Clinic-Collected-Optional Measures:

Tobacco Use: Screening & Cessation Intervention (TSC)
Major Depressive Disorder: Suicide Risk Assessment (SRA-A and SRA-C)
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC-CH)
Controlling High Blood Pressure (CBP-AD)

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U.S. Department of Health and Human Services

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2:30-4:00 PM ET

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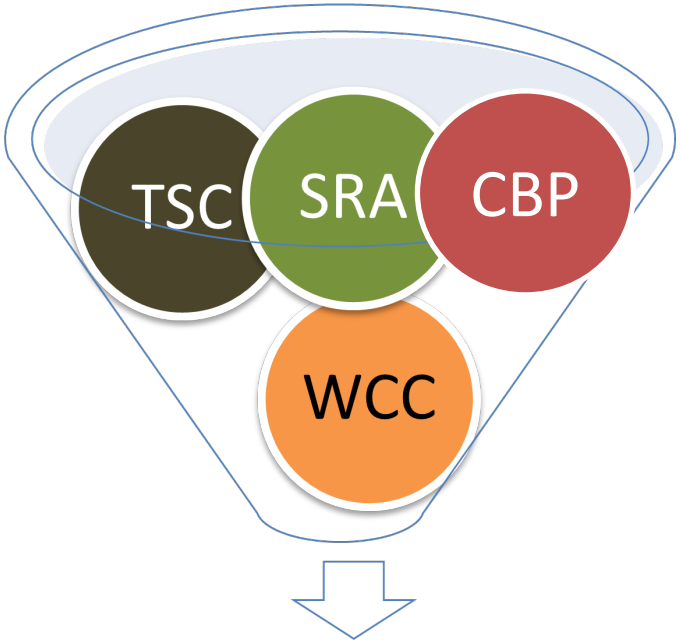
Logistics

- This webinar is being recorded and closed captioning is provided. The recording will be available about a week after the presentation and will be posted on the SAMHSA CCBHC website for later reference.
- Please mute your lines (Thank you!).
- We will have time for discussion and questions at the end. In the meantime, please put questions in the Q&A rather than the chat. We will address them at the end.

Intended audience for this webinar

1. Prospective and existing CCBHC Section 223 Demonstration state staff and CCBHCs
2. Independent state CCBHC initiative personnel
3. CCBHC-Expansion (CCBHC-PDI and -IA) grant clinics and SAMHSA GPOs

Today's Clinic-Collected Optional Measures



Identifying Need and Providing a Response

CBP: Controlling High Blood Pressure
SRA: Suicide Risk Assessment
TSC: Tobacco Screening & Cessation Intervention
WCC: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

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Poll #1--Clinics Only

I work at a clinic that is (identify one best answer):

1. An existing Section 223 demonstration CCBHC
2. A CCBHC-PDI or IA that is **not** also in an existing Section 223 demonstration state
3. Neither of the above
4. I am unsure

Poll #2—Current Demonstration Clinics Only

If you work at a clinic that is an existing Section 223 demonstration CCBHC, do you know whether your state will require any of the optional clinic-collected measures for CY 2025 and beyond? (select one best answer)

1. No, I have heard nothing about my state requiring collection of any optional measures in 2025 and beyond.
2. Yes, I know that my state will require one or more of the optional clinic-collected measures in 2025 and beyond.
3. I am uncertain.

Tobacco Use: Screening & Cessation Intervention (TSC)

Who?
Clients aged 18 years and older

Why?
Assessment of need and initial intervention

TSC Measure: Description and Source

- The TSC measure calculates the percentage of clients aged 18 years and older who were screened for Tobacco Use one or more times within the Measurement Year AND who received a Tobacco Cessation Intervention during the Measurement Year or in the six months prior to the Measurement Year if identified as a tobacco user. Three submeasures:
  - ✓ Screening for Tobacco Use
  - ✓ After a positive screen, received a Tobacco Cessation Intervention
  - ✓ Screening and, if positive, intervention
- Source: CMS MIPS CQMS #226 (2023), which is derived from a measure stewarded by NCQA

