

Behavioral Health is Essential To Health



Prevention Works



Treatment is Effective



People Recover



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

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



Speaker

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Logistics

- **Chat function for questions**
- **Poll questions**
- **Slide and webinar availability**

Webinar Schedule

- 1: July 12: Introduction and Background – **States and BHCs**
- 2: July 19: State-Reported Measures – **States Only**
- 3: July 26: State-Reported Measures – **States Only**
- 4: August 2: Clinic-Reported Measures – **States and BHCs**
- 5: August 9: Clinic-Reported Measures – **States and BHCs**
- 6: August 16: Special Issues – **States and BHCs**
- 7: August 23: Special Issues – **States and BHCs**
- 8: September 6: Non-Required Measures – **States Only**

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

Focus Today

Outstanding questions from Webinar 3
Examination of 4 BHC-lead measures

Outstanding Questions from Webinar 3



BHC-Lead Measures – Webinar 4

- **Time to Initial Evaluation (I-EVAL)**
- **Preventive Care & Screening: Body Mass Index (BMI) Screening & Follow-Up (BMI-SF)**
- **Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention (TSC)**
- **Preventive Care & Screening: Unhealthy Alcohol Use: Screening & Brief Counseling (ASC)**

Age and Stratification

Measure	Age Coverage	Stratification
Time to Initial Evaluation (I-EVAL)	Ages 12 and older	Medicaid, Dual Medicare & Medicaid, Other Ages 12-17 years, 18 years+
Preventive Care & Screening: Body Mass Index (BMI) Screening & Follow-Up (BMI-SF)	Ages 18 and older	Medicaid, Dual Medicare & Medicaid, Other
Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention (TSC)	Ages 18 and older	Medicaid, Dual Medicare & Medicaid, Other
Preventive Care & Screening: Unhealthy Alcohol Use: Screening & Brief Counseling (ASC)	Ages 18 and older	Medicaid, Dual Medicare & Medicaid, Other

Time to Initial Evaluation (I-EVAL) (1)

Time to Initial Evaluation (I-EVAL)

SAMHSA-Developed Metric

A. DESCRIPTION

Metric #1: The percentage of new consumers with initial evaluation provided within 10 business days of first contact

Metric #2: The mean number of days until initial evaluation for new consumers

Data Collection Method: Medical Records

Guidance for Reporting:

- This is a two-part measure and requires two different calculations.
- This metric is stratified by age (12–17 years, 18 years and older) and by whether the consumer is a Medicaid beneficiary, eligible for both Medicare and Medicaid, and other.
- Provider entities will rely on medical records to compile this information. There are several potential sources of information that may be used individually or together:
 - Electronic health records (including billing records)
 - Paper health records
 - A registry

Section A. Description

• Two metrics

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

• Data Collection Method

- *Medical Records*
- Continued next slide

Time to Initial Evaluation (I-EVAL) (2)

Guidance for Reporting:

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

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

30

Section A. Description (cont'd)

• Guidance for Reporting

- *2 parts*
- *Stratified (12-17, 18+, Payer)*

Reminder regarding Payers:

Medicaid: Medicaid beneficiaries including Title 19-eligible CHIP beneficiaries

Dually eligible (Medicare & Medicaid):

Dually eligible under Medicare and Medicaid

Other: Enrolled in neither program, including Title 21-eligible CHIP beneficiaries

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

Time to Initial Evaluation (I-EVAL) (3)

- Provider entities will rely on medical records to compile this information. There are several potential sources of information that may be used individually or together:
 - Electronic health records (including billing records)
 - Paper health records
 - A registry
 - An electronic scheduling system that is separate from the medical record and that is used to schedule and monitor appointments and critical time frames
 - A system similar to one developed by [NIATx](#) (the NIATx Outpatient Spreadsheet)
- Refer to the specific data-reporting template for the reporting requirements applicable to each measure and to the Appendices in Volume 2 of this manual.

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

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Time to Initial Evaluation (I-EVAL)

including the 6 months preceding the measurement year. The measurement period for the numerator is the measurement year.

Year before MY1	MY1
	Numerator MP
	Denominator MP

Section A. Description (cont'd)

• Guidance for Reporting

• *Medical record sources:*

- EHR (including billing)
- Paper records
- Registry
- Scheduling
- NIATx Outpatient Spreadsheet

• *Data reporting templates and appendices*

• Measurement Period

- *Denominator*
- *Numerator*

Time to Initial Evaluation (I-EVAL) (4)

DEFINITIONS

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

Section B. Definitions

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

Time to Initial Evaluation (I-EVAL) (5)

C. ELIGIBLE POPULATION

CRITERIA	REQUIREMENTS
Age	Report two age stratifications and a total rate: <ul style="list-style-type: none">• 12–17 years as of the end of the measurement year• 18 years and older as of the end of the measurement year• Total (both age groups)

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Time to Initial Evaluation (I-EVAL)

CRITERIA	REQUIREMENTS
Event/Diagnosis	Follow the steps below to identify the eligible population: <i>Step 1</i> Identify new consumers who contacted the provider entity seeking services during the measurement year. <i>Step 2</i> Identify consumers from step 1 aged 12 years and older as of the end of the measurement year.

