



# Integrated Services of Kalamazoo

*CBHC Quality Metrics overview*

*For 2023 Demonstration Kickoff*

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# CCBHC Clinic-Reported Measures

- The CCBHC itself must collect the relevant data points from the health record and report performance to MDHHS via an Excel template

Time to Initial Evaluation (I-EVAL)

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

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

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

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

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

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

Screening for Depression and Follow-Up Plan: Age 18 and Older (CDF-AD)

Depression Remission at Twelve Months (DEP-REM-12)

# CCBHC State-Reported Measures

- MDHHS calculates and reports CCBHC performance based on administrative data (Medicaid claims)

Housing Status (HOU)

Patient Experience of Care Survey (PEC)

Youth/Family Experience of Care Survey (Y/FEC)

Follow-Up After Emergency Department Visit for Mental Illness (FUM)

Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA)

Plan All-Cause Readmission Rate (PCR-AD)

Diabetes Screening for People with Schizophrenia or Bipolar Disorder who Are Using Antipsychotic Medications (SSD-AD)

Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD)

Follow-Up After Hospitalization for Mental Illness, ages 18+ (adult) (FUH-AD)

Follow-Up After Hospitalization for Mental Illness, ages 6 to 17 (FUH-CH)

Follow-up care for children prescribed ADHD medication (ADD-CH)^

Antidepressant Medication Management (AMM-AD)

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-BH)

# Quality Bonus Payments

- The potential Quality Bonus Payment is 5% of the total Demonstration Year Medicaid costs
- CCBHCs must meet all six minimum benchmarks to receive the QBP

Measure Name and NQF # (if applicable)	Measure Steward	Benchmark
Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-BH-C)	AMA-PCPI	23.9%
Major Depressive Disorder: Suicide Risk Assessment (SRA-A)	AMA-PCPI	12.5%
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-BH)	CMS	58.5%
Follow-Up After Hospitalization for Mental Illness, ages 21+ (adult) (FUH-BH-A)	NCQA	58%
Follow-Up After Hospitalization for Mental Illness, ages 6 to 21 (child/adolescent) (FUH-BH-C)	NCQA	70%
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-BH)	NCQA	IET-14 (Initiation) – 25%

# Metrics are changing FY24 -> FY25

- FY25 format isn't finalized yet by CMS/SAMHSA, but almost certainly will be different from FY24

Metric	Likely change
<b>HbA1c Control for Patients with Diabetes (HBD-AD)</b>	New metric and will likely be QBP
<b>Depression Remission at Six Months (DEP-REM-6)</b>	Different metric structure; not currently QBP and will likely become QBP
<b>Time to Services (I-SERV)</b>	New metric and will likely be QBP
<b>Screening for Social Drivers of Health (SDOH)</b>	New metric, not likely QBP but required for CCBHCs to report

# Useful references

- CMS Core Set specifications/value sets:  
<https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/index.html>
- SAMHSA guidance:  
<https://www.samhsa.gov/certified-community-behavioral-health-clinics/guidance-and-webinars>

# Summary

- Lots of detail!
- Easy to feel overwhelmed
- Takes a lot of time to understand in depth

# ISK's CCBHC Analytics History

- Oct 2018: CCBHC Expansion Grantee
- Jan 2019: Hired new position, Data Analyst
- Oct 2021: CCBHC Demonstration Site
- March 2022: Expanded Analytics Dept (+1.0 FTE)



**Almost 5 years now of at least 0.5 FTE  
dedicated staff for CCBHC metrics**

# A Framework Visible in Retrospect:

## Two realms of decision-making

Which metrics will get how much attention?

- Creates an overall organizational shift towards some areas and (by necessity) away from other areas

What activities get implemented inspired by those metrics?