MIPS: Merit-based Incentive Payment System; **CQMs:** Clinical Quality Measures; **NCQA:** National Committee for Quality Assurance

TSC Measure: Importance and Uses

- Importance: The US Preventive Services Task Force (USPSTF) recommends that clinicians ask all adults about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and U.S. Food and Drug Administration (FDA)-approved pharmacotherapy for cessation in adults who use tobacco (Grade A Recommendation) (U.S. Preventive Services Task Force, 2021).
- Use for Quality Improvement:
  - ✓ Implementation of routine screening
  - ✓ Provision of cessation intervention for adults who screen positive for use

TSC Measure: Data Source and Measurement Period

- Data source: Medical records (e.g., electronic health records)
- Measurement Period (aka, the time period data must cover): The Measurement Period for the ***denominator*** for all TSC submeasures is the Measurement Year. The Measurement Period for the ***numerator***, for submeasure 1, is the Measurement Year and, for submeasures 2 and 3, is the Measurement Year **and the prior six months**.

A Look-back period

aka: also known as

TSC Submeasure #1 -- Screening

TSC Submeasure #1: Calculation of Denominator

- Denominator is all clients in the Eligible Population:
  - ✓ All **clients** receiving at least **one CCBHC preventive service** or **two nonpreventive encounters** (identified by the listed Current Procedural Terminology [CPT®] **encounter codes** in the specification) during the Measurement Year
  - ✓ **Age** 18 years or older on date of service during the Measurement Year
  - ✓ **Excluding:** specific requirements related to **hospice use**
- Stratification: **payer, race, ethnicity**

Bold indicates data need.

TSC Submeasure #1: Calculation of Numerator

- Numerator is:
  - ✓ All **clients in the Denominator**
  - ✓ Numerator Met:
    a) Who **screened positive** for tobacco use during the Measurement Year, or
    b) Who **screened negative** for tobacco use during the Measurement Year
  - ✓ Numerator Not Met: Who were **not screened** for tobacco use during the Measurement Year

- **Documentation that screening happened (and the result (+/-))** or **did not happen during the MY**: identified with **code** in specification or equivalent information source

Bold indicates data need.

TSC Submeasure #1: Practice Example

Denominator

Number of people receiving CCBHC service in Measurement Year (MY)	2,500
Of those, service was one of the appropriate encounter codes	2,300
Of those, 18 or older at date of service	1,500
Of those, no hospice use during the MY	1,400
Denominator	**1,400**

Numerator

Number in Denominator	1,400
Screened positive during MY	850
Screened negative during MY	325
Not screened during MY	225
Numerator	**1,175**

TSC rate #1 = 1,175/1400 = .84 or 84%

TSC Submeasure #2 -- Tobacco Cessation Intervention

TSC Measure: Calculation of Denominator #2

- Denominator is all clients in the Eligible Population:
  - ✓ All **clients** receiving at least **one CCBHC preventive service** or **two nonpreventive encounters** (identified by the listed Current Procedural Terminology [CPT®] **encounter codes** in the specification) during the Measurement Year
  - ✓ **Age** 18 years or older on date of service during the Measurement Year
  - ✓ **Excluding:** specific requirements related to **hospice use**
  - ✓ Who were **screened for tobacco use and identified as a tobacco user in the numerator of Submeasure 1**
- Stratification: **payer, race, ethnicity**

Bold indicates data need.

TSC Measure: Calculation of Numerator #2

- Numerator is:
  - ✓ All **clients in the Denominator** of submeasure #2
  - ✓ Performance Met: Who **received tobacco cessation intervention during the MY or in the six months prior**
  - ✓ Performance Not Met: Who did not **receive tobacco cessation intervention during the MY or in the six months prior**
- **Documentation that intervention happened** or **did not happen during the MY or in the 12 months before that visit**: identified with **code** in specification or equivalent information source

Bold indicates data need.

