TEAM KENTUCKY®

CABINET FOR HEALTH AND FAMILY SERVICES

KY DMS CCBHC Quality Measures Training

2025

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Overview

- Quality Measures Overview
- KY CCBHC QM Program Requirements & Resources
- Clinic-collected QM Process & Measure Overview
- State-collected QM Process Overview
- Quality Measure Collection, Calculation, and Submission Timeline

Note: At the conclusion of this training please complete the KY CCBHC Quality Measures Attestation and submit with your application. See Attestation Information slide for more info. Submit any questions to: CCBHC@ky.gov.

What is a quality measure?

- Quality measures are standards for measuring the performance of healthcare providers to care for patients and populations.

To measure the performance of health care providers, health care systems, or insurers

To inform quality improvement initiatives in health care settings

To compare performance of providers over time or performance across providers

Note: Most CCBHC quality measures are expressed as a simple ratio over population. Some measures use a count of encounters, or of days elapsed between specific clinical events.

$$\text{rate} = \frac{\text{Numerator}}{\text{Denominator}} = \frac{(\textit{Number meeting standard})}{(\textit{Total eligible population})}$$

Source: Centers for Medicare & Medicaid Services. Measures Management System Homepage
Source: SAMHSA Presentation - Introducing Quality Measurement for CCBHC's and SAMHSA-funded CCBHC PDI and IA grantees (5/11/2023)

What data is collected?

Administrative Data

Claims or encounter data from billing records, such as Medicaid claims data

Medical Records Data

Paper or electronic medical records

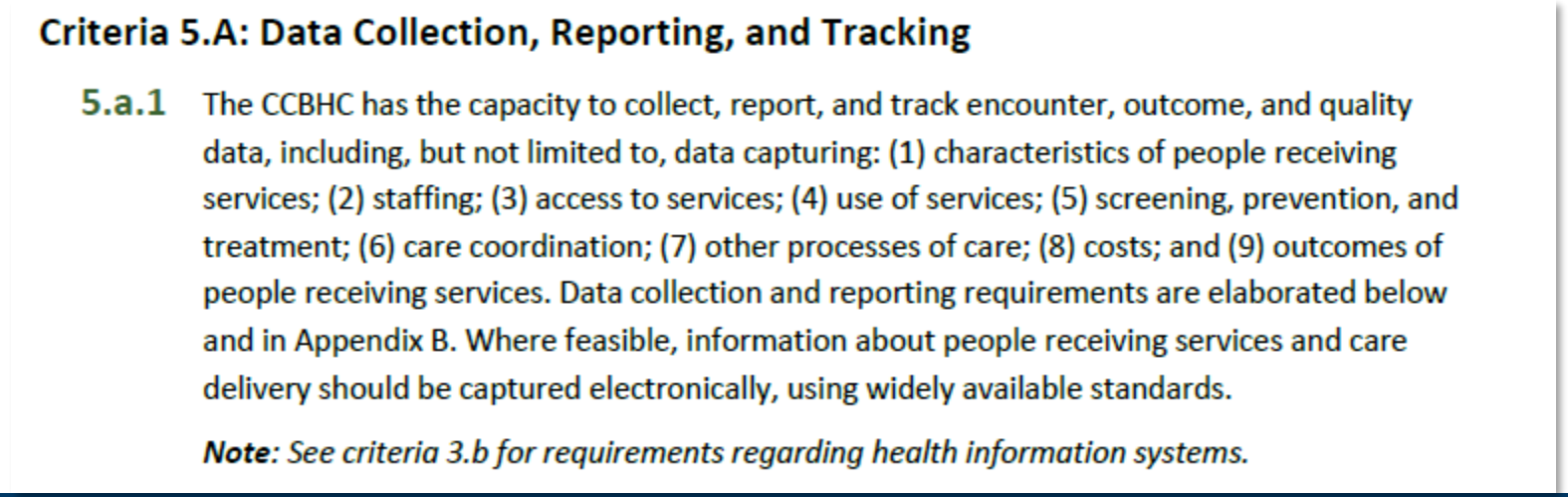
Survey Data

Information collected via survey, such as patient or family experience of care

Source: SAMHSA Presentation - Introducing Quality Measurement for CCBHC's and SAMHSA-funded CCBHC PDI and IA grantees (5/11/2023)

Why collect quality measure data?

1. Collection of quality measures data is required by federal statute governing the CCBHC demonstration. (Protecting Access to Medicare Act of 2014, Section 223)
2. Data is used to evaluate the performance of specific providers, clinics, and systems.
3. Data is used at the federal and state levels to evaluate the CCBHC demonstration.
4. Data is used to inform clinic Quality Improvement activities.



Criteria 5.A: Data Collection, Reporting, and Tracking

5.a.1 The CCBHC has the capacity to collect, report, and track encounter, outcome, and quality data, including, but not limited to, data capturing: (1) characteristics of people receiving services; (2) staffing; (3) access to services; (4) use of services; (5) screening, prevention, and treatment; (6) care coordination; (7) other processes of care; (8) costs; and (9) outcomes of people receiving services. Data collection and reporting requirements are elaborated below and in Appendix B. Where feasible, information about people receiving services and care delivery should be captured electronically, using widely available standards.

***Note**: See criteria 3.b for requirements regarding health information systems.*

Source: Adapted from - SAMHSA Presentation - Introducing Quality Measurement for CCBHC's and SAMHSA-funded CCBHC PDI and IA grantees (5/11/2023)

What quality measures are being collected?

Clinic-collected measures

- Collected and calculated by CCBHCs
- Finalized and sent to DMS no later than 9-months after the end of the Demonstration Year (Dec. 31st)

State-collected measures

- Collected and calculated by DMS
- Outcomes shared with clinics prior to submission

Clinic-collected measures

- ***TSC** - Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention
- **ASC** - Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling
- ***SRA –CH** - Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment
- ***SRA – A** - Adult Major Depressive Disorder (MDD): Suicide Risk Assessment
- **CDF-AD** - Preventative Care and Screening: Screening for Clinical Depression and Follow-Up Plan
- **I-SERV** - Time to Services
- **DEP-REM-6** - Depression Remission at 6 Months
- **SDOH** - Screening for Social Drivers of Health

*These measures are listed “Clinic-Collected Optional” in 2024 SAMSHA Technical Specifications and 2024 Data Reporting Template. <u>These measures are not optional and are required by KY DMS for all CCBHCs in the demonstration.</u>

All data from these measures comes from clinic Electronic Health Record (EHR) data. EHR updates will be required and meetings with QM Lead will be held to review EHR systems in depth.

