Alabama Department of Mental Health
connecting mind and wellness

Alabama Department of Mental Health

Certified Community Behavioral Health Clinics (CCBHCs)

Quality Reporting Manual

April 1, 2026

Table of Contents

Introduction and Purpose....3

Version History....4

Quality Measurement....5

- Quality Measure Guidance....5
  - Required Quality Measures....5
  - ADMH Quality Measure Guidance....7
  - Screening and Symptom Monitoring Tools....7
  - General Guidelines for Data Collection....8
  - Expectations for State Health Information Exchange (HIE) Integration....9
  - Survey Administration and Timeline....9
- Quality Measure Reporting....11
  - General Guidelines for Data Reporting....11
  - Benchmarking....14
  - Public Reporting....18
  - Netsmart Engagement and Standardized Reports....18
  - Ensuring Data Validity and Reliability....21
- CCBHC Expectations for Engaging with ADMH: Quality Measurement....22
  - One-on-One Meetings between CCBHCs and ADMH CCBHC Data Team....22
  - Data Collection and Quality Reporting Office Hours....22
  - CCBHC Quality Summits....23
- CCBHC Data Governance....23
  - Policies and Procedures....23
  - CCBHC Data Governance Committee....23

Quality Improvement....24

- Quality Improvement Plan Reporting....24
- Contents of Plan....24
- CCBHC Expectations for Engaging with ADMH: Quality Improvement....27

Introduction and Purpose

This document is the Quality Reporting Manual and is intended to provide guidance to Alabama Certified Community Behavioral Health Clinics (CCBHCs) on how to collect, leverage, and report quality data and documents in compliance with the Alabama CCBHC Demonstration program requirements. Although every effort is made to keep this Manual up to date, the information provided is subject to change.

The purpose of this manual is to:

- **Provide Standardized Guidance**: Establishing clear quality monitoring and improvement protocols for Alabama CCBHCs that align with state and federal policies. This includes specific data collection, quality reporting, and quality improvement plan documentation requirements.
- **Ensure Data Informed Decision Making**: Outline processes for using quality data to ensure the continuous delivery of high-quality care to Alabama communities.
- **Support Compliance with Regulations**: Ensure that Alabama CCBHCs meet state and federal regulatory requirements for quality measure reporting and quality improvement plan implementation. Compliance with these standards helps prevent fraud, waste, and abuse.

This CCBHC Quality Reporting Manual is intended to support CCBHC quality data collection and reporting in Alabama as a companion to the following:

- Alabama Comprehensive Provider Manual for Certified Community Behavioral Health Clinics (CCBHCs)
- The SAMHSA Certified Community Behavioral Health Clinic (CCBHC) Certification Criteria, established set of uniform standards providers must meet to be a CCBHC.

Questions or comments pertaining to the CCBHC Quality Reporting Manual may be directed to CCBHCDataTeam@mh.alabama.gov.

Version History

Version #	Date Published	Summary of Revisions
1	10/20/2025	Publication of the first iteration of the Alabama Certified Community Behavioral Health Clinic (CCBHC) Quality Reporting Manual
2	4/1/2026	• Updated value sets for the I-SERV measure. • Added table for targets/benchmarks for state and clinic-level quality measures. • Added text to clarify ADMH CCBHC requirement around HIE connectivity (bi-directional exchange with CCBHC EHR) • Added additional information on CCBHC site expectations. for MSHIP and YSS-F survey data collection and reporting. • Throughout, updated language to consistently use the term “People with Lived Experience (PWLE).” • Updated misspelling of assessment tools in Table 3 ADMH Recommended Tools for CCBHC Clinic-Collected Quality Measures. • Integrated information from March 2025 Errata documentation from SAMHSA pertaining to the CCBHC Quality Measure Specifications[1] • Made document ADA Compliant

[1] 2025 Errata for Quality Measures for Behavioral Health Clinics:Technical Specifications and Resource Manual

Quality Measurement

Quality Measure Guidance

In accordance with CCBHC Criteria 5.A: Data Collection, Reporting, and Tracking, CCBHCs must have the capacity to collect, report, and track specified quality data. Required clinic-level quality measures are to be reported to ADMH in accordance with the most current SAMHSA technical specifications. CCBHCs must collect and report the required Clinic-Collected quality measures, as specified in the SAMHSA CCBHC Quality Measures Technical Specifications Manual. Each measure specification includes a description of the measure; key definitions to be used in measure calculation; information on the measure's eligible population, denominator, numerator, exclusions; as well as additional useful notes.

Importantly, SAMHSA has issued guidance that CCBHCs and states should use the most current year's measure specification and value sets for measures that are derived from either the CMS Medicaid Adult or Child Core Sets or the Merit-based Incentive Payment System (MIPS) measure sources. While ADMH will work diligently to stay abreast of all measure specification updates and SAMHSA Errata for Quality Measures for Behavioral Health Clinics and communicate about changes as they are made, it is expected that CCBHCs will also do their due diligence.

Required Quality Measures

Below, in **Table 1**, are the five required measures for reporting by CCBHC clinics. Additional measures may be added in the future, at the discretion of ADMH. CCBHC clinics will be given ample time to implement new data collection and reporting processes and procedures prior to any changes to reporting requirements.

Table 1: Required CCBHC Clinic-Collected Quality Measures

Quality Measure	Measure Steward	Measure ID	Inclusion in Other Federal Reporting Programs
1. Time to Services (I-SERV)	SAMHSA	N/A	No
2. Depression Remission at Six Months (DEP- REM-6)	Minnesota Community Measurement	0711	No

3. Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling (ASC)	NCQA	2152	MIPS 431
4. Screening for Social Drivers of Health (SDOH)	CMS	N/A	MIPS 487
5. Screening for Clinical Depression and Follow-Up Plan (CDF-AD and CDF-CH)	CMS	0418, 0418e	MIPS 134

Table 2 below lists the 12 required state-level quality measures to be reported by the state annually. CCBHC clinics are responsible for accurate and timely entry of clinical data and submission of administrative claims to ensure valid and reliable calculation of all state quality measures.