- Creates direct impacts (both intended and unintended) on staff and individuals receiving services

**The important thing not to lose sight of**

**People's experience of care will  
be affected by the format of  
any CCBHC metrics initiatives**

# Which metrics to look at?

1. Clinical value of the subject area
2. Details/relevance of the metric's construction
3. Current baseline level of performance (including presence of any disparities)
4. What is incentivized
5. Data reporting requirements

To the extent possible, it seems best to avoid getting caught up in #4 and #5 so much that you neglect to think enough about #1, #2, #3

**A rundown of some of the CCBHC  
measures, and why ISK has or has  
not been focusing on them in  
various ways:**

# Adult BMI screening and followup (BMI-SF)

# Child BMI/Weight Assessment (WCC-BH)

- CCBHC-reported
- Not QBP / no min threshold

(the Attention-Meter)



- ISK “default” processes already drive an acceptable level of performance; decision not to engage in unnecessary QI activity
- BMI as a somewhat less useful/ appropriate statistic compared to other metabolic measures
- Need to be able to report data on the SAMHSA template as a Demonstration site (which is relatively easy)

# Preventive Care & Screening for adults: Tobacco Use (TSC) Alcohol Use (ASC)

- CCBHC-reported
- Not QBP / no min threshold



- Recognition that these screenings are clinically relevant and valuable
- But they are not incentivized, and existing ISK processes already drive a somewhat acceptable level of performance
- Therefore they are only getting a minor amount of attention beyond the minimum amount required to be able to report them on the SAMHSA template

# Suicide Risk Assessments:

**Adults (SRA-A)**

**Youth (SRA-BH-C)**

- **CCBHC-reported**
- **QBP: Thresholds of 12.5% for adults and 23.9% for youth**



- QBP incentivized metrics: Past high-effort QI projects have put processes in place that are now driving consistently much better performance than before (without continually requiring more effort)
- Suicide risk, suicide screening and prevention is a high priority for the organization overall
- But these specific metrics are constructed with a somewhat narrow focus (e.g. both apply only to individuals with diagnosed MDD), so they only form a small part of our overall QI efforts geared towards suicide prevention

# Followup after hospitalization for mental illness:

**Adults (FUH-AD)**

**Youth (FUH-CH)**

- **State-reported**
- **QBP: Thresholds of 58% for adults, 70% for youth**



- State-reported and QBP incentivized metrics – we are not required to prepare any data reporting, but we do monitor these continuously due to the incentive payment attached
- Clinical relevance is fairly high
- Previous QI projects with our PIHP based on these metrics, some strategies/processes already in place which tend to keep us safely above the minimum thresholds

# Adherence to Antipsychotics for adults with Schizophrenia (SAA)

- State-reported
- QBP: Threshold of 58.5%



- This metric is QBP incentivized, and we have continually been at risk of missing the minimum threshold (which puts the entire incentive payment at risk)
- BUT, our analysis has found a lot of noise caused by the metric's construction so that what it measures isn't consistently clinically meaningful
- Therefore we are moderating how much effort we put into it, out of a desire to balance appropriately with our efforts for other metrics

# Followup after Emergency Dept visits: Mental illness (FUM) Alcohol/Other drug dependence (FUA)

- State-reported
- Not QBP / no min thresholds



- We don't have to report the data, and there is no incentive payment attached... so we *could* ignore these metrics totally
- However, these metrics are clinically relevant, and our PIHP has alerted us to the presence of a racial disparity in our county, plus announced a region-wide QI project to close the gap and improve metric performance
- Therefore we do want to spend some moderate amount of effort here, if possible given capacity constraints

# Social Determinants of Health screening (Coming likely in 2025)

- There is no metric named yet, but ISK has an awareness of the huge clinical value of SDOH screening and is already working to put processes and monitoring in place
- Interest is high and this focus area would likely get a lot more attention at ISK if not for staff's limited capacity, attention being diverted towards other metrics (We hope to ramp up somewhat later in FY24)