D. MEDICAL RECORD METRIC SPECIFICATION #1

Section C. Eligible Population

- **Age stratification**
- **Event/Diagnosis**
 - *Step 1: All new consumers seeking services during the first 11 months of the measurement year (MY)*
 - *Step 2: Aged 12 years and older as of the end of the MY*

Time to Initial Evaluation (I-EVAL) (6)

Event/Diagnosis	Identify new consumers who contacted the provider entity seeking services during the measurement year. <i>Step 2</i> Identify consumers from step 1 aged 12 years and older as of the end of the measurement year.
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D. MEDICAL RECORD METRIC SPECIFICATION #1

Percentage of new consumers with initial evaluation provided within 10 business days of first contact

Denominator

The number of consumers in the eligible population (Section C)

Note: The measurement period for the denominator is the measurement year excluding the last 30 days of the measurement year and including the 6 months preceding the measurement year.

Numerator

The number of consumers in the eligible population who received an initial evaluation within 10 business days of the first contact with the provider entity during the measurement year.

Note: The measurement period for the numerator is the measurement year.

Exclusions

None.

Example Calculation

See Appendix I-EVAL to this measure.

E. MEDICAL RECORD METRIC SPECIFICATION #2

Section D. Medical Record Metric Specification #1

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

- Denominator: Number in eligible population (section C)
- Numerator: Number receiving IE within 10 business days of 1st contact during MY
- Notes re MPs
- Exclusions: None
- Example: Appendix

Time to Initial Evaluation (I-EVAL) (7)

None.

Example Calculation

See Appendix I-EVAL to this measure.

E. MEDICAL RECORD METRIC SPECIFICATION #2

The mean number of days until initial evaluation for new consumers

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Time to Initial Evaluation (I-EVAL)

Denominator

The number of consumers in the eligible population (Section C)

Note: The measurement period for the denominator is the measurement year excluding the last month of the measurement year and including the 6 months preceding the measurement year.

Numerator

The total number of days between first contact and initial evaluation for all members of the eligible population seen at the provider entity during the measurement year

Note: The measurement period for the numerator is the measurement year. Any who received an initial evaluation after the last day of the measurement year are treated as having been evaluated 31 days after initial contact.

Exclusions

None.

Example Calculation

See Appendix I-EVAL to this measure.

Section E. Medical Record Metric Specification #2

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

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

Time to Initial Evaluation (I-EVAL) (8)

F. ADDITIONAL NOTES

This measure is designed to require provider-level reporting but is not tested at the provider level.

It is likely that some new consumers will not have an appointment within 10 days because of their own schedules and non-urgent need. This situation is a recognized limitation of this measure that will affect all clinics. Trying to adjust for non-consumers who are offered but do not accept an appointment within 10 business days complicates the calculation unnecessarily.

Interpretation of scores:

Percentage of new consumers with initial evaluation provided within 10 business days: Better quality = Higher score

Mean number of days until initial evaluation for new consumers:
Better quality = Lower number

Section F. Additional Notes

- **BHC-level reporting**
- **Recognized limitation**
- **Interpretation of scores**
 - ***% with IE within 10 days: Higher = Better***
 - ***Mean number of days to IE: Lower = Better***

Time to Initial Evaluation (I-EVAL) (9)

Appendix I-EVAL: Time to Initial Evaluation

Metric #1: The percentage of new consumers with initial evaluation provided within 10 business days of first contact

Metric #2: The mean number of days until initial evaluation for new consumers

EXAMPLES

METRIC #1

The percentage of new consumers with initial evaluation provided within 10 business days of first contact:

Denominator: Calculate the denominator as follows, with the measurement period being the first 11 months of the measurement year (MY) and the 6 months preceding the MY contact:

1. 100 consumers contact clinic in first 11 months of the MY
2. 50 of those were not seen at the clinic in the 6 months preceding the MY contact
3. Of those 50, 20 were Medicaid eligible, 15 were both Medicare and Medicaid eligible, and 15 were neither.
4. Calculate as follows for stratification by payer:

Steps in calculation	Medicaid	Medicare & Medicaid	Neither	Total
Number of consumers who contact clinic in first 11 months of the MY	50	25	25	100
Number of those not seen at the clinic in the 6	20	15	15	50

Appendix I-EVAL: Time to Initial Evaluation

- Volume 2
- Examples for both metrics

Questions so far?

Time to Initial Evaluation (I-EVAL) (10)

2	Time to Initial Evaluation (I-EVAL)		
3	A SAMHSA-Developed Metric		
4	A. Measurement Year:		
5	Insert measurement year based on CCBHC or non-CCBHC status. For CCBHCs, enter DY1 or DY2. For non-CCBHCs, enter year such as FY2017.		Measurement year If entering data for a CCBHC, enter DY1 or DY2. If entering data for a non-CCBHC, enter data such as FY2017
6	B. Data Source:		
7	Select the data source type (Medical Records or Other):		If medical records data, select source (EHR, Paper Records, Both):
8	If other data source selected, specify source:		
9	C. Date Range:		
10	Denominator Start Date (mm/dd/yyyy)		
11	Denominator End Date (mm/dd/yyyy)		
12	Numerator Start Date (mm/dd/yyyy)		
13	Numerator End Date (mm/dd/yyyy)		
14	D. Performance Measure:		
15	Metric 1. The percentage of new consumers with initial evaluation provided within 10 business days of first contact		
16	Metric 2. The mean number of days until initial evaluation for new consumers		

A. Measurement Year

Row 5

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

Time to Initial Evaluation (I-EVAL) (11)

2	Time to Initial Evaluation (I-EVAL)		
3	A SAMHSA-Developed Metric		
4	A. Measurement Year:		
5	Insert measurement year based on CCBHC or non-CCBHC status. For CCBHCs, enter DY1 or DY2. For non-CCBHCs, enter year such as FY2017.		Select the data source type Input Medical Records Data or Other.
6	B. Data Source:		
7	Select the data source type (Medical Records or Other):	Medical Records Data	If medical records data, select source (EHR, Paper Records, Both):
8	If other data source selected, specify source:		Electronic Health Record (EHR) and/or registry data and/or practice management data
9	C. Date Range:		
10	Denominator Start Date (mm/dd/yyyy)		

