**RFS 24-77045**

**Attachment F**

**Quality Metrics Response Template**

**Background:** This Attachment includes two tables of quality metrics the State is requiring for Indiana’s use during the Demonstration Program: (1) **Table 1** includes “Clinic-Collected Metrics,” or metrics that will be collected by CCBHCs; and (2) **Table 2** includes “State-Collected Metrics,” or metrics that will be collected by the State. These metrics are critical to help the State track the growth of the behavioral health system, delivery of services, and outcomes achieved through the CCBHC expansion.

In accordance with the Certification Criterion 3.b.2 (see Attachment E), “The CCBHC is expected to share data with the State in accordance with the requirements set forth in its contractual agreement to provide CCBHC services."

The State acknowledges that SAMHSA has not provided technical specifications for all updated quality measures. The State will align with SAMHSA specifications once additional guidance is released and published.

Please enter information into the open columns, as applicable and as described in the instructions for each table.

**Table 1: Clinic-Collected Metrics**

**Background:** This section includes the quality metrics that each CCBHC will be required to collect and report on. Many metrics are sourced from the Certification Criteria for CCBHCs and are federally required. The State also plans to continue collecting twenty (20) metrics currently tracked by the CCBHC Bridge Grants.

**Instructions:** In the table below, please indicate whether you are currently collecting the following quality metrics. If you do currently capture and report all data required for the respective metric, please explain how you are currently doing so. If you do not currently capture and report data for the respective metric, please explain how you plan on doing so by the start of the Demonstration Program (anticipated on or around July 1, 2024).