**Many available metrics are still getting mostly ignored!**

**Largely metrics that have no incentive and no reporting requirement from us, and which have not been brought to our attention outside CCBHC.**

**We have limited capacity to look at any of these... but, I'm aware we might be missing opportunities ...**



- Routine Care Needs (ROUT)
- Documentation of Rx (DOC)
- Controlling High Blood Pressure (CBP)
- Housing status (HOU)
- All-Cause Readmissions (PCR)
- Diabetes Screening for People with Antipsychotics (SSD)
- Cardiovascular Monitoring (SMC)
- Adherence to Mood Stabilizers (AMS)
- Followup Care for Children with ADHD Rx (ADD-BH)
- Antidepressant Medication Management (AMM)

# What to consider about metrics --

1. Clinical value of the subject area
2. Details/relevance of the metric's construction
3. Current baseline level of performance (including presence of any disparities)
4. What is incentivized
5. Data reporting requirements

To the extent possible, it seems best to avoid getting caught up in #4 and #5 so much that you neglect to think enough about #1, #2, #3

# A Framework Visible in Retrospect:

## Two realms of decision-making



Which metrics will get how much attention?

- Creates an overall organizational shift towards some areas and (by necessity) away from other areas



What activities get implemented inspired by those metrics?

- Creates direct impacts (both intended and unintended) on staff and individuals receiving services

# Concrete activities inspired by a metric?

At least three dimensions along which to assess possible strategies, processes, activities:

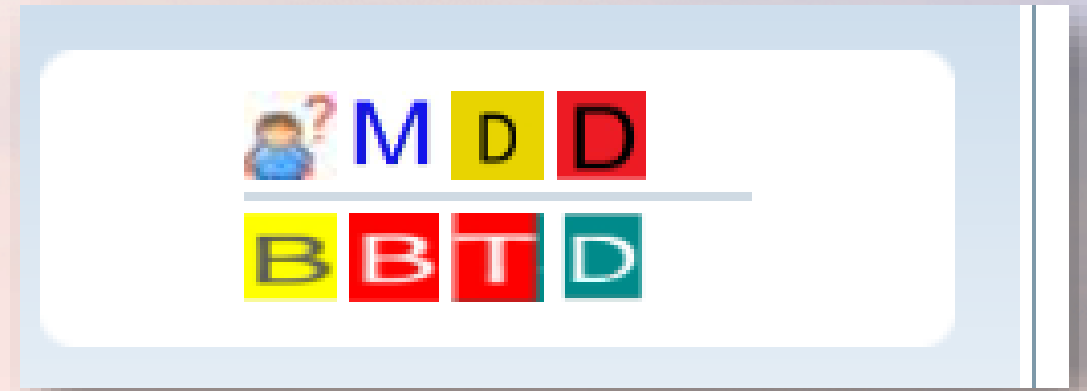
- Impact on the **metric** itself
- Impact on **staff** being asked to do something different
- Impact on the **consumers** receiving services

Again, ideally the focus would stay as much as possible on what strategies are good for staff and especially consumers

**A rundown of a few strategies attempted by ISK so far, and what impacts they seemed to have:**

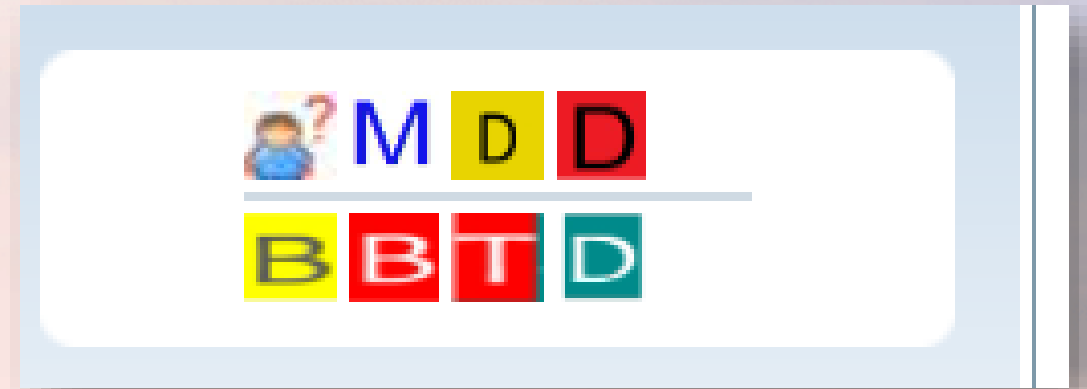
# Youth Suicide Risk Assessment (SRA-BH-C)