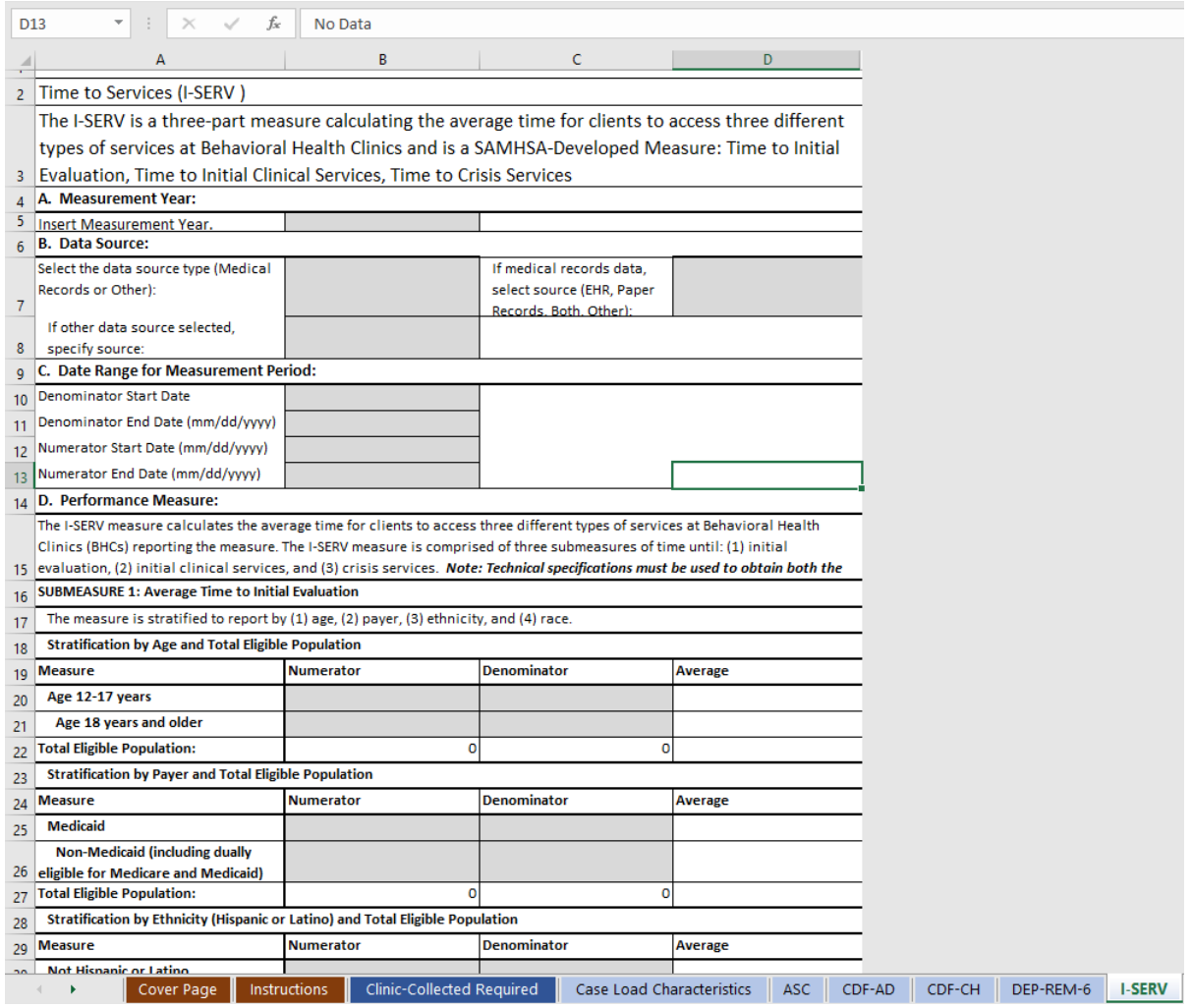
State-collected measures

- ***PEC –** Patient Experience of Care Survey
- ***YFEC** – Youth/Family Experience of Care Survey
- **AMM-AD** – Antidepressant Medication Management
- **OUD-AD** – Use of Pharmacotherapy for Opioid Use Disorder
- **SAA-AD** – Adherence to Antipsychotic Medications for Individuals with Schizophrenia
- **PCR-AD** – Plan All-Cause Readmissions Rate
- **ADD-CH** – Follow-Up Care for Children Prescribed Attention-Deficit Hyperactivity Disorder Medication
- **HBD-AD** – Hemoglobin A1c Control for Patients with Diabetes
- **IET-AD** – Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- **FUH-CH** & **FUH-AD** – Follow-up After Hospitalization for Mental Illness
- **FUM-AD** & **FUM-CH** – Follow-up After Emergency Department Visit for Mental Illness
- **FUA-AD** & **FUA-CH** – Follow up After Emergency Department Visit for Alcohol and Other Drug Dependence

Data for these measures comes from administrative claims, encounter, and pharmacy data. *PEC and *YFEC use survey data that clinics should already be collecting.

How are data reported?

- Quality Measures data are reported using the SAMHSA Data Reporting Template
- Potential CCBHCs should review "An Overview of Data Reporting Templates for Certified Community Behavioral Health Clinic Quality Measures" to review the basic components of the template
- Clinics will complete "Case Load Characteristics" and all KY required clinic-collected measures.



D13 | No Data

	A	B	C	D
2	Time to Services (I-SERV)			
3	The I-SERV is a three-part measure calculating the average time for clients to access three different types of services at Behavioral Health Clinics and is a SAMHSA-Developed Measure: Time to Initial Evaluation, Time to Initial Clinical Services, Time to Crisis Services			
4	**A. Measurement Year:**			
5	Insert Measurement Year.			
6	**B. Data Source:**			
7	Select the data source type (Medical Records or Other):		If medical records data, select source (EHR, Paper Records, Both, Other):	
8	If other data source selected, specify source:			
9	**C. Date Range for Measurement Period:**			
10	Denominator Start Date			
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	The I-SERV measure calculates the average time for clients to access three different types of services at Behavioral Health Clinics (BHCs) reporting the measure. The I-SERV measure is comprised of three submeasures of time until: (1) initial evaluation, (2) initial clinical services, and (3) crisis services. ***Note: Technical specifications must be used to obtain both the***			
16	**SUBMEASURE 1: Average Time to Initial Evaluation**			
17	The measure is stratified to report by (1) age, (2) payer, (3) ethnicity, and (4) race.			
18	**Stratification by Age and Total Eligible Population**			
19	**Measure**	**Numerator**	**Denominator**	**Average**
20	**Age 12-17 years**			
21	**Age 18 years and older**			
22	**Total Eligible Population:**	0	0	
23	**Stratification by Payer and Total Eligible Population**			
24	**Measure**	**Numerator**	**Denominator**	**Average**
25	**Medicaid**			
26	**Non-Medicaid (including dually eligible for Medicare and Medicaid)**			
27	**Total Eligible Population:**	0	0	
28	**Stratification by Ethnicity (Hispanic or Latino) and Total Eligible Population**			
29	**Measure**	**Numerator**	**Denominator**	**Average**
	Not Hispanic or Latino			

Cover Page | Instructions | Clinic-Collected Required | Case Load Characteristics | ASC | CDF-AD | CDF-CH | DEP-REM-6 | I-SERV

KY CCBHC Program Requirements & Resources

KY CCBHC QM Program Requirements

- All CCBHCs must:
  - Continuously
    - Collect data for all clinic-collected measures (Provider Type 16 CCBHC data only)
  - Quarterly
    - Send clinic-collected raw data to KY DMS
  - Annually
    - Calculate clinic-collected measures and lay the calculations into the SAMSHA Data Reporting Template.

Note: In a CCBHCs first year of the demonstration, KY DMS and the CCBHC will both calculate clinic-collected measures and work together in refining CCBHC QM calculations.