| **Quality Metric** | **Description** | **Are you currently collecting all data for this metric?** | **If so, how do you currently capture and report the data? If not, how do you plan to by 7/1/24?** |
| --- | --- | --- | --- |
| Time To Services (**I-SERV**) | Replaces I-EVAL, includes average time to: Initial Evaluation, Initial Clinical Services, and Crisis Services[[1]](#footnote-2) | Yes | The three key data points Inquiry Date, Assessment Date, and Treatment Start Date are documented in the EHR as they occur. This data is reported in accordance with SAMHSA-documented specifications. Crisis Services-reporting data is collected at the beginning of contact, where the variety of Crisis Services provided are documented, along with any potential response and completion times. |
| Depression Remission at Six Months **(DEP-REM-6**) | Percentage of adolescent patients 12 to 17 years of age and adult patients 18 years of age or older with major depression or dysthymia who reached remission six months (+/- 60 days) after an index event date | Yes | The DEP-REM-6 measure is completed in accordance with the SAMHSA documented specifications. Client’s age is based off their date of birth, captured at intake. Client’s diagnoses are determined at assessment. PHQ9 assessments are conducted every 6 months and/or as symptom changes indicate to assess progress and are then loaded into EHR. These datapoints allow for the DEP-REM-6 calculation to be made. Collection of this measure just began; workflows for expanding clinical awareness of the measure and how to inform practice are being developed. Full implementation of operational use will be completed by June 2024. |
| Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling (**ASC**) | Percentage of consumers aged 18 years and older who were screened at least once within the last 24 months for unhealthy alcohol use using a systematic screening method AND who received brief counseling if identified as an unhealthy alcohol user | Yes | The ASC measure is completed in accordance with the NQF 2152 Measure 431 registry. The AUDIT assessment tool, per the measure’s instructions, is utilized to screen the client for unhealthy alcohol use. The results of the screening are entered into the EHR and compared to the measure’s guidelines. Collection of this measure just began; workflows for expanding clinical awareness of the measure and how to inform practice are being developed. Full implementation of operational use will be completed by June 2024. |
| Screening for Clinical Depression and Follow-Up Plan (**CDF-CH and CDF-AD**) | Percentage of beneficiaries ages 12 to 17 screened for depression on the date of the encounter or 14 days prior to 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 eligible encounter | Yes | The CDF-CH and CDF-AD measures are completed in accordance with the documented SAMHSA specifications. Scores are utilized to connect the client with the appropriate type and level of care. Collection of this measure just began; workflows for expanding clinical awareness of the measure and how to inform practice are being developed. Full implementation of operational use will be completed by June 2024. |
| Screening for Social Drivers of Health (**SDOH**) | Percentage of patients 18 years and older screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety | No | The SAMHSA specifications allow for the Social Needs Screening Tool (AAFP) for SDOH data capture. SBH is currently waiting on the State to determine SDOH tool of choice. Preliminary work has been done to implement the Social Needs Screening Tool in the electronic record, as this tool balances the need for gathering this information while ensuring client ease of use. The agency will be ready to use this tool by 3/1/24 due to our preparation. If the State requires a different tool, the 3-6 months will be required to operationalize. |
| Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention (**TSC**) | Percentage of consumers aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation intervention if identified as a tobacco user | Yes | We currently collect this measure in both our Clinical Services programming and through our Nursing flow sheet to ensure that the screening happens for all clients in our care. Data is combined into a single repository. Reporting is done through a CQI dashboard. Collection of this measure just began; workflows for expanding clinical awareness of the measure and how to inform practice are being developed. |
| Controlling High Blood Pressure (**CBP-AD**) | Percentage of consumers ages 18 to 85 who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled during the measurement year based on the following criteria:  • Consumers ages 18 to 59 whose BP was <140/90 mm Hg  • Consumers ages 60 to 85 with a diagnosis of diabetes whose BP was <140/90 mm Hg  • Consumers ages 60 to 85 without a diagnosis of diabetes whose BP was <150/90 mm Hg  A single rate is reported and is the sum of all three groups. | Yes | Client blood pressure readings are taken by a credentialed nursing staff member and results are entered into our EHR. Work is being done to create reporting based upon the client’s age and the results of their BP measurement, so that additional steps may be taken to help control hypertension based on observed need. Collection of this measure just began; workflows for expanding clinical awareness of the measure and how to inform practice are being developed. Full implementation of operational use to inform care will be completed by June 2024. |
| Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-AD) | Percentage of consumers age 13 and older with a new episode of alcohol or other drug (AOD) dependence who received the following:  • Initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of the diagnosis  • Initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit | Yes | SBH collects drug and alcohol screening data and AOD diagnosis as part of our existing EMR data collection. We currently use this data in a one-on-one client to therapist manner and do not report on this measure in an aggregate manner. We do not see any issues with operationalizing this measure. Currently implementation will require our team to construct a report based on the technical guidance being rolled out by SAMSHA. Collection of this measure, as written, just began; workflows for expanding clinical awareness of the measure and how to inform practice are being developed. |
