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Wellbeing

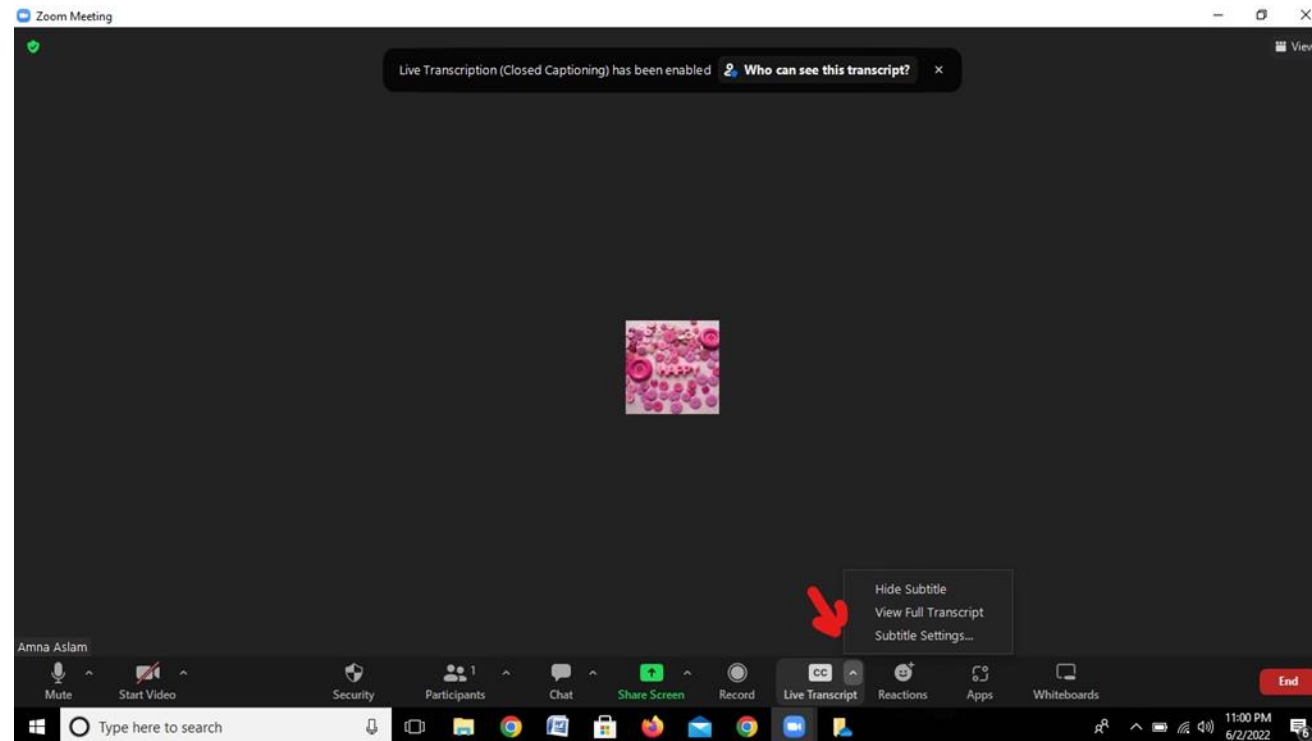
HEALTHY MINDS  
STRONG COMMUNITIES

# Understanding and Establishing Strong Practices for CCBHC Quality Measures

*January 9, 2025*

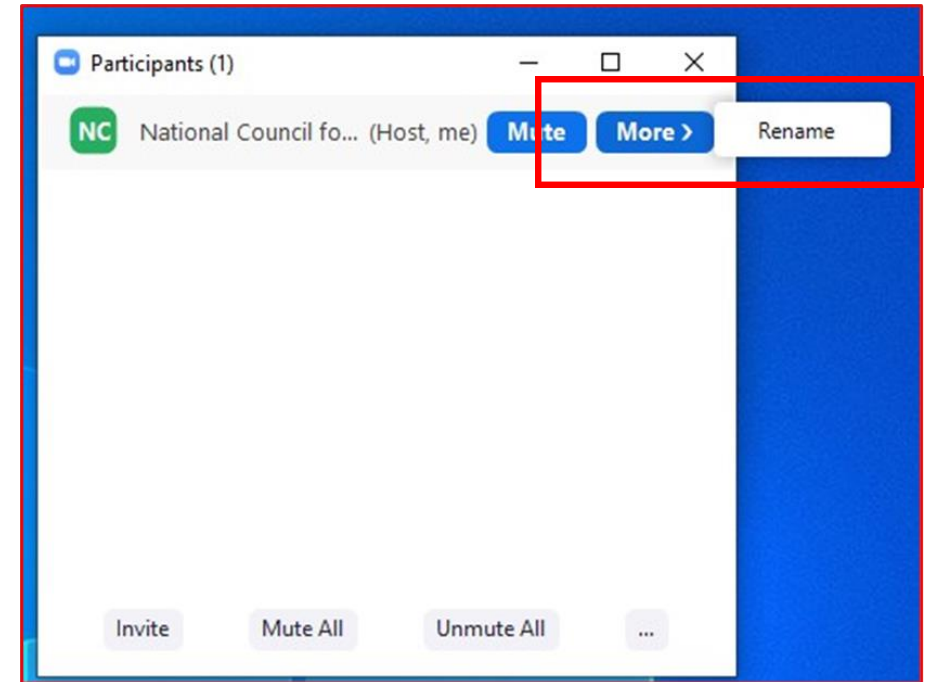
# How to Enable Closed Captions (Live Transcript)

Next to “Live Transcript”, click the arrow button for options on closed captioning and live transcript.

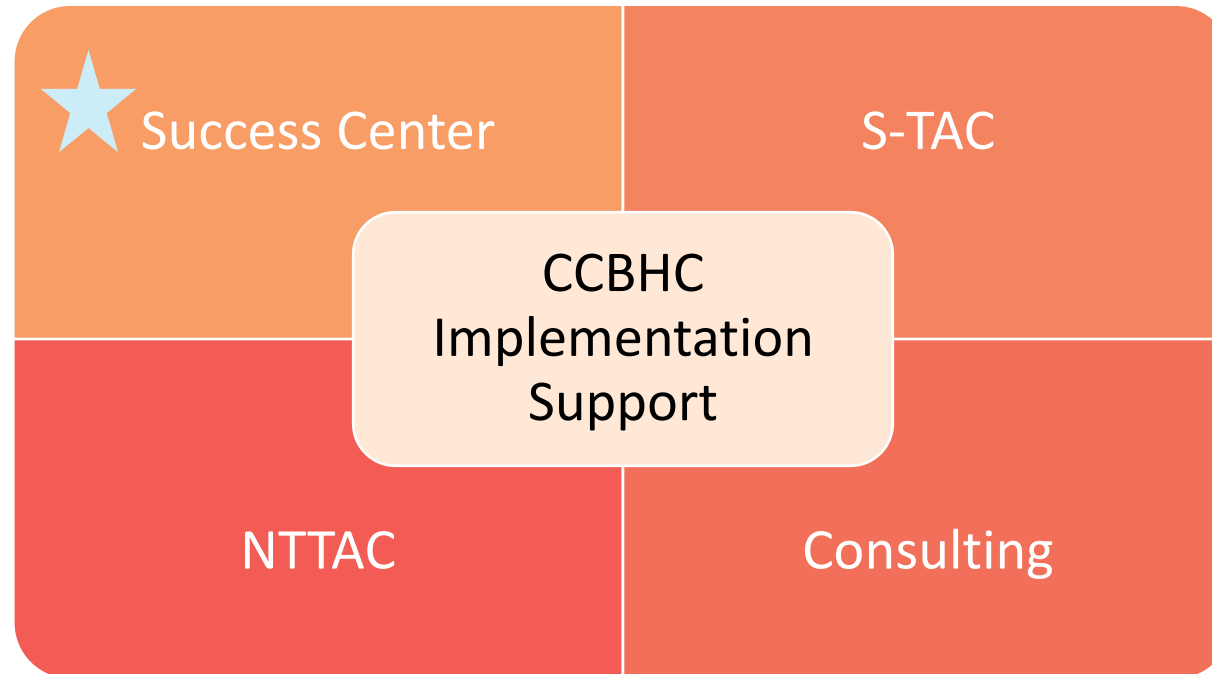


# Logistics

- Please join by video if you are able!
- Please rename yourself so your name includes your organization.
  - For example:
    - **D'ara Lemon, National Council**
  - To rename yourself:
    - Click on the **Participants** icon at the bottom of the screen
    - Find your name and hover your mouse over it
    - Click **Rename**
- If you are having any issues, please send a Zoom chat message to **D'ara Lemon, National Council**



# Implementation Support for CCBHCs



# Today's Presenters



**Brian Mallow, MSW**  
Senior Advisor, PIC



**John Gavino, LCSW**  
Director of CCBHC Fidelity and Compliance  
Family & Children's Services, Inc.



# Today's Learning Objectives

- Identify and review the required Clinic-Collected Quality Measures
- Provide examples of how to stand-up data systems, processes, and tracking for the Clinic-Collected Quality Measures
- How to engage in data sharing/reporting with the state
- Collaborating with other CCBHCs and establishing strong benchmarking practices



# Quick Poll

- What is your CCBHC status?
- What is your role at your organization?
- How ready is your CCBHC regarding collection and reporting of clinic-collected quality measures?



# CCBHC Quality Measures Resources



[SAMHSA CCBHC QM  
GUIDANCE & WEBINAR  
WEBSITE](#)



[2024 TECHNICAL  
SPECIFICATION  
MANUAL](#)



[2024 QUALITY  
MEASURE REPORTING  
TEMPLATE](#)



[2023 CERTIFICATION  
CRITERIA](#)



[FAQS ON QUALITY  
MEASURES](#)





# Why Clinic-Collected Quality Measures are Important

- Quantify the fundamental elements of the CCBHC Certification Criteria
- Establishes a baseline
- Opportunity to monitor changes to
  - Verify changes lead to improvements
  - Ensure improvements are sustained
- Set of consistent metrics allowing for benchmarking across CCBHCs



# Initial Considerations

Assess your current electronic health record (EHR): Does your EHR:

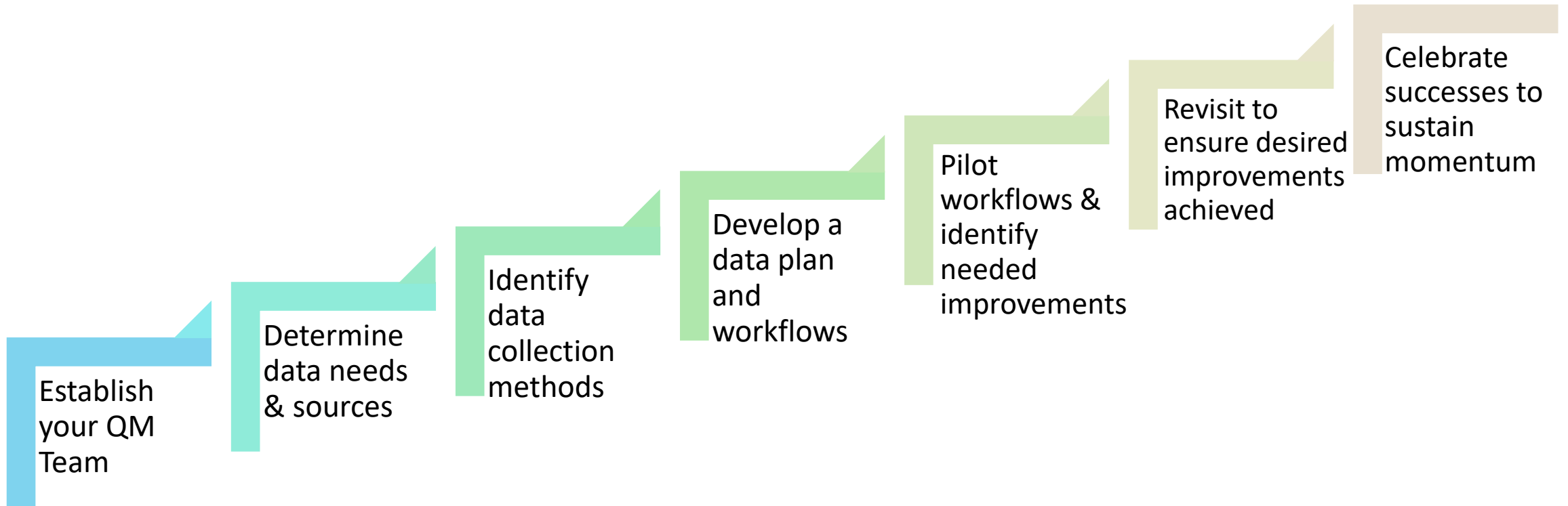
- Meet CCBHC Certification Criteria?
- Allow you to collect all data needed for the required measures?
- Produce user-friendly data dashboards including demographic breakdowns necessary for reporting?