KY CCBHC QM Program Requirements

- To prepare CCBHCs for QM reporting the following steps must be completed:
  - Review SAMSHA QM Webinars
  - Attend QM Introductory Meeting w/ KY DMS CCBCH Team and all scheduled follow-up meetings
  - Complete QM Electronic Health Record (EHR) Assessment
  - Finalize QM Data Use Agreement
  - Send and verify a QM Test Data submission

Note: Program Requirements must be completed prior to entering the demonstration. **The ability to fully report quality measures is required to be certified for the CCBHC demonstration.**

SAMHSA QM Resources

- The following resources are available from SAMHSA and must be reviewed prior to meeting with the CCBHC QM Lead:
  - 2024 Technical Specifications
  - 2024 Data Reporting Template
  - Webinars:
    - Preparing CCBHCs for Quality Measure Data Collection and Reporting (~1 hour/YouTube)
      - Slides (PDF)
    - Clinic-Collected Required Measures, Fall 2023 Webinar #1
    - Clinic-Collected Required Measures, Fall 2023 Webinar #2
      - Slides (PDF)
    - Clinic-Collected Required Measures, Fall 2023 Webinar #3 (~1 hour/YouTube)
      - Slides (PDF)
    - An Overview of Data Reporting Templates for CCBHC QMs (~.5 hour/YouTube)
      - Slides (PDF)

Clinic Data & Data Use Agreements

- To assist clinics with calculation of clinic-collected measures, clinics are required to transmit clinic-collected measure “raw data”* to DMS on a quarterly basis

- All CCBHCs must have the ability to send data to KY DMS through the MOVEit system

- DMS requires CCBHCs to have a data use agreement(DUA)between their agency, the Office of Data Analytics (ODA), and KY DMS, which allows DMS to receive raw data reports from each agency.

Note: *Raw data is data originally generated by a system, device or operation, that has not been processed or changed in any way.

Data Fields

- What “raw data” does DMS need?
  - EHR data for each required, clinic-collected measure, as well as demographic data, and survey data (PEC/YFEC)
- Data Submission Instructions with Data field definitions will be available to each potential CCBHC. This document should be reviewed prior to your initial meeting with KY DMS

Note: “Raw data” cannot come from a notes section of an EHR. It must be a fixed data point (click, radio button, check box, etc.)

Measures Data File

Field	Description
Date_Data_Pulled	Represents the date this record was retrieved from the internal syst CCBHC
Medical_Record_Number	Unique identifier of the consumer in your system
Date_Time_Initial_Contact	Date New Consumer first contacted the CCBHC (referral, called to se appointment, etc.) {New Consumer is defined as a consumer who has not received services in t prior to contact date. Date first contacted is defined as the first contact dat period of 180 days where no services were received by consumer regardless status (active, inactive, discharged, closed)}
Type_of_Initial_Contact	**R** = Routine service, screening identifies routine needs **U** = Urgent service, screening identifies an urgent need **E** = Emergent service, screening identifies an emergency/crisis need
SSN	Social Security Number
Date_Birth	Date of birth of the consumer
Date_Time_of_Service	Date the consumer received service or was admitted
DMS_Location_Identifier	DMS Location Identifier of the Certified location the consumer recei
Diagnosis_Code_1	ICD-10-CM Diagnosis Code in first position on electronic health reco any decimal points.
Diagnosis_Code_2	ICD-10-CM Diagnosis Code in second position on electronic health re any decimal points.
Diagnosis_Code_3	ICD-10-CM Diagnosis Code in third position on electronic health rec any decimal points.

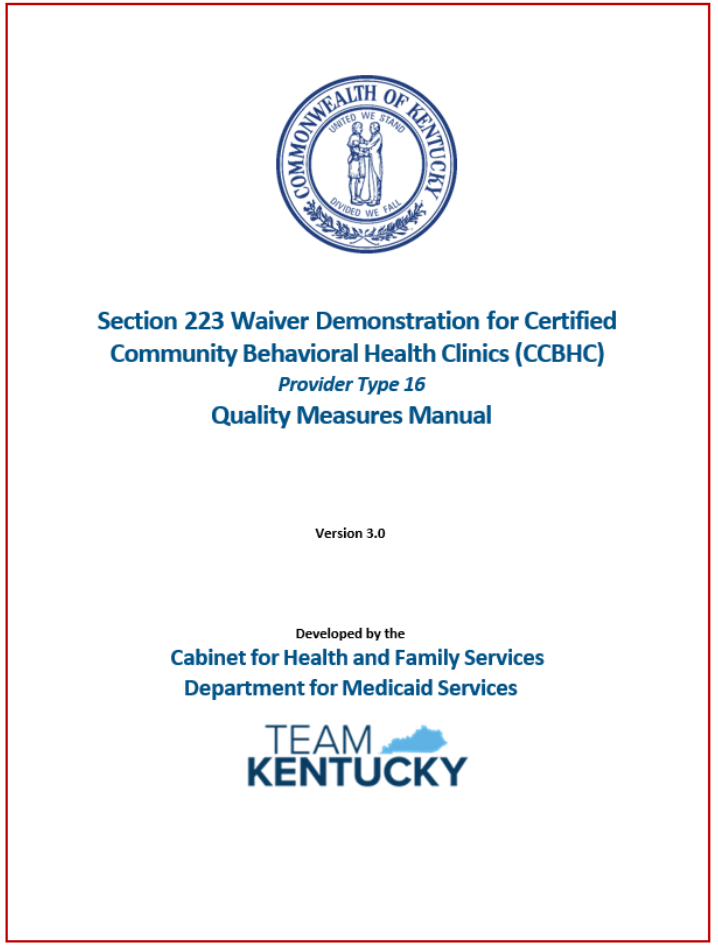
What quality measure guidance and resources are available?

- Kentucky DMS QM Resources
  - KY DMS Quality Measures Manual V3
  - One-on-One Technical Assistance
- SAMSHA Guidance
  - QM Technical Specifications, topic specific guidance, recorded webinars, and FAQs - CCBHC Quality Measures Guidance and Webinar Series | SAMHSA

Note: KY DMS resources are the primary source for Quality Measure calculation. Please send any questions about SAMHSA guidance vs KY DMS guidance, CCHBC@ky.gov. Include "Quality Measures in the subject line of your email.

KY Guidance and Resources

- Section 223 Waiver Demonstration for Certified Community Behavioral Health Clinics (CCBHC), *Provider Type 16,* Quality Measures Manual
  - This manual serves as the source document for the collection and transmission of CCBHC Quality Measures within the KY CCBHC Demonstration.
  - The manual includes the following:
    - Technical specifications
    - Calculation workflows
    - Data submission process
    - Annual timelines for preparation, calculation, and submission of quality measures
- One-on-One Technical Assistance (TA)
  - KY DMS will schedule monthly meetings (more if needed) with all clinics to answer QM questions, provide assistance with QM calculations, etc.



