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Quality Measurement and Data Collection Special Issues

Peggy O'Brien: Good afternoon and welcome to the sixth webinar in the Behavior Health Clinic Data Collection and Quality Reporting webinar series, presented by the Substance Abuse and Mental Health Services Administration. Today's topic is quality measurement and data collection special issues, and this is part one of two. I'm Peggy O'Brien, a Senior Research Leader at Truven Health Analytics, presenting on behalf of SAMSHA. Today we also have representatives of ASBI present.

There is a chat function where you can ask questions, and we encourage you to do so. I will pause at several points to respond to questions that people have about things that I've covered that may be confusing or about related matters that I haven't addressed. Most webinars have at least one poll question, which listeners will have time to answer and which we can discuss.

A PDF of the slides for each webinar is posted as a resource on the webinar site, and webinars themselves will be available on demand for a year after the event on the webinar site where you're listening to this presentation. All you need to do to access the on-demand webinar is to register. If you know someone who has not done so who would benefit from accessing webinars, encourage them to do so. The webinar also will be posted on the SAMSHA website, probably within about a week or two after it is presented. If there are people that have missed prior webinars, you can still register and go back and access the on-demand.

This is the webinar schedule with the intended audience identified in red. All are on Tuesday from 2:00 to 3:30 Eastern Time. The next webinar is the second of the two special issues webinars covering general subjects related to data collection, analysis, and reporting for these BHC quality measures.

Today I will be covering a wide range of topics, including continuous quality improvement and the role of data, sampling for hybrid measures, age coverage and stratification measure differences, and when someone is a BHC consumer. I also will go through a number of outstanding questions from earlier webinars. I will do this again on the webinar next week.

The first topic today is continuous quality improvement--CQI--and the role of data.

CQI is among the requirements that are placed on the CCBHCs as part of the certification criteria. Some of the themes included in the criteria are listed on this slide. The CQI program needs to be based on the needs of the BHC population and based on the BHC's performance. The CQI should be based on data and quality measure indicators, among other things. It focuses on improved quality of care and safety, such as suicide prevention. It should focus on improvement in performance. The CQI program is required to be documented and includes evaluation of CQI activities.

The criteria also require that it address, at a minimum, consumer suicide deaths or attempts, 30-day hospital readmissions for psychiatric or substance use reasons, and other events that state or applicable accreditation bodies may deem appropriate for examination and remediation as part of a CQI plan. Of course, the BHC may well identify something else that is very important in terms of quality or safety and decide to address that.

The Health Resources and Services Administration or HRSA defines quality improvement as systematic and continuous actions that lead to measurable improvement in health care services and the health status of targeted patient groups. HRSA also identifies four key QI principles. QI should work on the systems and their processes. QI should focus on patients. It should focus on being part of a team, and it should focus on the use of data.

Focusing on data helps to separate what is thought to be happening from what is really happening. Sometimes they're the same thing. Sometimes they aren't. Data can be surprising sometimes. Data establishes a baseline. If you start with low scores, that's okay. Improvement on low scores is what matters. It can help reduce an effective solution. If you can see that something is measurably working or not working, that helps you decide whether to continue down that course or move on to something else. Along the same lines, relying on data can help you monitor changes in your processes or procedures to see what effects there might be. It can show whether changes result in improvement, and it allows comparison across sites, if that is of interest to you.

The reason I am discussing this in the context of these webinars is that quality measures can help provide data to fuel CQI. As one example, the criteria say that consumer 30-day hospital readmissions for psychiatric or substance use problems should be addressed as part of CQI. The plan All-Cause Readmissions measure provides data that can be useful for this.

For data to be useful as part of CQI, it--the data--needs to have its own CQI with the state providing feedback on BHC-generated data and the state examining its own data quality. When BHCs submit data or measured results to states, the following all provide grist for ongoing refinement of the system at the state and BHC level. State feedback to BHCs regarding their data, state feedback to BHCs regarding major results, and BHC internal feedback and adjustment regarding both data and results.

For this to work, you need a continuous interdisciplinary team approach to building a robust behavioral health quality measurement system at the state and BHC levels. Built-in feedback loops that focus on improvements in care use the data and the team input to continuously re-exam and improve. This process of continuous learning should reinforce positive developments and avoid penalizing. For many, the focus with data collection up to this point may have been on reporting compliance--that is getting the data in, getting it in on time. In this context, it becomes about improving quality of services.

The very big data question is, how do BHCs get timely feedback so they can improve, especially if the data are not readily available to the BHC, such as pharmacy data for adherence measures or hospitalization or ED data? For the CCBHCs, in particular, this is especially critical because this is only a two-year demonstration, where it is hoped there will be improvement from DY1 to DY2.

Going beyond the data, though, it's helpful to remember CQI is designed to encourage response and improvement. Incorporating teams that include management providers, those with lived experience, and others involved in all aspects of BHC functioning helps the organization to consider the data from different perspectives. Regularly informing and engaging the BHC governing board on results of data analysis and how best to use that information can also fuel

quality improvement. These can help the BHC use the CQI data to inform its policies and practices.

On this slide are a couple of references that relate to CQI. The HRSA reference is one that I relied on a lot in preparing this presentation. Both may be useful to you as you establish or change your CQI program. Before I move on to the next subject, I'm going to stop and see if there are any questions about what I've covered on CQI.

Ame: Hi, Peggy. At the moment there are no questions.