First attempted strategy:  
Clinical Decision Support  
Flagging in the EHR



# Youth Suicide Risk Assessment (SRA-BH-C)

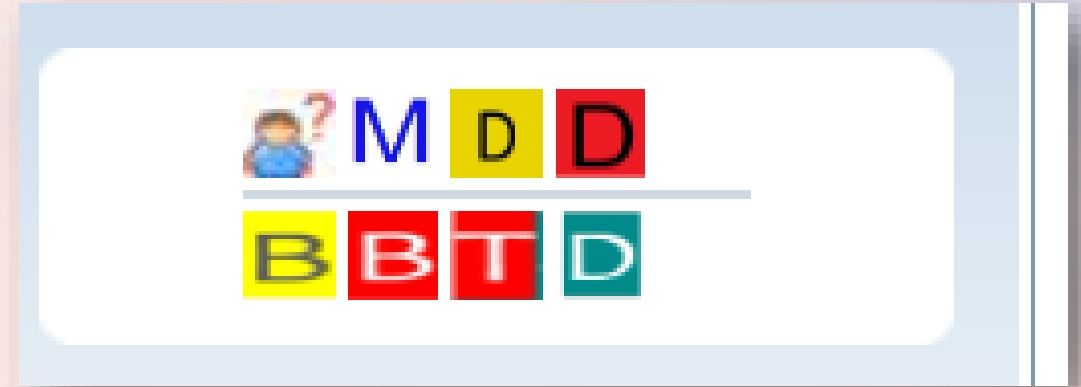
- Developed written protocol of when screenings, followups needed to occur based on CCBHC metrics specifications
- Built chart “flags” into the EHR that turn on automatically based on the appropriate logic, and turn off (when applicable) once the required screening is completed



# Youth Suicide Risk Assessment (SRA-BH-C)

## Pros:

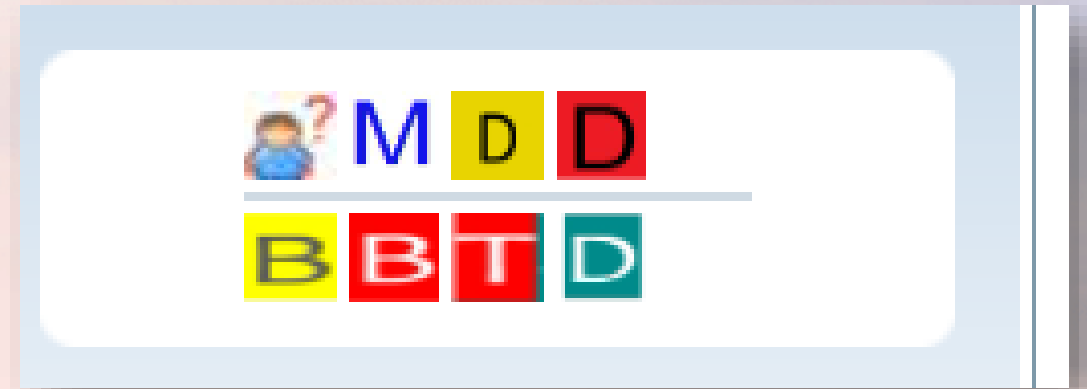
- Consistent visual reminder of something needing done
- Nice “checklist” type interaction is possible for staff
- Placed in a convenient location (directly in the client chart)