KY QM Workflow Example (SDOH)

Screening for Social Drivers of Health (SDOH)

Steward: Centers for Medicare & Medicaid Services
Abbreviation: SDOH
Version Year: 2023
PQRS#: 487
Technical Specifications:

- 2023 Quality Measures for Behavioral Health Clinics Technical Specifications and Resource Manual Preliminary Version
- 2023 Physician Quality Reporting System (PQRS)

Value Sets:

- 2023 Physician Quality Reporting System (PQRS)

Reporting Changes:
CCBHC Demonstration Modifications:
Kentucky CCBHC Modifications:

- Kentucky has developed an CCBHC Demonstration Services Codes List which will be used throughout the Demonstration and will define any Value Set Lists stated in the technical specifications.

Measure Data Collection Field List: The following list is in addition to identifying fields reported for all measures.

- SDOH_Screener_Date

KY QM Workflow Example (SDOH)

Measure Workflow

	Measure #24 Screening for Social Drivers of Health (SDOH) **DESCRIPTION** The SDOH measure calculates the Percentage of clients 18 years and older screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety. Note: This measure is to be reported once per Measurement Year for clients seen during the Measurement Year.
	Denominator Calculation:
Step Number	
D1	Client had at had a qualifying encounter, listed in the CCBHC Quality Measures Value Set List (Measure 25), as INCLUDED during the Measurement Year[2] =YES: Proceed to D2 =NO: Do not include in Denominator/Stop
D2	Client Age is ≥ 18 years of age on the date of service =YES: Proceed to D3 =NO: Do not include in Denominator/Stop
Denominator	**Total Unique Clients**
CMS Workbook	Report by age groups: 18+ yrs.; separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity
	Numerator Calculation:
N1	Begin Calculation with Denominator
N2	Client was screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety during using Standardized Health-Related Social Needs Screening Tool[1] the Measurement Year =YES: Include in Numerator/Stop =NO: Do not include in Numerator/Stop
Numerator	**Total Unique Clients**
CMS Workbook	Report by age groups: 18+ yrs.; separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity
Standardized Health-Related Social Needs (HRSN) Screening Tool [1]	HRSN is the term used by HHS to refer to an individual's unmet, adverse social conditions that contribute to poor health as a result of the community's underlying SDOH. (2018)
Measurement Year[2]	The standard 12-month reporting period common to all measures being reported by the Provider.

Clinic-collected Measures

Caseload Characteristics

Case Load Characteristics		
Characteristic	**Number**	**Percent**
Age		
0-11 years		
12-17 years		
18-64 years		
65+ years		
Sex		
Male		
Female		
Other		
Don't know		
Prefer not to state		
Gender Identity		
Female		
Male		
Transgender female		
Transgender male		
I use a different term		
Don't know		
Prefer not to state		
Ethnicity		
Not Hispanic or Latino		
Hispanic or Latino		
Unknown		

Race		
White		
Black or African American		
American Indian or Alaskan Native		
Asian		
Native Hawaiian or Other Pacific Islander		
More than one Race		
Unknown		
Insurance Status		
Medicaid (not Dually-Eligible)		
CHIP		
Medicare (not Dually-Eligible)		
Medicare and Medicaid Dually-Eligible		
VHA/TRICARE		
Commercially insured		
Uninsured		
Other		
Veteran or Military Status		
Active Duty Military		
Prior Military Service/Veteran		
Neither		
Total Clinic Population		

End of Worksheet

Preventative Care & Screening: Tobacco Use: Screening & Cessation (TSC)

DESCRIPTION

Percentage of consumers aged 18 years and older who were screened for tobacco use one or more times during the Measurement Period[3] AND who received Tobacco Cessation Intervention[2] during the Measurement Year or in the six months prior to the Measurement Year if identified as a tobacco user.

THERE ARE THREE SUMISSION CRITERIA FOR THIS MEASURE:

1. Percentage of clients aged 18 years and older who were screened for Tobacco Use one or more times within the Measurement Year
2. Percentage of clients aged 18 years and older who were identified as a tobacco user during the Measurement Year in submeasure 1 and who received a Tobacco Cessation Intervention during the Measurement Year or in the six months prior to the Measurement Year
3. Percentage of clients aged 18 years and older who were screened for Tobacco Use one or more times within the Measurement Year and, if identified as a tobacco user, received a Tobacco Cessation Intervention during the Measurement Year or in the six months prior to the Measurement Year, or identified as a tobacco non-user

KY Measure 4(M) – Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention (TSC)

- **Steward:** American Medical Association (AMA) & CPI Foundation (PCPI)
- **Abbreviation:** TSC
- **Version Year:** 2016
- **NQF#:** 0028e
- **PQRS#:** 226
- **eCQI:** CMS138v4
- **Technical Specifications DY1, DY2, DY3:**
  i. 2016 Metrics and Quality Measures for Behavioral Health Clinics Technical Specifications and Resource Manual
  ii. 2016 Physician Quality Reporting System (PQRS)
  iii. 2016 Electronic Clinical Quality Improvement (eCQI)
- **Technical Specifications DY4:**
  i. 2024 Metrics and Quality Measures for Behavioral Health Clinics Technical Specifications and Resource Manual
  ii. 2023 Physician Quality Reporting System (PQRS)
  iii. 2023 Electronic Clinical Quality Improvement (eCQI)
- **Value Set DY1, DY2, DY3:** 2016 Electronic Clinical Quality Improvement (eCQI) available for clinics to review on CCBHC Quality Measures Value Set List.
- **Value Set DY4:** 2016 Electronic Clinical Quality Improvement (eCQI) available for clinics to review on CCBHC Quality Measures Value Set List.
- **Reporting Years:** DY1, DY2, DY3, DY4

Preventative Care & Screening: Tobacco Use: Screening & Cessation (TSC)

SUBMEASURE 1: Percentage of clients aged 18 years and older who were screened for Tobacco Use one or more times within the Measurement Year			
The measure is stratified to report by (1) payer , (2) ethnicity, and (3) race.			
Stratification by Payer and Total Eligible Population			
Measure	**Numerator**	**Denominator**	**Rate (Percentage)**
Medicaid			
Non-Medicaid (including dually eligible for Medicare and Medicaid)			
Total Eligible Population:	0	0	
Stratification by Ethnicity (Hispanic or Latino) and Total Eligible Population			
Measure	**Numerator**	**Denominator**	**Rate (Percentage)**
Not Hispanic or Latino			
Hispanic or Latino			
Unknown			
Total Eligible Population:	0	0	
Stratification by Race and Total Eligible Population			
Measure	**Numerator**	**Denominator**	**Rate (Percentage)**
White or Caucasian			
Black or African American			
American Indian or Alaska Native			
Asian			
Native Hawaiian or Other Pacific Islander			
More than one race			
Unknown			
Total Eligible Population:	0	0	

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

DESCRIPTION

Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 12 months AND who received Brief Counseling[2] if identified as an unhealthy alcohol user.