Does your CCBHC have any Designated Collaborating Organization (DCO) partners?

- Is the DCO responsible for any clinic-collected quality measures data collection and reporting?



# Establishing a QM data infrastructure



# Establishing your QM Team

- What skills are needed on the team?
- What departments or levels of the organization are involved?
- Who is/are the data champion(s)?
- Who are the leaders that will support buy-in and motivation?
- Who is tasked with training efforts?

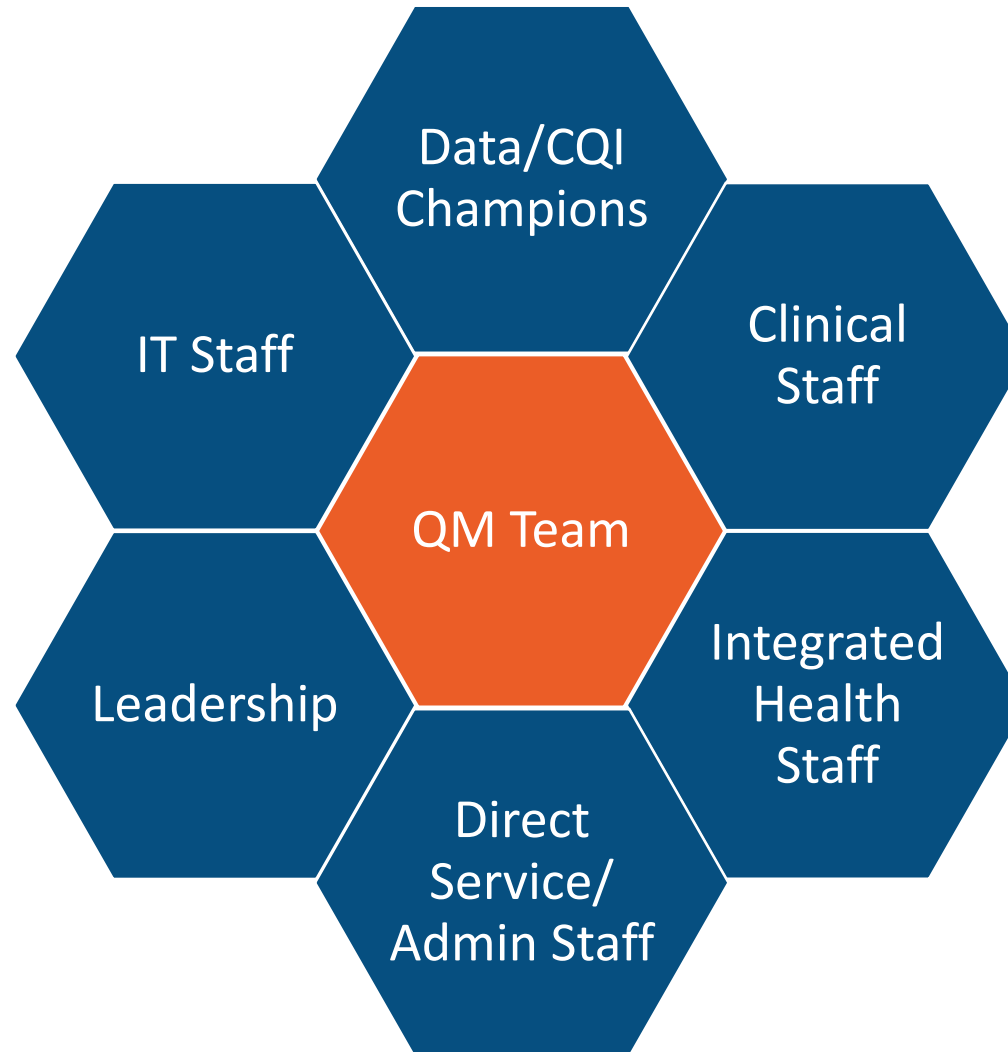


# Required Clinic-Collected Quality Measures

- Time to Services (I-SERV): Ages 12 and older
  - Average time to Initial Evaluation
  - Average time to Initial Clinical Services
  - Average time to Crisis Services
- Screening for Social Drivers of Health (SDOH): Ages 18 and older
- Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling (ASC): Ages 18 and older
- Screening for Clinical Depression and Follow-up Plan (CDF-CH and CDF-AD): Ages 12 and older
- Depression Remission at Six Months (DEP-REM-6): Ages 12 and older



# Establishing Your QM Team



# Data Needs and Sources

- Reference the [Quality Measures for Behavioral Health Clinics: Technical Specifications and Resource Manual](#)
- Map-out the data requirements
- Crosswalk the CPT/HCPCS codes with codes available in the EHR
  - Consider adding codes to support efficient processes
- Review existing data sources and screening tools to identify gaps
- Identify opportunities to integrate or link data from various systems



# Identify Data Collection Methods

Consult with state  
and other CCBHCs

Develop methods for  
gathering data

Determine if  
methods meet  
measure parameters

Promote methods  
that are efficient and  
effective for staff and  
individuals served

Develop data  
collection  
instruments as  
needed



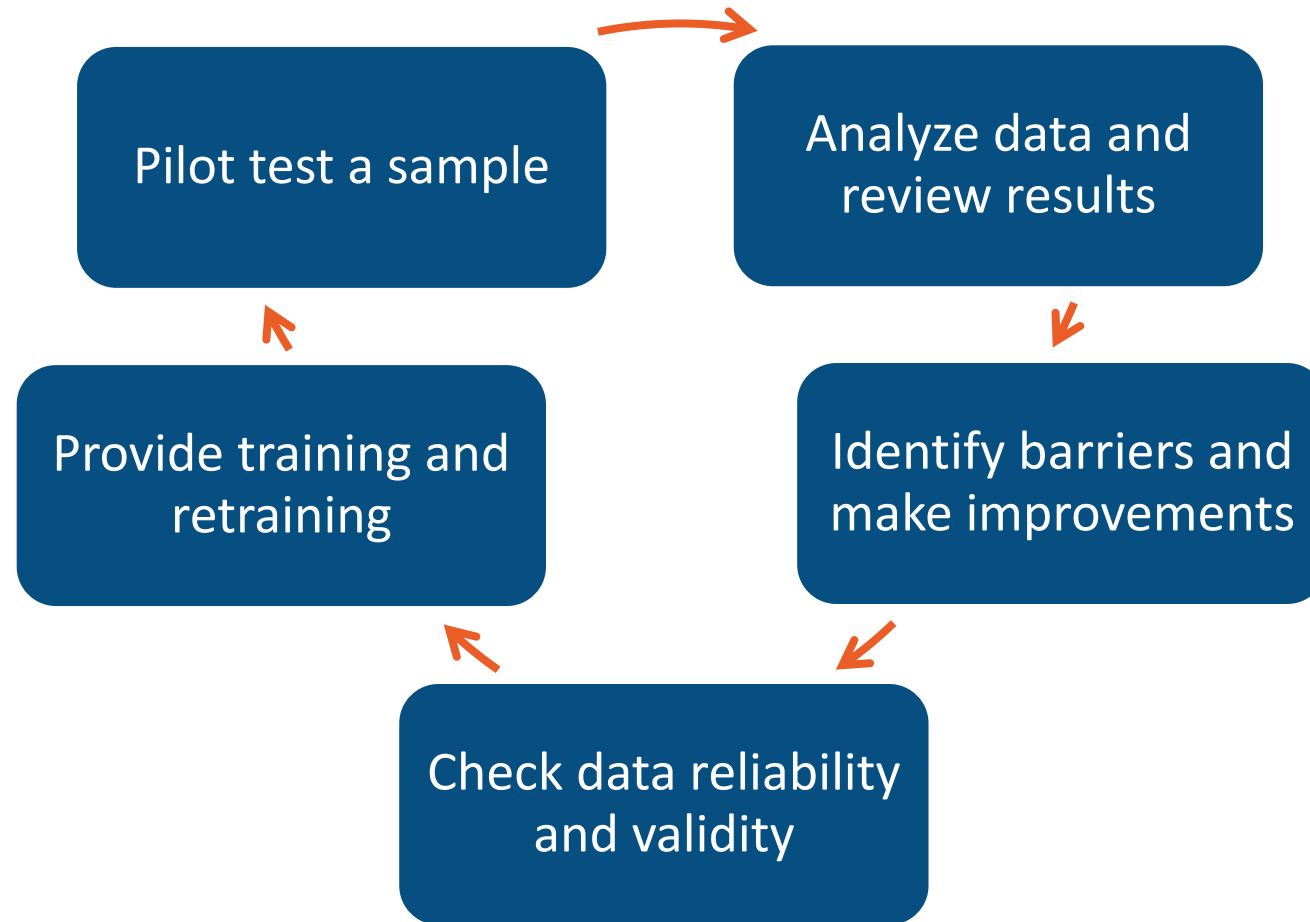


# Developing the Data Plan and Processes

- Determine how and when the data will be collected
- Identify if data collection should be built into existing workflows, new workflows should be developed, or both
- Clearly define roles and responsibilities for each component of the data collection, analysis, and reporting processes
- Identify ways of leveraging technology to support staff—e.g., automation, alerts
- Determine how data and results will be shared to provide context and interpretation



# Pilot Test and Refine Workflows



# Continue to Refine

- Continue to leverage CQI/PDSA to improve the workflows, processes, and results
- Continue to consult with QM team
- Remember to communicate frequently and effectively
- User-friendly access to data such as summary reports and dashboards supports greater use of data for micro and macro level analysis and improvements
- Celebrate wins to support buy-in, motivation, and momentum



# Establishing Strong Practices for CCBHC Quality Measures





# FCS

Family & Children's Services (FCS) promotes, supports, and strengthens the wellbeing and behavioral health of adults, children, and families.

# Quality Measures Workgroups

- **Family & Children's Services (FCS)**
  - Director of CCBHC
  - *Medical Director*
  - *Vice President, Medical Integration*
  - *Director of Integrated Health and Nursing Services*
  - Executive Vice President of CQI
  - Vice President of Access
  - Business Intelligence (BI) Team
  - Senior Program Director of Children's CCBHC
  - Director of Accreditation, Certification, & Regulatory Compliance
  - Director of CQI
  - Front line staff

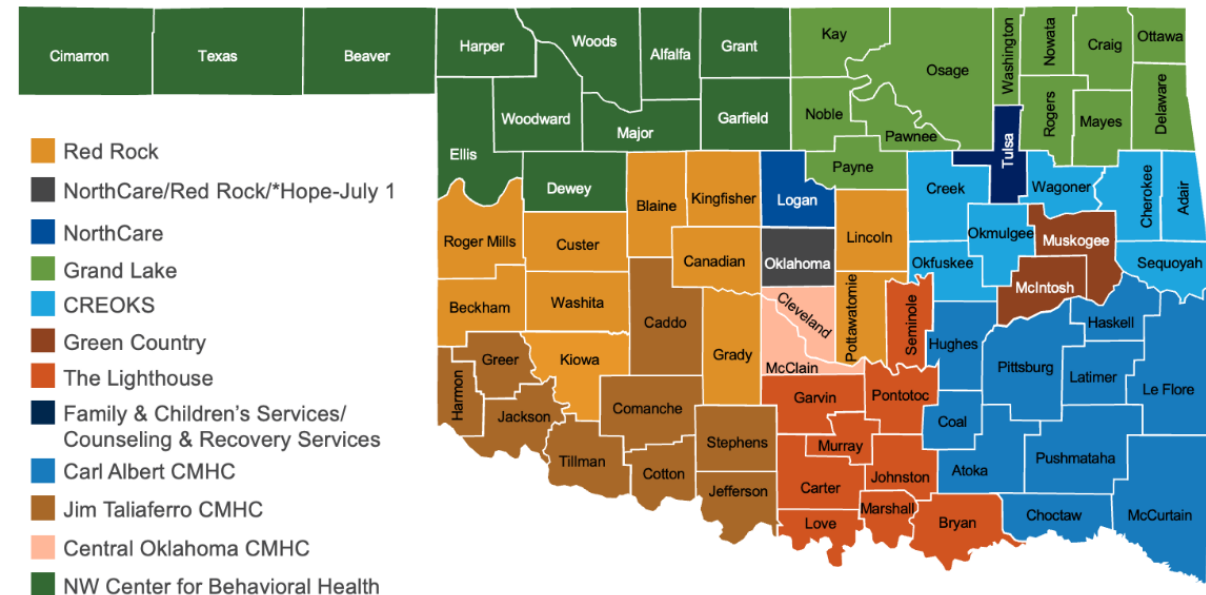


# Quality Measures Workgroups

- **Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS)**
  - Similarities and differences between SAMHSA and ODMHSAS
  - ODMHSAS Contract Monitoring requirements
  - 13 CCBHCs in Oklahoma
  - Common understanding of Terms



