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Certified Community Behavioral Health Clinics (CCBHC) Data and Reporting TA

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Virtual Meeting Housekeeping

- Please raise hand within the Zoom features or submit your question in the chat.
- When speaking, please identify yourself and your program/business/clinic.
- This meeting is being recorded and subject to public record.

Agenda

- Welcome!
 - Introductions
- General metric process
- High level metric spotting
 - Screening for Social Drivers of Health (SDOH)
 - Depression Remission at Six Months (DEP-REM-6)
- Q&A and peer learning discussion
- Wrap up
 - Resources/follow-up materials



General Metric Process

Data Calculations and Timelines

- **What is the measurement year (MY)?** January 1 to December 31 (example: January 1, 2025 – December 31, 2025). Clinics should submit rosters and clinic-led metrics to the [CCBHC Inbox](#).

Data Reporting Deadlines for Measurement Year (MY)

MY 2025	May 1, 2026	Medicaid rosters due to OHA
	September 31, 2026	Required clinic-led metrics due to OHA
	December 2026	OHA calculates state-led metrics
MY 2026	May 1, 2027	Medicaid rosters due to OHA
	September 31, 2027	Required clinic led-metrics due to OHA
	December 2027	OHA calculates state-led metrics

CCBHC Clinic-Led Metrics - Required

Clinics capture/report required clinic-led metrics and use the provided template to send to OHA. Please ensure there are policies and processes in place to capture these metrics as OHA does not calculate them.

↑ - indicates higher scores are better quality.

↓ - indicates lower scores are better quality.

Time to Services (I-SERV) ↓

Depression Remission at Six Months (DEP-REM-6) ↑

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

Screening for Social Drivers of Health (SDOH) ↑

Screening for Clinical Depression and Follow Up Plan (CDF-AD and CDF-CH) ↑

CCBHC Data Reporting Template – Clinic-Led

[SAMHSA's CCBHC Data Reporting Template](#)

- Updated in 2024 to reflect quality measure updates.
- Clinics will report the clinic-led measurement data with the template to OHA. OHA will report both clinic-led and state-led to SAMHSA.
- [SAMHSA's overview slides](#)
- [SAMHSA overview video](#)

Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling (ASC)			
Based on CMS MIPS CQMS #431 (2023), which is derived from a measure stewarded by the National Committee for Quality Assurance (NCQA)			
A. Measurement Year:			
Insert Measurement Year.			
B. Data Source:			
Select the data source type (Medical Records or Other):		If medical records data, select source (EHR, Paper Records, Both, Other):	
If other data source selected, specify source:			
C. Date Range for Measurement Period:			
Denominator Start Date (mm/dd/yyyy)			
Denominator End Date (mm/dd/yyyy)			
Numerator Start Date (mm/dd/yyyy)			
Numerator End Date (mm/dd/yyyy)			
D. Performance Measure:			
Percentage of clients aged 18 years and older who were screened for unhealthy alcohol use using a Systematic Screening Method at least once within the last 12 months AND who received brief counseling if identified as an unhealthy alcohol user. There are three (3) submeasures below. Note: Technical specifications must be used to obtain both the denominator and the numerator.			
SUBMEASURE 1: ALL CLIENTS WHO WERE SCREENED FOR UNHEALTHY ALCOHOL USE			
The measure is stratified to report by (1) payer , (2) ethnicity, and (3) race.			
Stratification by Payer and Total Eligible Population			
Measure	Numerator	Denominator	Rate (Percentage)
Medicaid			
Non-Medicaid (including dually eligible for Medicare and Medicaid)			
Total Eligible Population:		0	0

CCBHC State-Led Metrics - Required

OHA calculates these measures by using clinic's Medicaid rosters.

Patient Experience of Care Survey (PEC) ↑

Youth/Family Experience of Care Survey (YFEC) ↑

Antidepressant Medication Management (AMM-AD) ↑

Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD) ↑

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

Initiation and Engagement of Alcohol and Other Drug Dependencies Treatment (IET) ↑

↑ - indicates higher scores are better quality.

↓ - indicates lower scores are better quality.

CCBHC State-Led Metrics – Required Con't.

OHA calculates these measures by using clinic's Medicaid rosters.