THERE ARE THREE SUBMISSION CRITERIA FOR THIS MEASURE:

1) All patients who were screened for unhealthy alcohol use using a systematic screening method
2) All patients who were identified as unhealthy alcohol users who received brief counseling
3) All patients who were screened for unhealthy alcohol use using a systematic screening method and, if identified as unhealthy alcohol users received brief counseling, or were not identified as unhealthy alcohol users

KY Measure 5(M) – Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling (ASF)

- **Steward:** Physician Performance Measure, NCQA
- **Abbreviation:** ASF
- **Version Year:** 2016
- **NQF#:** 2152
- **PQRS#:** 431
- **eCQI:** N/A
- **Technical Specifications DY1, DY2, DY3:**
  i. 2016 Metrics and Quality Measures for Behavioral Health Clinics Technical Specifications and Resource Manual
  ii. 2016 Physician Quality Reporting System (PQRS)
- **Technical Specifications DY4:**
  i. 2024 Metrics and Quality Measures for Behavioral Health Clinics Technical Specifications and Resource Manual
  ii. 2023 Physician Quality Reporting System (PQRS)
- **Value Set DY1, DY2, DY3:** 2016 Electronic Clinical Quality Improvement (eCQI) available for clinics to review on CCBHC Quality Measures Value Set List.
- **Value Set DY4:** CQMS#431 2023
- **Reporting Years:** DY1, DY2, DY3, DY4

Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-CH)

DESCRIPTION

Percentage of client visits for those clients aged 6 through 17 years with a diagnosis of major depressive disorder (MDD) with an assessment for suicide risk.

KY Measure 6 (U) – Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-CH)

- **Steward**: American Medical Association (AMA) & CPI Foundation (PCPI)
- **Abbreviation**: SRA-CH
- **Version Year**: 2016 & 2023
- **NQF#:** 1365e
- **PQRS#:** 382
- **eCQI:** CMS177v11 (2023)
- **Technical Specifications DY1, DY2, DY3:**
  i. 2016 Metrics and Quality Measures for Behavioral Health Clinics Technical Specifications and Resource Manual
  ii. 2016 Electronic Clinical Quality Improvement (eCQI)
- **Technical Specifications DY4:**
  i. 2024 Metrics and Quality Measures for Behavioral Health Clinics Technical Specifications and Resource Manual
  ii. 2023 Electronic Clinical Quality Improvement (eCQI)
- **Value Set DY1, DY2, DY3:** 2016 Electronic Clinical Quality Improvement (eCQI) available for clinics to review on CCBHC Quality Measures Value Set List.
- **Value Set DY4:** 2023 Electronic Clinical Quality Improvement (eCQI) available for clinics to review on CCBHC Quality Measures Value Set List.
- **Reporting Years:** DY1, DY2, DY3, DY4

Adult Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-A)

DESCRIPTION

Percentage of all client visits for those clients that turn 18 or older during the measurement period in which a new or recurrent diagnosis of major depressive disorder (MDD) was identified and a Suicide Risk Assessment was completed during the visit.

KY Measure 7(U) – Adult Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-A)

- **Steward**: Mathematica; Developed by Mathematic, American Medical Association (AMA), PCPI® Foundation
- **Abbreviation**: SRA-A
- **Version Year**: 2016 & 2023
- **NQF#:** 0104e
- **PQRS#:** 107
- **eCQI:** CMS161v10 (2023)
- **Technical Specifications DY1, DY2, DY3:**
  i. 2016 Metrics and Quality Measures for Behavioral Health Clinics Technical Specifications and Resource Manual
  ii. 2016 Electronic Clinical Quality Improvement (eCQI)
- **Technical Specifications DY4:**
  i. 2024 Metrics and Quality Measures for Behavioral Health Clinics Technical Specifications and Resource Manual
  ii. 2023 Electronic Clinical Quality Improvement (eCQI)
- **Value Set DY1, DY2, DY3:** 2016 Electronic Clinical Quality Improvement (eCQI) available for clinics to review on CCBHC Quality Measures Value Set List.
- **Value Set DY4:** 2023 Electronic Clinical Quality Improvement (eCQI) available for clinics to review on CCBHC Quality Measures Value Set List.
- **Reporting Years:** DY1, DY2, DY3, DY4

Preventative Care and Screening: Screening for Clinical Depression and Follow-Up Plan (CDF-AD)

DESCRIPTION

Percentage of consumers aged 12 and older screened for clinical depression on the date of the encounter using an age-appropriate standardized depression screening tool, and if positive, a Follow-up Plan is documented on the date of the positive screen.

KY Measure 8(U) – Preventative Care and Screening: Screening for Clinical Depression and Follow-Up Plan (CDF-AD)

- **Steward:** Medicare & Medicaid Services
- **Abbreviation:** CDF-AD
- **Version Year:** 2023
- **NQF#:** 0418
- **PQRS#:** 134
- **Technical Specifications DY1, DY2, DY3:**
  i. 2016 Metrics and Quality Measures for Behavioral Health Clinics Technical Specifications and Resource Manual
  ii. 2022 Electronic Clinical Quality Improvement (eCQI)
- **Technical Specifications DY4, DY5, DY6:**
  i. 2023 Metrics and Quality Measures for Behavioral Health Clinics Technical Specifications and Resource Manual
  ii. 2023 Electronic Clinical Quality Improvement (eCQI)
- **Value Sets DY1, DY2, DY3:**
  i. 2022 Electronic Clinical Quality Improvement (eCQI) available for clinics to review on CCBHC Quality Measures Value Set List.
- **Value Sets DY4, DY5, DY6:**
  i. 2023 Electronic Clinical Quality Improvement (eCQI) available for clinics to review on CCBHC Quality Measures Value Set List.
- **Reporting Years:** DY1, DY2, DY3, DY4

Time to Services (I-SERV)

DESCRIPTION

The I-SERV measure calculates the average time for clients to access three different types of services at Behavioral Health Clinics (BHCs) reporting the measure.

The I-SERV measure is comprised of three sub-measures of time until provision of: (1) initial evaluation, (2) initial clinical services, and (3) crisis services.

KY Measure 22– Time to Services (I-SERV)

- **Steward:** SAMHSA
- **Abbreviation:** I-SERV
- **Version Year:** 2023
- **NQF#:** N/A
- **PQRS#:** N/A
- **eCQI:** N/A
- **Value Set:** Kentucky Defined Value Set List
- **Reporting Years:** DY4

Time to Services (I-SERV)

Metric #1: The Average number of days from Initial Contact until the provision of an Initial Evaluation for New Clients.

- The following CPT/HCPCS codes will be used to determine if Consumer received the Initial Evaluation: 90792, 90791, 96110, 96112, 97151, 96116, 96125, 96127, 96130, 96132, 96136, H0002, H0001, H0031

Metric #2: The Average number of days from Initial Contact until the provision of Initial Clinical Services for New Clients.

- The following CPT/HCPCS codes will be used to determine if Consumer received the Initial Clinical Services: 90832, 90833, 90834, 90836, 90837, 90838, 90845, 90865, 90875, 90887, 97153, 97155, 97156, T1007, 99202, 99203, 99204, 99205, H0015, H0032, H0035, S9480

Metric #3: The Average number of days from first Crisis Episode contact until the provision of Crisis Services for New Clients

- The following CPT/HCPCS codes will be used to determine if Consumer received the Crisis Services: 90839, 90840, H2011, S9484, 90792, 90791, 96127, H0002, H0001, H0031, 90832, 90834, 90837, 90846, 90847

Depression Remission at 6 Months (DEP-REP-6)

DESCRIPTION

The DEP-REM-6 measure calculates the Percentage of clients (12 years of age or older) with Major Depression or Dysthymia who reach Remission Six Months (+/- 60 days) after an Index Event Date.