TSC Submeasure #2: Practice Example

Denominator

Number receiving CCBHC service in Measurement Year (MY)	2,500
Of those, service was one of the appropriate encounter codes	2,300
Of those, 18 + at date of service	1,500
Of those, no hospice use	1,400
Of those, screened positive for tobacco use during the MY or in the 6 mos. prior to the MY	850
Denominator	**850**

Numerator

Number in Denominator	850
Received intervention	600
Did not receive intervention	250
Numerator	**600**

TSC rate #2 = 600/850 = .71

TSC Submeasure #2: Tobacco Cessation Intervention Defined

For purposes of the TSC measure, a tobacco cessation intervention includes brief counseling (3 minutes or less), and/or pharmacotherapy.

Note: Concepts aligned with brief counseling (e.g., minimal and intensive advice/counseling interventions conducted both in person and over the phone) are included in the numerator. Other concepts such as written self-help materials (e.g., brochures, pamphlets) and complementary/alternative therapies do not qualify for the numerator. Counseling also may be of longer duration or be performed more frequently, as evidence shows that higher-intensity interventions are associated with higher tobacco cessation rates.

TSC Submeasure #3 – Screening & Intervention

(***Providers need not use submeasure 3 unless they were reporting TSC as part of MIPS before 2018.***)

TSC Submeasure #3: Calculation of Denominator

- Denominator is all clients in the Eligible Population:
  - ✓ All **clients** receiving at least **one CCBHC preventive service** or **two nonpreventive encounters** (identified by the listed Current Procedural Terminology [CPT®] **encounter codes** in the specification) during the Measurement Year
  - ✓ **Age** 18 years or older on date of service during the Measurement Year
  - ✓ **Excluding:** specific requirements related to **hospice use**
- Stratification: **payer, race, ethnicity**

Bold indicates data need.

TSC Measure: Calculation of Numerator #3

- Numerator is:
  - ✓ All **clients in the Denominator**
  - ✓ Who, during the Measurement Year or six months prior:
    - Performance Met: (a) **screened positive** for tobacco use and **received tobacco cessation intervention** OR (b) **screened negative** for tobacco use
    - Performance Not Met: (a) were **not screened** for tobacco use OR (b) were **screened, found positive, and no tobacco cessation intervention** was provided
  - **Documentation that screening happened (and the result (+/-)); if positive, that tobacco cessation intervention occurred or did not occur during the MY or in the 6 months prior**: identified with **code** in specification or equivalent information source

Bold indicates data need.

TSC Submeasure #3: Practice Example

TSC rate #3 = 975/1400 = .70

Denominator

Number of people receiving CCBHC service in Measurement Year (MY)	2,500
Of those, service was one of the appropriate encounter codes	2,300
Of those, 18 or older at date of service	1,500
Of those, no hospice use during the MY	1,400
Denominator	**1,400**

Numerator

Number in Denominator	1,400
Not screened during MY or the six months before	225
Screened positive for tobacco use during MY or prior six months	850
Screened positive and received tobacco cessation intervention	650
Screened positive and did not receive intervention	200
Screened negative for tobacco use	325
Numerator	**975**

TSC: To Do in 2024, if you are going to use TSC

Needed for the TSC Measure:

1. Begin preparation for tobacco use screening and tobacco cessation intervention
2. Determine where, when, and how in the clinic workflow screening and, if needed, intervention, will be implemented and documented
3. Prepare documentation systems needed to capture whether screening and, if needed, intervention have occurred
4. Train staff regarding screening, intervention, and documentation
5. Begin collecting data for the numerator by July 1, 2024
6. Determine if you fall into a category that does not need to report submeasure 3 and, if so, whether you will calculate it anyway

Major Depressive Disorder: Suicide Risk Assessment (SRA-A and SRA-C)

Who?
Clients six (6) years and older with Major Depressive Disorder

Why?
Assessment of need

SRA-A Measures: Description and Source

- SRA-A calculates the 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 (SRA) was completed during the visit.
- This is an episode-based measure.
- Source: MIPS eCQM ID CMS161v11 (2023), stewarded by Mathematica Policy Research