Peggy O'Brien: Okay. Thank you, Ame. I will move on. If you have questions about CQI later and you think of something you want to ask, please be sure to do so. The next subject that I'm going to be talking about is sampling for hybrid measures. We talked about two hybrid measures last week, so this is kind of an extension of that discussion.

The BHC measures include these three hybrid measures--two that we covered last week which are the CDF or screening for clinical depression and follow-up plan, and WCC which is the weight assessment for children and adolescents--the BMI measure. The other one--controlling high blood pressure--CBP--will be covered in week eight.

For a WCC, you do have the choice of using a hybrid approach with or without sampling or an administration and billing records approach. We talked about that last week. For each of these measures, the source measure stewards have not developed sampling guidance, so the information I provide today is a way to get you pointed in the right direction as you go forward in trying to calculate these measures.

Sampling is typically used when data elements are not easily captured in administrative data. An example might be controlling blood pressure, which we have yet to discuss but where there are codes available to designate degree of blood pressure control, yet many providers do not use these codes. Sampling lets you conduct a systematic review of medical records for a representative sample, instead of requiring you to look at all medical records.

For a hybrid measure, the denominator may consist of a sample of the eligible population with the numerator calculated based on that sample using both administrative and medical records. This does differ by measure.

This picture is designed to show the nature of a sample for a hybrid measure. The large teal circle is the entire eligible population, the way that term is defined in the specific measure in Section C of the measure specification. The orange rectangle represents the sample from that eligible population. It will be a representative sample that is used as the denominator for the measure instead of the entire eligible population. The green circle with the N is the numerator or the subset of the denominator sample that satisfies the process or outcome that is being measured--for example, all of those who are screened for clinical depression and, if required, provided a follow-up plan.

The sampling requirements for these measures include that the sample be representative and random so everyone has an equal chance of inclusion. By representative this means that it is representative of the eligible population as defined for the measure, with age, in particular,

important if there is age stratification. Simple random sampling might involve assigning a number to each member of the population and then using either a software program or a random digit table to select the sample. If you need to stratify by age, you would first divide the overall eligible population into the requisite age groups and then select a random sample of each age group. The next slide provides more information on sample size.

HEDIS has certain requirements for sampling that should be used for the BHC measures. Specifically, the sample should be 411 individuals unless there are fewer consumers in the eligible population, in which case you use all or if special circumstances apply. I will discuss some special circumstances on the next slide that will allow you to use fewer than 411 individuals in some cases.

You should over sample to allow for substitution because you may think that some people fit into the eligible population, but you later find out they do not. Volume 2 of the technical specifications in Appendix C provides additional guidance on using a smaller sample size based on the administrative rate or past year's reported rate. That's what I'm going to talk about on the next slide.

This is a screenshot of Appendix C, which is a table showing how you may reduce the required sample of 411, depending on special circumstances. If you have a rate from the year before for a specific measure, which is not likely in the case of the CCBHCs for DY1 but certainly possible for DY2, or if there is a way to calculate it using administrative data, you may find that those rates, either the past year rate or using administrative data--you may find that those rates are 52% or higher. If those rates are 52% or higher, this table allows you to reduce your sample size depending on that administrative or past year rate. You can't see it on this screenshot, but if the administrative or past year rate was 95% or greater, the smallest sample size is 100. That's as small as you can go unless you happen to have a very tiny eligible population less than that.

There is a technical assistance document available on the CMS website that provides guidance on using the hybrid measure to calculate child or adult Medicaid core set measures. The address is on this screen but is also provided in the front matter to volume one of the specs.

As a reminder, the data reporting templates for the hybrid measures require that you state the sample size and the size of the measure eligible population in Section B on data source. You also should briefly describe your sampling approach in Section F under additional notes, and that is briefly because there isn't a whole lot of room for you to put a lot in there.

Before I pause for questions, I wanted to mention the three hybrid flow documents that we have prepared or will be finalizing. These are documents that are one or two pages that show the flow of sampling and calculation for the three hybrid measures. The CDF or screening for clinical depression and follow-up was provided last week. It was attached to the webinar as a resource--as a PDF that you could download. This week the hybrid flow document for WCC, which is the BMI--the child BMI measure--is also attached as a PDF in the resource section of the webinar site. You can access that and download it. When I discuss the controlling blood pressure measure in week eight, there will be a similar document for that as well. I am going to stop here and see if there are any questions about what I've covered on sampling for hybrid measures or going back to CQI, if somebody is interested in that.

Ame: The first question is from David Levine. How do you prove your sample is a random representative of the eligible population?

Peggy O'Brien: I think that that's a hard thing to do. I think that the demographic or the group where it is most important is age where you have stratified measures. There are some measures that are stratified by age and some that aren't. The way that you have to approach it is to determine the eligible population as that's defined in the specification. One mechanism is to simply assign random numbers to everybody in that population and draw a sample from that using some kind of random number generator. There are free mechanisms for doing this online. There are probably more sophisticated ways to do it as well, but that's the simplest way to do it.

Ame: The next question is from John McGrime. When stratifying by age, is there a standard or recommended age group to use?

Peggy O'Brien: Each measure will tell you if it's required to be stratified. I don't know what portion of the measures are stratified by age. Actually, I will get to that in a little bit. I will be talking more about age coverage and stratification, but each measure will specify whether it's stratified by age and what the age stratifications are. You go to the specifications and you will get that information. Also it is provided later in this webinar, because I will be touching on that.