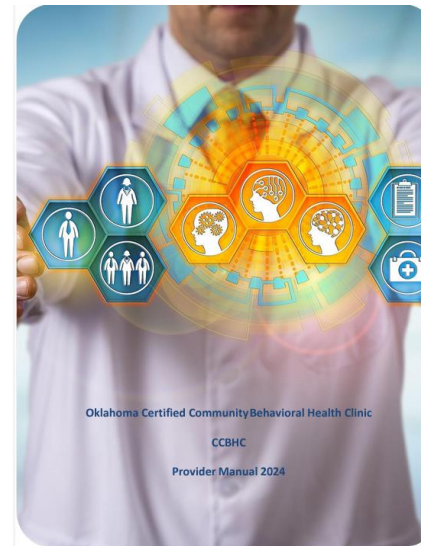
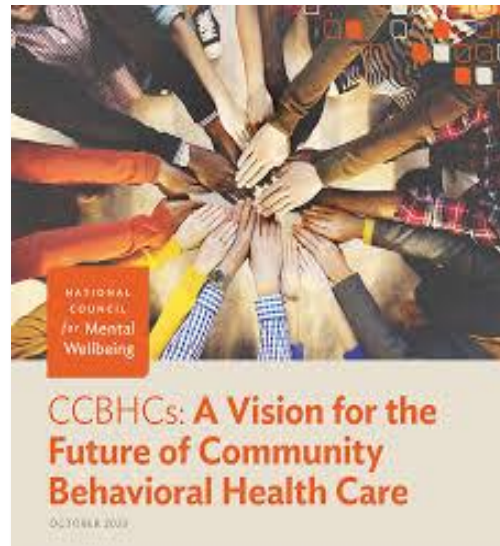
**OKLAHOMA**  
Mental Health &  
Substance Abuse





# Quality Measures Workgroups

- Other Oklahoma CCBHC partnership workgroup discussions
  - Better understand how other agencies implement the QMs
  - Ask questions
  - Internal benchmarking
  - Working and not working, successes and challenges





# Crosswalk Service Codes

ISERV Initial Clinical Service		
CPT Code	Avatar Code	Name of Service Selected by DMH
99202-99205		Medication Evaluation and Management for <b>Behavioral Health</b> , New Patient,
99202	703 - 99202 new pt EM px low-mod	
99203	704 - 99203 new pt EM px moderate	
99204	705 - 99204 new pt EM px mod-high	
99205	706 - 99205 new pt EM px mod-high	
99211-99215		Medication Evaluation and Management for <b>Behavioral Health</b> , Existing Patient,
99211	No Avatar Code	
99212	708 - 99212 est pt EM px minor	
99213	709 - 99213 est pt EM px low-mod	
99214	710 - 99214 est pt EM px mod-high	
99215	711 - 99215 est pt EM px mod-high	
H0004		Behavioral Health Counseling and Therapy (Individual, Group, or Family)
	29 - Interactive Psychotherapy	
	30 - Individual Counseling	
	31 - Group Counseling	
	32 - Family Counseling	
	34 - Individual Therapy Gambling	
	35 - Group Therapy Gambling	
	71 - Anger Management - Individual	
	72 - Anger Management - Group	
	130 - Individual Counseling SA	
	131 - Group Counseling SA	
	132 - Family/Marital Counseling SA	
	301 - Family w/out IP	
H0022		Substance Abuse Early Intervention Counseling
	8020 Substance Abuse Early Intervention Counseling	
S9444		Parenting Skills Training, Group (Families with Children 0-17) EBP
	8017 - Parent Skill Training Grp fam w/0-17 EBP (has same title as DMH)	
S9446		Group Behavioral Health Interventions, ages 6-17 (child is present)
	8016 - Parent Skill Training Grp fam w/6-17 EBP	
90849		Multiple-family group psychotherapy (ages 0-3)
	137 Multiple-family group psychotherapy (ages 0-3)	
90847		Family psychotherapy, conjoint psychotherapy with the patient present (ages 0-3)
	136 Family psychotherapy, conjoint psychotherapy with the patient present (ages 0-3)	
T1016		Targeted Case Management - Clients with SMI/SED or on the Most in Need list only
	54 - Case Mgmt for Custody Kids	
	8010 - Targeted CM - Client on MIN	
H2017		Individual/Group Rehabilitative Treatment, 6 years and older/Enhanced Illness Management & Recovery
	40 - Individual Rehab Treatment	
	41 - Group Rehab Training	

Clinical Service | Alcohol Screen | SDOH | Child-Adult Depression Screen | CH-AD ... (+) | ◀ ▶

# Service Codes

- Crosswalk service codes (HCPCS/CPT codes to EHR codes)
- Coordinate with Billing department, EHR department, and Data Team
  - Add service codes to EHR and programs
  - EHR form creation and auto populate codes
  - BI Data Team for Eligible Service Encounter Codes
  - Train staff on definition and use of codes

## Screening for Depression and Follow-Up Plan (CDF-AD)

**Table CDF-B. Codes to Document Depression Screen**

Code	Description
G8431	Screening for depression is documented as being positive and a follow-up plan is documented
G8510	Screening for depression is documented as negative, a follow-up plan is not required

**Table CDF-C. HCPCS Code to Identify Exclusions**

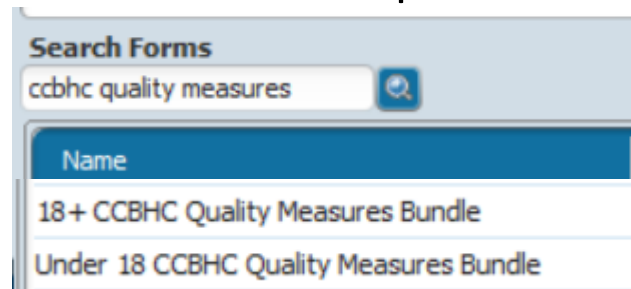
Code	Description
G9717	Documentation stating the patient has had a diagnosis of depression or has had a diagnosis of bipolar disorder

**Table CDF-A. Codes to Identify Outpatient Visits**

CPT	HCPCS
59400, 59510, 59610, 59618, 90791, 90792, 90832, 90834, 90837, 92625, 96105, 96110, 96112, 96116, 96125, 96136, 96138, 96156, 96158, 97161, 97162, 97163, 97165, 97166, 97167, 99078, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99318, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99339, 99340, 99401, 99402, 99403, 99483, 99484, 99492, 99493, 99384, 99385, 99386, 99387, 99394, 99395, 99396, 99397	G0101, G0402, G0438, G0439, G0444

# Form Creation

- EHR Quality Measures Form Creation
  - Copyrights and approvals to use forms and to embed in our EHR
  - Decide on the tool or questions to ask
  - EHR Team collaboration
  - Required sections on forms
  - Auto populate reporting codes and auto launch forms
  - Bundle forms together (CDF-AD/CH, DEP-REM-6, SDoH, and ASC)
  - Test and pilot the forms
  - Data pulled into data warehouse and the BI reports



The screenshot shows a search interface with the following elements:

- Search Forms** (Section Header)
- Search input field containing **ccbhc quality measures**
- Search icon (magnifying glass)
- Table of results with the following rows:

Name
18+ CCBHC Quality Measures Bundle
Under 18 CCBHC Quality Measures Bundle

Patient Health Questionnaire (PHQ) Modified ▶ PHQ Modified Quality Measure ▶ Social Drivers of Health ▶ Unhealthy Alcohol Use Quality Measure ▶

# Preliminary Screener-First Contact

**Preliminary Screener**

Assessment Date  T Y

Initial Contact Status  
 Initial contact  Initial contact after chart closed for a minimum of 6 months

**Urgent Need**

Ask if individual is having thoughts of wanting to kill themselves. Is there immediate danger?  
 Yes  No

If yes  
 Risk assessment completed  Call Center call transferred to COPES Time

Ask if individual is having any thoughts of harming or hurting others. Is there an immediate danger to others?  
 Yes  No

If yes  
 Risk assessment completed  Call Center call transferred to COPES Time

Does individual have any immediate health risks?  
 Yes  No

If yes  
 Called 911  Referred to Medical Hospital

Health Risk Is

Set initial appointment within one day if yes is answered to any of the Urgent Need questions.

# I-SERV: I-EVAL

Submitted 10/11/2024 at 02:18 PM by RICHARD DILLON O'CARROLL LPC CM II

**Preliminary Screener**

Assessment Date: 10/11/2024

Initial Contact Status:  Initial contact  Initial contact after chart closed for a minimum of 6 months

**Urgent Need**

Ask if individual is having thoughts of wanting to kill themselves. Is there immediate danger?  Yes  No

If yes:  Risk assessment completed  Call Center call transferred to COPEs Time: \_\_\_\_\_

Ask if individual is having any thoughts of harming or hurting others. Is there an immediate danger to others?  Yes  No

If yes:  Risk assessment completed  Call Center call transferred to COPEs Time: \_\_\_\_\_

Does individual have any immediate health risks?  Yes  No

If yes:  Called 911  Referred to Medical Hospital

**Health Risk Is**

Set initial appointment within one day if yes is answered to any of the Urgent Need questions.  Intake appointment set  Declined one day appointment  Declined to schedule appointment or walk in  Referred to walk in  Declined to schedule appointment due to timeframes available  Referred out due to limited availability of appointments

Intake Appointment Date: 10/11/2024 Program: MHC HOT

**Unsafe Substance Use**

Ask individual if they have used alcohol or drugs in the last 30 days?  Yes  No  Declined to complete  Child not available to answer screening questions

## Interventions/Actions Taken in Session:

Initial Evaluation: Staff gathered initial evaluation information including preliminary diagnoses; source of referral; reason for seeking care; identification of the client's immediate clinical care needs related to diagnosis; a list of current prescriptions and over-the-counter medications, as well as other substances the client may be taking; assessed if the client is a risk to self or to others, including suicide risk factors; assessed whether the client has other concerns for their safety; assessment of need for medical care with referral and follow-up as needed; and determination of whether the client is or ever has been a member of the U.S. Armed Services.

Date Of Service: 10/11/2024

Service Charge Code: I-Eval - new consumer (8015)

Service Code Additional Descriptor: Individual Therapy - Intake



# I-SERV: Initial Clinical Service

Submitted 10/11/2024 at 02:18 PM by RICHARD DILLON O'CARROLL LPC CM II

**Preliminary Screener**

Assessment Date: 10/11/2024

Initial Contact Status:  Initial contact  Initial contact after chart closed for a minimum of 6 months

**Urgent Need**

Ask: if individual is having thoughts of wanting to kill themselves. Is there immediate danger?

Yes  No

If yes:  Risk assessment completed  Call Center call transferred to COPEs Time: \_\_\_\_\_

Ask: if individual is having any thoughts of harming or hurting others. Is there an immediate danger to others?

Yes  No

If yes:  Risk assessment completed  Call Center call transferred to COPEs Time: \_\_\_\_\_

Does individual have any immediate health risks?

Yes  No

If yes:  Called 911  Referred to Medical Hospital

**Health Risk Is**

Set initial appointment within one day if yes is answered to any of the Urgent Need questions.

Intake appointment set  Declined one day appointment  Declined to schedule appointment or walk in  Referred to walk in  
 Declined to schedule appointment due to timeframes available  Referred out due to limited availability of appointments

Intake Appointment Date: 10/11/2024 Program: MHC HOT

**Unsafe Substance Use**

Ask: individual if they have used alcohol or drugs in the last 30 days?

