff should do the counseling. The center should follow any state or other requirements for licensure and training that would otherwise apply. Do what you should do normally. There's nothing in the measure that is specific or out of the ordinary in that regard.

Okay. Now, I'm stopping again for just a couple of questions. I'm going to go on to the alcohol screening measure after this one, which is very similar. Are there any questions specific to the tobacco screening measure? I know I rushed through it.

Ame: Peggy, your first question is by Ken Santoni. BMI and tobacco cessation are often being done as part of a regular office visit with the PCP or mental health professional. Is the

requirement that code actually be reported or is another method of documentation--a checkbox, clinical notes--permissible?

Peggy O'Brien: Yes, it would be permissible. You can use paper medical records. It's easier if you can have it set up in the system and it can be calculated more automatically, but a medical record is a medical record. You can paper or you can use electronic.

Ame: The next question is by Emily Dodge. How is cessation intervention designed? What if this person accepts having a phone call with the state and quits the line?

Peggy O'Brien: Let me look at the definition here. A brief counseling of three minutes or less and/or pharmacy therapy--so if there is documented brief counseling of three minutes or less and/or pharmacy therapy, you have tobacco cessation intervention.

Ame: The next question is by Brad Harman. Does e-cigarette use fall under tobacco use?

Peggy O'Brien: I believe that there is tobacco in an e-cigarette. I could be wrong, but I don't think so. I think there is tobacco in it, and that is considered a tobacco product.

Ame: The next question is by Ginger Bandene. Do the screening and brief intervention need to happy in the same session/the counter?

Peggy O'Brien: That is a good question. I think that I'm going to defer that and I'm going to look closely at the spec outside of the time allowed for this webinar and include that as a question in the questions and answers. Ame, I'm going to move on to the next measure. I know there are so many questions, but I have to try to cover this too.

This is the companion measure, which is for unhealthy alcohol use screening and brief counseling. Again, it's for individuals 18 or older seen during the measurement year. This begins on page 69 of the test specs. The measurement period for the denominator is the measurement year, so you're only, again, looking at the people that were seen during the measurement year. The numerator is the subset of those who were screened at least once during the past year--the demonstration year or the prior year--for unhealthy alcohol use using a systematic screening method and who received brief counseling if identified as an unhealthy alcohol user. The numerator measurement period is the measurement year in the prior year, just as with the other. You look back a year.

The definitions do tell you more about what screening is, and they include--there are definitions for the Audit and Audit-C. There's also a definition for brief counseling, which is brief counseling for unhealthy alcohol use--refers to one or more counseling sessions, a minimum of 5 to 15 minutes, which may include feedback on alcohol use and harm, identification of high risk situations for drinking and coping strategies, increased motivation, and the development of a personal plan to reduce drinking. This say may, so this is a very flexible definition.

You'll want to be careful, however, about what constitutes brief counseling here. It says 5 to 15 minutes for purposes of the quality measure, which may be different than what is required for reimbursement purposes under Medicaid. It's possible there are things that are counted here as brief counseling that might not be available under standard Medicaid.

There's also a definition of systematic screening method. You have to use one of the three methods that are identified in the measure. The scores that are associated with those that indicate unhealthy alcohol use are provided in the spec. These screens--and this kind of gets back to a question that was just asked about the other measure--these screens can be integrated into your EHR with appropriate result coding included, as can guidance about or a reminder about brief counseling. To the extent this can be something that is automated in your EHR that will help.

The only critical difference here from the tobacco measure is the eligible population. For this measure, once you would determine that they were seen at least once during the measurement and were 18 or older, you also need to see if there were at least two encounters at the BHC with the relevant codes or one preventive care measure with codes that come out of the source measure.

For the numerator code, use is again important. There are four different codes here--two indicating that performance was met, one indicating it wasn't, and one indicating documented medical reasons for not screening--for example, limited life expectancy. I'm going to stop again and answer a question that came into the SAMHSA mailbox about this measure.

Do all centers have to use the same screening approach and which staff is required to screen? All centers do not need to use the same screening approach. They should, however, all use one of the approaches that is defined as systematic in the measure. That is an Audit--and Audit-C or a single question screening, such as is in the definition. The measure does not specify which staff should do the screening. The center should follow any state or other requirements for licensure or training that would otherwise apply.