Ame: The next question is from Rebecca Hartman. How often will reporting be required--monthly, annually, or quarterly?

Peggy O'Brien: That is up to the states, to a certain extent. You are required to report annually. That is the requirement that's part of the criteria for the CCBHCs. If you're not a CCBHC and you're planning on using these measures, it really is up to the state. The requirement for reporting is annual. However, some states might decide that they want to get to the information sooner for a variety of reasons. That is entirely up to the state. There is no requirement from SAMHSA that there be anything more often than annual.

Again, there is a lot of information about these general sorts of questions like when to report and how often. It's found in the front matter to the specifications in volume one, so before you get to the specs there is a lot of introductory material that's very useful. Also webinar one--which you can access on demand if you have missed it or you want to review it--is available on the website where you are accessing this. You just have to register for it. I would suggest that you look at that if you want more information too.

Ame: The next question is from Bob Baloo. Does anyone have to approve the use of a hybrid measure and, if so, who?

Peggy O'Brien: Let's see. There are three hybrid measures, two of which are required for the CCBHC demonstration program. The controlling high blood pressure is not required as part of the demonstration program unless a state decides to make it so. You have two hybrid measures to consider. One of them is specified so you have an option of whether to use a hybrid approach or to use simply administrative data. I believe that's the WCC one--the BMI measure.

The other one--CDF--is a hybrid measure. As to whether you use sampling or not, that is up to you. In a lot of cases, it's simpler to do a sample than it is to do an entire population if you have to

review medical records. When I went through the two hybrid measures last week, I tried to point out as much as possible ways that things can be automated by using codes so that you can hopefully access information in your EHR without having to go through the records ad nauseum and have to search for things. There are ways to make it easier, but there are two measures that are required that are part of the CCBHC demonstration program, one of which has to be done as a hybrid.

Ame: The next question is from Monique Manod. When stratifying by age groups, does the number of items drawn out randomly from each group have to be proportional to the size of each age category?

Peggy O'Brien: It should be. Yes. If you have a measure, for instance, that is stratified by ages 18 to 64 and 65 and older, you would go to Section C of the specification where it tells you what the eligible population is, and you would determine what that eligible population is. Part of it has to do with age. It would be 18 and older. You would determine the eligible population, and then you would divide it into the two age groups--18 to 64, 65 plus. Within each of those groups, you then do a random sample. Then what you should have is you should have a selection of those that are in the older group and the younger. Then the two groups should be proportional to what the overall eligible population from 18 and up would be.

Ame: The next question is from Diane Shaffer. As part of the random sampling, do we also have stratification based on payment sources like those for age brackets?

Peggy O'Brien: Almost all of the measures are stratified by payer. There is nothing specific in any of the guidance that I've seen related to stratification by payer and random sampling. You do want your sample to be representative, so ideally it would be representative of payers. It would be representative of every other group--demographic group or otherwise--but the age stratification is, of the two, considered to be most important.

Ame: The last question is from Kim Santoni. I assume that if the percentage is a sum of one sample percentage or one of the percentages in the table, that the same reduction in sample size requirements will be allowed as well.

Peggy O'Brien: I think I'm going to have to read that question and answer it outside of this webinar. I want to make sure I understand it.

Ame: There are no more questions, Peggy.

Peggy O'Brien: Okay. Thank you. We actually have two poll questions. They're back-to-back. The first poll question is--this is just for the BHCs in attendance, and so if you're not a BHC, please don't answer it--does your organization use a certified EHR on the ONC Certified Health IT product list? Select one of the three answers--yes, no, or don't know.

Okay, so I'm going to move on and see what the results were. Okay, 60% yes, 13% no, and about 27% don't know. Okay. All right. The next question is related. If yes, does your organization attest to Meaningful Use? Again, select one of the three answers--yes, no, or don't know.

All right. Okay, 64% yes, 26% no, and about 10% don't know. That's good. Okay. All right, so this next section of the webinar is mainly intended to provide you with a resource to be able to determine differences in age coverage and differences in age stratification requirements between the BHC measures, EDIS measures, and the Medicaid adult and child core set measures. I know many states are reporting some of the BHC measures as Medicaid core measures, and some Medicaid managed care health plans within states may be reporting using HEDIS specifications. The tables on the next few slides are here for you to be able to tell the differences at a glance. This is in response to a question that we had about how strictly these measures adhere to the source measures, and one of the big differences may be age coverage or stratification.

This slide is just a list of all of the BHC measures that are not HEDIS or core measures. You have there the age requirements for the measures and the age stratifications. These are not in comparison to anything because there is nothing to compare them to.

This slide includes the measures that are BHC and Medicaid core measures, but are not HEDIS measures. As you can see, the screening for clinical depression measures adds those ages 12 to 17 which are not covered by the Medicaid adult core set version.

This slide shows the differences between the BHC measures and HEDIS measures that are not also Medicaid core measures. These are all the same. The 2017 HEDIS measures, a follow-up after ED visit, will be the same as the BHC measures because the BHC measures were taken directly from those 2017 HEDIS measures.

This table contains the measures that are all three. They are BHC measures. They are HEDIS measures, and they're Medicaid core measures. As you can see, except for initiation and engagement and alcohol and other drug treatment at the bottom, the Medicaid core measures and the BHC measures have the same coverage and stratifications. That is not always true for the HEDIS measures. For initiation and engagement, the BHC measures include those who are ages 13 to 17. In that respect it more closely parallels the HEDIS measure but not precisely.