Yes  No  Child not available to answer screening questions  
 Declined to complete

## Clinical Services:

99202-99205	Medication Evaluation and Management for <b>Behavioral Health</b> , New Patient,
H0004	Behavioral Health Counseling and Therapy (Individual, Group, or Family)
H0022	Substance Abuse Early Intervention Counseling
S9444	Parenting Skills Training, Group (Families with Children 0-17) EBP
S9446	Group Behavioral Health Interventions, ages 6-17 (child is present)
90849	Multiple-family group psychotherapy (ages 0-3)
90847	Family psychotherapy, conjoint psychotherapy with the patient present (ages 0-3)
T1016	Targeted Case Management - Clients with SMI/SED or on the Most in Need list only
T1017	Case Management
T2023	Case Management for custody kids
H2017	Individual/Group Rehabilitative Treatment/Enhanced Illness Management & Recovery
H2027	Psychoeducation and Counseling
H2017	Group Rehabilitative Treatment - Clients 12 - 17 years
H2019	Therapeutic Behavioral Services
H2027	Children's Family/Caregiver Psychoeducation - Group (ages 0-5)
S5110	Intensive In-home Supports, Skills Training, Individual 6 - 17 years
H0034	Medication Training and Support
T1012	Wellness Resource Skills Development
H2015	Peer Recovery Support/Peer Recovery Support - Family
96202	Group Caregiver Behavioral Management Training (family/caregiver) 18 and over
H0022	Substance Abuse Early Intervention Counseling
90832	counseling, 30 minutes
90834	counseling, 45 minutes
90837	counseling, 60 minutes
90846	family counseling w/o client present
90853	group counseling
H0043	housing
H2014	vocational
S5190	wellness
T1502	injection
G0136	Social Driver of Health Evaluation



# I-SERV: Time to Crisis Services

Assessment Date  
10/09/2024

Initial Contact Status  
 Initial contact  Initial contact after chart closed for a minimum of 6 months

**Urgent Need**  
Ask if individual is having thoughts of wanting to kill themselves. Is there immediate danger?  
 Yes  No

If yes  
 Risk assessment completed  Call Center call transferred to COPEs Time: 01:41 PM

Ask if individual is having any thoughts of harming or hurting others. Is there an immediate danger to others?  
 Yes  No

If yes  
 Risk assessment completed  Call Center call transferred to COPEs Time:

Does individual have any immediate health risks?  
 Yes  No

If yes  
 Called 911  Referred to Medical Hospital

Health Risk Is

Set initial appointment within one day if yes is answered to any of the Urgent Need questions.  
 Intake appointment set  Declined one day appointment  Declined to schedule appointment or walk in  Referred to walk in  
 Declined to schedule appointment due to timeframes available  Referred out due to limited availability of appointments

Intake Appointment Date  
10/10/2024

Program  
Adult Bridge

**Unsafe Substance Use**  
Ask individual if they have used alcohol or drugs in the last 30 days?  
 Yes  No  
 Declined to complete  Child not available to answer screening questions

Service Charge Code: CCBHC Crisis Intervention (465)

Service Charge Code: Triage (483)

Service Program: Crisis Care Center - C2 (1423)

COPEs Triage

**Intervention(s) Included**

Telephone  Mobile from telephone  Text  
 Mobile from text  Telephone from text  CRT from telephone  
 911 telephone  Mobile from 911 telephone  988  
 ART  Gilcrease  Mingo Valley  
 Riverside  School Crisis Team  Med Wise iPad  
 Care Link Navigation

Cleared Before Dispatch  
 Yes  No  N/A

911 Call Code [dropdown] Police Units [dropdown] Fire Units [dropdown]  
EMSA Units [dropdown] Follow Up [dropdown] High Utilizer [dropdown]  
Med Wise Location [dropdown]  
Qualified Census Tract [dropdown]

**Intervention Location**  
 Home  Phone  Community  
 School  Emergency Room  Other

If other, please explain [text area]

**Actions Taken**

Transportation provided  Food provided  Outreach  
 Coordinated with law enforcement  Coordinated with EMSA  Case management  
 Crisis intervention  Community referral-type  COPEs involved support system  
 Referred to Outpatient MH  Coordinated with treatment provider  Advocated for EOD  
 Advocated for DO  Request officer affidavit  Text follow-up

**Foms Used**

3rd Party Statement  LMHP  Child Abuse Reporting  APS Reporting  
 Safety Plan  Intervention Report  Authorization/Release of Records

**On Scene Disposition**  
 Immediate action required  Unable to locate  Crisis stabilized

# Screening for Social Drivers of Health (SDOH)

- SDoH
- Form
- Piloting
- BI Report
- HIE



Social Drivers of Health

The Accountable Health Communities Health-Related Social Needs Screening Tool

Assessment Date: [ ] [T] [Y] [ ] Status:  Draft  Final

Client:  Unable to complete due to decompensation.  Refused to complete/did not want to.

**Information**

1. Complete the following statement. I am answering this survey about...

Myself  My child  Another adult for whom I provide care  Other

Other (please describe your relationship to this person) [ ]

2. How many times have you received care in an emergency room (ER) over the last 12 months? If you are in the ER now, please count your current visit. Please do not count urgent care visits.

0 times  1 time  2 or more times

**Food**

Some people have made the following statements about their food situation. Please answer whether the statements were OFTEN, SOMETIMES, or NEVER true for you and your household in the last 12 months.

6. Within the past 12 months, you worried that your food would run out before you got money to buy more.

Often true  Sometimes true  Never true

7. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.

Often true  Sometimes true  Never true

**Transportation**

8. In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting to things needed for daily living?

Yes  No

**Utilities**

9. In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?

Yes  No  Already shut off

**Safety**

*Because violence and abuse happens to a lot of people and affects their health we are asking the following questions*

10. How often does anyone, including family and friends, physically hurt you?

Never  Rarely  Sometimes  Fairly often  Frequently

11. How often does anyone, including family and friends, insult or talk down to you?

Never  Rarely  Sometimes  Fairly often  Frequently

12. How often does anyone, including family and friends, threaten you with harm?

Never  Rarely  Sometimes  Fairly often  Frequently

13. How often does anyone, including family and friends, scream or curse at you?

Never  Rarely  Sometimes  Fairly often  Frequently

**Financial Strain**

14. How hard is it for you to pay for the very basics like food, housing, medical care, and heating? Would you say it is...

Service Charge Code: (8910) SDoH - Screening

**Domains**

Living Domain:  HRSN - Yes  HRSN - No

Food Domain:  HRSN - Yes  HRSN - No

Transportation Domain:  HRSN - Yes  HRSN - No

Utilities Domain:  HRSN - Yes  HRSN - No

Safety Domain:  HRSN - Yes  HRSN - No

Financial Strain Domain:  HRSN - Yes  HRSN - No

Employment Domain:  HRSN - Yes  HRSN - No

Family and Community Domain:  HRSN - Yes  HRSN - No

Education Domain:  HRSN - Yes  HRSN - No

Physical Activity Domain:  HRSN - Yes  HRSN - No

Substance Use Domain:  HRSN - Yes  HRSN - No

Mental Health Domain:  HRSN - Yes  HRSN - No

Disabilities Domain:  HRSN - Yes  HRSN - No



# Unhealthy Alcohol Use: Screening and Brief Counseling

- Negative score:

**Date Collected**  
12/12/2024

How many times in the past year have you had 5 or more drinks in a day?

How many times in the past year have you had 4 or more drinks in a day?

A score equal to or larger than 1 results in a positive screen.

**Medical Performance Exclusion**  
 Screening for unhealthy alcohol use not conducted due to medical reasons:

**Client received the following services due to positive screen for unhealthy alcohol use**

<input type="checkbox"/> Ask to discuss results and identify risk	<input type="checkbox"/> Refer to self-help / support group	<input type="checkbox"/> Asked feedback on results, alcohol use, and harms of use
<input type="checkbox"/> Reviewed pros and cons of alcohol use	<input type="checkbox"/> Referral to complete ASAM	<input type="checkbox"/> Collaboratively developed a personal plan to reduce drinking
<input type="checkbox"/> Refer to psychiatry for medication evaluation	<input type="checkbox"/> Link to PCP	
<input type="checkbox"/> Identification of high risk situations for drinking and coping strategies		
<input type="checkbox"/> What they would like to change about their alcohol use?	<input type="checkbox"/> What steps can you take to cut back your use?	

What are your reasons to cut back your use?

Referral to outpatient or inpatient substance use services



- Positive score:

**Unhealthy Alcohol Use Quality Measure**

**Assessment Date**  
10/09/2024

**Date Collected**  
10/09/2024

**Date of Birth**  
01/01/1970

**Age**  
54

**Gender**  
 Female  
 Male

How many times in the past year have you had 5 or more drinks in a day?

How many times in the past year have you had 4 or more drinks in a day?

A score equal to or larger than 1 results in a positive screen.

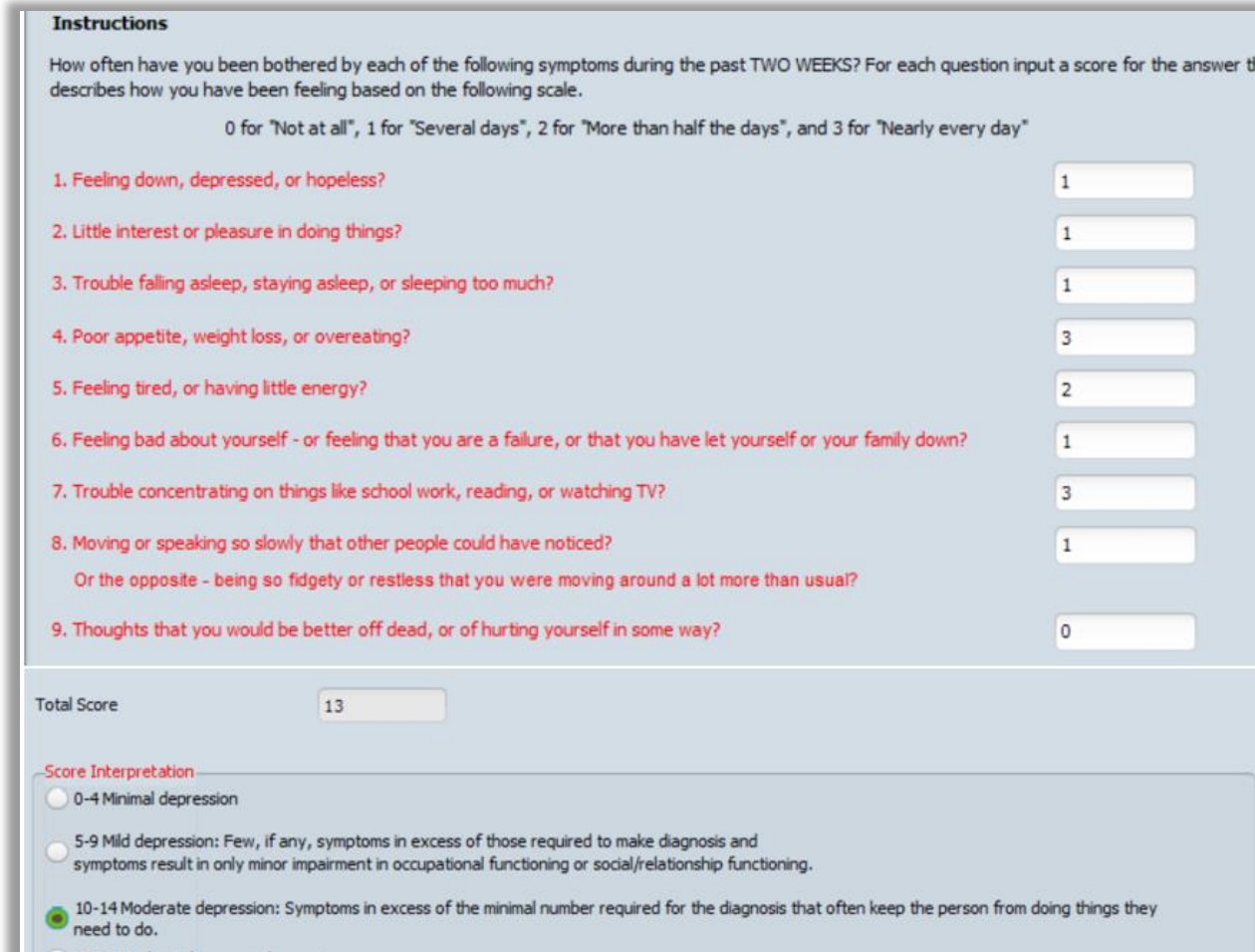
**Medical Performance Exclusion**  
 Screening for unhealthy alcohol use not conducted due to medical reasons:

**Client received the following services due to positive screen for unhealthy alcohol use**

<input checked="" type="checkbox"/> Ask to discuss results and identify risk	<input type="checkbox"/> Refer to self-help / support group	<input type="checkbox"/> Asked feedback on results, alcohol use, and harms of use
<input type="checkbox"/> Reviewed pros and cons of alcohol use	<input checked="" type="checkbox"/> Referral to complete ASAM	<input checked="" type="checkbox"/> Collaboratively developed a personal plan to reduce drinking
<input checked="" type="checkbox"/> Refer to psychiatry for medication evaluation	<input type="checkbox"/> Link to PCP	
<input checked="" type="checkbox"/> Identification of high risk situations for drinking and coping strategies		
<input type="checkbox"/> What they would like to change about their alcohol use?	<input type="checkbox"/> What steps can you take to cut back your use?	

# Screening for Depression & Follow-up Plan

- Percentage of clients 12 years and older who were **screened** for depression AND if **positive (score 10 or above)**, a **follow-up plan** is documented.
- **Annual** depression screening for clients.



**Instructions**

How often have you been bothered by each of the following symptoms during the past TWO WEEKS? For each question input a score for the answer that describes how you have been feeling based on the following scale.