| Hemoglobin A1c Control for Patients with Diabetes (HBD-AD) | Percentage of members 18-75 years of age in the measurement year with a diagnosis of diabetes (Type 1 and Type 2) whose hemoglobin A1c was at the following levels during the measurement year:  • HbA1c control (<8.0%)  • HbA1c poor control (>9.0%) (inverted rate) | Yes | A1c blood work is ordered by credentialed medical staff based upon client’s needs as established through assessment. Orders for lab work are submitted and results entered into EHR once the results are received, which makes this data point available. We are working with IHIE for lab data integration to modernize this process. Should a client’s HBA1c require control, per the HBD-AD measure, the proper pharmacological and educational steps will be taken to ensure the condition is correctly managed. Current reporting capability is still being developed. Workflows for expanding clinical awareness of the measure and how to inform practice are being developed. |
| Suicidality Risk Assessment | Clinics must utilize at **least one** of the following suicidality risk assessments:  **Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA):** Percentage of consumer visits for those consumers aged 6 through 17 years with a diagnosis of major depressive disorder with an assessment for suicide risk  **Adult Major Depressive Disorder: Suicide Risk Assessment (SRA):**  Percentage of patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified  **Ask Suicide-Screening Questions (ASQ):**  A brief (20-second) assessment that healthcare professionals can administer in a variety of settings (emergency department, inpatient medical unit, primary care clinics) to gauge suicide risk in patients. The toolkit website explains how to administer and respond to screening test results  **Suicide Assessment Five-Step Evaluation and Triage (SAFE-T)**: An assessment that can be used by mental health professionals during their first contact with an individual at risk of suicidal behavior and completed suicide. The five-step assessment includes identification of risk and protective factors; conducting an inquiry about suicidality; determining level of risk and selecting an appropriate intervention; and documenting the process, including a follow-up plan  **Columbia Suicide Severity Rating Scale (C-SSRS):**  Supports suicide risk assessment through a series of simple, plain-language questions that anyone can ask. The answers help users identify whether someone is at risk for suicide, assess the severity and immediacy of that risk, and gauge the level of support that the person needs | Yes | In accordance with the SAMHSA specifications, the Suicidality Risk Assessment is completed using the Columbia Suicide Severity Rating Scale at assessment, and at least every 180 days unless clinically indicated for more frequent risk assessments.  Current reporting is done on a client-by-client basis. Aggregate reporting is still in development and will be in place prior to the 7/1/24 deadline Collection of this measure, as written, just began; workflows for expanding clinical awareness of the measure and how to inform practice are being developed. |
| Number of Crisis Calls Received by Caller's County | Number of crisis calls received broken out by caller's county (if known) | Yes | The caller’s county is requested during call. If outside of SBH’s service area, data points of “Other Indiana County”, “Out of State”, “Out of Country”, or “Data Not Available” are used. Current reporting occurs through an internally developed CRSS Dashboard. |
| Number of Crisis Calls Received by Crisis Type (calls could be in multiple types) | Crisis Types: Suicidal; homicidal; adult mental health and serious mental illness; youth mental health and serious emotional disturbance; substance use disorder | No | SBH currently does not track crisis types for the crisis services provided. This will be addressed when we redesign the crisis note documentation process. Collection of the appropriate list of options to the encounter to allow for the capture type/types of presenting issues, along with proper staff training, will be required. Reporting will be added to our CRSS Dashboard before 3/1/24. |
| Number of Unique Individuals Provided a Mobile Crisis Service By Individual's Location County | Number of unique individuals provided a mobile crisis service broken out by county client is in | Yes | At present, Mobile Crisis Services are confined to Vanderburgh County. Expansion to Warrick County is planned for 1/1/24. Each Mobile Crisis response is documented, along with various outcome measures, such as contact start time, departure time, and arrival on scene. Reporting on this measure is a part of our CRSS Dashboard. |
| Number of Unique Individuals Provided a Mobile Crisis Service by Crisis Type | Crisis Types: Suicidal; homicidal; adult mental health and serious mental illness; youth mental health and serious emotional disturbance; substance use disorder | No | SBH currently does not track crisis types by the proposed criteria categories. This will be addressed when we redesign the crisis note documentation process as part of our work to meet CRSS requirements. Adding the appropriate list of options to the encounter note to facilitate capture of the proper type/types of presenting issues, along with staff training, will be required. Reporting will be added to our CRSS Dashboard before 3/1/24. |
| Number of Unique Individuals Referred to Mobile Crisis from the Following Entities | Referral Entities: Law enforcement; medical hospitals; psychiatric hospitals; behavioral health providers; schools; Department of Child Services; faith-based organizations; homeless shelter; family and friends | Yes | SBH currently collects the referral or call source data. Our current documentation, based upon the offering of crisis services for over two years, does not include all the listed referral entities and includes some categories that are not in the provided list, and will thus require a modification of our crisis documentation which is easily added as a referral entity. This will be complete before 3/1/24. |