B. Data Source

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

Time to Initial Evaluation (I-EVAL) (12)

2	Time to Initial Evaluation (I-EVAL)		
3	A SAMHSA-Developed Metric		
4	A. Measurement Year:		
5	Insert measurement year based on CCBHC or non-CCBHC status. For CCBHCs, enter DY1 or DY2. For non-CCBHCs, enter year such as FY2017.		
6	B. Data Source:		
7	Select the data source type (Medical Records or Other):	If medical records data, select source (EHR, Paper Records, Both):	
8	If other data source selected, specify source:		
9	C. Date Range:		
10	Denominator Start Date (mm/dd/yyyy)		Denominator Start Date Input date in the following format - mm/dd/yyyy
11	Denominator End Date (mm/dd/yyyy)		
12	Numerator Start Date (mm/dd/yyyy)		
13	Numerator End Date (mm/dd/yyyy)		
14	D. Performance Measure:		
15	Metric 1. The percentage of new consumers with initial evaluation provided within 10 business days of first contact		
16	Metric 2. The mean number of days until initial evaluation for new consumers		

C. Date Range

- *Denominator Start Date (mm/dd/yyyy)*
- *Denominator End Date (mm/dd/yyyy)*
- *Numerator Start Date (mm/dd/yyyy)*
- *Numerator End Date (mm/dd/yyyy)*

Time to Initial Evaluation (I-EVAL) (13)

14 **D. Performance Measure:**

15 Metric 1. The percentage of new consumers with initial evaluation provided within 10 business days of first contact

16 Metric 2. The mean number of days until initial evaluation for new consumers

17 These metrics are stratified to report by age (12–17 years, 18 years and older) and are stratified to report by Medicaid, Medicare & Medicaid, other, and total population.

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

19 Measure	Numerator	Denominator	Rate
20 Age 12-17 years	9	33	27.27%
21 Medicaid	2	10	20.00%
22 Medicare & Medicaid	3	11	27.27%
23 Other	4	12	33.33%
24 Age 18+ years	18	42	42.86%
25 Medicaid	5	13	38.46%
26 Medicare & Medicaid	6	14	42.86%
27 Other	7	15	46.67%
28 Total (all Age Groups)	27	75	36.00%
29 Medicaid	7	23	30.43%
30 Medicare & Medicaid	9	25	36.00%
31 Other	11	27	40.74%

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

33 Measure	Numerator	Denominator	Rate
34 Age 12-17 years	0	0	
35 Medicaid			
36 Medicare & Medicaid			
37 Other			
38 Age 18+ years	0	0	
39 Medicaid			
40 Medicare & Medicaid			

D. Performance Measure

- *Metric 1*
- *Metric 2*
- *Stratifications*
- *Table for data entry*
 - **Auto-calculates**
 - **Auto-populates roll-up table (next slide)**

Time to Initial Evaluation (I-EVAL) (14)

Roll-up worksheet

Roll-up All Measures			
BHC-Lead CCBHC-Required Measures			
Time to Initial Evaluation (I-EVAL)			
Metric #1: Percentage of New Clients with Initial Evaluation within 10 Business Days			
Measure	Numerator	Denominator	Percentage
Age 12-17 years	9	33	27.27%
Medicaid	2	10	20.00%
Medicare & Medicaid	3	11	27.27%
Other	4	12	33.33%
Age 18+ years	18	42	42.86%
Medicaid	5	13	38.46%
Medicare & Medicaid	6	14	42.86%
Other	7	15	46.67%
Total (all age groups)	27	75	36.00%
Medicaid	7	23	30.43%
Medicare & Medicaid	9	25	36.00%
Other	11	27	40.74%
Metric #2: Mean Number of Days until Initial Evaluation			
Measure	Numerator	Denominator	Mean
Age 12-17 years	0	0	
Medicaid	0	0	

Time to Initial Evaluation (I-EVAL) (15)

6 E. Adherence to Measure Specifications:

7 Population included in the denominator (indicate yes or no for each of the options below):

8 Medicaid population	Yes		
9 Title XIX-eligible CHIP population			
0 Title XXI-eligible CHIP population			
1 Other CHIP enrollees			
2 Medicare population			
3 Medicare and Medicaid Dually-Eligible population			
4 VHA/TRICARE population			
5 Commercially insured population			
6 Uninsured population			
7 Other		If Other, explain whether the denominator is a subset of definitions selected above, please further define the denominator, and indicate the number of consumers excluded:	
8 Did your calculation of the measure deviate from the measure specification in any way?		If Yes, the measure differs: Explain how the calculation differed and why.	
9 Does this denominator represent your total measure eligible population as defined by the Technical Specifications for this measure?		If No, the denominator doesn't represent your total eligible population, explain which populations are	

Indicate whether the Title XIX-eligible CHIP population is included in the denominator by selecting Yes or No

E. Adherence to Measure Specifications:

- *Population included (Rows 47-57)*
 - Did your calculation of the measure deviate from the specification (Row 58)
 - Does the denominator represent the total eligible population (row 59)
 - Specify the size of the population included in the denominator (Row 60)
- *Continued*

Time to Initial Evaluation (I-EVAL) (16)