0 for "Not at all", 1 for "Several days", 2 for "More than half the days", and 3 for "Nearly every day"

1. Feeling down, depressed, or hopeless?	1
2. Little interest or pleasure in doing things?	1
3. Trouble falling asleep, staying asleep, or sleeping too much?	1
4. Poor appetite, weight loss, or overeating?	3
5. Feeling tired, or having little energy?	2
6. Feeling bad about yourself - or feeling that you are a failure, or that you have let yourself or your family down?	1
7. Trouble concentrating on things like school work, reading, or watching TV?	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you were moving around a lot more than usual?	1
9. Thoughts that you would be better off dead, or of hurting yourself in some way?	0

Total Score

**Score Interpretation**

0-4 Minimal depression

5-9 Mild depression: Few, if any, symptoms in excess of those required to make diagnosis and symptoms result in only minor impairment in occupational functioning or social/relationship functioning.

10-14 Moderate depression: Symptoms in excess of the minimal number required for the diagnosis that often keep the person from doing things they need to do.

**Who?**  
Clients not diagnosed with depression/bipolar

**Why?** To assess need & begin treatment

# Screening for Depression Follow Up: (CDF-CH &AD)

**Patient Health Questionnaire (PHQ) Modified Quality Measure  
Depression Screening**

**Assessment Date**  
12/13/2024 [T] [Y] [Calendar Icon]

PHQ Modified Quality Measure not indicated at this time

**Due to a positive depression screening, the follow up plan for the treatment of depression includes**

<input type="checkbox"/> Education regarding medication treatment	<input checked="" type="checkbox"/> Recommend myStrength modules
<input checked="" type="checkbox"/> Refer to a provider for additional evaluation	<input type="checkbox"/> Refer to Primary Care Physician
<input checked="" type="checkbox"/> Schedule new therapy session or refer to therapy	<input type="checkbox"/> Schedule next CM appointment
<input checked="" type="checkbox"/> Schedule prescriber visit	<input type="checkbox"/> Schedule rehab services
<input type="checkbox"/> Schedule staffing/treatment team	



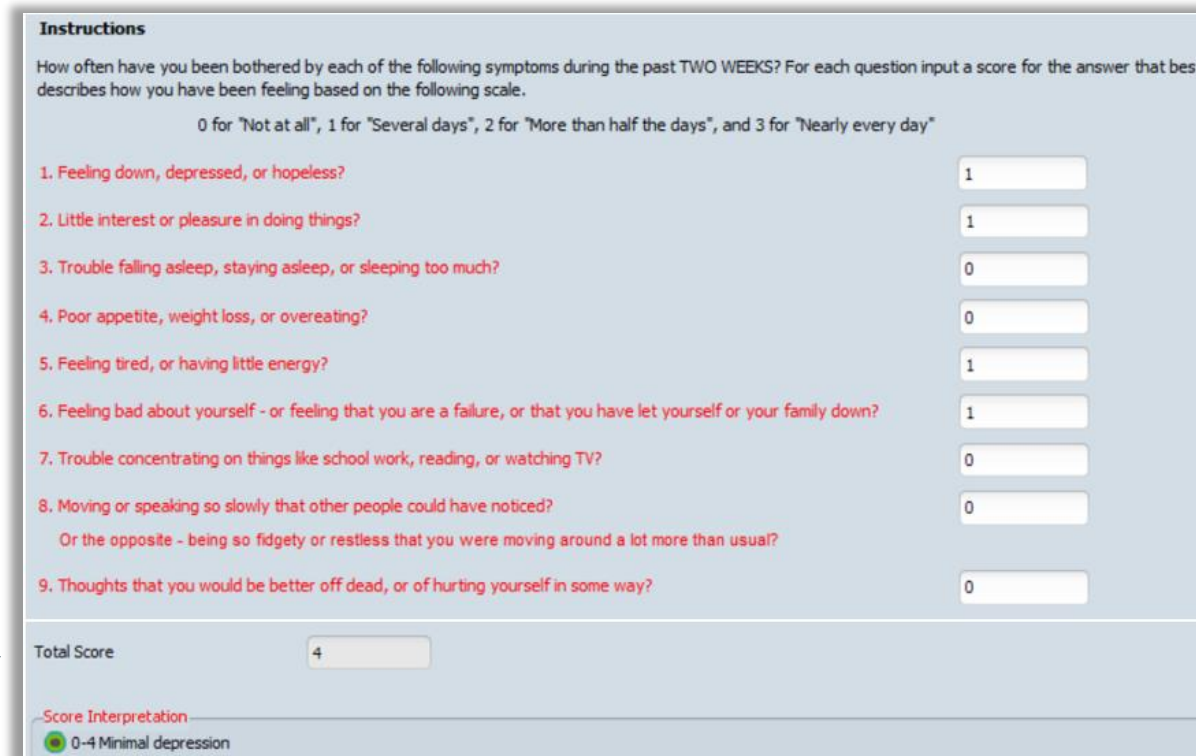
**Practitioner**  
JOHN GAVINO (003928)

**Service Charge Code**  
(G8431) Depression Screen - Positive

# Depression Remission at Six Months

- Percentage of clients 12 years and older with a diagnosis of Depression who reach readmission six months (+/- 60 days) after an index even date.
- **Index Event Date** – the date on which both the first instance of elevated *PHQ* **greater than nine** (same encounter date or 7 days prior) AND **diagnosis of Depression** or Dysthymia during the MY.
- **Remission** - Score of less than five.

**Who?**  
Clients  
already  
diagnosed  
with  
depression



**Instructions**  
How often have you been bothered by each of the following symptoms during the past TWO WEEKS? For each question input a score for the answer that best describes how you have been feeling based on the following scale.  
0 for "Not at all", 1 for "Several days", 2 for "More than half the days", and 3 for "Nearly every day"

1. Feeling down, depressed, or hopeless?	1
2. Little interest or pleasure in doing things?	1
3. Trouble falling asleep, staying asleep, or sleeping too much?	0
4. Poor appetite, weight loss, or overeating?	0
5. Feeling tired, or having little energy?	1
6. Feeling bad about yourself - or feeling that you are a failure, or that you have let yourself or your family down?	1
7. Trouble concentrating on things like school work, reading, or watching TV?	0
8. Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you were moving around a lot more than usual?	0
9. Thoughts that you would be better off dead, or of hurting yourself in some way?	0

Total Score: 4

**Score Interpretation**  
0-4 Minimal depression

**Why?** To  
know  
treatment  
outcomes



# Depression Remission at Six Months

		Index screening may be 7 days before first possible IED																			
Months:		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
		MY																			
		Denominator MP: 12 mo MY																			
		Numerator MP: 6 mo +/- 60 days after IED																			
If IED=x, R may be measured:	x					R	R	R	R	R											
If IED=x, R may be measured:		x					R	R	R	R	R										
If IED=x, R may be measured:			x					R	R	R	R	R									
If IED=x, R may be measured:				x					R	R	R	R	R								
If IED=x, R may be measured:					x					R	R	R	R	R							
If IED=x, R may be measured:							x					R	R	R	R	R					
If IED=x, R may be measured:									x					R	R	R	R	R			
If IED=x, R may be measured:											x				R	R	R	R	R		
If IED=x, R may be measured:													x			R	R	R	R	R	
If IED=x, R may be measured:															x		R	R	R	R	R
If IED=x, R may be measured:																	x	R	R	R	R

IED: Index Event Date; MY: Measurement Year; MP: Measurement Period; R: Six Month Remission may be measured, depending on date, 4-8 months after IED (6 months (+/- 60 days)).

# Workflow Development

- Develop walk through of your system. Multiple access points, system wide similarities, and program individual differences.
- Client perspective/staff perspective.
- Minor and major changes that will occur. Elicit feedback.
- How will staff know which clients are due for QM, when are they due, how frequent, who sends the reports (Data Specialist on teams), when to review the reports?
- Which staff will obtain the QM, where, when, and how within the clinic workflow.
- Train staff on documentation.



# Workflow Development

- Make it easy for staff such as required fields, auto populate service codes, customizable templates, alerts, prompts, to-do tasks, appointment reminders/placeholders, etc.
- Dashboards to monitor progress. Compare performance across staff, teams, and programs.
- Data reports and alerts to notify team members of due dates.
- Build in continuous quality improvement efforts.
- Identify areas of low quality for targeted improvement efforts.
- Data reported to States encouraged care monitoring systems to support clinic-specific quality improvement efforts.
- State Technical Assistance- webinars and direct support:
  - Explain the measures
  - Examples of how to extract information and calculate measures from EHR (ex: what queries to run; what numerators and denominators to use; etc.)
  - Explain how to complete the reporting template spreadsheet
  - Ensures all agencies have mutual understanding of definitions/terms

# How did you integrate your intake process to help fulfill both the CCBHC state requirements and your other accreditation requirements?

- Two-part Intake process. In-person, telehealth, and walk in capacity
  - PRSS: Kiosk –screeners and assessments
  - Therapist: Review assessments and care plan
- IEVAL and start the Comprehensive Evaluation on the first day of intake.
- Assign to primary program then same day walk-in to med clinic psychiatry, PCP coordination, Medicaid enrollment, resource room, case management, etc.

**Welcome to Family & Children's Services!**

260703

<b>Adults</b>	<b>Children</b>
<a href="#">Adult Intake with Screener</a>	<a href="#">CATS Demographics CCPU</a>
<a href="#">Adult Intake without Screener</a>	<a href="#">Child Intake Under 6</a>
<a href="#">Adult TPR</a>	<a href="#">Child Intake Ages 6-8</a>
<a href="#">CFSC Adult Intake</a>	<a href="#">Child Intake Ages 9-11</a>
<a href="#">CFSC Adult TPR</a>	<a href="#">Child Intake Ages 12-13</a>
	<a href="#">Child Intake Ages 14-17</a>



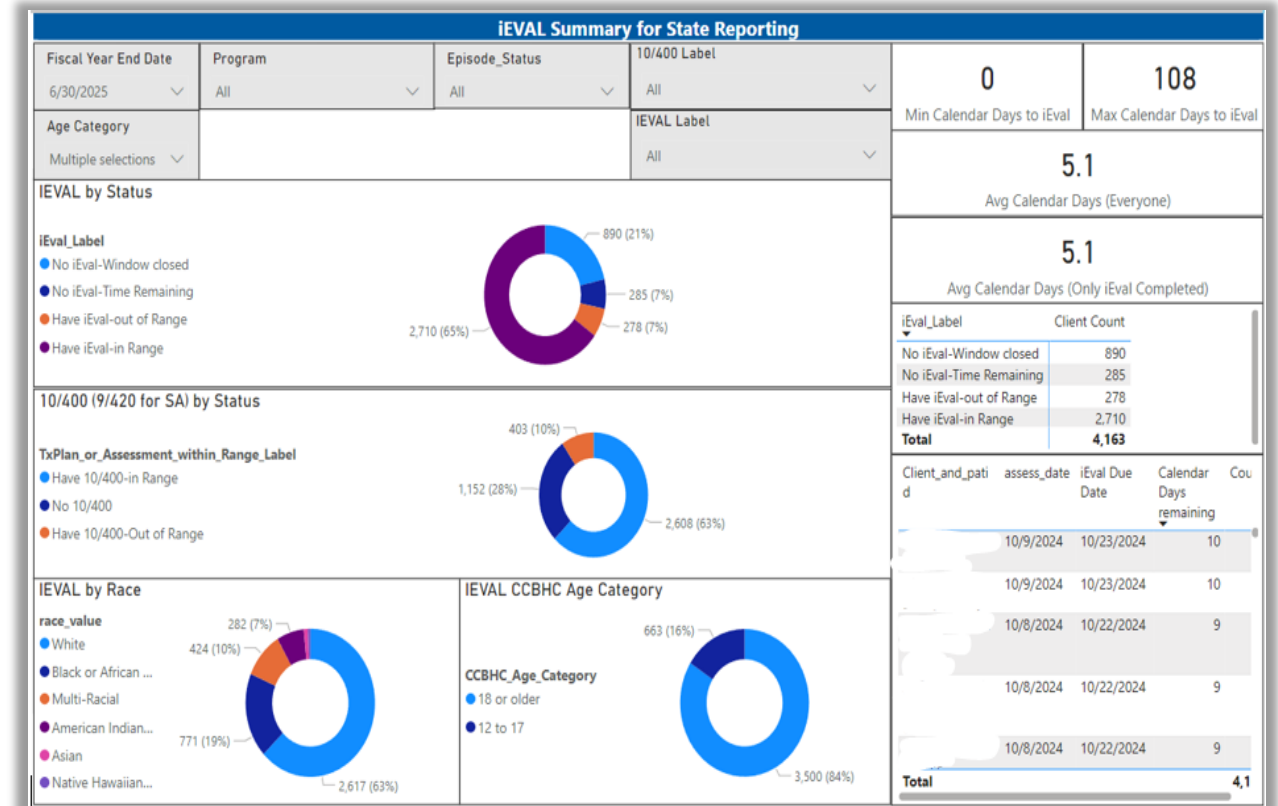


# How do you triage clients, complete comprehensive evaluations, collect physical health measures, and assess social determinants of health of your clients? Did you split these items up into different visits?