CMS: Centers for Medicare & Medicaid Services; **MIPS eCQM:** Merit-based Incentive Payment System electronic Clinical Quality Measures

SRA-C Measures: Description and Source

- SRA-C calculates the 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
- This is an episode-based measure.
- Source: MIPS eCQM ID CMS177v11 (2023), stewarded by Mathematica Policy Research

CMS: Centers for Medicare & Medicaid Services; **MIPS eCQM:** Merit-based Incentive Payment System electronic Clinical Quality Measures

SRA-A & SRA-C Measures: Importance and Uses

- Importance: “In 2021, suicide was among the top 9 leading causes of death for people ages 10-64. Suicide was the second leading cause of death for people ages 10-14 and 20-34.” (CDC, 2023a)
- Use for Quality Improvement:
  - ✓ Implementation of routine suicide risk assessment in those with Major Depressive Disorder.
  - ✓ Identifies those in need of further intervention upon assessment.
- Potential use for PPS

SRA-A & SRA-C Measures: Data Source and Measurement Period

- Data source: Electronic medical records
- Links to eCQMs:
  - ✓ Adult: 2023 eCQM ID CMS161v11
  - ✓ Child: 2023 eCQM ID CMS177v11
- Measurement Period (aka, the time period data must cover): The Measurement Period for both the denominator* and the numerator is the Measurement Year.

* For the adult denominator, to determine if an episode is recurrent, you will need to be able to look back 105 days to determine if it is recurrent or on-going (i.e., was there a MDD diagnosis for the person in the past 105 days? If yes, it is not new or recurring. If no, it is either new or recurring.)

aka: also known as

SRA-A & SRA-C Measures: Calculation of Denominator

- Denominator includes all clients in the Eligible Population:
  - ✓ All visits of **clients** receiving a **CCBHC service** during the Measurement Year
  - ✓ Who fall into the appropriate **age** range (Adult/Child) during the Measurement Year:
    - ✓ Adult: Turn 18 years or older during the MY when a new diagnosis of MDD, single or recurrent episode, is identified
    - ✓ Child: Age 6 through 17 years with a diagnosis of MDD.
- Stratification: **payer, race, ethnicity**

SRA-A & SRA-C Measures: Calculation of Numerator

- Numerator is:
  - ✓ All **visits identified as constituting the Denominator:**
    - ✓ Adult: new diagnosis of MDD, single or recurrent episode, was identified
    - ✓ Child: any visit with a diagnosis of MDD
  - ✓ Where a **Suicide Risk Assessment (SRA) was completed** during the visit
    - ✓ For adults, an SRA should be completed at the visit during which a new diagnosis is made or at the visit during which a recurrent episode is first identified. For the purposes of this measure, an episode of MDD would be recurrent if a client has not had an MDD-related encounter in the past 105 days. If there is a gap of 105 or more days between visits for MDD, that would imply a recurrent episode. The 105-day look-back period is an operational provision and not a clinical recommendation, or definition of relapse, remission, or recurrence.
    - ✓ For those younger than 18, an SRA should be performed at every visit for MDD during the Measurement Period.

SRA-A Measure: Practice Example

Denominator

Number CCBHC visits by people receiving a CCBHC service in Measurement Year (MY)	9,867
Of those, visits in which a new diagnosis of MDD, single or recurrent episode, is identified AND the client is age 18 or older at some point during the MY	1,750
Denominator	**1,750**

Numerator

Number in Denominator	1,750
SRA conducted during each of those visits	1,700
SRA not conducted during each of those visits	50
Numerator	**1,700**

SRA-A rate = 1,700/1,750 = .97 or 97%

SRA-C Measure: Practice Example

Denominator

Number CCBHC visits by people receiving a CCBHC service in Measurement Year (MY)	9,867
Of those, visits in which a client ages 6 through 17 years has a diagnosis of MDD	3,400
Denominator	**3,400**

Numerator

Number in Denominator	3,400
SRA conducted during each of those visits	2,500
SRA not conducted during each of those visits	900
Numerator	**2,500**