Okay, we're really running out of time, and so I'm going to do one poll here. You can pick as many of these as you want. The goal of including these last three measures is to assure screening and prevention related to BMI, tobacco, and alcohol use. Each contains codes designed to allow recording of whether the numerator requirements were satisfied. For instance, was screening done? Was follow-up or intervention done? You can pick any of these that apply to you--we will not have staff trained to carry out the procedure, we do not have the codes in our EHRs, we don't think we can modify our EHRs to include the codes, we do not think staff will consistently carry out the procedures annually or as may otherwise be required, we will have to get the data from our DCOs and they may not carry out the procedures or code properly, other, or we do not expect this to be a problem. Those are all of the possible things that I could think of that could go wrong here. We want to find out which ones you're concerned about.

Okay. Let's see what the results are. Cutting to the chase down at the bottom--53% do not expect this to be a problem. The biggest group that see a problem here is we don't have the codes in our EHRs, but it looks like most people think you can modify your EHRs to include the codes--not everybody--concern about staff carrying out the procedures, concern about DCOs, and then other. Okay. Ame, in the chat box, is there any information about what other might be or are there other questions related to this measure?

Ame: The first question is from Tim McGuire. Is it the case that the Audit and Audit-C are the only tools to use for unhealthy alcohol use?

Peggy O'Brien: No. There is one other option, and that's the brief screening option, which I kind of rushed to get through, so I didn't read it out loud. It's a single question screen, I believe, about number of drinks, and it differs for men and women. There is like the Audit and Audit-C in the definitions. There is also information about what score you need to be considered as having unhealthy alcohol use. It is limiting. There are only three possible ways to satisfy this measure in terms of screening.

Ame: The next question is from Juliana Harper. If we have other screens already embedded in our EHR versus the audit, can we use those instead?

Peggy O'Brien: My instinct is to say that the measure requires that you use these screens, in particular. I do want to confer with others about if there is any room for leeway. I think that one thing that's very important is that the screen needs to be age and population appropriate. That's a big issue, but I'm going to see what else I can dig up in the way of a better answer outside of the webinar. One more question, Ame.

Ame: The next question is from Eric Flossie. Is the cage appropriate since we have that in our EMR?

Peggy O'Brien: Okay, and that kind of goes to what I just answered. Just to be clear about the cage, the cage is only validated for certain groups--adults, I believe--so it wouldn't be appropriate for adolescents. It is not one of the ones that's identified as being appropriate within the measure. My instinct is to say no again, but again, I want to check and see what other people say about this and include a good answer in the written questions and answers. I'm going to move on at this point, so I can get through everything I have to do at the end of the webinar.

Here's the upcoming webinar schedule. We're going to go through--I have five clinic-reported measures planned for next week. That means it's even going to be harder than this week. The following two weeks are special issues, and there are things that we are going to be talking about specifically related to data collection, analysis, and reporting, but there also will hopefully be time in there to kind of go back to some of these measures that I may have given short (shirt) to, and specifically with an eye towards the kinds of questions that didn't get answered or they got asked, and try to address them a little bit more fully. In addition to the things that we'll cover in the special issues, we hopefully will also be able to do that. Then on September 6, we cover the measures that are not required as part of the CCBHC demonstration. These are all at the same time and place.

These are the measures for next week. I'm not going to read them to you. These are the kinds of things that we're thinking about for the special issues--sampling and calculating hybrid measures. I'll be talking about some hybrid measures next week. Quality bonus measures--we'll have a guest speaker I think from CMS. A little bit about data for dually eligible enrollees--maybe, if we have time, lessons learned in our state visits.

Peggy O'Brien: We'll be talking about continuous quality improvement and the role of data in that. When is a person a CCBHC consumer? I hope to address that in one of the special issues webinar, and again, issues or questions that were raised in the earlier webinars.

This slide and the two slides that follow are just kind of for your reference. If you want to find out what webinar a specific measure was addressed in, you can come back to this and find it.

The last thing here is I know I rushed through this and I know that there are questions that are sitting in the chat box that I have to answer outside of this webinar, but any additional questions that you have, please submit them to this mailbox that you see on your screen. You can ask questions about things we covered today, the measures that I will be covering next week. Please feel free to ask questions in advance, so I can try to insert them--things related to the special issues or any other questions that you have on data collection analysis and reporting. We'll try to get them responded to in the appropriate webinar, otherwise in another fashion.

I also want to remind you that there are office hours that people are signing up for already. We have a good number of people signed up and we hope to have more that SAMHSA is putting together to be able to provide a little bit more individualized TA related to these quality measures and the data reporting. We do ask that you get us your questions in advance, because the time slots are limited, and we want to be able to actually have the information for you so that we can provide it to you when we talk to you. Please get the questions to us in advance. Please sign up if you have questions and you haven't already signed up, and we'll schedule a time for you. I believe that an email went out from SAMHSA today reminding you about how to do that and the times that are still available, so take advantage of it, please.