S1 Provide the following information for each rate/stratification:			
S2 For Metric #1: Percentage of New Clients with Initial Eval within 10 Business Days			
S3 Age Range: 12-17 years			
S4 Did the numerator differ for the 12-17 years age range?	No	if numerator differs, explain the deviation in the next cell:	
S4 Did the denominator differ for the 12-17 years age range?	No	if denominator differs, explain the deviation in the next cell:	
S5 Did the calculation differ in some other way for the 12-17 years age range?		if other, explain the deviation in the next cell:	Did the calculation differ in some other way for age range 12-17 years? (Yes or No)
S6			
S7 Age Range: 18+ years			
S8 Did the numerator differ for the 18+ years age range?		if numerator differs, explain the deviation in the next cell:	
S9 Did the denominator differ for the 18+ years age range?		if denominator differs, explain the deviation in the next cell:	
S10 Did the calculation differ in some other way for the 18+ years age range?		if other, explain the deviation in the next cell:	
S11 Medicaid Population:			
S12 Did the numerator differ for the Medicaid population?		if numerator differs, explain the deviation in the next cell:	
S13 Did the denominator differ for the Medicaid population?		if denominator differs, explain the deviation in the next cell:	
S14 Did the calculation differ in some other way for the Medicaid population?		if other, explain the deviation in the next cell:	
S15 Medicare & Medicaid Population:			
S16 Did the numerator differ for the Medicare & Medicaid population?		if numerator differs, explain the deviation in the next cell:	

E. Adherence to Measure Specifications: (continued)

- *Metric #1*
 - Age Range 12-17
 - Age Range 18+
 - Medicaid
 - Medicare & Medicaid
 - Other
- *Same for Metric #2*

Time to Initial Evaluation (I-EVAL) (17)

F. Additional Notes

06	Did the denominator differ for the neither Medicaid nor Medicare & Medicaid population?		If denominator differs, explain the deviation in the next cell:	
07	Did the calculation differ in some other way for the neither Medicaid nor Medicare & Medicaid population?		If other, explain the deviation in the next cell:	
08	Total Eligible Population:			
09	Did the numerator differ for the Total Eligible population?		If numerator differs, explain the deviation in the next cell:	
10	Did the denominator differ for the Total Eligible population?		If denominator differs, explain the deviation in the next cell:	
11	Did the calculation differ in some other way for the Total Eligible population?		If other, explain the deviation in the next cell:	
12	F. Additional Notes:			
13				
14	End of Worksheet			

Additional Notes field
Please note anything you would like to tell us about reporting this measure:

Questions so far?

Preventive Care & Screening: Body Mass Index (BMI) Screening & Follow-Up (BMI-SF)(1)

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

Year before MY1	MY1
	Numerator MP
	Denominator MP

Preventive Care & Screening: Body Mass Index (BMI) Screening & Follow-Up (BMI-SF)(2)

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

Based on a measure stewarded by the Centers for Medicare & Medicaid Services (NQF #0421, PQRS #128)

A. DESCRIPTION

Percentage of consumers aged 18 years and older with a BMI documented during the current encounter or during the previous six months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the current encounter

Normal Parameters: Age 65 years and older BMI ≥ 23 and < 30 kg/m²
 Age 18 - 64 years BMI ≥ 18.5 and < 25 kg/m²

Data Collection Method: Medical Records

Guidance for Reporting:

- This measure is stratified by whether the consumer is a Medicaid beneficiary, eligible for both Medicare and Medicaid, and other.
- There is no diagnosis associated with this measure. This measure is to be reported a minimum of once per measurement year for consumers seen during the reporting year. This measure may be reported by eligible professionals who perform the quality actions described in the measure based on the services provided at the time of the qualifying visit and the measure-specific denominator coding. The BMI may be documented in the medical record of the provider or in outside medical records obtained by the provider. If the most recent documented BMI is outside of normal parameters, then a follow-up plan must be documented during the encounter or during the previous six months of the current encounter. The documented follow-up plan must be based on the most recent documented BMI outside of normal parameters, example: "Consumer referred to nutrition counseling for BMI above normal parameters" (See Definitions for examples of a follow-up plan treatments). *If more than one BMI is reported during the measure period, the most recent BMI will be used to determine if the performance has been met*

A. Description

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

Preventive Care & Screening: Body Mass Index (BMI) Screening & Follow-Up (BMI-SF)(3)

- This measure is stratified by whether the consumer is a Medicaid beneficiary, eligible for both Medicare and Medicaid, and other.
- There is no diagnosis associated with this measure. This measure is to be reported a minimum of once per measurement year for consumers seen during the reporting year. This measure may be reported by eligible professionals who perform the quality actions described in the measure based on the services provided at the time of the qualifying visit and the measure-specific denominator coding. The BMI may be documented in the medical record of the provider or in outside medical records obtained by the provider. If the most recent documented BMI is outside of normal parameters, then a follow-up plan must be documented during the encounter or during the previous six months of the current encounter. The documented follow-up plan must be based on the most recent documented BMI outside of normal parameters, example: "Consumer referred to nutrition counseling for BMI above normal parameters" (See Definitions for examples of a follow-up plan treatments). *If more than one BMI is reported during the measure period, the most recent BMI will be used to determine if the performance has been met.*
- Provider entities will rely on medical records to compile this information. There are several potential sources of information that may be used individually or together:

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A. Description (cont'd)

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

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

- Electronic health records (including billing records)
- Paper health records
- A registry
- Please refer to the most recent source measure PQRS #128 at PQRS Measures for encounter codes needed to calculate this measure.
- Refer to the specific data-reporting template for the reporting requirements applicable to each measure and to the Appendices in Volume 2 of this manual.