- **Triage:** Behavioral Health Assessment (BHA), Client Assessment Record (CAR), the Level of Care Utilization System (LOCUS), Youth OHIO Scales, Health Risk Appraisal, Psychiatric Hospital Discharge, ASAM/(T-)ASI, and residences/primary location.
- **Assigned to a primary program.**
- **Quality Measures at separate visits:**
  - Unhealthy Alcohol Use (ASC), Body Mass Index, Nutrition and Physical Activity, Nicotine Cessation Screener (TSC)
  - LPN/RN for further review of medical conditions and a Health Physical Assessment.
  - We have data reports that track clients and compliance rates.

# Reports

- BI reports-
  - Pilot reports (Sandbox vs Live)
    - Building the quarries and reports
    - Client data entered in forms
    - Data Warehouse
  - Several Reports:
    - Staff version (simple view)
    - Clients Needing IEVAL
    - Dashboards
    - State Measure for Reporting includes eligible population, exclusions, etc.



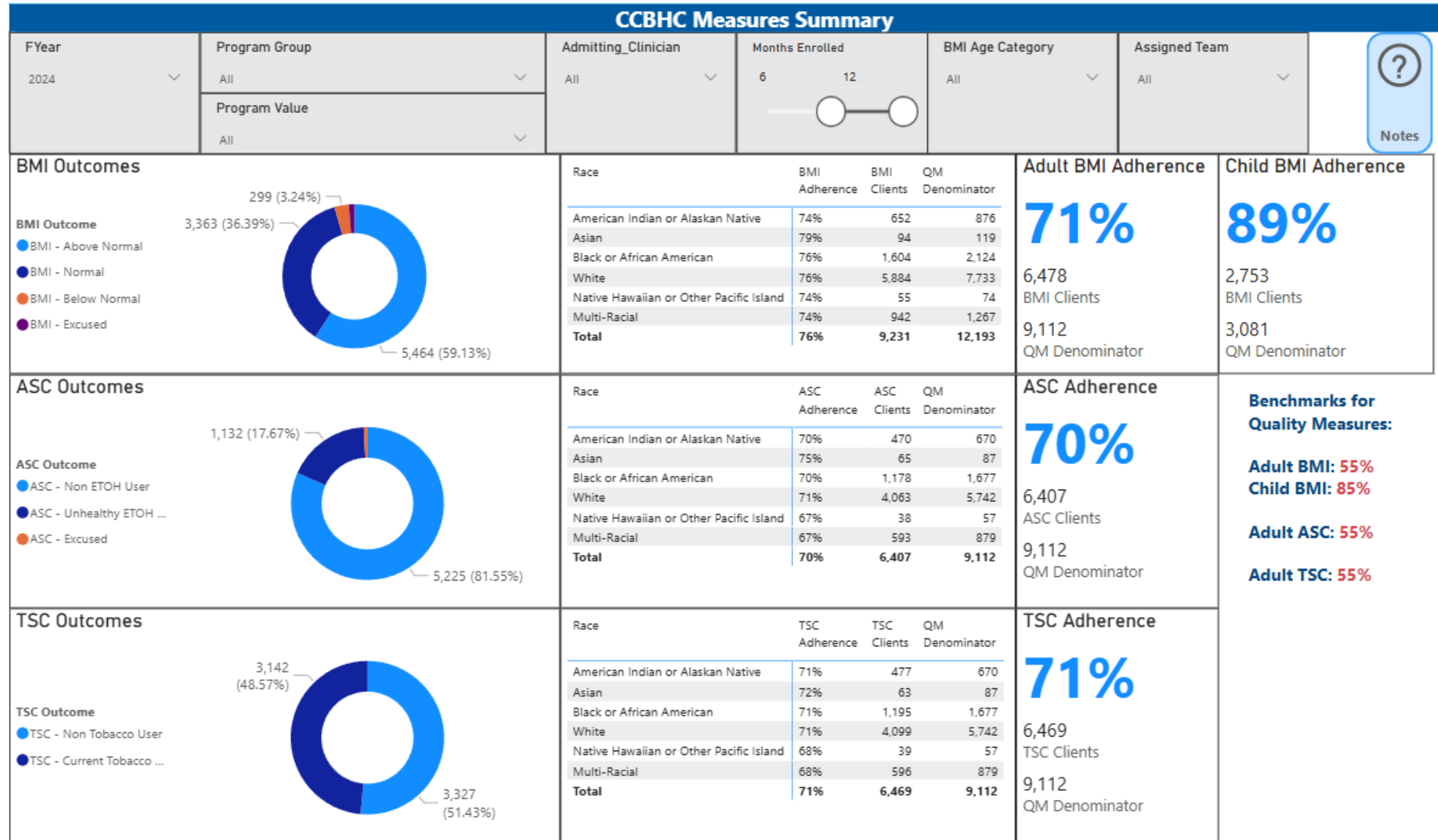
# Reports

No iEVAL Completed and No Assessment/TP							
patid	Program	iEVAL Label	10/400 Label	Episode_Status	Fiscal Year End Date		
All	All	All	All	All	6/30/2025		
iEval_Label		Client Count					
No iEval-Window closed		1,008					
No iEval-Time Remaining		387					
<b>Total</b>		<b>1,395</b>					

Client_and_patid	Calendar Days remaining	Prelim Screener Date	iEval Due Date	Scheduled_intake_date	1st Service provided on Intake Date	Program of service on intake date	Provider of service intake date
	2	10/1/2024	10/15/2024	10/2/2024	No Show (904)	Pre Admit MHC Intake	WILDE,SUMMER
	2	10/1/2024	10/15/2024				
	2	10/1/2024	10/15/2024	10/1/2024			
	2	10/1/2024	10/15/2024	10/2/2024	Intake No Show (9018)	Pre Admit Appointment Holding	FOWLER,TRESA
	2	10/1/2024	10/15/2024	10/10/2024	Cancelled without 24hr Notice (903)	Pre Admit Appointment Holding	ROGERS,REGINA
	2	10/1/2024	10/15/2024	10/23/2024			
	2	10/1/2024	10/15/2024	10/14/2024			
	2	10/1/2024	10/15/2024	10/18/2024			
	2	10/1/2024	10/15/2024	10/4/2024	Cancelled without 24hr Notice (903)	Pre Admit Appointment Holding	MURRAY,LAURA
	2	10/1/2024	10/15/2024				
	2	10/1/2024	10/15/2024	10/9/2024	BMI - normal no f/up plan required (8903)	School Based Services	FRIZZELL,JUBILEE
	2	10/1/2024	10/15/2024	10/7/2024	Referral SA (106)	Pre Admit Substance Abuse Adults	SOLIS,ISABEL
	2	10/1/2024	10/15/2024	10/2/2024			
	2	10/1/2024	10/15/2024	10/11/2024	Intake No Show (9018)	Pre Admit Appointment Holding	ROGERS,REGINA
	2	10/1/2024	10/15/2024				
	2	10/1/2024	10/15/2024	10/2/2024	No Show (904)	Pre Admit East - Intake	HARRIS,TOMMY
	2	10/1/2024	10/15/2024	10/1/2024	No Show (904)	Pre Admit MHC Intake	DUKE,ASHLEY

# Quality Measures



# Reports


Adult Client Quality Measures Summary for State Reporting							
FYear	QM Needs	Admitting Clinician	Episode Status	Program	Program Group		
2025	QM Due	GOULD,AMANDA (005372)	Episode is Open	All	All		
ASC Screener & Follow Up Count	Latest ASC Outcome	Latest ASC Screener Date	Program Value	Admitting Clinician	Appointment Date	Clinician	Appointment Program
0	ASC - Unhealthy ETOH Use	2/9/2024	Adult Bridge	GOULD,AMANDA (005372)	1/2/2025	WHIDBY,NICHELE (005421)	Adult Bridge (3612)
0			Adult Bridge	GOULD,AMANDA (005372)			
0	ASC - Non ETOH User	3/1/2024	Adult Bridge	GOULD,AMANDA (005372)			
0	ASC - Non ETOH User	3/1/2024	MHC Intake	GOULD,AMANDA (005372)			
0	ASC - Non ETOH User	11/10/2021	Adult Bridge	GOULD,AMANDA (005372)	1/2/2025	ROBERTS,RACHEL (004558)	Adult Psych non-physician (3103)
0			Adult Bridge	GOULD,AMANDA (005372)			
0			MHC Intake	GOULD,AMANDA (005372)			
0			Adult Bridge	GOULD,AMANDA (005372)	1/2/2025	WHIDBY,NICHELE (005421)	Adult Bridge (3612)
0			MHC Intake	GOULD,AMANDA (005372)	1/2/2025	WHIDBY,NICHELE (005421)	Adult Bridge (3612)
0	ASC - Non ETOH User	4/27/2023	Adult Bridge	GOULD,AMANDA (005372)			
0	ASC - Non ETOH User	4/27/2023	MHC Intake	GOULD,AMANDA (005372)			
0			Adult Bridge	GOULD,AMANDA (005372)	1/3/2025	BOZWORTH,LESLIE (005436)	Adult Bridge (3612)
0	ASC - Non ETOH User	2/27/2024	Adult Bridge	GOULD,AMANDA (005372)	1/6/2025	RATLIFF,DEBORAH (005809)	Adult Bridge (3612)
0			Adult Bridge	GOULD,AMANDA (005372)	1/2/2025	WHIDBY,NICHELE (005421)	Adult Bridge (3612)
0			MHC Intake	GOULD,AMANDA (005372)	1/2/2025	WHIDBY,NICHELE (005421)	Adult Bridge (3612)
0			Adult Bridge	GOULD,AMANDA (005372)			
0			Adult Bridge	GOULD,AMANDA (005372)	1/2/2025	WHIDBY,NICHELE (005421)	Adult Bridge (3612)
0			MHC Intake	GOULD,AMANDA (005372)	1/2/2025	WHIDBY,NICHELE (005421)	Adult Bridge (3612)
0			Adult Bridge	GOULD,AMANDA (005372)	1/2/2025	WHIDBY,NICHELE (005421)	Adult Bridge (3612)
0			Adult Bridge	GOULD,AMANDA (005372)	1/2/2025	WHIDBY,NICHELE (005421)	Adult Bridge (3612)
0			Adult Bridge	GOULD,AMANDA (005372)	1/2/2025	WHIDBY,NICHELE (005421)	Adult Bridge (3612)
0			Adult Bridge	GOULD,AMANDA (005372)	1/6/2025	WAGNER,RICHARD (004269)	MHC Adult Psychiatry (3003)
0			MHC Intake	GOULD,AMANDA (005372)	1/6/2025	WAGNER,RICHARD (004269)	MHC Adult Psychiatry (3003)
0			Adult Bridge	GOULD,AMANDA (005372)	1/3/2025	HOGAN,MELISSA (003760)	MHC Adult Psychiatry (3003)
0			MHC Intake	GOULD,AMANDA (005372)	1/3/2025	HOGAN,MELISSA (003760)	MHC Adult Psychiatry (3003)
0			Adult Bridge	GOULD,AMANDA (005372)	1/2/2025	WHIDBY,NICHELE (005421)	Adult Bridge (3612)
0	ASC - Non ETOH User	2/13/2023	Adult Bridge	GOULD,AMANDA (005372)	1/2/2025	WHIDBY,NICHELE (005421)	Adult Bridge (3612)
0	ASC - Non ETOH User	2/13/2023	MHC Intake	GOULD,AMANDA (005372)	1/2/2025	WHIDBY,NICHELE (005421)	Adult Bridge (3612)

# Screening for Depression Follow Up: (CDF-CH &AD)

Start date:  End date:

Program(s):  Clinician(s):

Episode status:

 **PHQ Modified Outcomes Report**  
*Life Changing.*

	Total PHQs	Improved	Unchanged	Declined	% Improved	% Improved or Unchanged
<b>Overall Summary Statistics</b>	11376	5364	3705	2307	47%	80%