I think that that's everything that I have to say on this webinar, and we have about eight minutes left--seven minutes--now. Ame, if there are other questions in the chat box that I can try and answer in this brief period of time, I'll do so. Otherwise, I will make sure that they get answered some other way. Do we have questions?

Ame: Yes. The first question is from Ashley Fur. For clarification, will we be reporting across all insurers and not just Medicare?

Peggy O'Brien: Okay. For the BHC reporting--the ones that we're talking about today and next week--you will report on the consumer population at the CCBHC or BHC for which you're reporting. That's everybody. The way that the measures are stratified means that you will provide rates for those who are Medicaid only, which will probably be a large number of them, for those who are dually eligible--that is people who have both Medicare and Medicaid--and then everybody else without regard to what kind of insurance they have. You have the two defined insurance categories that I just mentioned, plus everybody else, whether they're uninsured or have commercial insurance or have RiteCare or something like that. Those fall into the other category.

Ame: Does the screening have to occur at the CCBHC?

Peggy O'Brien: Okay. This is the danger of not answering the question right after I talk about the measure. I'm not sure which screening it is, but for the BMI--no it doesn't. For the adult BMI can be at any provider. For the alcohol and tobacco, I think the goal or the objective would be to have it be done at the CCBHC. It's a routine part of screening and care, and that's something that is one of the core responsibilities of the CCBHC. Screening for tobacco use and screening for alcohol use should be done at the CCBHC. Again, for both of those the quality measure allows

you to look back a year before the demonstration year to see if the screening happened. If you don't have that information, then it's in your best interest to make sure that you do it during the demonstration year.

Ame: The next question is from Travis Gaddy. When you were referring to the BMI codes, were you talking about ICD 10 codes?

Peggy O'Brien: No. We were talking about either CPT codes or HCPCS codes, and they are provided in the source measures for these measures that we talked about today--the three screening and intervention measures. For some of them the HCPCS codes are included in the spec, so they're written down in there and they're easy to find. For all of the others, there is a link in section A of the spec that will take you to the source measure, and you can get the codes there. It's the only way we could do it.

Ame: The next question is from Monique Monod. If the BMI was taken and a plan to address the issue was documented, then the consumer is seen again within a week or so, do we have to have another plan as well, even though we already have one documented and it's being implemented?

Peggy O'Brien: No, you do not. They just want to make sure that this is done at least once a year or once every two years, depending on the measure that we're talking about. It's just a routine screening that should be done once a year or every two years, depending on whether it's the tobacco screening or the BMI screening.

Ame: The next question is from Emily Dodge. What if there was screening for alcohol or tobacco within the previous year, but it was done with the approved engine it recorded?

Peggy O'Brien: Yeah. That's a unfortunate fact that you wouldn't be actually satisfying the requirements of the measure, unfortunately. It would be--and for a lot of people it might not be a bad thing to be screened again this year using the appropriate screen--appropriate as they're defined in the measure. I'm not going to say that the ones that were used were inappropriate. It's just that to count, they should be the ones that are listed in the measurement.

Ame: The question is from Karen Edwards. Will the CCBHC measures replace reporting required for an HBG, an SAPTBDG, such as uniform reporting system tables and the mental health client data reporting and treatment episode dataset?

Peggy O'Brien: No. Unfortunately, I'm sorry to have to say, this is an addition. This is for the demonstration program. If you're not a CCBHC--if you're a BHC and you're state is considering adopting these, then it would be the state's decision to use them and would be in addition to the existing requirements that you may have for other purposes.

Ame: The next question is from Monique Monod. For insurance stratifications, since one category is Medicaid and some states have expanded Medicare--for example, Michigan has Healthy Michigan--will Healthy Michigan be considered part of the Medicaid group or considered part of other in the stratification?

Peggy O'Brien: Expanded Medicaid is Medicaid, so what the questioner was asking is do the people that are included in the more expanded Medicaid coverage count as Medicaid? They count as Medicaid, as long as that is part of the state's approved plan--the expansion.

Ame: The last question, given the time, is from Monique Monod. If during the evaluation year the insurance changes for a given consumer from Medicaid to dual--at the beginning the consumer was Medicaid only. In the middle of the year, the consumer is dual--where do we consider this consumer?

Peggy O'Brien: They're Medicaid. The front matter to the specs in volume one tells you more information about that. I really refer you all to that, because I think it's important to read it, and also back to webinar one, where a lot of this general information is included. That's available on demand. I think I have to stop now. Thank you and we will resume next week at the same time.