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

Preventive Care & Screening: Body Mass Index (BMI) Screening & Follow-Up (BMI-SF)(4)

B. DEFINITIONS

TERM	DEFINITION
Body Mass Index (BMI)	<p>BMI is a number calculated using the Quetelet index—weight divided by height squared (W/H^2)—and is commonly used to classify weight categories. BMI can be calculated using:</p> <p>Metric Units: $BMI = \text{Weight (kg)} / (\text{Height [m]} \times \text{Height [m]})$</p> <p>OR</p> <p>English Units: $BMI = (\text{Weight [lbs]} \times 703) / (\text{Height [in]} \times \text{Height [in]})$</p>
Follow-Up Plan	<p>Proposed outline of treatment to be conducted as a result of a BMI out of normal parameters. A follow-up plan may include, but is not limited to:</p> <ul style="list-style-type: none">• Documentation of education• Referral (for example a registered dietician, nutritionist, occupational therapist, physical therapist, primary care provider, exercise physiologist, mental health professions, or surgeon)• Pharmacological interventions• Dietary supplements• Exercise counseling• Nutrition counseling

B. Definitions

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

Preventive Care & Screening: Body Mass Index (BMI) Screening & Follow-Up (BMI-SF)(5)

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

TERM	DEFINITION
Not eligible for BMI Calculation or Follow-Up Plan	<p>A consumer is not eligible if one or more of the following reasons are documented:</p> <ul style="list-style-type: none"> • Consumer is receiving palliative care • Consumer is pregnant • Consumer refuses BMI measurement (refuses height and/or weight) • Any other reason documented in the medical record by the provider why BMI measurement was not appropriate • Consumer is in an urgent or emergent medical situation where time is of the essence, and to delay treatment would jeopardize the consumer's health status
Provider Entity	The provider entity that is being measured (i.e., BHC)

C. ELIGIBLE POPULATION

CRITERIA	REQUIREMENTS

B. Definitions (cont'd)

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

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

Provider Entity	The provider entity that is being measured (i.e., BHC)
-----------------	--

C. ELIGIBLE POPULATION

CRITERIA	REQUIREMENTS
Age	Consumers aged 18 years and older on the date of service during the measurement year
Event/Diagnosis	<p>Follow the steps below to identify the eligible population:</p> <p><i>Step 1</i> Identify consumers flagged as having been seen at the provider entity at least once during the measurement year</p> <p><i>Step 2</i> Identify consumers from step 1 who are aged 18 years or older on the date of service during the measurement year. Relevant codes (Current Procedural Terminology [CPT®] or Healthcare Common Procedure Coding System [HCPCS]) are identified in the most recent source measure specification. <i>Note:</i> The types of eligible encounters are limited to those listed.</p>

C. Eligible Population

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

Preventive Care & Screening: Body Mass Index (BMI) Screening & Follow-Up (BMI-SF)(7)

D. MEDICAL RECORDS SPECIFICATION

Denominator

The number of consumers in the eligible population (Section C)

Note: The measurement period for the denominator is the measurement year.

Numerator

The number of consumers in the eligible population with a documented BMI during the encounter or during the previous six months AND, when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the current encounter.

Numerator Quality-Data Coding Options: The options below indicate the coding possibilities related to the numerator. The first three, where performance is met, indicate situations where the data point is included in the numerator. The fourth and fifth, where performance is not met, means that the data point is excluded from the numerator.

Performance Met: BMI is documented within normal parameters and no follow up plan is required (G8420)

OR

Performance Met: BMI is documented above normal parameters and a follow-up plan is documented (G8417)

OR

Performance Met: BMI is documented below normal parameters and a follow-up plan is documented (G8418)

Performance Not Met: BMI not documented and no reason is given (G8421)

OR

Performance Not Met: BMI documented outside normal parameters, no follow-up plan documented, no reason given (G8419)

Numerator Instructions:

- **Height and Weight:** An eligible professional or their staff is required to measure both height and weight. Both height and weight must be measured within six months of the current encounter and may be obtained from separate encounters. Self-reported values cannot be used.

D. Medical Records Specification

- *Denominator – Eligible Population*
- *Numerator:*
 - **Restated**
 - **Numerator Quality Data Coding Options**
 - *Three codes where numerator is satisfied*
 - *Two codes where it is not*
- **Continued next slide**

Preventive Care & Screening: Body Mass Index (BMI) Screening & Follow-Up (BMI-SF)(8)

Numerator Instructions:

- **Height and Weight:** An eligible professional or their staff is required to measure both height and weight. Both height and weight must be measured within six months of the current encounter and may be obtained from separate encounters. Self-reported values cannot be used.

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

- **Follow-Up Plan:** If the most recent documented BMI is outside of normal parameters, then a follow-up plan is documented during the encounter or during the previous six months of the current encounter. The documented follow-up plan must be based on the most recent documented BMI, outside of normal parameters, example: "Consumer referred to nutrition counseling for BMI above normal parameters." (See Definitions for examples of a follow-up plan treatments)
- **Performance Met for G8417 and G8418**
 - If the provider documents a BMI and a follow-up plan at the current visit **OR**
 - If the consumer has a documented BMI within the previous six months of the current encounter, the provider documents a follow-up plan at the current visit **OR**
 - If the consumer has a documented BMI within the previous six months of the current encounter **AND** the consumer has a documented follow-up plan for a BMI outside normal parameters within the previous six months of the current visit

Note: The measurement period for the numerator is the measurement year and the previous 6 months.