# Youth Suicide Risk Assessment (SRA-BH-C)

## Cons:

- Complicated metric specs created complicated, hard to understand flag logic
- Many screenings with CCBHC metrics attached -> Many different flags, likely started creating “flag fatigue” and was crowding out other flags with greater clinical importance
- Created emphasis on documentation processes – doing things the way the flag logic expected – and maybe not enough of emphasizing suicide care



# Youth Suicide Risk Assessment (SRA-BH-C)

Another early strategy:  
Caseload reports for clinicians

Client Id	Client Name	Procedure Code	Clinician	Status	Date Of Service	Minutes	At Risk Reason	Suicide Risk Assessment
[REDACTED]	[REDACTED]	Miscellaneous	[REDACTED]	Complete	2/2/2022 3:00:00 PM	20	Active MDD diagnosis; No PHQ within past year	
[REDACTED]	[REDACTED]	Miscellaneous	[REDACTED]	Complete	2/2/2022 10:00:00 AM	30	No PHQ within past year	
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[REDACTED]	[REDACTED]	90791:GT Assessment	[REDACTED]	Complete	2/2/2022 2:00:00 PM	42	Most recent PHQ, 02/02/22: Total score 18 and Yes on Question 9	Columbia, PHQ
[REDACTED]	[REDACTED]	90791:GT Assessment	[REDACTED]	Complete	2/2/2022 10:30:00 AM	37	No PHQ within past year	
[REDACTED]	[REDACTED]	H0036:GT HOME BASED	[REDACTED]	Complete	2/2/2022 4:15:00 PM	45	No PHQ within past year	



## Suicide Risk Assessment for At-Risk Consumers

Ran: 3/23/2022 8:00:27 AM

Start Date: 2/2/2022 12:00:00 AM -05:00

End Date: 2/2/2022 12:00:00 AM -05:00

# Youth Suicide Risk Assessment (SRA-BH-C)

- Self-service report built into the EHR where clinicians could view their caseload with known suicide risk factors, and upcoming appointments where a SRA would be expected according to the ISK policies inspired by the CCBHC metric

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Services of Kalamazoo

**Suicide Risk Assessment for At-Risk Consumers**

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# Youth Suicide Risk Assessment (SRA-BH-C)

Pros:

- None

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Services of Kalamazoo

**Suicide Risk Assessment for At-Risk Consumers**

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# Youth Suicide Risk Assessment (SRA-BH-C)

## Cons:

- Clinicians not accustomed to running their own self-service reports, rarely or never go to that area of the EHR, maybe don't really have time to do so
- No one ran and looked at the report at all! (based on looking at usage logs)

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Suicide Risk Assessment for At-Risk Consumers

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# Youth Suicide Risk Assessment (SRA-BH-C)

The strategy that seems to have landed best:

**Deliberately reducing documentation burden**



# Youth Suicide Risk Assessment (SRA-BH-C)

- Making a SRA available directly within the Progress Note, instead of clinicians needing to go pull up a separate document

## Suicide Risk

Did clinician assess suicide risk? \*

Yes  No

Risk reported:

None  Thoughts  Intent  Plan  Means  Behavior  Attempt  Other

# Youth Suicide Risk Assessment (SRA-BH-C)

- Making the baseline SRA follow the simplest possible format that meets the metric, and allowing clinicians to decide when a more thorough tool is clinically indicated

## Numerator Definition

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 consumer.