| Number of Naloxone Dispensations During Mobile Crisis | Number of Naloxone dispensations during mobile crisis | No | Naloxone is widely distributed via the provision of services throughout our community; the amounts are not currently documented. The documentation of distributing Naloxone will require a modification of our work process and crisis documentation. Reporting of this measure will be added to our CRSS Dashboard as unique contacts that received Naloxone kit/kits through mobile services. This will be completed by 3/1/2024. |
| Number of Unique Individuals Who Received a Follow-up Contact | Number of Unique Individuals Who Received a Follow-up Contact (e.g. telephone call, in-person visit) | Yes | SBH’s current follow-up process relies upon the person in crisis to consent to any follow-up contact. This consent is documented and forwarded to staff members assigned to complete follow-up contact within a 72-hour period. The results of these follow-up attempts are documented. Reporting exists as an ad hoc process conducted daily through the supervision staff. Crisis note redesign is expected to create an automated follow-up process that can be assigned to individual staff for easier tracking of follow up. |
| Number of Mobile Crisis Services Provided In Person | Number of mobile crisis services provided in person | Yes | The individual mobile responses are documented In the EHR and reported via CRSS Dashboard. |
| Mean Mobile Crisis Response Times | Average of total number of minutes between first contact requesting crisis services and mobile crisis team arriving "on-scene" with individual | Yes | Mobile response (depart and arrival) times are documented, though not reported. A modification of the CRSS Dashboard to report the Mean Mobile Crisis Response Time is in the planning stage, however, capacity to report will be available before 7/1/24. |
| Mean Mobile Crisis Times | Average of total number of minutes "on-scene to resolution" with the individual | Yes | Mobile response (depart and arrival) times are documented, though not reported. A modification of the CRSS Dashboard to report the Mean Mobile Crisis Time is in the planning stage, however, capacity to report will be available before 3/1/24. |
| Number of Mobile Crisis Responses Resolved in the Community | Number of mobile crisis responses resolved in the community (e.g. crisis de-escalated, higher level care not required) | Yes | The results of mobile response are documented and reported on the CRSS Dashboard. |
| Number of Unique Individuals Receiving Crisis receiving and stabilization services (“CRSS”) | Number of individuals provided a CRSS broken out by county client is in | Yes | Everyone receiving CRSS is documented to the fullest extent allowed by the individual. Should said individual wish to remain anonymous, this is respected, however the documentation of services provided, along with the location as to where the individual was located (county), is still maintained. |
| Number of Unique Individuals Provided CRSS by Crisis Type | Crisis Types: suicidal; homicidal; adult mental health and serious mental illness; youth mental health and serious emotional disturbance; substance use disorder | No | SBH currently does not track crisis types for the crisis services provided. This will be addressed when we redesign the crisis note documentation process. Adding the appropriate list of options to the encounter to allow for the capture type/types of presenting issues, along with proper staff training, will be required. This will be complete before 3/1/24. |
| Number of Unique Individuals Referred to CRSS from the Following Entities | Referral Entities: Law enforcement; medical hospitals; psychiatric hospitals; behavioral health providers; schools; Department of Child Services; faith-based organizations; homeless shelter; family and friends | Yes | SBH currently collects the referral or call source data. Our current documentation, based upon the offering of crisis services for over two years, does not include all of the listed referral entities and includes some categories that are not in the provided list, and will thus require a modification of our crisis documentation which will occur prior to 3/1/24. |
| Number of Naloxone Dispensations During CRSS | Number of Naloxone dispensations during mobile crisis | No | Currently Naloxone is widely distributed throughout our community; the amounts are not currently documented. The documentation of distributing Naloxone will require a modification of our work process and crisis documentation. Reporting of this measure will be added to our CRSS Dashboard as unique contacts that received Naloxone kit/kits through CRSS services. This will be complete prior to 3/1/24. Need clarification if data is needed for all crisis services, or just mobile responses. |
| Number of Unique Individuals Who Received a Follow-up Contact | Number of individuals who received a follow up contact (e.g. telephone call, in-person visit) | Yes | SBH’s current follow-up process relies upon the person in crisis to consent for any follow-up contact. This consent is documented and forwarded to staff members assigned to complete follow-up contact within a 72-hour period. The results of these follow-up attempts are documented. Reporting exists as an ad hoc process conducted daily through the supervision staff. Crisis note redesign is expected to create an automated follow-up process that can be assigned to individual staff for easier tracking of follow-up. Aggregate reporting will be done through the CRSS dashboard. |
| Mean Length of Stay in Hours in CRSS | Average of total number of hours in CRSS | Yes | The arrival and departure times at the Crisis Unit are documented. There is a plan in place to add this reporting to the CRSS Dashboard which will be complete prior to 7/1/24. |