Program	Current Assessment Date	Current Score	First Assessment Date	First Score	Score Improvement	Most Recent TX Plan Expiration	Future Appointment
MHC Intake	7/30/2024	0	12/14/2021	0	—	1/29/2025	HERNANDEZ,ANGELINA Med Injection 2025-01-03 09:00 AM
Womens Justice Team	7/12/2024	0	10/17/2017	21	▲	1/11/2025	
Adult Bridge	7/10/2024	15	6/28/2017	8	▼	1/9/2025	
MHC Intake	8/26/2024	6	6/18/2021	14	▲	2/25/2025	
Live Well	7/19/2024	5	2/21/2019	17	▲	1/18/2025	JONES,MELANIE Individual Counseling 2024-11-15 10:00 AM
MHC Adult Psychiatry	10/16/2024	18	8/12/2019	24	▲	11/14/2024	HERNANDEZ,ANGELINA Med Injection 2024-11-13 09:40 AM
MHC Intake	8/7/2024	7	11/6/2017	18	▲	2/6/2025	YOUNG,LANA Individual Rehab Treatment 2024-11-14 12:00 PM
MHC Adult Psychiatry	8/26/2024	7	11/6/2017	18	▲	2/6/2025	YOUNG,LANA Individual Rehab Treatment 2024-11-14 12:00 PM
MHC PACT 1	9/8/2024	2	10/9/2018	9	▲	3/31/2025	
MHC Intake	7/16/2024	3	9/6/2019	3	—	1/15/2025	GONZALEZ,DANIEL Care Coordination 2024-11-13 01:30 PM
	10/8/2024	12	11/14/2017	4	▼	4/16/2025	PARSONS,KAETE-MARIE Individual Rehab Treatment 2024-11-27 01:00 PM
	9/30/2024	6	5/20/2020	24	▲	3/29/2025	
MHC Adult Psychiatry	9/30/2024	8	5/20/2020	24	▲	3/29/2025	
MHC Intake	10/31/2024	0	5/22/2018	0	—	5/24/2025	STROH,ANDREA Individual Rehab Treatment 2024-12-02 08:00 AM
Pre Admit Substance Abuse Adults	11/11/2024	8	10/27/2017	10	▲	11/29/2024	
MHC Intake	8/21/2024	0	11/19/2018	24	▲	3/10/2025	MATHEWS,KIA Wellness Resource General 2024-11-18 01:00 PM
	8/19/2024	9	8/19/2024	9	—	2/18/2025	WATKINS,DEBRA Individual Counseling 2024-11-18 09:30 AM
MHC Adult Psychiatry	7/31/2024	12	5/1/2017	10	▼	4/29/2025	BRADLEY,MARISSA Follow Up Psychiatry 2024-11-13 10:00 AM
MHC Intake	10/30/2024	13	5/1/2017	10	▼	4/29/2025	BRADLEY,MARISSA Follow Up Psychiatry 2024-11-13 10:00 AM
MHC Adult Psychiatry	7/3/2024	7	5/18/2017	11	▲	5/6/2025	
MHC Intake	11/7/2024	11	5/18/2017	11	—	5/6/2025	
Live Well	8/26/2024	19	1/22/2018	15	▼	2/25/2025	YOUNG,LANA Targeted CM - SMI/SED/MIN 2024-11-15 09:00 AM
	7/22/2024	21	9/14/2018	20	▼	1/21/2025	CLARK,JODY Therapeutic Behavioral Service - PRSS 2024-11-14 01:00 PM
Adult Psych non-physician	7/1/2024	6	7/17/2017	19	▲	5/7/2025	COOLEY,FERNANDA Doxy - F/U 2024-12-03 02:30 PM
MHC Adult Psychiatry	8/23/2024	18	7/17/2017	19	▲	5/7/2025	COOLEY,FERNANDA Doxy - F/U 2024-12-03 02:30 PM



# Quality Measures Workgroups

- **FCS CCBHC Network of Champions**
  - High level
  - Q&A
  - CQI
  - Pilot
  - Demo reports
  - Action steps
  - Develop time limited workgroups
  - Updates and changes (FY to Calendar Yr)
  - Review outcomes

**CCBHC**  
**Clinic Collected Required Quality Measures**  
**2025**

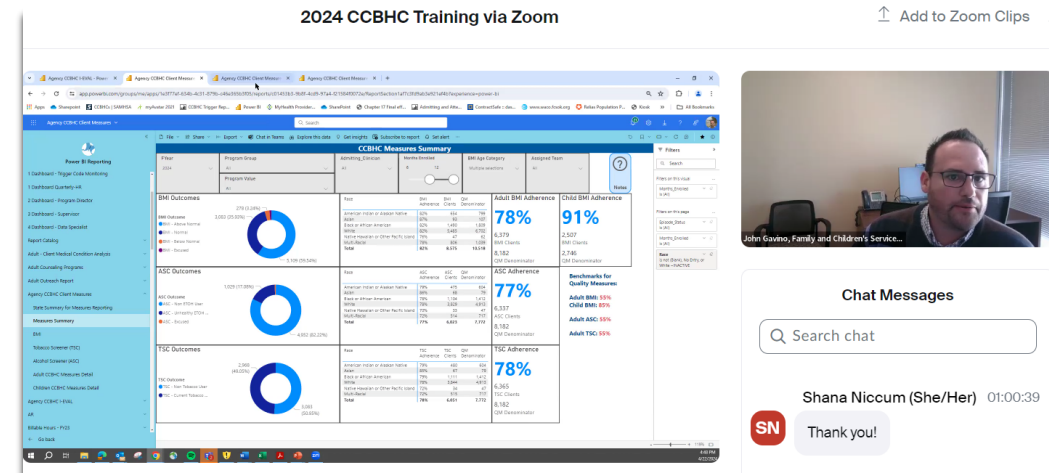
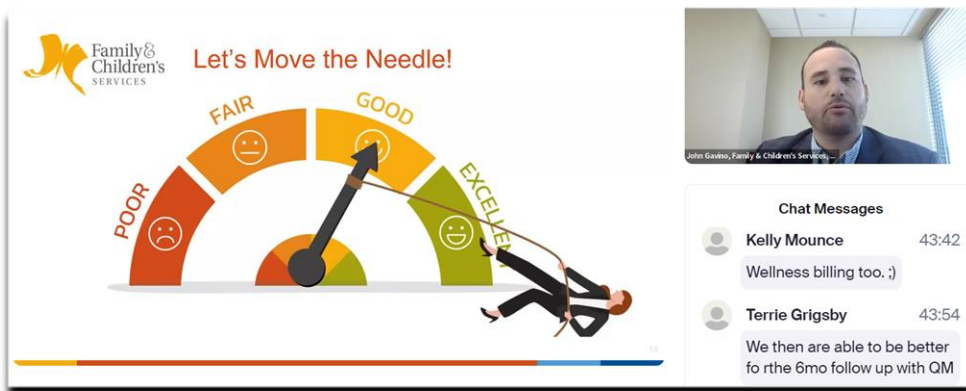
Time to Services (I-SERV)  
Social Drivers of Health  
Unhealthy Alcohol Use: Screening and Brief Counseling  
Screening for Depression & Follow-up Plan  
Depression Remission at Six Months  
Tobacco Use: Screening and Cessation Intervention  
Weight Assessment and Counseling

Family & Children's SERVICES

Participants: Angela Adamy, Angie Fineran, Ashlee Housley, Mary Ellen..., Lindsey G..., Kathy Loehr, Joe Meren..., Julie Foster, John Gavino, Alicia Zu...

# Quality Measures Workgroups

- CCBHC Training with Supervisors and Data Specialists
  - Program level details and specifics
  - Live program examples and workflows
  - Demo BI reports
  - Technical Assistance, Q&A
  - Encourage follow up questions
  - Updates and changes





# Quality Measures: Staff Trainings

- FCS CCBHC Network of Champions / CCBHC Training with Supervisors and Data Specialists

## Summary of Improvement! FY23 to Present



### Adult:

BMI, Tobacco, Alcohol Screen

- 50% to 78%
- ↑ 28% Improvement

### Child:

BMI

- 86% to 91%
- ↑ 5% Improvement



Let's Move the Needle!



# Last Quarter of Measurement Year

FYyy		Oct	Nov	Dec	Jan	Total
⊕ FY24	Open CCBHC Enrolled Client	11,775	12,026	12,047	12,202	<b>48,050</b>
	Active Enrolled CCBHC Client	10,502	10,757	10,667	10,757	<b>42,683</b>
	% of Active Enrolled CCBHC Client	89%	89%	89%	88%	<b>89%</b>
	Active Enrolled Clients with Trigger Service	8,887	8,991	8,643	9,264	<b>35,785</b>
	% of Active Enrolled CCBHC Client w Trigger (of Total Active)	85%	84%	81%	86%	<b>84%</b>
	% of Active Enrolled CCBHC Client w Trigger (of Total Open)	75%	75%	72%	76%	<b>74%</b>

# Top Performers and Feedback

- Service code report to show who our top 30 staff.
- Obtain feedback on the measures and workflows.



Position	Svc Count	Clients	Position (Top 30 Staff)	Count
Family Support Provider	566	560	Care Coordinator/Case Manager	11
Therapist	652	521	Therapist	10
Therapist	944	476	Nurse	4
PRSS	986	463	PRSS	4
Care Coordinator	857	437	Family Support Provider	1
Nurse	849	400	<b>Grand Total</b>	<b>30</b>
Therapist	396	392		
Care Coordinator	821	387		
Therapist	670	331		
Therapist	593	298		
Care Coordinator	584	293		
Therapist	561	280		
PRSS	606	262		
Care Coordinator	494	237		
Nurse	537	236		
Care Coordinator	465	234		
PRSS	462	231		
Case Manager	465	224		
Care Coordinator	462	223		
Nurse	424	214		
Case Manager	515	205		
Care Coordinator	412	204		
Care Coordinator	462	200		
Nurse	418	197		
PRSS	466	185		
Therapist	394	159		
Therapist	402	157		
Therapist	487	151		
Therapist	442	134		
Care Coordinator	429	121		



# What Is Working?

- Client improved outcomes
- Reports give us the information we need.
- Workflows on who manages the data and roles of staff for follow up activities
- Wellness services, connect to PCP & Nursing.
- Integrated and holistic care.
- Collaborate w/ physical health providers and other treatment facilities (ASAM, Detox, and Residential Treatment).
- Show stakeholders we are improving client's health outcomes.
- Show the incremental gains teams are making to reach their goals.
- QM forms are a vehicle to start the conversation for treatment and get to the outcomes. Outcomes tell the story.
- SDoH form found it much more useful and insightful than the other QM forms.
- Complete Quality Measures at Intakes and Care Plan Updates.
- Supervisor leads discussion in huddles and reports help with data tracking.
- Supervisors champion this initiative, how it benefits clients, staff, and program.
- Team effort on collecting Quality Measures.

# What Could Be Better?

- The process is time consuming.
- Competing priorities for developing the BI reports from the development team.
- Increasing staff and client investment and motivation to engage in quality measures.
- Incentives: wellness budget, resource room, thrift store tokens (active wear), nutrition groups, MyPlate portion food plates, MyStrength, water bottles, tape measures, pedometers, jump ropes
- How to motivate staff even when it feels like a compliance measure?
- Some Clients with SUD have difficulty remembering how many times they have drank X amount of drinks in the last year.
- QM at times seems repetitive along with other state requirements.

## As you went through this transition, are there any key lessons learned or things you wish you knew before you started that might be helpful for us?

- Fortunate for Medicaid Expansion and support from ODMHSAS.
- Executive Leadership support and involvement
- Dedicated staff solely focused on the CCBHC compliance and fidelity.
- Several change champions and workgroups.
- Add key positions in clinical, compliance, quality, and data.
- Breaking down silos or departments to streamline CCBHC workflows and build upon process improvements and to ensure programs don't fall behind.
- Participate in the trainings and resources such as National Council TA, SAMHSA, and your state department.
- Collaborate with other CCBHCs
- Things take longer than expected and do constant CQI/training.