Table 2: Required CCBHC State-Collected Quality Measures

Measure	Measure Steward	Measure ID	Inclusion in Other Federal Reporting Programs
1. Patient Experience of Care Survey (PEC	SAMHSA	N/A	No
2. Youth/Family Experience of Care Survey (YFEC)	SAMHSA	N/A	No
3. Follow-Up After Hospitalization for Mental Illness (FUH)	NCQA	0576	Adult and Child Core Sets
4. Follow-Up After Emergency Department Visit for Mental Illness (FUM)	NCQA	3489	Adult and Child Core Sets
5. Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA)	NCQA	3488	Adult and Child Core Sets
6. Initiation & Engagement of Substance Use Disorder Treatment (IET)	NCQA	0004	Adult Core Set
7. Use of Pharmacotherapy for Opioid Use Disorder (OUD)	CMS	3400	Adult Core Set
8. Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	CMS	1879	Adult Core Set
9. Plan All Cause Readmissions (PCR)	NCQA	1768	Adult Core Set

Measure	Measure Steward	Measure ID	Inclusion in Other Federal Reporting Programs
10. Follow-Up Care for Children Prescribed Attention-Deficit Hyperactivity Disorder (ADHD) Medication (ADD-CH)	NCQA	0108	Child Core Set
11. Glycemic Status Assessment for Patients with Diabetes (GSD-AD)*	NCQA	1820	Adult Core Set

* The Glycemic Status Assessment for Patients with Diabetes (GSD-AD) measure replaced the Hemoglobin A1c Control for Patients with Diabetes (HBD-AD) measure, following notification from the HBD-AD measure steward that it is being retired and will not be maintained. This decision was communicated from SAMHSA in March 2025 and went into effect for MY 2025.

Note: Antidepressant Medication Management (AMM, 0105) was removed from the required measure list for state-level quality measure reporting beginning in MY 2026.

ADMH Quality Measure Guidance

For the *Time to Services* (I-SERV) measure, ADMH will provide annual guidance on acceptable value sets and codes that can be used to calculate measure performance. In **Appendix A**, please find the codes that ADMH has approved for use in the I-SERV measure. Please note that these are subject to change as continued review is underway, but all updates will be communicated in a timely manner to all CCBHCs.

Additional ADMH revisions to quality measure value sets or specifications will be communicated in a timely manner to CCBHCs. If a clinic must deviate from the reporting of a quality measure specification as written, the CCBHC should inform the ADMH CCBHC Data Team in writing, as early in the Measurement Year as possible. These deviations may necessitate discussions with Netsmart to ensure proper data ingestion.

Screening and Symptom Monitoring Tools

Four of the five required clinic-lead quality measures necessitate the use of standardized tools and instruments to collect relevant data for measure calculation, some of which are also included in the CCBHC Comprehensive Assessment process detailed in the ADMH CCBHC Provider Manual. **Table 3** below highlights the tools that ADMH requires CCBHCs to use for quality measure data collection, though, for the SDOH, CDF, and ASC quality measures, CCBHCs may use other standardized and validated instruments, as

detailed in the measure specifications. If the CCBHC plans to deviate from the list below, **CCBHCs should submit a list of the other tools and instruments they plan to use (with the population and clinical justification) to the ADMH CCBHC Data Team inbox for approval within the first quarter of the Measurement Year (by March 31 of each year).** This information will be useful to ADMH for future planning and implementation support, as well as ensuring all CCBHCs are using validated and acceptable instruments.

Table 3: Required Tools for CCBHC Clinic-Collected Quality Measures

2025 Required Clinic-Lead Quality Measure	Required Tools for Use in Measure Data Collection
1. Time to Services (I-SERV)	N/A
2. Depression Remission at Six Months (DEP-REM-6)	PHQ-9 PHQ-9M (Modified for teens and adolescents)
3. Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling (ASC)	AUDIT-C*
4. Screening for Social Drivers of Health (SDOH)	Protocol for Responding to and Assessing Patient's Risks and Experiences (PRAPARE) **or** another Standardized Health Related Social Needs (HRSN) Screening, such as: • Accountable Health Communities Health Related Social Needs Screening Tool (2017) and (2021) • WellRx Questionnaire (2014) • American Academy of Family Physicians (AAFP) Screening Tool (2018)
5. Screening for Clinical Depression and Follow-Up Plan (CDF-AD and CDF-CH)	PHQ-9*

* For the CDF and ASC measures, the list of screening tools included in the measure specifications includes other validated instruments not listed in this table. Although clinics **must** integrate the PHQ-9 and AUDIT-C into their clinical workflows, providers may use clinical discretion in selecting the best instrument for use with a particular individual (e.g., pregnant or postpartum women), as long as it one of the approved tools named in the measure specification.

General Guidelines for Data Collection

Below are guidelines to assist clinics in collecting and reporting required quality measures.

Measurement Years and Measurement Periods

Two periods of time are especially important to interpreting CCBHC quality measure specifications: Measurement Periods and Measurement Years. They are defined as follows:

> **Measurement Period.** The specific time period for which data are needed for the numerator and denominator of a given measure. Measurement Periods may differ for the numerator and denominator, or they may be the same. They may or may not be the same as the Measurement Year.
>
> **Measurement Year.** The standard 12-month reporting period that is common to all measures being reported by CCBHCs (January 1–December 31).

Required Stratifications

SAMHSA requirements stipulate that CCBHC quality measures will be stratified by, at minimum, age, payer, race, and ethnicity (see each measure specification for detail). Stratification by payer requires identification of individuals receiving CCBHC services as either (1) Medicaid beneficiaries, including Title 19-eligible CHIP beneficiaries, or (2) Others, including those dually enrolled under Medicare and Medicaid, Title 21-eligible CHIP beneficiaries, those reliant on other payment sources, and people who lack insurance.

Future guidance will be provided to CCBHCs about additional payer stratifications that ADMH would like to collect standardized data on (e.g., dual enrollees, commercial).