**Table 2: State-Collected Metrics**

**Background:** This section includes the quality metrics that the State will collect and report on during the Demonstration Program. Sites selected for Demonstration through this RFS will be expected to work with the State to accurately capture and report each metric in this section. Many metrics are federally required; others are metrics the State has elected to collect.

**Instructions:**  In the table below, please indicate whether you are currently collecting any data on the quality metrics that will be collected by the State. If you do currently capture and report data for the respective metric, please explain how you are currently doing so. For each metric, please confirm your commitment to work with the State to ensure the State can accurately capture and report the metric.

| **Quality Metric** | **Description** | **Are you currently collecting any data for this metric? If so, how do you currently capture and report it?** | **Confirm your commitment to work with the State to capture this metric. Describe any challenges you foresee in helping capture this data.** |
| --- | --- | --- | --- |
| Patient Experience of Care Survey | Annual completion and submission of Mental Health Statistics Improvement Program (MHSIP) Adult Consumer Experience of Care Survey, identifying results separately for BHCs and comparison clinics and oversampling those clinics | Yes, currently captured through DARMHA. Currently analyzed by the state. We also use this data to provide status and progress reports to our leadership team and Board of Directors. | SBH is committed to continuing to work with the state to capture this metric. There are no current foreseen challenges to capturing this data. |
| Youth/Family Experience of Care Survey | Annual completion and submission of Youth/Family Services Survey for Families (YSS-F) Experience of Care Survey, identifying results separately for BHCs and comparison clinics and oversampling those clinics | Yes, currently captured through DARMHA. Currently analyzed by the state. We also use this data to provide status and progress reports to our leadership team and Board of Directors. | SBH is committed to continuing to work with the state to capture this metric. There are no current foreseen challenges to capturing this data. |
| Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD) | Percentage of consumers ages 19 to 64 during the measurement year with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period  [SAA-AD](onenote:https://southwesternhealthcare.sharepoint.com/sites/DataAnalyticsGroup/SiteAssets/Data%20Analytics%20Group%20Notebook/Miscellaneous.one#SAA-AD&section-id={71C708C9-E5F7-4F66-AEA2-C3D77C4D9545}&page-id={EAEDB10C-88FB-4F1F-9DEB-623C44E8A106}&end)  ([Web view](https://southwesternhealthcare.sharepoint.com/sites/DataAnalyticsGroup/_layouts/OneNote.aspx?id=%2Fsites%2FDataAnalyticsGroup%2FSiteAssets%2FData%20Analytics%20Group%20Notebook&wd=target%28Miscellaneous.one%7C71C708C9-E5F7-4F66-AEA2-C3D77C4D9545%2FSAA-AD%7CEAEDB10C-88FB-4F1F-9DEB-623C44E8A106%2F%29)) | Yes, we can only track medications discernment by limited access to pharmacy data. We have no current reporting methodology, tables for raw data can be requested and validated so that reports can be designed. | SBH is committed to working with the state to collect this measure by 7/1/24 and on an ongoing basis.   Challenges to reporting will come from limited methods to collect and define dispensation of the medication. Further clarification and finalization of the criteria for the measure are expected to help clarify how to track and report on it. |
| Follow-Up After Hospitalization for Mental Illness, ages 18+ (adult) (FUH-AD) | Percentage of discharges for consumers age 21 and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner. Two rates are reported:  • Percentage of discharges for which the consumer received follow-up within 30 days of discharge  • Percentage of discharges for which the consumer received follow-up within 7 days of discharge | Yes, currently discharge notes are captured through EHR and by a discharge awareness workflow. We can determine diagnosis by crosstabulation with our diagnosis table. OP visits are part of our service table record as are IOP services. Currently, the specifics of this measure are not directly reported upon however with minor adjustments we would be able to modify current CQI reporting to report on this measure by 7/1/24. | SBH is committed to working with the state to collect this measure by 7/1/24 and on an ongoing basis.  Challenges to reporting will come from establishment of the discharge awareness workflow that involves agreements with discharging agencies and our inhouse staff. IHIE implementation of ADT alerts will assist (in progress) |
| Follow-Up After Hospitalization for Mental Illness, ages 6 to 17 (child/adolescent) (FUH-CH) | Percentage of discharges for children and adolescents ages 6-17 who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner. Two rates are reported:  • Percentage of discharges for which children received follow-up within 30 days of discharge  • Percentage of discharges for which children received follow-up within 7 days of discharge | Yes, currently discharge notes are captured through the EHR and by a discharge awareness workflow. We can determine diagnosis by crosstabulation with our diagnosis table. OP visits are part of our service table record as are IOP services. Currently the specifics of this measure are not directly reported upon however with minor adjustments we would be able to modify current CQI data collection process to report on this measure. | SBH is committed to working with the state to collect this measure by 7/1/24 and on an ongoing basis. IHIE implementation of ADT alerts will assist (in progress) |