This is one of the simple but significant changes that you'll find in these measures from existing measures that you state or a health plan in your state may be calculating at this point. I know you're not going to retain all of this or memorize it, so again, these kinds of slides are here for you to use after these webinars. They're available in the PDFs that are on the resources on the webinar, or they're available if you watch it on demand.

Moving on, SAMHSA recently sent out to the states a document that offers guidance as to when someone is a BHC consumer. SAMHSA asked that I address this as part of one of the special issues webinars, so this is my attempt to do so.

This is important for three reasons. First of all, it helps determine if a person is counted in a quality measure calculation. Whoever is using these measures, whether it's a CCBHC or some other BHC that is using them, this will help determine whether you count somebody. This also helps determine if services are reimbursable under the prospective payment system or PPS, if these people are served at a CCBHC. It also helps to determine if the CCBHC certification criteria apply.

The way that this is divided is into established or existing BHC clients. That is people that were being seen at the BHC before it became a CCBHC. People that are clients, and then the BHC becomes certified, the demonstration starts, and it's suddenly a CCBHC. I first address those people. Then after that, I will talk about the non-established new BHC clients--people that are new to the clinic that were not seen before when it was pre-CCBHC. I'll talk about both of those in order.

First of all, for the established and existing BHC clients--for purposes of the CCBHC, someone who is already an established or existing client at a BHC--becomes a CCBHC consumer the first time they receive a demonstration service at the CCBHC after the BHC becomes a CCBHC. The demonstration service is one that falls within the scope of services in the CCBHC criteria. This includes any CCBHC services provided by the CCBHC, including by telehealth, mobile in-home services, services in settings outside the four walls of the clinic such as in schools or homeless shelters, to the extent that the CCBHC offers those approaches or modalities. However, if the service is received from a DCO before any service is received directly from the CCBHC, it is only a CCBHC service, and the person only becomes a CCBHC consumer if the service by the DCO was authorized and coordinated by the CCBHC once it became a CCBHC.

For people who are not established or existing clients of the BHC that have just become a CCBHC, they become a CCBHC consumer upon receipt of the preliminary screening and risk assessment that is used to determine acuity of needs with identifying and payment information gathered by the CCBHC. This includes, again, any CCBHC services provided by the CCBHC, including if it is received by telehealth, by mobile in-home services, or services outside the four walls of the clinic.

Okay. I think that I'm missing a bullet here, so I'm going to tell you what you're missing. Still on the non-established new BHC clients, if a DCO provides non-crisis services, they are not a CCBHC consumer unless the CCBHC itself--not the DCO--has first done the preliminary screening and risk assessment needed to determine acuity of needs. If the service is a crisis service provided by a state sanctioned crisis system that's acting as a DCO, the person becomes a CCBHC consumer upon receipt of the crisis service and another of the nine services in the CCBHC scope of service which is delivered by the CCBHC. This is designed to assure that there is some greater linkage to the CCBHC than just receipt of crisis services by the affiliated DCO state-sanctioned crisis system.

If a person is referred from a hospital or ED, they become a CCBHC consumer if the CCBHC performs a preliminary screening and risk assessment and gathers basic identifying information. This gets to the question someone asked in relation to the initial evaluation measure related to a prescreening of somebody in a hospital. If that prescreening includes the CCBHC performing a preliminary screening and risk assessment, that becomes the first contact, and the person becomes a CCBHC consumer just as if they had the screening and risk assessment as a walk-in or over the phone.

Okay. That's a lot to cram into a few slides. Hopefully, people have seen the document that SAMHSA sent out. If you haven't, the state program directors do have it. I'm going to stop and see if I can answer any questions related to this.

Ame: The first question is by Diane Shaffer. Can services provided in jail be counted as a CCBHC service?

Peggy O'Brien: I think that that's a question that probably needs to be answered by CMS, because there are issues about Medicaid and correctional institutions. The CCBHC PPS is a Medicaid instrument. In terms of Medicaid and PPS, that's really got to be a CMS question.

In terms of what the CCBHC may be offering that is not part of the PPS, my guess is that the answer would be yes. There are requirements in the care coordination criteria for coordinating care with correctional institutions. I think that the big issue, however, is the Medicaid issue. That is a question that should be addressed to CMS. I encourage you to contact the CMS question mailbox for that.

Ame: The next question is by Donald Thompson. What is the period of time that is allowed between the DCO crisis service and the time when the person is seen at the CCBHC--same day, 30 days?

Peggy O'Brien: I think that that probably needs to be governed by the state's PPS. Some states will be PPS1, so you've got a daily visit. I think that that would be daily. If you are a state with a PPS that is 30 days, then it would be monthly. That goes for the PPS. I think I'd need to think about the question as it might relate to other subjects such as counting a person within the quality measures.

Ame: The next question is from Ginger Bandeen. For other referrals besides hospitals, does the same criteria apply for the measurement of I-Eval? Does first contact only occur once a preliminary screening of the individual is provided by the CCBHC, not at the time of referral by an outside agency?

Peggy O'Brien: Yes, and I actually--I think that's one of the questions I may be covering later in the webinar. If it's not this week, it's next week, but I will digress right here, because I think it's important. I was thinking about this in relation to I-Eval to make sure that everybody is clear about this.