Expectations for State Health Information Exchange (HIE) Integration

ADMH requires all CCBHCs to ensure their current Electronic Health Records (EHRs) are integrated with Alabama One Health Record's (ALOHR's) HIE. This allows for full data reporting, as required by the demonstration grant. Connectivity between ALOHR and Netsmart's CAREConnect or CareManager platform or another third-party population management platform does not meet ADMH connectivity requirements.

Survey Administration and Timeline

The State is responsible for reporting two survey measures to SAMHSA as part of the CCBHC demonstration:

- **Patient Experience of Care (PEC) Survey (Adults 18+):** This survey measures the satisfaction and experiences of adult individuals receiving mental health

services. It is designed to capture perceptions of access to care, quality of services, staff interactions, and overall effectiveness of treatment.

- **Youth/Family Experience of Care (YFEC) Survey (Youth 0–17):** This survey gathers feedback from youth (where appropriate) and their families regarding the mental health services received. It aims to understand their perspectives on engagement, cultural responsiveness, family involvement, and the perceived benefits of care for the youth. **Note:** in contrast to the adult survey above, this youth survey is typically completed by a parent, caregiver, or guardian on behalf of the youth who actually received care at the CCBHC location.

These survey measures leverage two existing surveys fielded by the state, the annual *Mental Health Statistics Improvement Program (MHSIP) Adult Consumer Experience of Care Survey* and the annual *Youth/Family Services Survey for Families (YSS-F) Experience of Care Survey*. The data resulting from these surveys will be crucial for both evaluating the effectiveness of CCBHCs in delivering integrated, person-centered, high-quality behavioral health services, as well as informing continuous quality improvement efforts. **Although the results of these surveys are reported by ADMH, CCBHCs have an important role in helping to collect survey data from** individuals receiving CCBHC services.

CCBHCs are expected to participate in the State's Office of Quality Improvement and Risk Management annual training and technical assistance offerings. Questions related to survey data collection should be directed to the ADMH CCBHC Data Team at: CCBHCDataTeam@mh.alabama.gov. High level information on data collection and reporting is provided below.

Survey Requirements for Certified Community Behavioral Health Clinics

CCBHCs must administer the *Mental Health Statistics Improvement Program (MHSIP) Adult Consumer Experience of Care Survey* and the annual *Youth/Family Services Survey for Families (YSS-F) Experience of Care Survey* annually. These surveys measure consumer and family perceptions related to access to services, quality and appropriateness of care, participation in treatment, outcomes and functioning, and cultural competence. These surveys must be offered to consumers and youth family members receiving any service covered under the CCBHC model, including outpatient mental health services, psychiatric services, substance use disorder services, care coordination, peer support, crisis services, community-based services, and residential or supportive housing services.

Survey Administration Period

Surveys are administered during a three-month data collection period, typically from April through June of each year. CCBHCs are expected to begin survey promotion at the start of the data collection window and continue outreach throughout the entire period, even if target sample sizes are reached before the window closes. ADMH will provide materials for outreach, in English and Spanish, to CCBHCs in advance of the survey administration period.

Sampling Methodology

Surveys use convenience sampling, in accordance with SAMHSA guidance.

Sample Size Expectations

ADMH has a target goal of 300 completed Adult MHSIP surveys and 300 completed Youth Family surveys for each CCBHC site to support data reliability and comparability.

Survey Format and Accessibility

All surveys are administered electronically using Qualtrics. For individuals who do not wish to take the survey electronically, a paper version is available. Paper survey responses should be entered into Qualtrics by CCBHC staff. More detail on this process can be found in the surveying resource packet sent to all CCBHCs by the State.

Quality Measure Reporting

The section below provides CCBHCs with important details on how to report CCBHC quality measure data to ADMH.

General Guidelines for Data Reporting

Reporting Timelines

As outlined in **Table 4** below, CCBHCs that are active for six (6) months or longer in a given Measurement Year are required to annually submit aggregate data for each clinic-collected quality measure to ADMH, in accordance with SAMHSA CCBHC criteria. This means that CCBHCs added to the Demonstration between January 2 and June 30 for a given demonstration calendar year must report quality measures for the partial calendar year beginning on their start date. CCBHCs added on or after July 1 are not required to report quality measures for that partial year. For newly added CCBHCs, the measurement period begins on the effective start date of their Demonstration participation and should be clearly defined for quality measure reporting, unless the start date is July 1 or later, in which case reporting is deferred.

Measure performance, submitted in the SAMHSA-specified CCBHC Clinic Data Reporting Template, must be submitted to ADMH nine (9) months after the end of the Measurement Year (by **September 30** of the year following the Measurement Year). To ensure data is reported in the most current SAMHSA template, the CCBHC Data Team will email each CCBHC with a copy of the correct spreadsheet prior to the data reporting deadline. Data should be submitted to the ADMH Data Team email address: CCBHCDataTeam@mh.alabama.gov.

CCBHCs will be issued a reminder email from the ADMH CCBHC Data Team for any missed deadlines. Note that CCBHCs will also be asked to resubmit any data that does not meet ADMH's quality assurance requirements (described in more detail below in the section '*Ensuring Data Validity and Reliability*').

CCBHCs will be asked to submit a final attestation of their data prior to ADMH submission to SAMHSA. ADMH will submit all required data, including both clinic- and state-collected quality measures, to SAMHSA by **December 31** of the year following the Measurement Year.

In addition, ADMH requires that all CCBHCs submit test data, in the CCBHC Reporting Template, to the ADMH CCBHC Data Team by **April 30** of the year following the first Measurement Year that they are active in the CCBHC demonstration program.

Table 4: Required CCBHC Clinic-Collected Quality Measure Reporting Timeline

Calendar Year	Measurement Year	CCBHC Data Submission to ADMH	ADMH Data Submission to SAMHSA
2025	January 1 – December 31, 2025	**Test Submission:** April 30, 2026 **Final Submission:** Sept 30, 2026	December 31, 2026
2026	January 1 – December 31, 2026	**Test Submission** (New CCBHCs in MY only): April 30, 2027 **Final Submission** (all CCBHCs): Sept 30, 2027	December 31, 2027

As noted above, CCBHCs that enter the CCBHC program with fewer than six (6) months remaining in the Measurement Year are not required to have quality measure data submitted to SAMHSA. However, these clinics are still required to submit test data submissions and quality data to ADMH.