Exclusions: A consumer is not eligible for BMI calculation or development of a follow-up plan if one or more of the following reasons are documented:

D. Medical Records Specification (cont'd)

- *Numerator:*
 - **Numerator Instructions**
 - *How to obtain height and weight*
 - *Follow-Up Plan*
 - *Performance Met*
 - **Cont'd next slide**

Preventive Care & Screening: Body Mass Index (BMI) Screening & Follow-Up (BMI-SF)(9)

Exclusions: A consumer is not eligible for BMI calculation or development of a follow-up plan if one or more of the following reasons are documented:

- Consumer is receiving palliative care
- Consumer is pregnant
- Consumer refuses BMI measurement (refuses height and/or weight)
- Any other reason documented in the medical record by the provider why BMI measurement was not appropriate
- Consumer is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the consumer's health status

Relevant quality-data codes for non-eligibility include:

BMI Documented, Consumer not Eligible: BMI not documented, with documentation the consumer is not eligible for BMI calculation (G8422)

OR

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

BMI Documented Outside of Normal Limits, Follow-Up Plan not Documented, Consumer not Eligible: BMI is documented as being outside of normal limits, follow-up plan is not documented, documentation shows the consumer is not eligible (G8938)

Incomplete Reporting Exclusion: Failure to record quality-data codes necessary for computing the numerator means that the consumer is excluded from the denominator.

Example Calculation
See Appendix BMI-SF.

E. ADDITIONAL NOTES

D. Medical Records Specification (cont'd)

- *Exclusions FROM DENOMINATOR & NUMERATOR:*
 - **Relevant quality-data codes for non-eligibility**
 - **Incomplete Reporting Exclusion**
- *Example Calculation: Appendix BMI-SF*

Preventive Care & Screening: Body Mass Index (BMI) Screening & Follow-Up (BMI-SF)(10)

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

BMI Documented Outside of Normal Limits, Follow-Up Plan not Documented, Consumer not Eligible: BMI is documented as being outside of normal limits, follow-up plan is not documented, documentation shows the consumer is not eligible (G8933)

Incomplete Reporting Exclusion: Failure to record quality-data codes necessary for computing the numerator means that the consumer is excluded from the denominator.

Example Calculation

See Appendix BMI-SF.

E. ADDITIONAL NOTES

The source measure is designed for the Medicare population and is not risk adjusted. The source measure was specified at both the provider and other levels. This measure is modified from the source measure to provide a specification consistent in format to other measures in this set of BHC measures.

Interpretation of score: Better quality = Higher score

E. Additional Notes

- *Information on source measure*
 - Medicare population
 - Not risk adjusted
 - Specified at provider and other levels
 - Modified here to be consistent with other BHC measures in format
- *Interpretation of score: Better quality = higher score*

Preventive Care & Screening: Body Mass Index (BMI) Screening & Follow-Up (BMI-SF)(11)

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

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

Percentage of consumers aged 18 years and older with a BMI documented during the current encounter or during the previous six months AND with a BMI of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the current encounter.

Normal Parameters: Age 65 years and older BMI ≥ 23 and < 30 kg/m²

Age 18 - 64 years BMI ≥ 18.5 and < 25 kg/m²

EXAMPLE

Eligible Population or Denominator: Calculate the denominator as follows, with the measurement period being the measurement year (MY):

1. Consumers aged 18 years or older who were seen at the clinic with one of the denominator-eligible encounter codes during the MY: 200
2. Exclusions:
 - a. BMI Not Documented, Consumer Not Eligible: 15
 - b. BMI Documented Outside of Normal Limits and Follow-Up Plan Not Documented in MY, Consumer Not Eligible: 4
 - c. No quality-data codes reported: 1
200-20=180
3. Of the 180 non-excluded consumers, 100 are Medicaid beneficiaries, 20 are Medicaid & Medicare eligible, and 60 are neither.

Calculate as follows:

Steps in calculation	Medicaid	Medicaid & Medicare	Neither	Total

Appendix BMI-SF Example Calculation

Questions so far?

Poll Question 1

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

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

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

Option 3: Both of the above.

Option 4: Other

If you wish, please briefly indicate your “other” approach in the chat box.

Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention (TSC)(1)

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

Year before MY 1	MY1
Numerator MP	
	Denominator MP

Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention (TSC)(2)

Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention (TSC)

Based on a measure stewarded by the American Medical Association (AMA) and CPI® Foundation (PCPI®) (NQF #0028, PQRS # 226)

A. DESCRIPTION

Percentage of consumers aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user

Data Collection Method: Medical Records

Guidance for Reporting:

- This measure is stratified by whether the consumer is a Medicaid beneficiary, eligible for both Medicare and Medicaid, and other.
- This measure is to be reported once per measurement year for consumers seen during the measurement year.
- This measure is intended to reflect the quality of services provided for preventive screening for tobacco use.
- Provider entities will rely on medical records to compile this information. There are several potential sources of information that may be used individually or together:
 - Electronic health records (including billing records)
 - Paper health records
 - A registry
- Please refer to the most recent source measure PQRS #226 at [PQRS Measures](#) for codes needed to calculate this measure.
- Refer to the specific data-reporting template for the reporting requirements applicable to each measure and to the Appendices in Volume 2 of this manual.

Measurement Period: The measurement period for the denominator is the measurement year and, for the numerator, is the measurement year and the prior year.