The criteria have a set of evaluations that build off of each other. The first is this preliminary screening and risk assessment which is supposed to happen at first contact. It's a very basic screening that is designed to determine acuity of needs. It's very limited in its scope. The content is described in the scope of services section of the criteria. The timing is discussed in the access section which is section two. Building on that risk assessment and preliminary screening is the initial evaluation.

Depending on the acuity that's determined in the preliminary screening, somebody has to get an initial evaluation within a certain amount of time. It's ten business days if they presented as routine, which is what the I-Eval measure is looking at. If it is urgent, it is, I believe, one business day. If it's emergency, it has to be dealt with promptly, immediately, and appropriately. I would refer you to criteria program requirements two and four, if you need to review this. That's where this preliminary screening and risk assessment is coming from and how it feeds into the initial evaluation measure.

Ame: The next question is from April Thompson. Is there a timeframe based on when the service was authorized by the BHC relating to whether or not they are a new or existing consumer, for example, a preliminary screen completed in 2014, and the services are ongoing since?

Peggy O'Brien: I think I would need to think about that one. The application of any of this is for new consumers who are coming in after this becomes a CCBHC. You need to look at it in that context. However, I think I want to look at the question and think about it more and try to answer it in a later webinar instead of trying to answer it off the cuff here.

Ame: The next question is from Margaret Morris. How would one apply the second bullet on slide 36 as services received from a DCO?

Peggy O'Brien: It's slide 36. Okay, so I assume this is the one. Ame, can you read the question again, please?

Ame: The question is, how would one apply the second bullet on slide 36 as services received from the DCO?

Peggy O'Brien: These are existing clients--people who were already--okay. Okay, so the BHC becomes a CCBHC--let's just say it's January 1st, because that's the easiest thing to think about. Somebody comes into one of the organizations that's a DCO. It wasn't a DCO before January 1st, but now it is, and they get a service. Let's say they come in on January 5th to the DCO. They're an existing client of the BHC, but they have not gone into the CCBHC between January 1st and 5th. They're being seen first at a DCO.

The only way that that visit to the DCO is a CCBHC service that's enumerated for purposes of the PPS and counted, is if that DCO visit was authorized and coordinated by the CCBHC sometime between January 1st and 5th, when it became a CCBHC and when the person went to the DCO. Like if a person went to a DCO and there was no coordination between the CCBHC and the DCO during that interim period after they became a CCBHC, then that visit to a DCO would not be an enumerated service. It would be a service that is reimbursable under Medicaid, the way it would've been before the CCBHC came into existence. There has to be that preliminary involvement by the CCBHC.

Ame: The next question is by Tim McGuire. How does MA eligibility affect whether or not a consumer is included in the data that the CCBHC is reporting on?

Peggy O'Brien: Okay. For the measures that are CCBHC lead measures, which are the ones that we talked about the past two weeks--prior to that, it was the state lead measures--every person who is a CCBHC consumer is considered part of the population from which you get the eligible population for each measure. You're looking at everybody, as long as they fit the criteria for the measure. That's where the stratification comes in. You're stratifying them by pair. You're stratifying them as Medicaid beneficiaries, as duly-eligible beneficiaries, or everybody else.

The CCBHCs for the BHC reported measures--they look at everybody. For the state reported measures, the state lead measures, the states are looking at the Medicaid population and the duly-eligible population to the extent possible because states do not have access generally to the other population. That would be TRICARE or commercial or uninsured. Some segment of the state

might, but in general it's not easy to access that information. For the states, it's just Medicaid and duals.

Ame: The next question is by Shelly Irleg. Several services can be provided over the phone, such as case management. Will these services count as a BHC service?

Peggy O'Brien: That is I think, in part, up to the states and what is allowed within the state. It depends on the service. Case management in and of itself--targeted case management is one of the nine overarching services that is a scope of service for our CCBHCs. That should be included. There are a few restrictions that are explicit in the criteria on telephone. One of them has to do with the initial evaluation. I do not recall any other specific restrictions. I think there may be restrictions within states about how services can be provided, for instance, by telehealth, but in general the only restriction I know of is the requirement related to the initial evaluation.

Ame: The next question is from Pat Lojack. In reference to slide 38, what if the crisis service is provided by the CCBHC? Will the person then be considered a CCBHC consumer or still need an additional service?

Peggy O'Brien: Thirty-eight--okay, and that I think is the bullet that I was missing. That bullet said something along the lines of, if you have a crisis system that is run by the CCBHC, so it's not a state-sanctioned crisis system that is acting as a DCO for the CCBHC--the person becomes a CCBHC consumer upon receipt of that crisis service. I urge you to look at the document that SAMHSA provided to the program directors sometime in the past week, because that is explicitly covered there. All of these different possibilities that I've talked about in the slides are also covered there.

Ame: The next question is from Michelle Reed. Where can we find the list of CPT or of HCPCS PPS codes that will be covered as part of the PPS?

Peggy O'Brien: Okay. I would answer that by saying you need to probably contact CMS for the best answer to that, because you are talking about the PPS and payment. If you are asking about a specific measure, I could tell you where to find the CPT codes or the HCPCS codes that apply, but the CCBHC and the PPS are designed to include the nine overarching services, and that includes things such as physical health screening and monitoring and psych rehab and targeted case management and outpatient psychotherapy and so forth. A lot of discretion is left to the states in terms of how they are defining those services. It's not a simple question with a simple answer.