SRA-C rate = 2,500/3,400 = .74 or 74%

SRA-A Resources

A Suicide Risk Assessment is defined as follows in the measure specification:
"The specific type and magnitude of the suicide risk assessment is intended to be at the discretion of the individual clinician and should be specific to the needs of client. At a minimum, suicide risk assessment should evaluate:

1) Suicidal ideation
2) Client's intent of initiating a suicide attempt

AND, if either is present,

3) Client plans for a suicide attempt
4) Whether the client has means for completing suicide

Low burden tools to track suicidal ideation and behavior such as the Columbia-Suicide Severity Rating Scale (C-SSRS) and the Suicide Assessment Five-Step Evaluation and Triage (SAFE-T) can also be used. Because no validated assessment tool or instrument fully meets the aforementioned requirements for the suicide risk assessment, individual tools or instruments have not been explicitly included in coding."

SRA-C Resources

A Suicide Risk Assessment is defined as follows in the measure specification:

“The specific type and magnitude of the suicide risk assessment is intended to be at the discretion of the individual clinician and should be specific to the needs of the client. At a minimum, suicide risk assessment should evaluate:

1. Risk (e.g., age, sex, stressors, comorbid conditions, hopelessness, impulsivity) and protective factors (e.g., religious belief, concern not to hurt family) that may influence the desire to attempt suicide.
2. Current severity of suicidality.
3. Most severe point of suicidality in episode and lifetime.

Low burden tools to track suicidal ideation and behavior such as the Columbia-Suicidal Severity Rating Scale can also be used. Because no validated assessment tool or instrument fully meets the aforementioned requirements for the suicide risk assessment, individual tools or instruments have not been explicitly included in coding.”

According to the 2023 electronic specification, “Use of a standardized tool(s) or instrument(s) to assess suicide risk will meet numerator performance, so long as the minimum criteria noted above is evaluated. Standardized tools can be mapped to the concept "Intervention, Performed": "Suicide risk assessment (procedure)" included in the numerator logic [in the current electronic specification], as no individual suicide risk assessment tool or instrument would satisfy the requirements alone.”

SRA Measures: To Do in 2024, if you are going to use SRA-A or SRA-C

Needed for the SRA-A and SRA-C Measure:

1. Begin preparation for suicide risk assessment (SRA) for all children with a MDD diagnosis and for all adults where MDD is newly identified or a new recurrence is identified
2. Determine where, when, and how in the clinic workflow SRA will be implemented and documented
3. Prepare documentation systems needed to capture whether an SRA was conducted and the results obtained
4. Train staff regarding conducting SRAs and documentation thereof

Also VERY Important:

1. If an SRA indicates risk of suicide or self-harm, be prepared to respond with an appropriate intervention (and to document it)

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC-CH)

Who?
Children and adolescents ages 3 to 17

Why?
Assessment of need and initial intervention

WCC-CH Measure: Description and Source

- WCC-CH calculates the percentage of children ages 3 to 17 who had an outpatient visit with a primary care practitioner (PCP) or obstetrician/gynecologist (OB/GYN)* and who had evidence of the following during the measurement year:
  - ✓ Body mass index (BMI) percentile documentation
  - ✓ Counseling for nutrition
  - ✓ Counseling for physical activity
- Source: CMS Medicaid Child Core Set Measure (2023), which is derived from a measure stewarded by NCQA

* Medical personnel beyond PCPs or OB/GYNs can conduct services contemplated within the specification, if they operate within the scope of their licensure. Because this is a deviation from the measure Technical Specification, the deviation should be indicated in the section of the data reporting template where adherence or non-adherence to the Technical Specification is reported.