Section A. Description

- *Narrative of measure*
- *Data Collection Method: Medical Records*
- *Guidance for Reporting:*
 - **Stratified by payer**
 - **Report once per MY if seen that year**
 - **Source of records**
 - **Code sources**
 - **Template and Appendices (example & codes)**
 - **Measurement period**

Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention (TSC)(3)

B. DEFINITIONS

TERM	DEFINITION
Provider Entity	The provider entity that is being measured (i.e., BHC)
Tobacco Cessation Intervention	Includes brief counseling (3 minutes or less) and/or pharmacotherapy
Tobacco Use	Includes use of any type of tobacco

C. ELIGIBLE POPULATION

CRITERIA	REQUIREMENTS
Age	Consumers aged 18 years or older on the date of service during the measurement year
Event/Diagnosis	<p>Follow the steps below to identify the eligible population:</p> <p><i>Step 1</i> Identify consumers seen at the provider entity during the measurement year.</p> <p><i>Step 2</i> Identify consumers from step 1 who were aged 18 years and older on the date of service during the measurement year.</p> <p><i>Step 3</i> Identify consumers from step 2 who had an eligible encounter at the provider entity during the measurement year. Relevant codes (Current Procedural Terminology [CPT®] or Healthcare Common Procedure Coding System [HCPCS]) may be found in the most recent source measure.</p>

B. Definitions:

- *Provider Entity*
- *Tobacco Cessation Intervention*
- *Tobacco Use*

C. Eligible Population:

- *Age: 18 and older on date of service during MY*
- *Event/Diagnosis:*
 - **Step 1: Seen at Provider Entity**
 - **Step 2: Age 18 or older**
 - **Step 3: Eligible encounter in MY (source measure)**

Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention (TSC)(4)

D. MEDICAL RECORD SPECIFICATION

Denominator

The number of consumers in the eligible population (Section C)

Note: The measurement period for the denominator is the measurement year.

Incomplete Reporting Exclusion: Failure to record quality-data codes necessary for computing the numerator means that the consumer is excluded from the denominator.

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Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention (TSC)

Numerator

The number of consumers who were screened for tobacco use at least once within 24 months **AND** who received tobacco cessation intervention if identified as a tobacco user

Numerator Options: The options below indicate the coding possibilities related

D. Medical Record Specification

- *Denominator:*
 - **Section C**
 - **Incomplete Reporting Exclusion**
- Continued next slide*

Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention (TSC)(5)

D. Medical Record Specification

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

Numerator

The number of consumers who were screened for tobacco use at least once within 24 months AND who received tobacco cessation intervention if identified as a tobacco user

Numerator Options: The options below indicate the coding possibilities related to the numerator. The first two, where performance is met, indicate situations where the data point is included in the numerator. The third, where performance is not met, means that the data point represents a quality failure and is not counted in the numerator.

Performance Met: Consumer screened for tobacco use AND received tobacco cessation intervention (counseling, pharmacotherapy, or both), if identified as a tobacco user (see most recent source measure for codes)

OR

Performance Met: Consumer screened for tobacco use and identified as a non-user of tobacco (see most recent source measure for codes)

Performance Not Met: Tobacco screening OR tobacco cessation intervention not performed, reason not otherwise specified (see most recent source measure for codes)

Exception:² Documentation of medical reason(s) for not screening for tobacco use (e.g., limited life expectancy, other medical reasons) (see most recent source measure for codes)

Note: The measurement period for the numerator is the measurement year and the prior year. For CCBHCs that do not have access to this information for the year prior to Demonstration Year 1 (DY1), screening should occur during DY1.

Example Calculation: See Appendix TSC.

E. ADDITIONAL NOTES

Both this measure and the source measure were specified at the provider level. Neither is risk adjusted. This measure is modified from the source measure to provide a specification consistent in format to other measures in this set of BHC measures. The substance of the measure is unchanged.

Interpretation of score: Better quality = Higher score

² The AMA PCPI specifications refer to "exceptions" in circumstances where many specifications would reference "exclusions." We retain the AMA PCPI language for consistency with the original measure. The AMA PCPI measures also place exceptions in numerator calculations.

Questions so far?

Preventive Care & Screening: Unhealthy Alcohol Use: Screening & Brief Counseling (ASC)(1)

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

Year before MY 1	MY1
Numerator MP	
	Denominator MP

Preventive Care & Screening: Unhealthy Alcohol Use: Screening & Brief Counseling (ASC)(2)

B. Definitions

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

Preventive Care & Screening: Unhealthy Alcohol Use: Screening & Brief Counseling (ASC)

B. DEFINITIONS

TERM	DEFINITION
AUDIT and AUDIT-C	The AUDIT is the Alcohol Use Disorders Identification Test and the AUDIT-C is an abbreviated version of the AUDIT. Both were developed by the World Health Organization.
Brief Counseling	Brief counseling for unhealthy alcohol use refers to one or more counseling sessions, a minimum of 5–15 minutes, which may include feedback on alcohol use and harms, identification of high-risk situations for drinking and coping strategies, increased motivation, and the development of a personal plan to reduce drinking.
Provider Entity	The provider entity that is being measured (i.e., BHC)
Systematic Screening Method	For purposes of this measure, one of the following systematic methods to assess unhealthy alcohol use must be utilized. Systematic screening methods and thresholds for defining unhealthy alcohol use include: <ul style="list-style-type: none">• AUDIT Screening Instrument (score ≥ 8)• AUDIT-C Screening Instrument (score ≥ 4 for men; score ≥ 3 for women)• Single Question Screening - How many times in the past year have you had 5 (for men) or 4 (for women and all adults older than 65 years) or more drinks in a day? (response ≥ 2)

Preventive Care & Screening: Unhealthy Alcohol Use: Screening & Brief Counseling (ASC)(3)