Ame: The next question is by Tracy Lether. The manual has us stratify by payer, but the template asks us to indicate which Medicaid program groups are included. Do we need to verify that a member of each program type is in the measure or indicate that they are in the population served as a whole?

Peggy O'Brien: That's a question that I think I'd prefer to answer with the template in front of me and with the question in writing in front of me, so I can make sure that I answer it accurately. There are different parts of that section of the template. There's the part where you stratify by payer, and that's a relatively simple distinction between the different payer groups--not necessarily simple, but somewhat. Then there is the section that also provides all of these

different categories of payer possibilities. Those do not require enumeration, but I think I prefer to try and answer the question outside the webinar. There will be opportunities for me to answer outstanding questions in webinar seven and eight. This one will definitely not make it into seven, but it hopefully would make it into eight.

Ame: The next question is by Jerry Stork. If there is a client only on Medicare but not Medicaid, how are they stratified in terms of the insurers?

Peggy O'Brien: They're only on Medicare and not Medicaid. They become an other. You have a choice between Medicaid only, dually eligible so somebody who has both Medicare and Medicaid, and then other which is everybody else. That includes just pure Medicare.

Ame: We have a comment from Tim Santori. The definition for a new non-established client seems to contradict something said earlier--that one becomes a CCBHC client as soon as they call for an appointment, whether they ever show up or not. This certainly makes more sense.

Peggy O'Brien: Okay. I think that the distinction there is between whether they get counted in the I-Eval measure, which is what we were talking about a couple of weeks ago, because they may call. If they do call and they seek an appointment and they get that preliminary screening and risk assessment on that call, then they do become a CCBHC consumer, and they get counted in the numerator for that measure of the initial evaluation.

Ame: There are no more questions, Peggy.

Peggy O'Brien: Okay, so I am going to move on. Okay, so I'm going to spend some time addressing some outstanding questions that were asked in earlier webinars that either weren't answered because I didn't know the answer, or they may deserve additional clarification. The first questions are general, and the rest are specific to measures covered in webinar four.

Is there an official start date to the demonstration year? We are a little confused about what exact date to use to begin pulling data. Each state will establish its demonstration year start date. They may begin as early as January 1, 2017, or as late as July 1, 2017. Whenever your state begins the demonstration, that is when the demonstration year starts and that is when the measurement year starts.

This question related to accessing Part D medication data--to stratify for the dually eligible on measures such as adherence to antipsychotic medications for individuals with schizophrenia, we will need access to Part D medication data, and we may not be able to access it. This relates to state lead measures. There is information on how to access Part D data available at this link that's on the bottom of the slide here. I believe that CMS may also be intending to share some information about this on their SharePoint site.

For payer stratification, does the other category include the uninsured? The other category does include the uninsured, as well as anyone else who doesn't fall into either Medicaid or dually eligible Medicare and Medicaid categories. In addition to uninsured, other examples of individuals in the other category might include the commercially insured, those with only Medicare, or those with TRICARE benefits. There is the same slide over again. Okay. All right.

Moving on to the measures that we talked about in webinar four--the I-Eval--again, and there were a lot of questions about this that I thought needed clarification. Somebody asked for the age ranges when they say 12 to 17 and 18+. Does the individual fall into the 18+ on their birthday? That would be the 18th birthday--and is the 17-and-a-half-year-old in the 17 age bracket? Yes. The person becomes 18+ on their 18th birthday, and on the day prior to that falls into the 12 to 17 age bracket. This way of determining age bracket is universal across the measures, no matter what the brackets are. That's the way that it's determined.

Somebody asked us to define initial evaluation. You have a slide here with a lot of writing on it. The measure of time to initial evaluation defines it as follows--some certification standards such as the CCBHC certification criteria, require that an initial evaluation be carried out for new consumers within a specified timeframe based on acuity of needs. In the case of a CCBHC, this initial evaluation is due within ten business days of first contact for those who present with routine non-emergency or non-urgent needs. That standard is used in the specification. Other standards may exist for other entities and the specification can be adapted accordingly. That's from the specification, page 31. That last sentence refers to if the measure is being used by a non-CCBHC.

The second bullet notes that the CCBHC certification criteria provide additional information at criteria 2.b.1, which is on timing, and 4.d.3, which is on content. This is for purposes of the CCBHC demonstration program, and BHCs that are using this measure that are not CCBHCs may have different standards to meet.

Someone asked about same day evaluations for this initial evaluation measure. If a consumer calls and is transferred to a clinician and an initial evaluation is done over the phone, does that count as zero days? Similarly, if they called and asked to come into the office for evaluation, does that time also count as zero days? As a reminder, the criteria calls for preliminary screening and risk assessment to determine level of acuity, followed by an initial evaluation with timing of that based on the acuity.

If a clinician performs the preliminary screening and risk assessment at first contact, the person still needs to receive an initial evaluation within whatever period is indicated by their acuity. If they do receive the initial evaluation which really builds on the preliminary screening on that call, the initial evaluation was performed in zero days. If a person calls and seeks an appointment, the preliminary screening and risk assessment should be performed on that call. If they come into the office that day and receive an initial evaluation, that is also within zero days.