KY Measure 23 – Depression Remission at 6 Months (DEP-REM-6)

- **Steward:** Minnesota Community Measurement
- **Abbreviation:** DEP-REM-6
- **Version Year:** 2023
- **NQF#:** 0711
- **PQRS#:** 370
- **eCQI:** CMS159v11
- **Value Set:** 2023 eCQI Value Set
- **Demo Years in Use:** DY4

Social Drivers of Health (SDOH)

DESCRIPTION

The SDOH measure calculates the Percentage of clients 18 years and older screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety.

KY Measure 24 – Screening for Social Drivers of Health (SDOH)

- **Steward:** CMS
- **Abbreviation:** SDOH
- **Version Year:** 2023
- **NQF#:** N/A
- **PQRS#:** 487
- **eCQI:** N/A
- **Value Set:** CQMS#487 2023
- **Reporting Years:** DY4

Patient Experience of Care Surveys

Patient Experience of Care Surveys

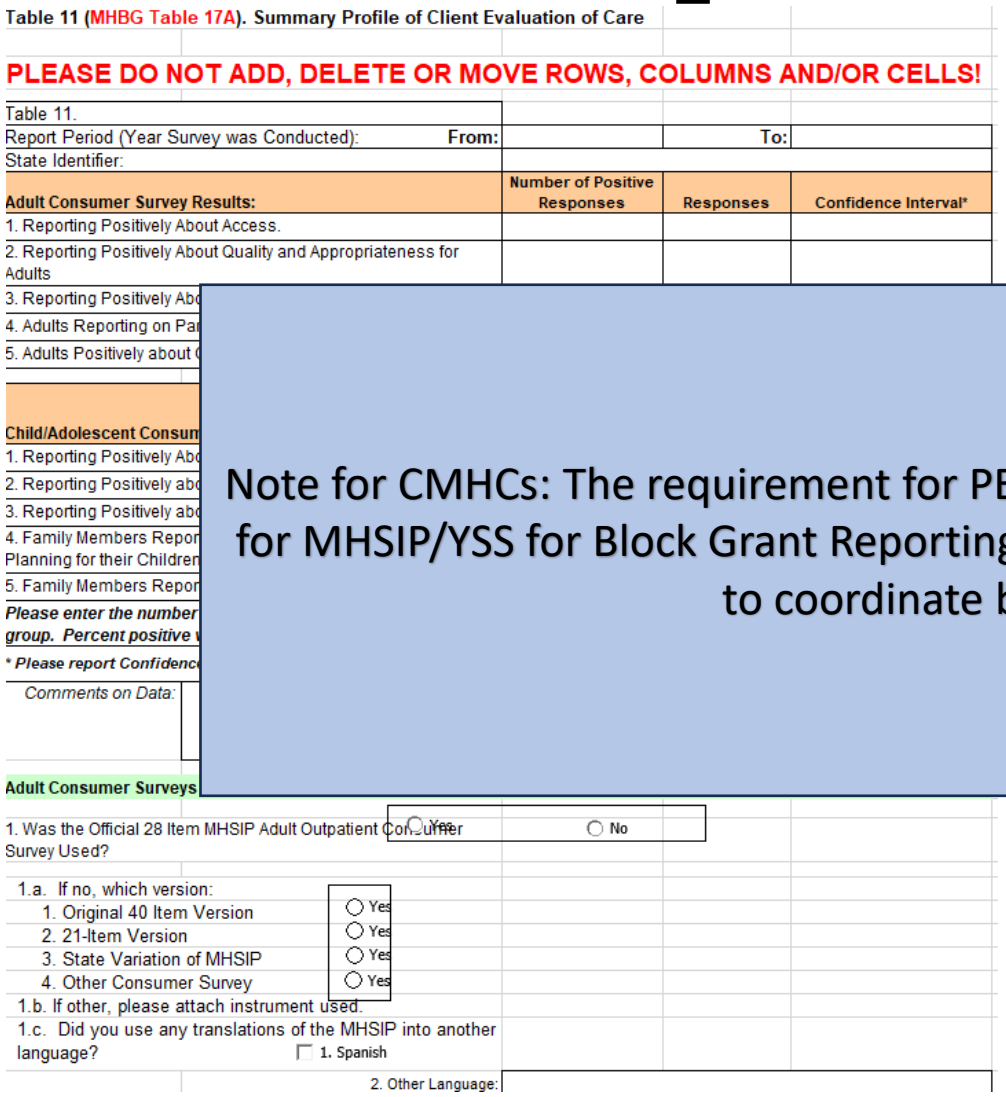


Table 11 (MHBG Table 17A). Summary Profile of Client Evaluation of Care

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

Table 11.
Report Period (Year Survey was Conducted): From: To:
State Identifier:

Adult Consumer Survey Results:	Number of Positive Responses	Responses	Confidence Interval*
1. Reporting Positively About Access.			
2. Reporting Positively About Quality and Appropriateness for Adults			
3. Reporting Positively Abo			
4. Adults Reporting on Par			
5. Adults Positively about			

Child/Adolescent Consum
1. Reporting Positively Abo
2. Reporting Positively abo
3. Reporting Positively abo
4. Family Members Repor Planning for their Children
5. Family Members Repor
Please enter the number group. Percent positive
* Please report Confidenc
Comments on Data:

Adult Consumer Surveys

1. Was the Official 28 Item MHSIP Adult Outpatient Consumer Survey Used? ○ Yes ○ No

1.a. If no, which version:
1. Original 40 Item Version ○ Yes
2. 21-Item Version ○ Yes
3. State Variation of MHSIP ○ Yes
4. Other Consumer Survey ○ Yes
1.b. If other, please attach instrument used.
1.c. Did you use any translations of the MHSIP into another language? ☐ 1. Spanish
2. Other Language:

Note for CMHCs: The requirement for PEC and Y/FEC Surveys is separate from the requirement for MHSIP/YSS for Block Grant Reporting. CMHCs will work directly to KY DMS and KY DBHDID to coordinate both reporting requirements.

- All CCBHCs must distribute Patient Experience of Care and Youth/Family Experience of Care Surveys
- Surveys will be sent to CCBHCs in April and collected until the end of November of each
- per
- v many
- survey link
- KY DMS will download the survey data, calculate results for the PEC and Y/FEC Surveys and complete the required URS tables.