CMS: Centers for Medicare & Medicaid Services; **NCQA:** National Committee for Quality Assurance

WCC-CH Measure: Importance and Uses

- Importance: In the United States in 2017–March 2020, “among children and adolescents aged 2–19 years, the prevalence of obesity was 19.7%” (Stierman B, et al., 2021).
- Use for Quality Improvement:
  - ✓ Permits awareness of important physical health indicator in children and adolescents
  - ✓ Provides information important for whole person care in response to need among youth served
- Potential use for PPS

WCC-CH Measure: Data Source and Measurement Period

- Data source: Administrative, hybrid, or electronic health record [if you are to use this, the most current electronic health record specification, as referenced in the Medicaid Child Core Set, is at eCQI Resource Center
- Measurement Period (aka, the time period data must cover): The Measurement Period for the WCC **denominator** and **numerator** is the Measurement Year.

aka: also known as

WCC-CH Measure: Calculation of Denominator

- Denominator is all clients in the Eligible Population:
  - ✓ All **clients** with an outpatient visit during the Measurement Year.
  - ✓ **Age** 3 to 17 as of December 31 of the Measurement Year
  - ✓ **Excluding:**
    - ✓ Clients in hospice care or who were pregnant during the Measurement Year.
    - ✓ Optional exclusion: If client died during Measurement Year.
- Stratification: **payer, race, ethnicity**

WCC-CH Measure: Calculation of Numerator

- Numerator is:
  - ✓ All **clients in the Denominator:**
    - ✓ Submeasure #1: Whose BMI profile was recorded during the Measurement Year
    - ✓ Submeasure #2: Who received counseling regarding nutrition during the Measurement Year
    - ✓ Submeasure #3: Who received counseling regarding physical activity during the Measurement Year

Note: Counseling may be to the caregiver, as appropriate.

WCC-CH Measure (submeasure #1): Practice Example

Denominator

Number of people receiving CCBHC service in Measurement Year (MY)	2,500
Of those, service was one of the appropriate outpatient encounter codes	2,300
Of those, age 3-17 years on Dec. 31, MY	545
Of those, no exclusion met during the MY	489
Denominator	**489**

Numerator

Number in Denominator	489
BMI properly recorded during MY	350
BMI not recorded during MY	139
Numerator	**350**

WCC-CH rate #1 = 350/489 = .72 or 72%

WCC-CH Measure: To Do in 2024, if you are going to use WCC-CH

For the measure:

- Begin to ensure that BMI, counseling for nutrition, and counseling for physical activity are captured at least annually for children and youth and the results are documented
- Prepare documentation systems needed to capture results of BMI and counseling and that relevant staff are trained to use that system
- Train relevant staff in low burden counseling for nutrition and physical activity

Also important:

- When BMI indicates physical issues around weight (high or low), ensure referral is made for any relevant interventions if they cannot be provided in the clinic

Controlling High Blood Pressure (CBP-AD)

Who?
Adults ages 18 to 85

Why?
Monitoring of need

CBP-AD Measure: Description and Source

- CBP-AD calculates the percentage of clients ages 18 to 85 who had a diagnosis of hypertension and whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year.
- Source: CMS Medicaid Adult Core Set Measure (2023), which is derived from a measure stewarded by NCQA

CMS: Centers for Medicare & Medicaid Services; **NCQA:** National Committee for Quality Assurance

CBP-AD Measure: Importance and Uses

- Importance: In the United States in 2017–March 2020, “among adults aged 18 and over, the age-adjusted prevalence of hypertension was 45.1%” (Stierman B, et al., 2021).
  - ✓ The US Preventive Services Task Force (USPSTF) recommends screening for hypertension in adults 18 years or older (Grade A Recommendation) (USPSTF, 2021).
- Use for Quality Improvement:
  - ✓ Permits awareness of important physical health indicator
  - ✓ Provides information important for provision of whole person care
- Potential use for PPS

CBP-AD Measure: Data Source and Measurement Period

- Data source: Administrative, hybrid, or electronic health record [if you are to use this, the most current electronic health record specification, as referenced in the Medicaid Adult Core Set, is at https://ecqi.healthit.gov/ecqm/ec/2022/cms165v10]
- Measurement Period (aka, the time period data must cover): The Measurement Period for the CBP-AD **denominator** is the Measurement Year **and the prior year** and, for the **numerator**, is the Measurement Year.