As a further reminder, the criteria encouraged the initial evaluation to be performed in person. This gets to one of the questions that was just asked. Criterion 2.b.1 states that for those presenting with emergency or urgent needs, the initial evaluation may be conducted telephonically or by telehealth, but an in-person evaluation is preferred. If the initial evaluation is conducted telephonically, once the emergency is resolved the consumer must be seen in person at the next subsequent encounter and the initial evaluation reviewed. That is the standard that is in the CCBHC criteria.

For the tobacco use screening and cessation intervention measure, a question was asked as to whether e-cigarette use falls under tobacco use. I was uncertain about that, so I decided to see

what the FDA said. The measure specification includes in the definition of tobacco use any kind of tobacco. The U.S. Food and Drug Administration regulates e-cigarettes as deemed tobacco products. I include three references here for you to look at if you're interested in finding out what a deemed tobacco product is.

For the measure of screening and intervention for unhealthy alcohol use, if we have other screens already embedded in our EHR but not the audit, can we use those instead? The response to this is that the AUDIT, the AUDIT-C, and a single question screen that's specified in the ASC measure are permissible. Those are the screens you can use to satisfy the numerator. The audit has been validated across gender, age, and cultures, and there is a reference at the bottom of this slide that can provide you with more information about the audit.

Also, as I noted in a webinar when this measure was discussed, the CAGE which is often a default alcohol screen in EHRs is validated for adults, but it is not validated for adolescents and is best used as a measure of very heavy alcohol use. It also is not well suited for use with certain other populations such as pregnant women. The ASC measure is designed to have you using screening devices that are more generally validated.

Is the AUDIT tool in the public domain? The AUDIT was developed by the World Health Organization and is available from them as well as from other sources. You can access it on the World Health Organization website. The reference is there. It's available in Japanese, Spanish, and Slovenian. It's freely available but may not be sold or used for commercial purposes. Because CCBHCs are all either private, not-for-profit entities, or governmental entities, I believe that would not be considered to be a commercial purpose.

Again, for the measure of screening and intervention for unhealthy alcohol use, do the screening and brief intervention need to happen in the same session or encounter? The measure specification doesn't indicate one way or the other. If you are screening someone for alcohol use, however, the time for a brief intervention is when they are screened, and the screening shows that they have a problem that requires a brief intervention. It should happen in the same encounter.

In the webinar when I was discussing tobacco screening and the alcohol screening measures, this question came into the chat box. Volume 1 calls this counseling intervention, whereas Volume 2 calls this cessation intervention. Is there somewhere where terms are defined? If I understand this question correctly, this is the response. There are two different measures. One is tobacco use screening and cessation intervention--TSC. The other is unhealthy alcohol use, screening, and brief counseling--ASC. That's how they're titled in Volume 1 where the specifications are provided, as well as in Volume 2 where there are appendices for both of them. I give the numbers for those measures and their definitions on the slide. Both of them have definitions--the tobacco for cessation intervention and the alcohol for brief counseling.

The adult BMI measure prompted this question. The measure relates to a BMI during the encounter or within six months prior. This appears to be encounter-based rather than member-based. If a member has multiple encounters during the measurement year, are all encounters evaluated? The answer is this is not an encounter-based measure. It is a consumer measure. The denominator looks at those at the pertinent age who are seen at the BHC at least once in the

measurement year who have at least one of the eligible encounters. This looks at data for the measurement year only to identify the eligible population and is designed to capture those seen during the measurement year.

The numerator then looks at those out of the eligible population who have a documented BMI and, if needed, a follow-up plan. The data used to see if the BMI and follow-up plan were documented are encounters during the measurement year, but the BHC can also look back six months prior to the eligible encounter to see if BMI was documented earlier. If you have the encounter early in the year, you may go back into the prior year. This is only to give the reporter a six-month grace period in which to have performed the screening. Only one BMI screening is counted, and that is the most recent.

For the measure of screening and cessation intervention for tobacco use, it was asked how is cessation intervention defined? What if the person accepts having a phone call with the state quit line? A tobacco cessation intervention includes brief counseling--three minutes or less--and/or pharmacotherapy. That's the definition that's in the measure specification. To be in the denominator, however, the eligible encounters must be provided by a provider entity which is the BHC. This does not preclude use of a quit line, but there should be a brief intervention by the BHC as well. Three minutes or less of brief intervention might encompass an introduction to the quit line.

With regard to tobacco screening and the BMI measures, the following was asked. BMI and tobacco cessation screening and intervention are often done as part of a regular office visit with the PCP or mental health professional. Is the requirement that the codes--that is the G codes--actually be reported or is another method of documentation such as a checkbox, clinical notes, permissible? This is a simple question with a complicated answer.

The data reporting templates give you the option of indicating that you are using administrative or medical records, with the latter being electronic and/or paper. Yet, for tobacco screening and adult BMI screening measures, the specifications specifically state that failure to use the quality data codes means the person is excluded from the denominator and the numerator. They are not counted, which is not what SAMHSA wants. SAMHSA would like to know, in the population that this applies to, if they're being screened.

The preference is that the codes are used and that the process is as automated as possible. Failing that, you could use some other form of documentation, but you should try to make sure that it's in the EHR and can be captured to allow you to automate the process. You should work toward use of the codes. There is a place in the data reporting template, if there is some way that you don't adhere to the precise requirements of a specification that you can indicate that you have deviated from it in some way. There is clearly an anticipation that not everything is going to be reported perfectly, but SAMHSA and CMS want to know if there is a deviation, what it was.