Eligible Population and Client Attribution

In the broadest sense, the eligible population for clinic-level quality measures includes all individuals receiving CCBHC services within a CCBHC. For each quality measure, the measure specification will further define the denominator-eligible population who satisfy the measure-specific eligibility criteria, which may include requirements such as age or continuous enrollment.

Continuous Medicaid enrollment requirements apply to determining the eligible population for some clinic-level measures. If a measure specification does not include requirements for continuous enrollment, the insurance status at the time of the first visit during the Measurement Year should be used for purposes of measure stratification.

With regard to attribution of individuals receiving CCBHC services, CCBHC clinics are responsible for including all individuals who have had one or more visits within the scope of CCBHC core services during the Measurement Year. Include all individuals who received CCBHC services, regardless of payor or which CCBHC site (if multiple) within a clinic the individual received care in.

Unit of Reporting

The unit of reporting for CCBHC quality measures is the CCBHC, regardless of how many clinics or entities comprise a single CCBHC. If a core service is rendered by a Designated Collaborating Organization (DCO), it is the responsibility of the CCBHC to arrange for access to relevant DCO data, as legally permissible upon creation of the relationship.

As a best practice, integration of DCO data into the CCBHC medical record and the Netsmart platform is recommended. Per SAMHSA CCBHC requirements, it is the responsibility of the CCBHC to arrange for access to quality data, as legally permissible, upon creation of a relationship with a DCO. CCBHCs should ensure that consent is obtained and documented as appropriate, and that releases of information are obtained for each affected person. CCBHCs should work with the State, their clinic IT team, and the DCO to ensure there is appropriate data exchange for the purposes of quality reporting. The CCBHC is responsible for ensuring DCO data is included in clinic quality reporting efforts.

Denominator Sizes

CCBHCs should report all denominators, regardless of size, to ADMH. Denominators fewer than 30 (<30) will not be publicly reported by the state, but will be reported to

SAMHSA, per CCBHC certification requirements. ADMH is committed to complying with federal and state laws pertaining to health information privacy and security. ADMH will apply data privacy rules and guidelines around minimum table cell sizes to all publicly available quality information to protect the confidentiality of individuals receiving CCBHC services.

Reporting of Specification Deviations

If a clinic must deviate from the reporting of a quality measure specification as written, the CCBHC should ensure *Section E. Adherence to Measure Specifications* of the reporting template is filled out. This section requires the reporter to indicate: (1) if they deviated from the measure's technical specification in any way when reporting and, if so, how and why there was deviation; and (2) whether the denominator represents the total eligible population as defined by the technical specifications and, if not, why not and how it varied. Of note, any deviations should be proactively communicated by the CCBHC to the ADMH CCBHC Data Team prior to data submission.

Additional Reporting of CCBHC Quality Data

As outlined in **CCBHC Criteria 5.A: Data Collection, Reporting, and Tracking, Subsection 5.a.3**, CCBHCs are required to participate in discussions with the national evaluation team and participate in other evaluation-related data collection activities as requested. Further, CCBHCs may be asked by ADMH to submit additional data or reports on an ad hoc basis.

Benchmarking

Although at this time, ADMH is not providing quality bonus payments to CCBHCs based on benchmark attainment or year-over improvements in quality measure performance, it is important to use quality measure benchmarks for the purposes of quality improvement and determining if performance rates fall within a reasonable range during the first few years of demonstration.

Below, in **Tables 5a and 5b**, are the initial target benchmarks developed for both clinic and state quality measures, based on various publicly available data (e.g., Medicaid Core Set reporting, MIPS reporting, CCBHC National Evaluation, published CCBHC quality measure performance results from other states).

Tables 5a.1 – 5a.5

Initial Quality Measure Target Benchmarks (Clinic Accountability):

Table 5a.1 – Time to Services (I-SERV)

Target Benchmark*	Reference (Links Included)
Avg Time to Evaluation: 8-10 business days	2022 CCBHC National Evaluation Findings; Rhode Island State CCBHC Quality Manual
Avg Time to Clinical Services: 6-9 business days	2022 CCBHC National Evaluation Findings; Rhode Island State CCBHC Quality Manual
Avg Time to Crisis Services: 3-4 hours	2022 CCBHC National Evaluation Findings; Rhode Island State CCBHC Quality Manual

*Note: No current national benchmark available. This manual will be updated when a benchmark is available.

Table 5a.2 – Depression Remission at Six Months (DEP-REM-6)

Target Benchmark	Reference (Links Included)
8-10%	DY1 Average from 2022 CCBHC Quality Measure Reports; MNCM State 2023 MY rate

Table 5a.3 – Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling (ASC)

Target Benchmark	Reference (Links Included)
59%	DY1 Average from 2022 CCBHC Quality Measure Reports

Table 5a.4 – Screening for Social Drivers of Health (SDOH)

Target Benchmark	Reference (Links Included)
N/A	No current national benchmark is available. This manual will be updated when a benchmark is available.