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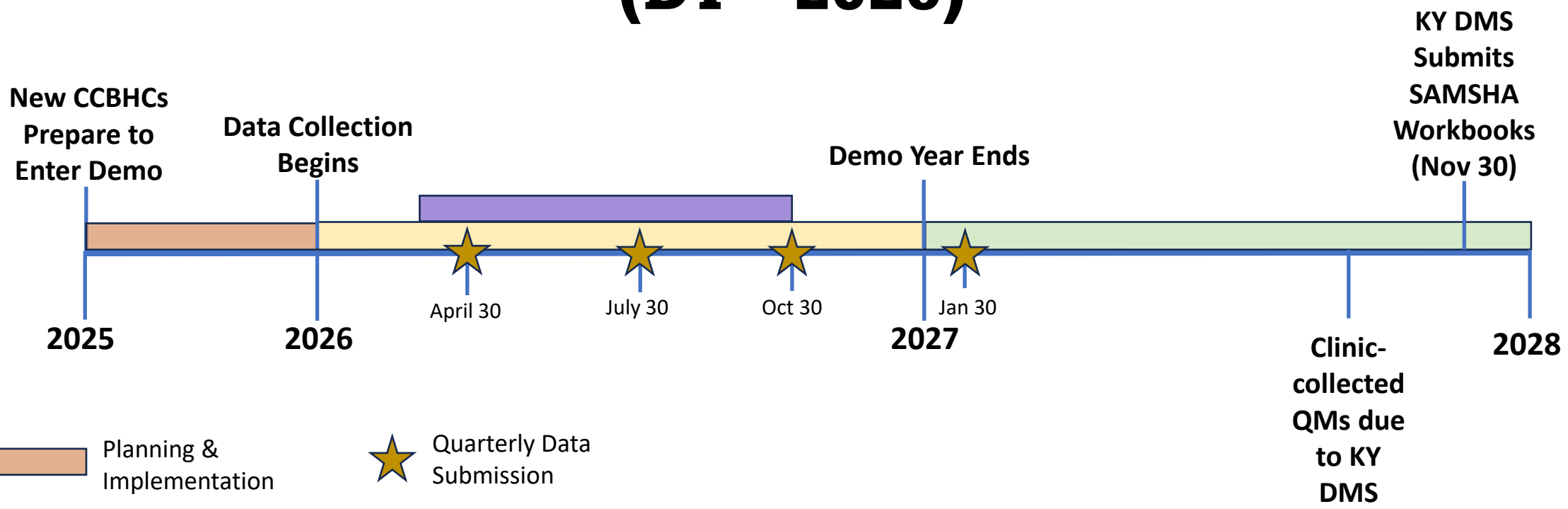
State-collected QM Process Overview

State-collected QM Process

- All State-collected measures are calculated by DMS using Medicaid, administrative, and pharmacy claims data
- Individual meetings will be scheduled with each clinic to review and discuss State-collected measures. CCBHCs should review the slides from 2024 SAMSHA webinars on State-collected measures during their first year in the demonstration
    - Webinar #1 – State-collected Required Measures (PDF)
    - Webinar #2 – State-collected Required Measures (PDF)
- Calculation of State-collected measures will begin in July/August after a demonstration year concludes.
- As measures calculation occurs, DMS may request meetings with individual clinics or send Information Requests for additional needed information.
- State-collected measures information will be provided to CCBHCs for review prior to submission to SAMSHSA.

Quality Measure Collection, Calculation, and Submission Timeline

CCBHC Quality Measure Timeline (DY - 2026)



Planning & Implementation

Data Collection

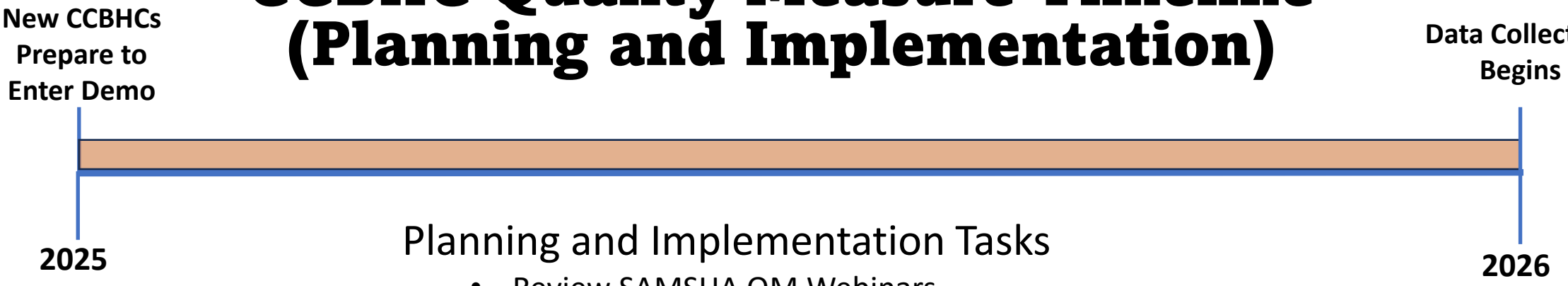
Data Calculation & Submission

Quarterly Data Submission

PEC & YFEC Survey Collection

Note: Dates used in this timeline are subject to change. Please consult the most recent KY DMS CCBHC QM Manual or CCBHC SharePoint page for exact processes and dates.

CCBHC Quality Measure Timeline (Planning and Implementation)

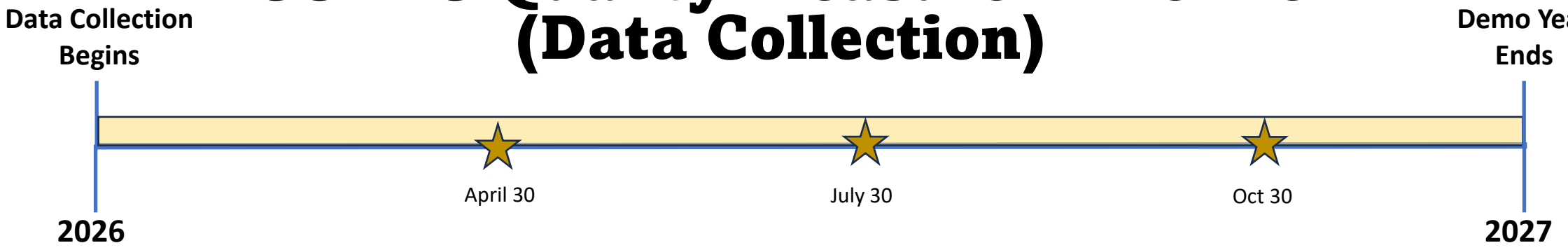


Planning and Implementation Tasks

- Review SAMSHA QM Webinars
- Attend QM Introducing Meeting w/ KY DMS CCBCH Team (additional meetings to follow)
- Complete QM Electronic Health Record (EHR) Assessment
- Finalize QM Data Use Agreement
- Send and verify a QM Test Data submission

Note: All program requirements must be completed prior to entering the demonstration. **The ability to fully report quality measures is required to be certified for the CCBHC demonstration.**

CCBHC Quality Measure Timeline (Data Collection)