Suicide risk assessment can include:

- specific inquiry about suicidal thoughts, intent, plans, means, and behaviors
- identification of specific psychiatric symptoms (e.g., psychosis, severe anxiety, substance use) or general medical conditions that may increase the likelihood of acting on suicidal ideas
- assessment of past and, particularly, recent suicidal behavior

# Youth Suicide Risk Assessment (SRA-BH-C)

**Currently and looking forward to the future:  
Building out a fuller  
Suicide Reduction  
Care Pathway**

- More comprehensive focus on suicide care in general, not just on proper documentation. Lots of training, building a culture of greater suicide awareness and competency
- Covers the entire ISK service population, not just the smaller populations narrowly defined by the CCBHC metric specifications

# Youth Suicide Risk Assessment (SRA-BH-C)

Overall lessons learned:

- Building metric support into the EHR can have varying levels of success, depending on specific design choices. A healthy respect for human factors is necessary!
- In the end, we were able to discover an approach that is
  - ✓ Great for our metric performance
  - ✓ Comfortable and meaningful for clinicians
  - ✓ Genuinely improves the quality of care for our consumers

But it took a few tries. Being able to iterate, learn from past strategies and move away from what isn't really working

# Antipsychotics Adherence (SAA)

## Strategy of outreach calls

- If someone with an oral medication is missing the SAA metric, then that means they have **gaps or delays** in obtaining their meds from the pharmacy
- Ideally we would like to call any individual who has such a gap or delay, and troubleshoot with them how to get their meds as soon as possible
  - Didn't know about the new order? Confused about pharmacy location? Needs ride? Needs delivery? Etc.

# Antipsychotics Adherence (SAA)

Inspired by “Targeted Universalism”, and the theory of aiming for systemic improvements instead of administrative tricks or checklist-following:

- Developing **targeted** strategies with the metric denominator population in mind;
- But then, applying those strategies more **universally** to a broader population, not only those who will get measured by the metric. (When practical, to the entire ISK service population)

# Antipsychotics Adherence (SAA)

## Strategy of outreach calls

- Calling people with a current gap or delay is the **targeted** strategy
- It's impossible to implement because we don't have access to timely information about such gaps and delays
- The more universal strategy is to **call everyone** soon after they have a new antipsychotics Rx order from us, to check in that everything is OK with it (including confirming that they successfully picked it up from the pharmacy)

# Antipsychotics Adherence (SAA)

## Strategy of outreach calls

- Calling everyone with a new **antipsychotics** Rx is still a targeted strategy that focuses on the only type of medication that matters for SAA
- But there are other types of medication where consistent adherence is similarly important from a clinical perspective
- We decided to expand our outreach calls to all new Rx orders for antipsychotics OR mood stabilizers

# Antipsychotics Adherence (SAA)

## The SAA metric only applies to:

- Medicaid population
- With Antipsychotics prescriptions
- Must have diagnosed Schizophrenia
- Adults only

## Our strategy of outreach calls is implemented for:

- All ISK clients regardless of insurance
- With Antipsychotics OR Mood Stabilizers Rx
- With or without any specific diagnosis
- Any age (adults & youth)

# Antipsychotics Adherence (SAA)

**Directing strategies beyond the specific metric-qualified population:**

- Creates equity between Medicaid and non-Medicaid consumers
- Exposes a greater number of individuals to the strategy's positive impacts
- Makes it less confusing for staff to know what to do (metric criteria are complex!)
- Doesn't actually have too much of a higher cost, compared to targeting the metric population very narrowly

# Antipsychotics Adherence (SAA)

Outreach calls are creating opportunities for helping people with the basic steps of obtaining medications, as planned.

We have also found other positive results that we didn't anticipate:

- Consumers reporting side effects that they forgot to tell the doctor at their recent appointment
- Opportunity to clarify dosage changes, etc.
- Answering questions not related to prescriptions (labs, therapy appointments, etc ...)
- Consumers being appreciative of the check-in

# Antipsychotics Adherence (SAA)

Overall lessons learned, so far:

- It's hard to move the needle on this metric
- It has paid off to focus on what impacts we are creating for staff and especially consumers. Focusing primarily on directly impacting the metric would have created more frustration and possibly been demoralizing, due to the difficulty

# Questions



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