Okay, so I'm going to stop for questions and see if there are any questions at this point.

Ame: Hi, Peggy. The first question is by Jim Banks. Does a veteran discharge status honorable or dishonorable have any bearing on their ability to receive CCBHC services?

Peggy O'Brien: No. There's nothing in the criteria that says anything about discharge status. There is a requirement that you ask--because one of the nine services is intensive community services for veterans and members of the active duty military services--that you ask their military status or their veteran status when you do an intake of them. That is, in part, so that you satisfy the requirements for serving that population but also so that you can know the person and also know what services need to be provided in accordance with the standards that apply. There is nothing related to honorable or dishonorable discharge.

Ame: The next question is by Rick Garlip. Regarding the first question, if the state begins a demonstration year on January 1st and allows individual CCBHCs to begin services anytime between January 1st and June 30th, would the demonstration year begin on January 1st or when the CCBHC begins services?

Peggy O'Brien: That's a good question. I think that's a possibility that had never occurred to me. I think I want to defer this one and get back to it. I need to talk to SAMHSA about how they are thinking about this.

Ame: The next question is from Tracy Leber. For the age question, what if the client is 17 when they are admitted, but turn 18 within a week. How are they counted in the initiation and engagement measure?

Peggy O'Brien: Okay. For the initiation and engagement in alcohol and other drug treatments, which I don't have the specifications in front of me, so I can't tell you what they say, but in every measure there is a section where it tells you how to determine age. It will tell you whether it is the first day of the measurement year, the last day of the measurement year, if it's the day that a specific service that's being counted--there age on that date. It really is by specification by measure. What I encourage you to do for initiation and engagement is to go to that specification, and it's either in Section A, which is the general reporting guidance, or it's in Section C where the eligible population is defined. There's always an age component to that. I would suggest that you look there.

Ame: The next question is from Rick Pilot. The suicide risk assessment for adolescents says someone age 6 to 17 years at the start of the measurement year, but the adult suicide risk assessment says someone age 18 years on date of encounter. Could a client be counted in both measures?

Peggy O'Brien: It sounds like it's possible. I would need to think about it. I think the goal was to have them be mutually exclusive, but that's a question I want to look at more closely.

Ame: The next question is from Donald Thompson. Just to be clear, if the screening and risk assessment occurs at a hospital or ED prior to any contact with the CCBHC but then is referred and appears at the CCBHC on the same day the crisis service cost is reimbursable by the CCBHC covered under the PPS?

Peggy O'Brien: Yes. Let me restate it to make sure that I'm getting right, so that I'm answering the right question. A person is, for instance, seen in an emergency room or in a hospital or is seen perhaps by a state sanctioned DCO crisis team. The person has never been to the BHC before. They have this screening which fulfills whatever requirements there are for the preliminary screening and risk assessment which are basic risk kinds of questions. Then they show up at the CCBHC for services that same day. They then are a CCBHC consumer, yes.

Ame: The next question is by Ginger Bandeen. If the most recent BMI is missing a needed follow-up plan and the eligible encounter happens after the BMI, that consumer would not be included in the numerator, even if previous encounters happened under a previous BMI that was normal?

Peggy O'Brien: That is one that I need to think about. I'd have to answer it with the measure in front of me. That's one that I'll get back to.

Ame: Peggy, there are no more questions.

Peggy O'Brien: Okay. Great. Okay, so the next two webinars--the next webinar is next week--August 23rd. We will have a guest speaker--actually, two guest speakers--from CMS. They will be talking about quality bonus measures and payments. Included in that will be some discussion about data for the dually eligible population, as it relates to quality bonus measures and payments. I will talk about some of the lessons that we learned from the state visits that we undertook in the spring. I will answer a lot more outstanding questions.

Unfortunately, the questions that I left hanging today won't get into webinar seven, because we have to have them prepared in advance, so those questions will be in that webinar eight. There are a number of questions from webinar five, in particular, that I will be answering next week and also some outstanding questions where I've gotten answers from CMS too. Stay tuned for that.

Then in week eight we will go through the BHC measures that are not required of CCBHCs as part of the demonstration program. These are the measures that were in the original CCBHC criteria that were later determined not to be required for the demonstration, but they are part of the BHC measures. I believe some states may decide they want to use them, and they are available for other non-CCBHC states to use, so I will be covering those, probably because I think there are maybe 11 of them. There are a fair number. I won't go into as much detail as I have on the others. I also want to save some time for outstanding questions. You will have seen things that indicate that webinar eight is for the states only, but BHCs are welcome to attend.

This and the next two slides are the ones I always include that show which webinar each measure is discussed in. If you want to go back and look at either the PDF that is the slides or view the on-demand presentation, you can go to the webinar that has the measure of interest to you.

Any additional questions, please submit to the SAMHSA Data TA mailbox. The address is on the screen there--about materials covered today, material that's scheduled for next week, anything else related to data collection, analysis, and reporting. We will try to answer them.

As a reminder, you can access a PDF of the slides on the webinar site, and you can view and listen on demand on the webinar site--old ones too--just register, and they will be on the SAMHSA website as well once they are posted. I believe that the first three are posted on the SAMHSA YouTube website, and four and five will be up before too long, I hope. That will continue after each one. Also, just a reminder that we do have office hours, and a lot of states have taken us up on the office hours. If you haven't and you're interested, there are still times available. Thank you, and I'll be back next week.