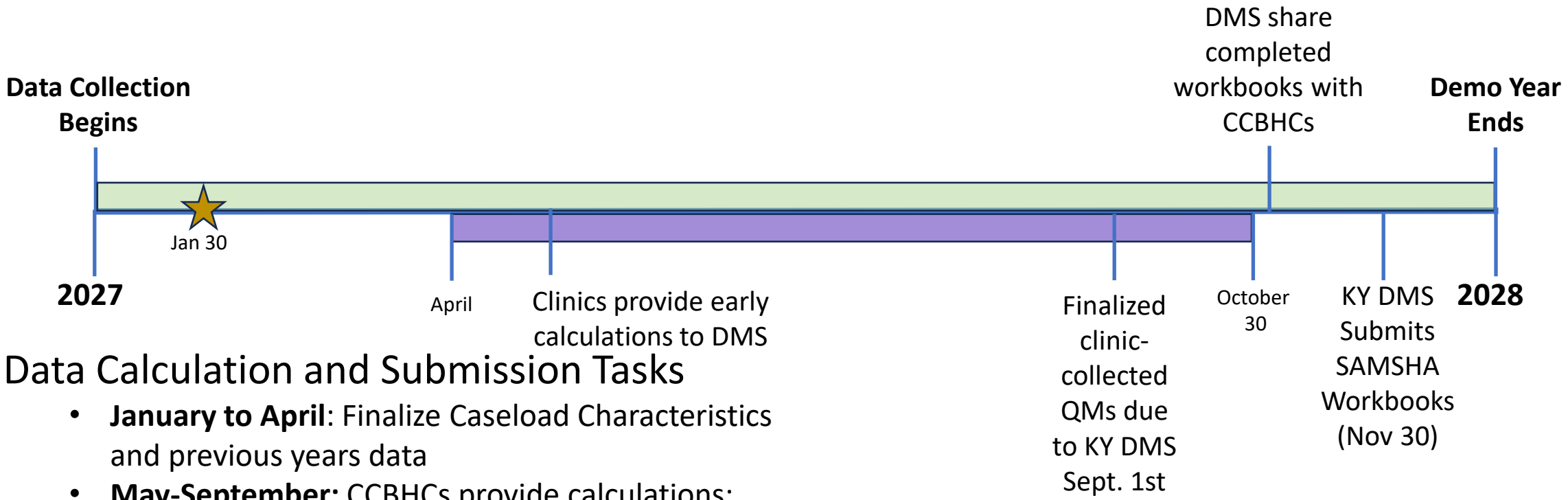


Data Collection Tasks

- Work with CCBHC data teams in their development of QM calculation processes
- Review quarterly data submissions and assist CCBCH data teams with adjustments and error logs

Quarterly Data Submission

CCBHC Quality Measure Timeline (Data Calculation and Submission)



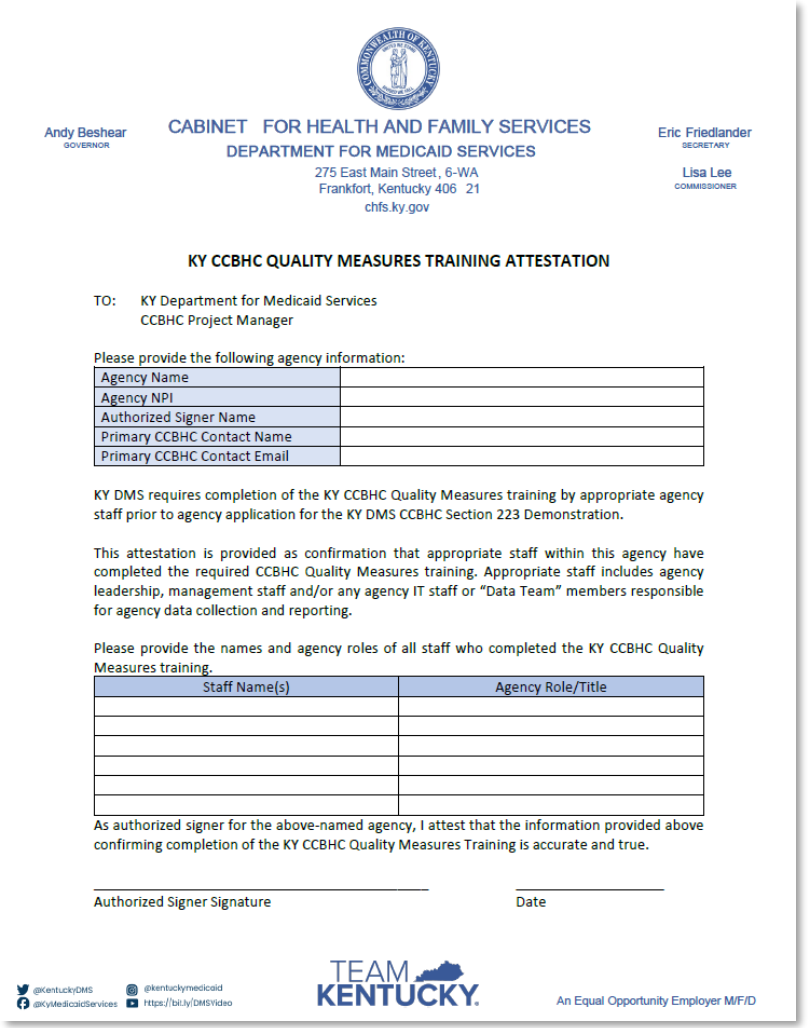
Data Calculation and Submission Tasks

- **January to April**: Finalize Caseload Characteristics and previous years data
- **May-September:** CCBHCs provide calculations; DMS reviews calculations; DMS and CCBHCs work together to finalize workbooks
- **November:** Finalize workbooks, share results with CCBHCs, submit workbooks to SAMHSA

Attestation Information

Attestation Information

- KY CCBHC Quality Measures training must be completed prior to submitting your CCBHC application.
- Upon completion of this training, please complete the CCBHC Quality Measures Training Attestation found on the CCBHC webpage and submit the attestation with your CCBHC application.
- After your application has been approved, the CCBHC QM lead will be in touch with next steps and to schedule a face-to-face meeting



Andy Beshear
GOVERNOR

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DEPARTMENT FOR MEDICAID SERVICES
275 East Main Street, 6-WA
Frankfort, Kentucky 406 21
chfs.ky.gov

Eric Friedlander
SECRETARY

Lisa Lee
COMMISSIONER

KY CCBHC QUALITY MEASURES TRAINING ATTESTATION

TO: KY Department for Medicaid Services
CCBHC Project Manager

Please provide the following agency information:

Agency Name	
Agency NPI	
Authorized Signer Name	
Primary CCBHC Contact Name	
Primary CCBHC Contact Email	

KY DMS requires completion of the KY CCBHC Quality Measures training by appropriate agency staff prior to agency application for the KY DMS CCBHC Section 223 Demonstration.

This attestation is provided as confirmation that appropriate staff within this agency have completed the required CCBHC Quality Measures training. Appropriate staff includes agency leadership, management staff and/or any agency IT staff or "Data Team" members responsible for agency data collection and reporting.

Please provide the names and agency roles of all staff who completed the KY CCBHC Quality Measures training.

Staff Name(s)	Agency Role/Title

As authorized signer for the above-named agency, I attest that the information provided above confirming completion of the KY CCBHC Quality Measures Training is accurate and true.

Authorized Signer Signature

Date

@KentuckyDMS @kentuckymedicaid
@KyMedicaidServices https://bit.ly/DMSVideo

TEAM KENTUCKY

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Final Thoughts

Quality measure planning and implementation is labor intensive and hard work!

CCBHC are encouraged to:

- Be proactive and maintain open communications with KY DMS. We're here to help!
- Utilize SAMSHA training and resources
- Talk to established CCBHCs about their QM processes
- Feel free to schedule additional meetings with Ky DMS staff whenever needed
- Ask lots of questions and let us know if there is anything our team can do to assist you with being successful as a CCBHC!