



Feedback to the Community Health Resources Commission

Consortium on Coordinated Community Supports Data Subcommittee | February 20, 2024

Q1. As part of their regular reporting to the CHRC, should grantees be required to report process and outcomes measures for ALL students/families served through their school-based programs, or just ADDITIONAL students/families served as a result of grant funding?

A1: Any reporting by grantees should encompass only activities funded by this round of CHRC grants. Including reports about activities not funded by the CHRC will prevent the CHRC from documenting the impact that its \$110 million invested in school mental health funding achieved. The ability to secure future funding will be jeopardized if adequate demonstration of the result achieved from this round of funding.

Q2. Should PSC-17 be the recommended assessment tool to measure outcomes for all applicants with Tier 3 interventions? Should it be required?

A2: The PSC-17 is not an appropriate tool to measure “outcomes for all applicants with Tier 3 interventions.” The PSC-17 measures the change in symptom severity among individual children, but it does not measure a grantee’s outcomes. A grantee providing therapy in a high-poverty school may treat children with higher acuity and greater social determinants of health than a grantee serving a less impoverished population. The “outcome” of a grantee would thus depend on a risk-adjusted comparison of outcomes based on population served; raw change on the PSC-17 score by itself is insufficient to measure and compare the performance of grantees.

We recommend that the CHRC mandate the use of the PSC-17 on Tier 3 interventions. To support grantees in the successful implementation of Measurement-Based Care, we recommend collecting: (1) client engagement, measured as numerator of clients who completed assessment over denominator number of clients invited to complete assessment; (2) reliable change in PSC-17 scores, as calculated per mandated data definition; (3) recovery or percentage of those entering with moderate or greater risk and moving to low or no risk per mandated data definition; and (4) clinician engagement, measured as numerator of clinicians employed by grantee in this program who reviewed data in preceding 30 days over denominator of all clinicians employed by grantee in this program, pursuant to a mandated data definition.

Given the complexity of the data required to effectively measure successful implementation of Measurement-Based Care, we recommend that grantees share this data monthly with the MBC Learning Collaborative for benchmarking and quality improvement purposes.

At the end of the year, the MBC Learning Collaborative can consolidate the data for a report to the CHRC to demonstrate the total number of youth engaged statewide, total youth achieving reliable change and recovery, and change in clinician engagement.

Q3. How should Tier 1 and Tier 2 outcomes be measured by grantees? Surveys? Other means?

A3: N/A

4. Should satisfaction surveys be required for all interventions, as a process measure? Should satisfaction surveys be used as an outcome measure for Tier 1 and 2 interventions? Both? What are some suggestions for satisfaction surveys?

A4: Many existing healthcare providers already collect patient satisfaction surveys pursuant to other payer or accreditation mandates. If satisfaction surveys are required, we encourage the CHRC to allow providers to use existing tools to meet this requirement.

Q5. In addition to the standardized outcomes data reported across all interventions, should grantees be required to collect and report customized outcomes data for each of their different types of interventions?

A5: No.

Q6. How should grantees measure and report average wait times for services? Is this practical?

A6. For purposes of standardization and effective reporting, CBH strongly recommends that the data definition for measuring time to access care follow the existing definition in use by grantees who are Certified Community Behavioral Health Clinics (CCBHCs). The CCBHC time-to-access-care measure encompasses: data of first contact with patient, date of initial evaluation, and date of family-centered, diagnostic and treatment-planning evaluation, and date of first clinical intervention or service.

Q7. Given that we are trying to develop a standardized data collection form, what process/outcomes measures should be collected for grants that focus on school staff training?

A7: N/A

Q8. What student demographic information should be collected and reported? What would be practical for grantees?

A8: Provider EMRs collect patient data about race, ethnicity and sex. Few EMRs are programmed to capture sexual orientation and gender identity, and reporting such data by youth population may be challenging when parents have access to youth responses.

Q9. Should applicants be required to report on funding leveraged from Medicaid, commercial insurance, etc? If so, what should they report? Is this practical?

A9: If grants are intended for interventions or populations that are not covered by insurance, it is unclear how grantees should be leveraging insurance funding to support the grants. To support broadening insurance coverage consistent with evidence-based practice, CBH recommends that Medicaid provide a report to the CHRC by January 1, 2025, on the status of Medicaid reimbursement for Measurement-Based Care through CPT code 96127. This CPT code is currently covered by Medicaid only as a primary behavioral health intervention, but is not available to behavioral health providers engaged in ongoing measurement of a client's symptoms. Medicaid coverage of the evidence-based practice of Measurement-Based Care would free up state general fund dollars to cover activities that are not reimbursed by insurance. Because grantees' ability to leverage Medicaid funding is predicated upon a change in Medicaid policy, CBH recommends that Medicaid provide an update on its coverage plans for Measurement-Based Care.

Q10. How frequently should data be reported to the CHRC? Semi-annually?

A10: CBH recommends the submission of data annually.

Q11. What suggestions do you have for the Measurement-Based Care learning collaborative?

A11: N/A.