Table 5a.5 – Screening for Clinical Depression and Follow-Up Plan (CDF-AD and CDF-CH)

Target Benchmark	Reference (Links Included)
51%	DY1 Average from 2022 CCBHC Quality Measure Reports

Table 5b: Initial Quality Measure Target Benchmarks (State Accountability)

Measure	Target Benchmark	Reference (Links Included)
Patient Experience of Care Survey (PEC)	Access: 88% Appropriateness: 84% Outcomes: 82% Participation: 82% General: 89% Connectedness: 79% Function: 82%	Mental Health Statistic Improvement Program. (MHSIP). (2025). Alabama CCBHC program.
Youth/Family Experience of Care Survey (YFEC)	Access: 86% Cultural Sens.: 93% Outcomes: 77% Participation: 86% General: 86% Connectedness: 84% Function: 84%	Youth Satisfaction Survey for family/guardians (YSS-F). (2025). Alabama CCBHC program.
Follow-Up After Hospitalization for Mental Illness (FUH)- 7 Day Follow-Up	**Ages 6 to 17:** AL Avg.: 39.7% US Median: 44.8% **Ages 18-64:** AL Avg.: 31.6% US Median: 32.3%	AL Medicaid Average for MY 2024 (Medicaid Scorecard- Child)
Follow-Up After Hospitalization for Mental Illness (FUH)- 30 Day Follow-Up	**Ages 6 to 17:** AL Avg.: 62.6% US Median: 70.0% **Ages 18-64:** AL Avg.: 49.4% US Median: 51.4%	AL Medicaid Average for MY 2024 (Medicaid Scorecard- Adult)
Follow-Up After Emergency Department Visit for Mental Illness (FUM) – 7 Day Follow-Up	**Ages 6 to 17:** AL Avg.: 45.8% US Median: 50.8% **Ages 18-64:** AL Avg.: 28.3% US Median: 35.3%	AL Medicaid Average for MY 2024 (Medicaid Scorecard- Child)
Follow-Up After Emergency Department Visit for Mental Illness (FUM) – 30 Day Follow-Up	**Ages 6 to 17**: AL Avg.: 62.5% US Median: 69.3% **Ages 18-64:** AL Avg.: 40.8% US Median: 50.7%	AL Medicaid Average for MY 2024 (Medicaid Scorecard- Adult)

Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA)- 7 Day Follow Up Indicator	**Ages 13 to 17:** AL Avg.: 18.1% US Median: 21.5% **Ages 18-64:** AL Avg.: 16.5% US Median: 25.8%	AL Medicaid Average for MY 2024 (Medicaid Scorecard- Child)
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA)- 30 Day Follow-Up	**Ages 13 to 17:** AL Avg.: 37.0% US Median: 33.0% **Ages 18-64:** AL Avg.: 35.2% US Median: 37.6%	AL Medicaid Average for MY 2024 (Medicaid Scorecard- Adult)
Initiation & Engagement of Substance Use Disorder Treatment (IET) - Initiation	AL Avg.: 42.8% US Median: 44.2%	AL Medicaid Average for MY 2024 (Medicaid Scorecard- Adult)
Initiation & Engagement of Substance Use Disorder Treatment (IET) - Engagement	AL Avg.: 7.8% US Median: 15.7%	AL Medicaid Average for MY 2024 (Medicaid Scorecard- Adult)
Use of Pharmacotherapy for Opioid Use Disorder (OUD)	AL Avg.: 68.3% US Median: 60.5%	AL Medicaid Average for MY 2024 (Medicaid Scorecard- Adult)
Antidepressant Medication Management (AMM)- Acute Phase	AL Avg.: 58.3% US Median: 61.1%	AL Medicaid Average for MY 2024 (Medicaid Scorecard)
Antidepressant Medication Management (AMM)- Continuation Phase	AL Avg.: 27.7% US Median: 42.1%	AL Medicaid Average for MY 2024 (Medicaid Scorecard)
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	AL Avg.: 73.1% US Median: 61.2%	AL Medicaid Average for MY 2024 (Medicaid Scorecard)
Plan All Cause Readmissions (PCR)	US Median: 0.99 (0/E Readmissions Ratio)	PCR-AD MY 2024 Medicaid Scorecard
Follow-Up Care for Children Prescribed Attention-Deficit Hyperactivity Disorder (ADHD) Medication (ADD-CH)- Initiation Phase	AL Avg.: 40.2% US Median: 47.4%	AL Medicaid Average for MY 2024 (Medicaid Scorecard- Child)
Follow-Up Care for Children Prescribed Attention-Deficit Hyperactivity Disorder (ADHD) Medication (ADD-CH)- Continuation and Maintenance Phase	AL Avg.: 81.8% US Median: 54.8%	AL Medicaid Average for MY 2024 (Medicaid Scorecard- Child)

Hemoglobin A1c Control for Patients with Diabetes (HBD-AD)- Poor Control (>9.0%)	AL Avg.: 92.6% US Median: 38.8%	[AL Medicaid Average for MY 2024 (Medicaid Scorecard- Adult)]
Glycemic Status Assessment for Patients with Diabetes (GSD-AD)*	HBD-AD Historical Benchmarks: AL Avg.: 6.5% US Median: 52.1%	Benchmarks for GSD are not yet available. HBD-AD may be used until GSD benchmarks are available. AL Medicaid Average for MY 2024 (Medicaid Scorecard- Adult)

* The Glycemic Status Assessment for Patients with Diabetes (GSD-AD) measure replaced the Hemoglobin A1c Control for Patients with Diabetes (HBD-AD) measure. This decision was communicated from SAMHSA in March 2025 and went into effect for MY 2025.

Note: Antidepressant Medication Management (AMM, 0105) was removed from the required measure list for state-level quality measure reporting beginning in MY 2026.

Public Reporting

CCBHC quality data will be sent to SAMHSA, in accordance with the CCBHC Certification Criteria, as outlined above. In addition, to ensure transparency and public access to important quality data, ADMH will also develop an annual CCBHC Quality Report with detail on CCBHC and state-level quality measures and outcome performance and improvement. ADMH is committed to complying with federal and state laws pertaining to health information privacy and security. ADMH will apply data privacy rules and guidelines around minimum table cell sizes to all publicly available quality information to protect the confidentiality of CCBHC individuals receiving CCBHC services.