| Follow-Up After Emergency Department Visit for Mental Illness (FUM-CH & FUM-AD) | Percentage of emergency department (“ED”) visits for consumers 6 years of age and older with a primary diagnosis of mental illness, who had an outpatient visit, an intensive outpatient encounter or a partial hospitalization for mental illness. Two rates are reported:  • Percentage of ED visits for which the consumer received follow-up within 30 days of the ED visit  • Percentage of ED visits for which the consumer received follow-up within 7 days of the ED visit | No | SBH is committed to working with the state to collect this measure by 7/1/24 and on an ongoing basis.  Challenges to reporting will come from no access to ED data. Tracking and reporting will be dependent on a working IHIE ADT alerts which is still in development. Potential MOUs with local Hospitals for notification of ED services and admissions of clients will be pursued as care coordination processes are being explored. We believe that IHIE ADT alerts will greatly increase the consistent valid flow of information while reducing the FTE required to operationalize this requirement and incorporate tracking into the EHR. Care Coordination may also be a vector for expanding services required to track this measure. |
| Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA-CH and FUA-AD) | Percentage of ED visits for consumers 13 years of age and older with a primary diagnosis of alcohol or other drug (AOD) dependence, who had an outpatient visit, an intensive outpatient encounter or a partial hospitalization for AOD. Two rates are reported:  • Percentage of ED visits for which the consumer received follow-up within 30 days of the ED visit  • Percentage of ED visits for which the consumer received follow-up within 7 days of the ED visit | No | SBH is committed to working with the state to collect this measure by 7/1/24 and on an ongoing basis.  Challenges to reporting will come from limited to no access to ED data. Potential MOUs with local Hospitals for notification of ED services and admissions of clients will be pursued in the pursuit of care coordination processes are being explored. We believe that IHIE ADT Alerts will greatly increase the consistent valid flow of information while reducing the FTE required to operationalize this requirement and incorporate tracking into the EHR. Care Coordination may also be a vector for expanding services required to track this measure. |
| Plan All-Cause Readmissions Rate (PCR-AD) | For consumers age 18 and older, the number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days. Data are reported in the following three categories:  • Count of Index Hospital Stays (IHS) (denominator)  • Count of 30-Day Readmissions (numerator)  • Readmission Rate | No | Currently SBH is able to collect this data through liaison staff that works at three of the local hospitals to find and document this data. We are unable to identify inpatient stays in other facilities outside the three in our region.  SBH is committed to working with the state to collect this measure by 7/1/24 and on an ongoing basis.  Challenges to reporting will come from limited to no access to hospital data beyond staff manually collecting it at hospitals locally. Potential MOUs with local Hospitals for notification of ED services and admissions of clients will be pursued as care coordination processes are being explored. We believe that IHIE ADT Alerts will greatly increase the consistent valid flow of information while reducing the FTE required to operationalize this requirement and incorporate tracking into the EHR. Care Coordination may also be a vector for expanding services required to track this measure. |
| Antidepressant Medication Management (AMM-BH) | Percentage of consumers age 18 and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment. Two rates are reported:  • Effective Acute Phase Treatment: Percentage of consumers who remained on an antidepressant medication for at least 84 days (12 weeks)  • Effective Continuation Phase Treatment: Percentage of consumers who remained on an antidepressant medication for at least 180 days (6 months)   [AMM-BH](onenote:https://southwesternhealthcare.sharepoint.com/sites/DataAnalyticsGroup/SiteAssets/Data%20Analytics%20Group%20Notebook/Miscellaneous.one#AMM-BH&section-id={71C708C9-E5F7-4F66-AEA2-C3D77C4D9545}&page-id={8AAC9BA3-1FE3-4A90-99F5-A695344F7235}&end)  ([Web view](https://southwesternhealthcare.sharepoint.com/sites/DataAnalyticsGroup/_layouts/OneNote.aspx?id=%2Fsites%2FDataAnalyticsGroup%2FSiteAssets%2FData%20Analytics%20Group%20Notebook&wd=target%28Miscellaneous.one%7C71C708C9-E5F7-4F66-AEA2-C3D77C4D9545%2FAMM-BH%7C8AAC9BA3-1FE3-4A90-99F5-A695344F7235%2F%29)) | Yes, SBH can track medications prescribed by diagnosis in the electronic medical record, and duration of those prescriptions. However, compliance with medication via pharmacy pick up is limited to Genoa Pharmacy (in house pharmacy with BAA relationship). | SBH is committed to working with the state to collect this measure by 7/1/24 and on an ongoing basis.  Medications prescribed by external providers are recorded by staff in the SBH electronic record and updated each visit.  Challenges to reporting will come from limited access to Pharmacy data. To enhance relationships with pharmacies outside of Genoa Pharmacy, potential MOUs with local pharmacies for notification of fill status and care coordination processes are being explored. We believe that IHIE will greatly increase the consistent valid flow of information while reducing the FTE required to operationalize this requirement and incorporate tracking into the EHR. Care Coordination may also be a vector for expanding services required to track this measure. |