# Data Sharing With The State

AutoSave Off SPA Quality Measures Template - Read-Only

File Home Insert Draw Page Layout Formulas Data Review View Automate Help Acrobat

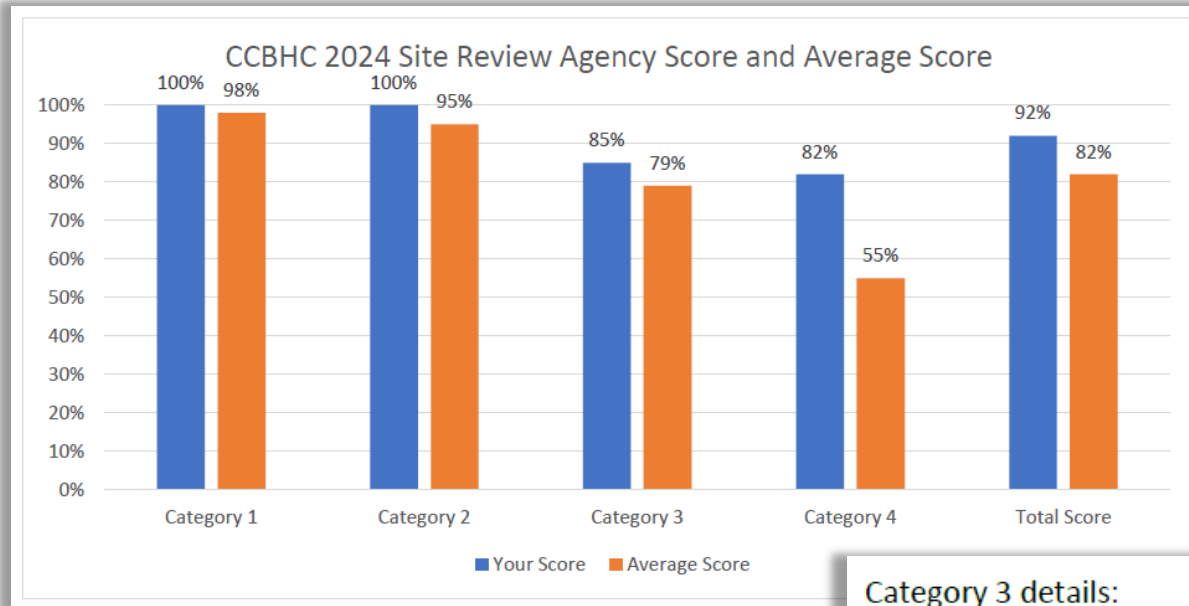
Clipboard Font Alignment Number Styles Cells

T9

Case Load Characteristics		
Characteristic	Number	Percent
<b>Age</b>		
0-11 years		
12-17 years		
18-64 years		
65+ years		
<b>Gender</b>		
Women		
Men		
Other		
Unknown		
<b>Ethnicity</b>		
Not Hispanic or Latino		
Hispanic or Latino		
Unknown		
<b>Race</b>		
White		
Black or African American		
American Indian or Alaskan Native		
Asian		
Native Hawaiian or Pacific Islander		
More than one Race		
Unknown		
<b>Insurance Status</b>		
Medicaid (any Medicaid program)		
Medicare		
Medicare and Medicaid Dually-Eligible		
VHA/TRICARE		
Commercially insured		
Uninsured		
Other		
<b>Veteran or Military Status</b>		
Active Duty Military		
Prior Military Service/Veteran		
Neither		
<b>Total Clinic Population</b>		

Facility-Lead Measures case load characteristics I-EVAL BMI-SF WCC-BH TSC ASC State-Lead CCBHC Measures FUM FUA PCR-BH SSD

# Fidelity Review Data Outcomes



## Category 3 details:

Item #	Reviewed	Agency Score Per Item
17	Initial Evaluation	99%
18	Primary Care Screening/Monitoring	95%

Item #	Reviewed	Avg Score Per Item
17	Initial Evaluation	90%
18	Primary Care Screening/Monitoring	82%



# Benchmarking: IEVAL Adult

CCBHC_Age_Category	iEval in Range	Total Client	%
<input checked="" type="checkbox"/> <b>18 years or older</b>	<b>5,337</b>	<b>8,169</b>	<b>65%</b>
American Indian or Alaskan Native	373	584	64%
Asian	48	67	72%
Black or African American	848	1,485	57%
White	3,378	5,096	66%
Native Hawaiian or Other Pacific Island	30	43	70%
Multi-Racial	660	894	74%

5.9
Avg Calendar Days (Everyone)
3.5
Avg Calendar Days (Have iEval in Range)

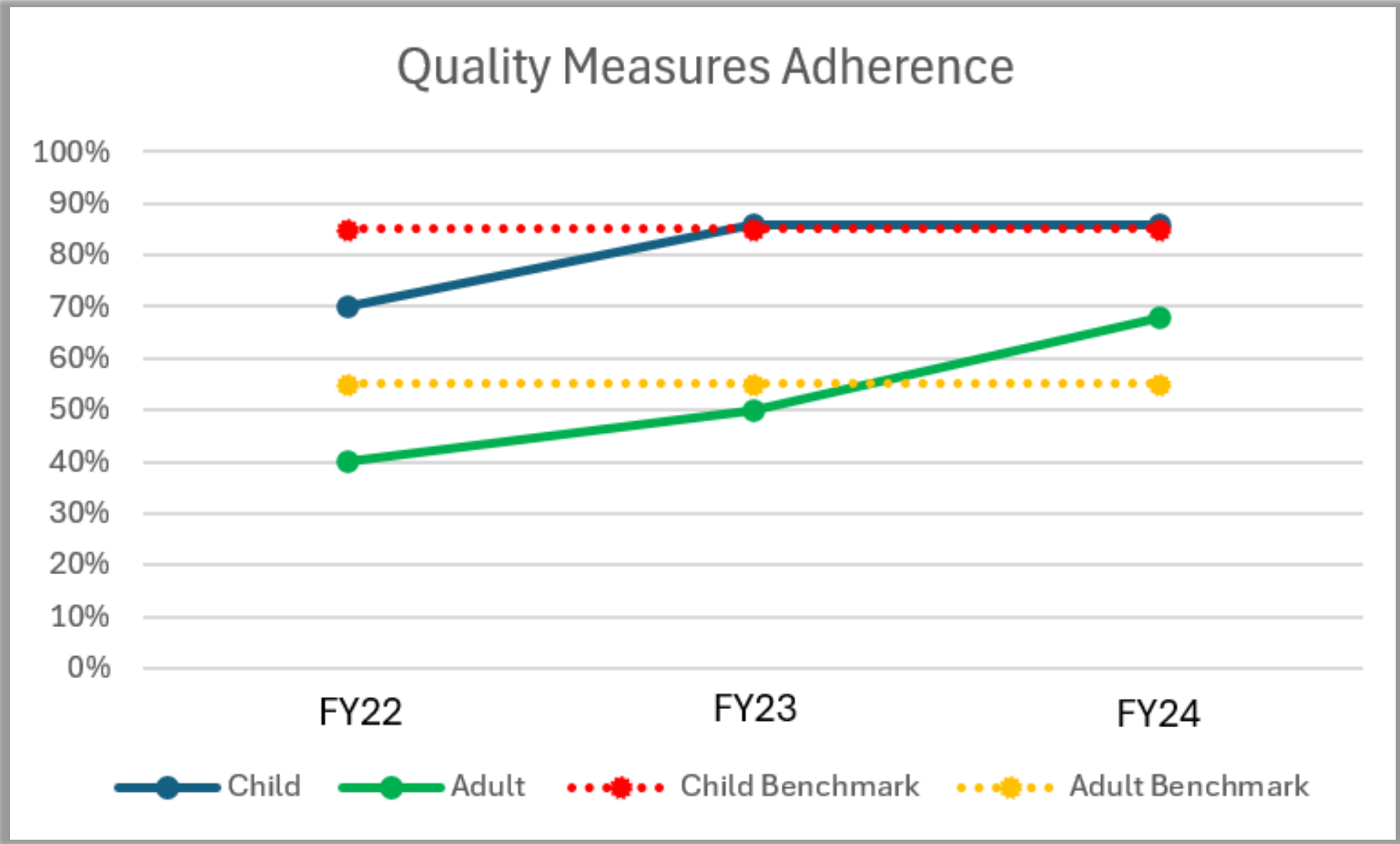
Initial Evaluation for New Clients Adult ( age 18+)			
	Denominator	% within 10 days	Average # days
MN	10,923	40%	20.3
MO	31,177	70%	10.1
NJ	10,715	81%	7.5
NV	1,596	89%	4.3
NY	16,922	82%	5.9
OK	10,684	71%	4.9
OR	11,793	66%	8.0
PA	5,242	72%	4.9
<b>Aggregate</b>	<b>99,052</b>	<b>69%</b>	<b>9.0</b>

# Benchmarking: Unhealthy Alcohol Screening Adult

ASC Adherence (18+)			
Race	ASC Clients	QM Denominator	ASC Adherence
American Indian or Alaskan Native	469	672	70%
Asian	64	86	74%
Black or African American	1,180	1,677	70%
White	4,063	5,740	71%
Native Hawaiian or Other Pacific Island	38	56	68%
Multi-Racial	594	880	68%
<b>Total</b>	<b>6,408</b>	<b>9,111</b>	<b>70%</b>

	Unhealthy Alcohol Use Screening and Brief Counseling	
	Denominator	%
<b>Aggregate</b>	<b>144,360</b>	<b>62%</b>
MN	9,605	51%
MO	37,596	54%
NJ	10,080	76%
NV	353	84%
NY	29,671	69%
OK	15,333	65%
OR	28,100	58%
PA	13,622	42%

# Benchmarking and CQI



## How have you been able to improve client experiences and outcomes using the CCBHC model?

- Satisfaction Surveys
- CCBHC Needs Assessment
- CQI
- Evaluate client outcomes
- Client interviews/focus groups
- Review grievances and complaints
- Staff/leadership input/walkthroughs
- CCBHC advisory board
- Expand access, service menu, Quality Measures, and capacity
- Additional services such as Health and Wellness Groups, Care Coordination with PCP, IOP and continuum of care services, community providers
- Staffing -better access, lower staff to client ratios, and improve client outcomes
- Data informed and driven
- Technical Assistance and Site Reviews/Audits focus

# Q & A

- Questions?



Thank you!

# Office Hours for CCBHC Demo Sites

## Have Questions? We've Got Answers!

Drop by our monthly office hours for an open, friendly space to ask anything about this month's topic, next month's focus, or general inquiries. Plus, learn from peers facing similar challenges!

## Upcoming Office Hours: January 17, 2025, at 1-2 pm E.T

- Cadence: Every second Friday from 1-2 pm E.T (\*except for January and July 2025 due to Holidays).

[Register here.](#)





# Other QM Resources for States & Clinics

- Clinic-Collected Quality Measures Resources

- Building Infrastructure for Clinical Quality Measures: Session 1 [recording and slides](#)
- Building Infrastructure for Clinical Quality Measures: Session 2 [recording and slides](#)
- Building Infrastructure for Clinical Quality Measures: Session 3 [\(recording and slides coming soon\)](#)
- I-SERV, SDOH, ASC Webinar [recording](#) and [slides](#).
- CDF-AD and CH, DEP-REM-6 Webinar [recording](#) and [slides](#).
- TSC, SRA-A and C, WCC-CH, CBP-AD Webinar [recording](#) and [slides](#).
- Clinic Quality Measures Office Hours [recording](#) and [slides](#).

- State-Collected Quality Measures Resources

- AMM, SAA, ADD, OUD, HBD, PEC & YFEC Webinar [recording](#) and [slides](#).
- FUH, FUM, FUA, IET, and PCR Webinar [recording](#) and [slides](#).
- State Quality Measures Office Hours, Part 1 [recording](#) and [slides](#).
- State Quality Measures Office Hours, Part 2 [recording](#) and [slides](#).



# Coming soon...

## CCBHC Designated Collaborating Organizations: Frequently Asked Questions

The DCO FAQ document answers questions the National Council for Mental Wellbeing receives frequently about the DCO model. Information in the document is current as of January 2025 and will be updated should additional guidance on DCOs be published by the SAMHSA or the Centers for Medicare and Medicaid Services (CMS).



# CCBHC Success Center Support

CCBHC Success Center News and Events  
Subscription Link:

<https://www.thenationalcouncil.org/program/ccbhc-success-center/implementation-support/#subscribe-form>.

Questions? Contact us at:

[CCBHC@TheNationalCouncil.org](mailto:CCBHC@TheNationalCouncil.org)

Visit our Success Center website at:

<https://www.thenationalcouncil.org/program/cbhc-success-center/>



# Thank You!

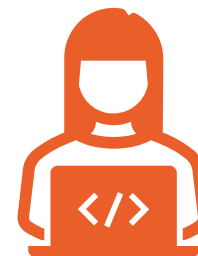
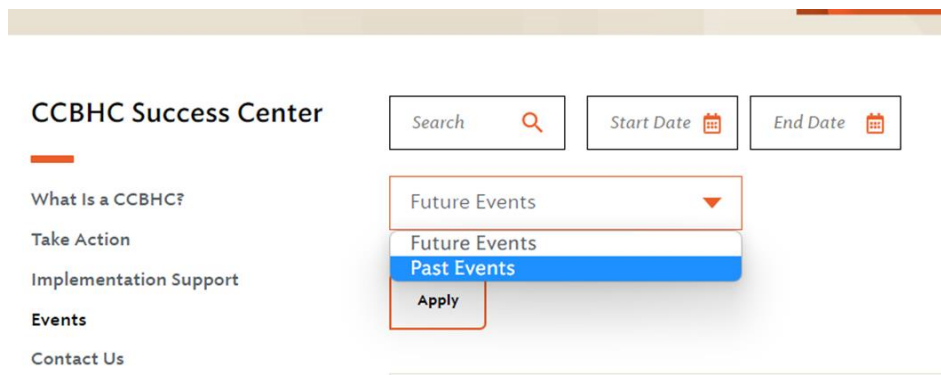
Thank you for attending today's webinar.

Slides and the session recording link will be available on the CCBHC Success Center website under "Events" > "Past Events" within 2 business days.

Your feedback is important to us!

Please complete the [brief event survey](#) that will open in a new browser window at the end of this meeting.

*You may also scan the QR code (below) to fill out the survey!*



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