Netsmart Engagement and Standardized Reports

ADMH has taken measures to ensure high-quality data collection and reporting capacity for CCBHCs through contracting with Netsmart to leverage their comprehensive population health platform and ensure connection to data exchange with relevant entities and databases. Netsmart's Population Health Platform includes a fully packaged suite of solutions to best manage large scale population health initiatives and provide support for the CCBHC program. The following components are included in their Population Health Platform:

- **Data Platform** – An agnostic data repository that draws data from various sources, such as the state HIE, One Health Record; Hospitalizations, Discharge,

and Transfer (ADT) data; Medicaid Management Information System (MMIS); and CCBHC EHRs, among others, to create one real-time central data repository and dashboard.
- **CareManager** – Netsmart's Care Coordination platform allows for management of populations, documentation, alerts, worklists, and risk stratification. This is where aggregate data can be viewed and actioned to improve outcomes.
- **CareConnect** – Enables the exchange of clinical information between a Health Information Exchange (HIE) and provides a secure way to share clinical and administrative information. The "inbox" function of CareConnect allows direct secure messaging with external providers like hospitals, labs, etc.
- **CarePathways** – Provides KPI Dashboards for clinical and operational decision-makers to determine if the organization is moving in the right direction to achieve organizational goals. This module also provides Measures Reporting, which is a web-based reporting solution providing industry standard quality measures, including denominator, numerator, and performance rates. SAMHSA CCBHC Quality Measures can be run and viewed withing this module.

ADMH selected this suite of tools specifically to work with CCBHCs and other state and community partners, rather than require them to undergo costly adaptations to their existing platforms and data programs.

Accessing Netsmart Platforms and Assistance

As part of CCBHC demonstration participation, all CCBHCs will receive access to the entire Netsmart Population Health Platform suite as well as tailored support tools to effectively use it, including:

- Login information and support to access Netsmart's data platform.
    - For CarePathways, each provider is allotted up to five (5) logins for Measures and the KPI Dashboard.
- Ongoing technical assistance and training.
- Maintenance of the SAMHSA CCBHC clinic measures within the Netsmart platform, as well as on-demand pre-built reports to run measures.
- Maintenance of the risk stratification model that populates for the CCBHC population.

Providers entering the CCBHC Demonstration Program will be asked to engage with Netsmart as early as possible to ensure full use of the platform upon program go-live.

The ADMH CCBHC Data Team will guide all CCBHCs through the Netsmart engagement process, which will include, at minimum:

- Attending an initial kick-off call with the Netsmart team and the ADMH CCBHC Data Team to discuss timeline for onboarding, business rule development processes, current EHR functionality and vendor, and other topics, to be sent in advance to the CCBHC.
- Executing Netsmart and ADMH contracts, including Data Use Agreements (DUAs) and contract documentation.
- Meeting regularly with Netsmart and ADMH CCBHC Data Team to develop business rules and establish Netsmart connectivity with the CCBHC EHR and other relevant data sources.
- Identifying individuals to attend and participate in Netsmart training.
- Regularly reviewing data in the Netsmart platform and flagging any validity or reliability issues that are identified when compared to clinic data with both the Netsmart and ADMH Data Team.

All CCBHCs will be responsible for identifying the relevant staff to engage with Netsmart on an ongoing basis and take responsibility for the functionality and use of the platform. CCBHCs will also be required to identify the individuals within the organization that should have access to the various components of the Netsmart platform and regularly review these roles. If a CCBHC needs to change Netsmart user roles at any time (e.g., staff member is no longer with the organization or their role has changed), please let the CCBHC Data Team and Netsmart know as soon as possible.

At any time, if a CCBHC identifies data anomalies or issues, the CCBHC should reach out to Netsmart and the ADMH CCBHC Team. Please include the CCBHC Data Team (CCBHCDataTeam.DMH@mh.alabama.gov) on all correspondence with Netsmart (i.e., issues, meetings, emails). For providers using Netsmart's myAvatar, continue to use your current support process for any myAvatar-related issues.

Accessing Standardized Quality Reports and Dashboards in Netsmart

The Netsmart platform has been designed to support CCBHC quality measure calculation and reporting. The platform will automatically ingest the most current SAMHSA quality measure technical specifications and validate that the measure specifications are accurately and reliably calculating quality measure performance rates. Of note, responsibility for the accuracy of quality measure data is the responsibility of ADMH and the CCBHCs. **CCBHCs should also calculate and validate quality measure**

performance rates outside of the Netsmart system and attest to the final data they submit to ADMH.

All CCBHCs will be provided with training and technical assistance on use of the CarePathways, including how to pull standardized quality measure performance reports. The CarePathways Measures Reporting Center can be found online at Measures Reporting - Netsmart Resource Center. This includes information on how to navigate the program, including a "Measures Portal Guide" and "Navigating CarePathways Measure Portal 3.0" training video.

Ensuring Data Validity and Reliability

Ensuring the validity and reliability of quality data used for quality reporting is the responsibility of both the CCBHCs and the state. ADMH has developed a robust quality assurance and data governance framework to support data quality. ADMH has also put in place a CCBHC Data Governance Steering Committee to regularly meet and provide enhancements to the CCBHC Data Governance framework and policies.

Initial Quality Review

Upon receipt of competed quality measure reporting templates from clinics, the ADMH Data Team will conduct a rapid quality assurance (QA) assessment. All submitted files must pass all QA assessment criteria to be accepted. Any deficient data must be corrected and resubmitted by the CCBHC within **15 business days** of receiving the QA assessment report returned to the CCBHC by the ADMH CCBHC Data Team.

This rapid QA assessment will review submitted data across the four C.A.R.T. dimensions: Completeness, Accuracy, Reasonableness, and Timeliness.

- **Completeness:** Ensure all required fields in the CCBHC data reporting template are complete and there are no missing or null fields.
- **Accuracy:** Ensure reported data values adhere to data format requirements and valid ranges.
  - **Format Requirements:** Ensure proper data type is being used (e.g., numerical or text data) and that all numerical values are not out of range (e.g., quality performance does not exceed 100% or is not below 0%)
  - **Section E: *Adherence to Measure Specifications*** should be filled out completely.

- **Reasonableness:** Ensure reported data is logical and consistent with expected trends.
    - **Section E: *Adherence to Measure Specifications*** should include reasonable explanations as to why a deviation from the measure specification was necessary.
- **Timeliness:** Ensure data is submitted to the ADMH CCBHC Data Team by the stated deadline (*April 30 for test data, September 30 for final locked data*).