A look-back period

aka: also known as

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CBP-AD Measure: Description of Denominator

- Denominator is all clients in the Eligible Population:
  - ✓ All **clients** who had at least two visits (satisfying encounter codes) on different dates of service with a diagnosis of hypertension on or between January 1 of the year prior to the Measurement Year and June 30 of the Measurement Year.
  - ✓ **Age** 18 -85 years of age
  - ✓ **Excluding:**
    - ✓ Required exclusions include requirements related to hospice or palliative care
    - ✓ Optional exclusions include requirements related to frailty, advanced illness, dementia, kidney disease, pregnancy, nonacute inpatient admissions, or death during the Measurement Year
- Stratification: **payer, race, ethnicity**

CBP-AD Measure: Calculation of Numerator

- Numerator is:
  - ✓ All **clients in the Denominator**
  - ✓ Whose most recent blood pressure is **adequately controlled** (systolic blood pressure < 140 mmHg and diastolic blood pressure < 90 mmHg) during the Measurement Year

CBP-AD Measure: Practice Example

Denominator

Number of people receiving CCBHC service in Measurement Year (MY)	2,500
Of those, service used an appropriate encounter code	2,400
Of those, 18-85 years at date of service	2,140
Of those, no exclusions met	1,955
Denominator	**1,955**

Numerator

Number in Denominator	1,955
Most recent blood pressure reading during MY <140/90	647
Most recent blood pressure reading during MY ≥140/90	1,308
Numerator	**647**

CBP-AD rate = 645/1,955 = .33

CBP-AD Measure: To Do in 2024, if you are going to use CBP-AD

For the measure:

- Begin to ensure that blood pressure monitoring occurs as clinically appropriate and that readings obtained are documented
- Prepare documentation systems needed to capture results of blood pressure monitoring and that relevant staff are trained to use that system

Also important:

- When hypertension is identified, have appropriate clinician provide or refer to appropriate clinician to provide any relevant interventions

Upcoming Quality Measure Webinars

Upcoming Quality Measure Webinars

Schedule of Clinic-Collected Measure-Specific Webinars

Friday, October 27, 2023

– Clinic-Collected-Required Measures: I-SERV, SDOH, ASC

Wednesday, November 1, 2023 Clinic-Collected-Required Measures: CDF-AD & CH, DEP-REM-6

Thursday, November 9, 2023 (TODAY)

– Clinic-Collected-Optional Measures: TSC, SRA-A & C, CBP, WCC

Subsequent Technical Assistance

November or December 2023, Office Hours for Clinic-Collected Measures

January 18, 2024, State-Collected-Required Measures Part 1

February 15, 2024, State-Collected-Required Part 2 and Optional Measures

Late February or March 2024, Reporting Template and Commonly Asked Quality Measure Questions

March 2024, Office Hours for State-Collected Measures

Questions and Discussion

Poll #3

In the last 90 minutes, I have learned *(please select the best option)*:

A. A lot of useful new information
B. Some useful new information
C. Very little new information
D. Not sure
E. Other *(please add comments to the chat box)*

References

- CDC, 2023a. Facts About Suicide. Available at Facts About Suicide - CDC
- Stierman B, Afful J, Carroll MD, Chen TC, Davy O, Fink S, et al. National Health and Nutrition Examination Survey 2017–March 2020 prepandemic data files—Development of files and prevalence estimates for selected health outcomes. National Health Statistics Reports; no 158. Hyattsville, MD: National Center for Health Statistics. 2021.
- U.S. Preventive Services Task Force (USPSTF) (2021). A & B Recommendations.

Thank You

SAMHSA's mission is to lead public health and service delivery efforts that promote mental health, prevent substance misuse, and provide treatments and supports to foster recovery while ensuring equitable access and better outcomes.

Direct Quality Measure Questions to:

CCBHCMeasuresSubmission@samhsa.hhs.gov

www.samhsa.gov

1-877-SAMHSA-7 (1-877-726-4727) ● 1-800-487-4889 (TDD)