| Follow-Up Care for Children Prescribed Attention-Deficit Hyperactivity Disorder (ADHD) Medication (ADD-CH) | Percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported:  • Initiation Phase: Percentage of children ages 6 to 12 as of the Index Prescription Start Date (IPSD) with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase.  • Continuation and Maintenance (C&M) Phase: Percentage of children ages 6 to 12 as of the IPSD with an ambulatory prescription dispensed for ADHD medication who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended   [ADD-CH](onenote:https://southwesternhealthcare.sharepoint.com/sites/DataAnalyticsGroup/SiteAssets/Data%20Analytics%20Group%20Notebook/Miscellaneous.one#ADD-CH&section-id={71C708C9-E5F7-4F66-AEA2-C3D77C4D9545}&page-id={1518A835-CA1A-4118-AB27-2B1E73674F68}&end)  ([Web view](https://southwesternhealthcare.sharepoint.com/sites/DataAnalyticsGroup/_layouts/OneNote.aspx?id=%2Fsites%2FDataAnalyticsGroup%2FSiteAssets%2FData%20Analytics%20Group%20Notebook&wd=target%28Miscellaneous.one%7C71C708C9-E5F7-4F66-AEA2-C3D77C4D9545%2FADD-CH%7C1518A835-CA1A-4118-AB27-2B1E73674F68%2F%29)) | Yes, SBH can track medications prescribed by diagnosis in the electronic medical record, and duration of those prescriptions. However, compliance with medication via pharmacy pick up is limited to Genoa Pharmacy (in house pharmacy with BAA relationship). | SBH is committed to working with the state to collect this measure by 7/1/24 and on an ongoing basis.  Challenges to reporting will come from limited methods to collect and define dispensation of the medication. Further clarification and finalization of the criteria for the measure are expected to help clarify how to track and report on it.  Challenges to reporting will come from access to Limited Pharmacy data outside of Genoa Pharmacy. Tracking and reporting will be dependent on a working IHIE which is still in development. Potential MOUs with local pharmacies for notification of fill status and care coordination processes are being explored. We believe that IHIE will greatly increase the consistent valid flow of information while reducing the FTE required to operationalize this requirement and incorporate tracking into the EHR. Care Coordination may also be a vector for expanding services required to track this measure. |
| Use of Pharmacotherapy for Opioid Use Disorder (**OUD-AD**) | Percentage of Medicaid beneficiaries ages 18 to 64 with an opioid use disorder (OUD) who filled a prescription for or were administered or dispensed an FDA-approved medication for the disorder during the measurement year.  This metric includes a Total rate as well as four separate rates representing the following four types of FDA-approved drug products:  • Buprenorphine  • Oral naltrexone  • Long-acting, injectable naltrexone  • Methadone (MOU) | Yes, SBH can track medications prescribed by diagnosis in the electronic medical record, and duration of those prescriptions (and sort by Medicaid insurance type). However, compliance with medication via pharmacy pick up is limited to Genoa Pharmacy (in house pharmacy with BAA relationship).  Administration of injectable medications is trackable in the electronic record.  • Methadone (MOU)—get take home doses for self admin from local clinic. Formal arrangements to collect this data may present logistical difficulties due to the structural factors inherent in the local governance and ownership of the company. | SBH is committed to working with the state to collect this measure by 7/1/24 and on an ongoing basis.  Challenges to reporting will come from limited pharmacy data for medication dispensed vs. prescribed. Further clarification and finalization of the criteria for the measure are expected to help clarify how to track and report on it.  We intend to expand our internal prescribing of MAT by 7/1/2024. We also are working to increase care coordination for those who receive expanded MAT and to extend this care coordination to those receiving services from our external MAT providers.  We will track this expanded service through developing our ability to monitor coordination through our EHR. We will target information in our prescriber documentation as well as documentation through client report.  Candidates for MAT not receiving MAT services will be reevaluated on a regular basis about MAT to see if circumstances have changed. |
| Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH) | Percentage of children and adolescents 1–17 years of age who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment | Yes | We capture psychosocial care for all clients, including young children and adolescents, as part of our services table, and we capture medication data through our prescribers’ written orders. Age is collected as part of our general intake. We do not currently report on this item but have the capacity to quickly build a reporting structure to do so by 7/1/24. Collection of this measure, as written, just began; workflows for expanding clinical awareness of the measure and how to inform practice are being developed. |

1. SAMHSA is currently changing metric from I-EVAL to I-SERV [↑](#footnote-ref-2)