CCBHC Expectations for Engaging with ADMH: Quality Measurement

To support the success of the CCBHC model for both CCBHC sites and the state of Alabama, regular data and quality meetings will be hosted by ADMH CCBHC Data Team staff. Taken together, these meetings will ensure the state is implementing the CCBHC quality and data collection requirements with fidelity, as well as being a trusted partner to CCBHCs and community organizations within the state in monitoring and advancing the service quality. Importantly, these data and quality meetings outlined below will be provided in addition to CCBHC training and technical assistance opportunities related to data and quality and ongoing Netsmart meetings available to sites. **It is an expectation that all CCBHC sites send representatives to all the meetings below.**

One-on-One Meetings between CCBHCs and ADMH CCBHC Data Team

On a quarterly basis, CCBHCs are expected to attend a one-hour check-in meeting with the ADMH CCBHC Data Team. During these sessions, CCBHC representatives and ADMH Data Team staff will review current quality measure performance; set and review quality improvement initiatives, goals, and progress; discuss challenges and successes related to quality improvement and measurement; and solve problems collaboratively.

Data Collection and Quality Reporting Office Hours

Twice per month, informal office hours will be hosted by the ADMH CCBHC Data Team to support CCBHC quality and analytic staff in efforts related to data collection, quality monitoring, and quality improvement. The ADMH team will come prepared to discuss any relevant program updates or address any questions received from CCBHCs relevant to data and quality; however, CCBHC representatives are encouraged to come to these sessions with questions or challenges to discuss with the group.

CCBHC Quality Summits

The CCBHC Quality Summits, which will be held twice per calendar year, are an important opportunity to bring together CCBHC program staff and leadership, relevant stakeholders, state partners, and CCBHC representatives. The purpose of the Summits are to share updates and best practices related to CCBHC quality and data reporting, foster enthusiasm and collaboration for the CCBHC model, and identify opportunities for improvement. Summits may be held virtually or in-person.

CCBHC Data Governance

ADMH has developed a robust quality assurance and data governance framework to support data quality. This framework aligns with the framework currently used by Medicaid. ADMH has also put in place a CCBHC Data Governance Steering Committee to regularly meet and provide enhancements to the CCBHC Data Governance framework and policies. Details on these can be found below.

Policies and Procedures

ADMH has developed a CCBHC Data Governance Framework, which establishes policies, standards, practices, and overall guiding principles for managing data across Alabama's CCHBCs, and ensuring alignment with the SAMHSA CCBHC Certification Criteria, as well as federal and state regulations (e.g., HIPAA, 42 CFR Part 2, USCDI, HL7, etc.). The objectives of data governance within Alabama's CCBHC Program are to ensure that data is managed as a valuable resource throughout its lifecycle. This policy:

- Ensure Data Quality.
- Protects Data Protects and Security.
- Promotes Regulatory and Policy Compliance.
- Enables Data-Driven Decision-Making.
- Standardizes Data Processes.
- Clarifies Data Roles and Responsibilities.

CCBHC Data Governance Committee

The CCBHC Data Governance Committee is a specialized group with cross-functional membership that provides guidance and subject matter expertise to the ADMH CCBHC team related to the development, refinement, and implementation of data governance and use policies and procedures. The Committee is responsible for monitoring data quality issues and feedback and developing tactical solutions and policies to address

identified challenges or limitations of the CCBHC data infrastructure. CCBHC data and quality subject matter experts may be invited to participate on this committee or provide information to the committee for the purposes of enhancing the CCBHC program.

Quality Improvement

Quality Improvement Plan Reporting

In accordance with CCBHC Criteria 5.B: Continuous Quality Improvement Plan, CCBHCs must develop, implement, and maintain an effective annual CCBHC-wide continuous quality improvement (CQI) plan for the services provided. This plan should guide data-driven continuous efforts to improve the quality of behavioral and physical health care within the organization. CCBHCs should consider the use of both qualitative and quantitative data in their CQI plan and activities, and leverage data from clinic- and state-collected quality measures, Community Needs Assessment findings, known significant events, internal clinic key performance indicators or measures, and client and provider satisfaction efforts.

On an annual basis, each CCBHC must provide a CQI plan to the ADMH CCBHC Data Team by March 1 of each calendar year. The preferred format for this submission is a Word or PDF document. Each CQI plan must include, at minimum, the contents specified in the following section. CCBHCs may email CQI plans to the ADMH CCBHC Data Team at CCBHCDataTeam@mh.alabama.gov.

Contents of Plan

To assist with the development of plans, should CCBHCs not already have one in place, an outline has been provided below. Each CQI plan must include, at minimum, the following components:

1. **Quality improvement goals, objectives, and measures with time-bound targets:**
   In this section, CCBHCs should define the goals and objectives of CQI efforts for the period covered by the CQI plan. This should include, at minimum:
   - Clear description of each goal and objective.
   - For each objective in the plan, list the person(s) responsible and time frames associated with targets.
   - The performance measures to be achieved through each objective. *Note, the quality measures from the clinic-collected and state-collected CCBHC measure sets should be prioritized and used where appropriate.*

At least one goal should be monitored using CCBHC quality measures per year.

- Identify the activities or projects associated with each objective.
- Which of the nine CCBHC Required CCBHC Services are impacted by the CQI objectives and activities. As a reminder, these are (1) Crisis Services; (2) Outpatient Mental Health and Substance Use Services; (3) Person- and Family-Centered Treatment Planning; (4) Community-Based Mental Health Care for Veterans; (5) Peer Family Support and Counselor Services; (6) Targeted Care Management; (7) Outpatient Primary Care Screening and Monitoring; (8) Psychiatric Rehabilitation Services; and (9) Screening, Diagnosis and Risk Assessment.

2. **Project identification, alignment with strategic plan and initiation process:**
   In this section, CCBHCs should describe and demonstrate how improvement areas were identified and how they were prioritized for project activity. Include how data is used to identify gaps in quality or areas for improvement. At minimum, the CCBHC should discuss monitoring the following data in identifying improvement areas:
   - Known significant events including, at a minimum: (1) deaths by suicide or suicide attempts of people receiving services; (2) fatal and non-fatal overdoses; (3) all-cause mortality among people receiving CCBHC services; and (4) 30-day hospital readmissions for psychiatric or substance use reasons.
   - Events the state or applicable accreditation bodies may deem appropriate for examination and remediation as part of a CQI plan.
   - Current performance on clinic-collected and state-collected CCBHC quality measures.
   - Community Needs Assessment data.
   - Satisfaction data for both individuals receiving CCBHC services and CCBHC staff/providers.