C. Eligible Population

- *Event/Diagnosis:*
 - **Step 1: Seen at Provider Entity**
 - **Step 2: Age 18 years and older on date of service during MY**
 - **Step 3: Either:**
 1. *At least 2 encounters at provider entity (relevant codes in source measure) OR*
 2. *One preventive care visit (relevant codes in source measure)*

CRITERIA	REQUIREMENTS
Event/Diagnosis	<p>Follow the steps below to identify the eligible population:</p> <p><i>Step 1</i> Identify consumers seen at the provider entity during the measurement year.</p> <p><i>Step 2</i> Identify consumers from step 1 who were aged 18 years and older on the date of service during the measurement year.</p> <p><i>Step 3</i></p> <ol style="list-style-type: none">1. Identify consumers from step 2 who met either of the following criteria during the measurement year: Had at least two encounters at the provider entity during the measurement year. Relevant codes (Current Procedural Terminology [CPT®] or Healthcare Common Procedure Coding System [HCPCS]) may be found in the most recent source measure. <p>OR</p> <ol style="list-style-type: none">2. Had one preventive care visit. Relevant codes (Current Procedural Terminology [CPT®] or Healthcare Common Procedure Coding System [HCPCS]) may be found in the most recent source measure.

Preventive Care & Screening: Unhealthy Alcohol Use: Screening & Brief Counseling (ASC)(4)

Preventive Care & Screening: Unhealthy Alcohol Use: Screening & Brief Counseling (ASC)

Numerator

The number of consumers who were screened at least once within the last 24 months for unhealthy alcohol use using a systematic screening method AND who received brief counseling if identified as an unhealthy alcohol user.

Numerator Options: The options below indicate the coding possibilities related to the numerator. The first two, where performance is met, indicate situations where the data point is included in the numerator. The third, where performance is not met, means that the data point represents a quality failure and is not counted in the numerator.

Performance Met: Consumer identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a systematic screening method and received brief counseling (G9621)

OR

Performance Met: Consumer not identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a systematic screening method (G9622)

Performance Not Met: Consumer not screened for unhealthy alcohol screening using a systematic screening method OR consumer did not receive brief counseling, reason not given (G9624)

Exception:³ Documentation of medical reason(s) for not screening for unhealthy alcohol use in the measurement year or the year prior (e.g., limited life expectancy, other medical reasons) (G9623)

Note: The measurement period for the numerator is the measurement year and the prior year. For CCBHCs who do not have access to this information for the year prior to Demonstration Year 1 (DY1), screening should occur during DY1.

Example Calculation: See Appendix ASC.

³ The AMA PCPI specifications refer to "exceptions" in circumstances where many specifications would reference "exclusions." We retain the AMA PCPI language for consistency with the original measure. The AMA PCPI measures also place exceptions in numerator calculations.

- **Numerator**
 - *Performance met:*
 - **Unhealthy alcohol use screened for and identified and brief counseling provided**
 - **Unhealthy alcohol use screened for and not identified**
 - *Performance not met:*
 - **Not screened OR brief counseling not provided despite positive screen**

Poll Question 2

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

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

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

Questions?

Upcoming Webinar Schedule

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

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

Preview of Next Webinars

Webinar 5: August 9, 2016

Five BHC-Lead Measures

- Weight Assessment for Children/Adolescents: Body Mass Index Assessment for Children/Adolescents (WCC-BH) –Administrative or Hybrid
- Screening for Clinical Depression and Follow-Up Plan (CDF-BH)
- Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-BH-C)
- Adult Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-A)
- Depression Remission at Twelve Months (DEP-REM-12)

Preview of Next Webinars

Webinars 6 & 7: August 16 & 23, 2016

Special Issues:

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

BHC Measures (1)

Measure	State or BHC Lead	CCBHC Required	CCBHC Not Required	Webinar
SSD	State	✓	n/a	2
SAA-BH	State	✓	n/a	2
ADD-BH	State	✓	n/a	2
IET-BH	State	✓	n/a	2
PCR-BH	State	✓	n/a	2
FUM	State	✓	n/a	3
FUA	State	✓	n/a	3
FUH-BH-A	State	✓	n/a	3
FUH-BH-C	State	✓	n/a	3
HOU	State	✓	n/a	3
PEC	State	✓	n/a	3
Y/FEC	State	✓	n/a	3

BHC Measures (2)

Measure	State or BHC Lead	CCBHC Required	CCBHC Not Required	Webinar
I-EVAL	BHC	✓	n/a	4
BMI-SF	BHC	✓	n/a	4
TSC	BHC	✓	n/a	4
ASC	BHC	✓	n/a	4
CDF-BH	BHC	✓	n/a	5
WCC-BH	BHC	✓	n/a	5
SRA-BH-C	BHC	✓	n/a	5
SRA-A	BHC	✓	n/a	5
DEP-REM-12	BHC	✓	n/a	5

BHC Measures (3)

Measure	State or BHC Lead	CCBHC Required	CCBHC Not Required	Webinar
ROUT	BHC	n/a	✓	8
TX-EVAL	BHC	n/a	✓	8
SUIC	BHC	n/a	✓	8
DOC	BHC	n/a	✓	8
CBP-BH	BHC	n/a	✓	8
SU-A	State	n/a	✓	8
APM	State	n/a	✓	8
SMC	State	n/a	✓	8
AMS-BD	State	n/a	✓	8

Contact Information

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

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

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

Behavioral Health is Essential To Health



Prevention Works



Treatment is Effective



People Recover