3. **Key elements of the quality improvement effort's structure, for example:**
   In this section, CCBHCs should include information on how the chose quality improvement intervention or program is to be structured, including:
   - Organizational structure (who is accountable for this QI effort and where in the organization are they located).
   - Roles and responsibilities (who is involved in this QI effort).

- CQI oversight committee or team (who is responsible for overseeing and strategically guiding this effort and how are members identified/rotated).
- Staffing and administrative support (what additional supports are needed to ensure the QI effort is appropriately deployed and tested).
- Budget and resource allocation.

4. **Relationship between quality improvement projects identified and the CCBHC's strategic vision and mission**
   CCBHCs should carefully consider and describe how QI efforts are aligned with the strategic vision and mission of the organization.

5. **CCBHC CQI Methodology and Continuous Monitoring of CQI Plan, Goals, and Objectives**
   In this section, CCBHCs should clearly articulate the CQI methodology employed by the organization to incrementally test and measure CQI interventions and improvements to stated goals and objectives. This should include:
   - Means by which data are collected and analyzed.
   - How progress toward achieving stated goals and objectives is measured.
   - Actions taken to make improvements based on progress reports and ongoing data monitoring and analysis.

6. **Current CCBHC efforts to develop and maintain a culture of quality with the organization**
   CCBHCs should describe how they foster and maintain a culture of quality within their organization, including, but not limited to:
   - The CCBHC's approach to how staff and clinicians are provided training and continuing education on CQI best practices and how CQI impacts their specific role.
   - Types of quality improvement training conducted within the organization.
   - Regular communication of quality improvement activities conducted in the CCBHC through mechanisms such as staff meetings and presentations, publicly displayed story board or information on CQI projects, quality committee meeting minutes, or quality newsletters.
   - Processes and procedures in place to assess the effectiveness of the quality improvement plan and improvement activities, which may include:

- Review of the process and the progress toward achieving goals and objectives.
- Efficiencies and effectiveness obtained, and lessons learned.
- Satisfaction data for both individuals receiving CCBHC services and CCBHC staff/providers.
- Description of how reports on progress were used to revise and update the CQI plan.
- Desired future state of quality in the organization.

CCBHC Expectations for Engaging with ADMH: Quality Improvement

The CQI Plan and resulting progress indicators and results will be a foundational component of the ongoing data and quality conversations between the CCBHC and the ADMH CCBHC Data Team. CCBHCs can expect to review their CQI Plans and progress towards their CQI goals and objectives with the CCBHC Data Team staff throughout the year. A typical schedule may look like the following:

- **Quarter 1 of Calendar Year**
  - **Q1 Quarterly 1:1 Meeting CQI topics:**
    - Review of final data for previous year's CQI goals and progress made on closing identified quality gaps.
    - Discussion of ongoing conversations within CCBHC around goal and objective setting based on available data.
  - **CQI Requirements:**
    - CQI Plan due to State CCBHC Data Team by **March 1.**
- **Quarter 2 of Calendar Year**
  - **Q2 Quarterly 1:1 Meeting CQI topics:**
    - Review of final CQI goals and objectives set by CCBHC. This includes the specific goals and objectives, measurable indicators selected, action steps and timelines for selected interventions, and assigned responsibilities.
  - **CQI Requirements**:
    - ADMH CCBHC Data Team to approve CQI plan and verify that plan meets CCBHC requirements by **April 1** of calendar year.
    - If ADMH identified a need for any updates or revisions to the CQI plan, the CCBHC must make the updates and return the plan **within 2 weeks**.
- **Quarter 3 of Calendar Year: Review CQI Progress**
  - **Q3 Quarterly 1:1 Meeting CQI topics:**

    - Review progress on CQI goals and objectives (i.e., progress on metrics of success, lessons learned, changes made or recommended on current projects/interventions).
- **Quarter 4 of Calendar Year:**
  - **Q4 Quarterly 1:1 Meeting CQI topics:**
    - Review progress on CQI goals and objectives (i.e., progress on metrics of success, lessons learned, changes made or recommended on current projects/interventions).
    - Discuss planning and development of CQI plan and corresponding goals/objectives for upcoming calendar year.

Appendix A: ADMH-Approved Codes for *Time to Services* (I-SERV) Measure

I-SERV Measure Component	Definition*	Allowable Codes
Initial Contact	First time an individual or guardian contacts a CCBHC to obtain services in a six-month period. First Contact may be by telephone. First Contact for a CCBHC should include the required preliminary screening and risk assessment and collection of basic data about the person that includes insurance information.	75492-9 (LOINC)
Initial Evaluation	The Initial Evaluation is due within 10 Business Days of First Contact for those who present with "routine" non-emergency or non-urgent needs.	96150, 96156, 96158, 90791
Initial Clinical Services	Initial Clinical Services occur after a preliminary screening and risk assessment to determine acuity of needs and after or at the time of an Initial Evaluation. CCBHC criteria require the Initial Clinical Services to occur within 10 Business Days of First Contact for those who present with "routine" non-emergency or non-urgent needs.	*90792, 90832, 90834, 90837, 90839, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99384, 99385, 99386, 99387, 99394, 99395, 99396, 99397, H0002, 90849, 90853, G9008, G9002, H0036, H0046, H0038*
First Crisis Episode Contact	A Crisis Service Episode begins when the Crisis Service provider (whether a CCBHC or its crisis DCO) receives a contact related to needed Crisis Services for a client for the first time in 24 hours.	78709-3 (LOINC)
Crisis Services	Crisis services are those provided by CCBHCs in accordance with the CCBHC Certification Criteria (Criteria 2.c).	90839, H2011, S9485