Plan All-Cause Readmissions Rate (PCR-AD) ↓

Follow-Up Care for Children Prescribed Attention-Deficit Hyperactivity Disorder (ADHD) Medication (ADD-CH) ↑

Glycemic Status Assessment for Patients with Diabetes (GSD-AD) ↑

Follow-Up After Emergency Department Visit for Mental Illness (FUM-CH and FUM-AD) ↑

Follow-Up After Hospitalization for Mental Illness (FUH-CH and FUH-AD) ↑

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

↑ - indicates higher scores are better quality.

↓ - indicates lower scores are better quality.



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High Level Metric Spotting

Screening for Social Drivers of Health (SDOH)*

SDOH “are the nonmedical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life” ([CDC, 2022](#)).

Performance measure: The SDOH measure calculates the percentage (numerator/denominator) of clients 18 years of age and older screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety.

Requirements: Patient is required to have a standardized health related social needs screening done once per measurement year (January 1 – December 31).

**Based on Centers for Medicare and Medicaid Services (CMS) Merit-based Incentive Payment System (MIPS) [CQMS #487 \(2023\)](#), stewarded by CMS.*

Screening for Social Drivers of Health (SDOH)

Examples of standardized screening tools (including but not limited to):

[Accountable Health Communities Health Related Social Needs Screening Tool](#) (2017)

[Accountable Health Communities Health Related Social Needs Screening Tool](#) (2022)

[The Protocol for Responding to and Assessing Patients' Risks and Experiences \(PRAPARE\) Tool](#) (2016)

[WellRx Questionnaire](#) (2017)

[American Academy of Family Physicians \(AAFP\) Screening Tool](#) (2018)

Screening for Social Drivers of Health (SDOH)

Eligible clients: Clients who are 18 years and older on date of services during measurement year and seen at CCBHC for at least one encounter during the measurement year.

Numerator: All eligible clients screened for food insecurity, housing instability, transportation needs, utility difficulties and interpersonal safety. Clients can be screened multiple times, but the measure only requires one screening per measurement year. Relevant numerator codes can be found in the [2024 SAMHSA Technical Specifications and Resource Manual](#).

Denominator: All clients in eligible population. Relevant denominator codes can be found in the [2024 SAMHSA Technical Specifications and Resource Manual](#).

SDOH Stratification

Payor

Medicaid only

Non-Medicaid (including dual MK/MC)

Ethnicity

Hispanic or Latino

Not Hispanic or Latino

Unknown

Race

American Indian or Alaska Native

Asian

Black or African American

Native Hawaiian or other Pacific Islander

White or Caucasian

More than one race

Unknown

Depression Remission at Six Months (DEP-REM-6)*

Performance measure: The DEP-REM-6 measure calculates the percentage of clients (12 years of age or older) with major depression or dysthymia who reach remission six months (+/- 60 days) after an Index Event Date. Note: Technical specifications must be used to obtain both the denominator and the numerator.

Index Event Date: The first date in the calendar year where the client has an elevated [Patient Health Questionnaire – 9 item version \(PHQ-9\)](#) (appropriate for ages 18 and older) or [PHQ-9 Modified for Teens and Adolescents \(PHQ-9M\)](#) (appropriate for ages 11-17) greater than **nine** and a diagnosis of depression or dysthymia. The screening using PHQ-9 or PHQ-9M can occur up to seven days prior to the encounter.

*Based on Centers for Medicare and Medicaid Services (CMS) Merit-based Incentive Payment System (MIPS) [CQMS #370 \(2023\)](#), stewarded by MN Community Measurement (NQF #0710).

Depression Remission at Six Months (DEP-REM-6)

Eligible clients: Clients 12 years of age and older at the time of their Index Event Date, seen at CCBHC, who have an active diagnosis of major depression or dysthymia at a client encounter during measurement year and who have an Index Event Date PHQ-9 or PHQ-9M score greater than nine.

Numerator: All clients in the denominator who achieved remission at six months (+/- 60 days) as demonstrated by a PHQ-9 or PHQ-9M score of less than five. Relevant numerator codes can be found in the [2024 SAMHSA Technical Specifications and Resource Manual](#).

Denominator: All clients in eligible population. Relevant denominator codes can be found in the [2024 SAMHSA Technical Specifications and Resource Manual](#).

Exclusions: All clients with an active diagnosis of any of the following - bipolar disorder, personality disorder, schizophrenia, psychotic disorder, or pervasive developmental disorder at any time prior to end of numerator measurement period or if the provider reports a twelve-month remission measure as the measure assessment period. Clients who have died prior to end of numerator measurement period. Clients receiving hospice or palliative care. Relevant exclusion codes can be found in the [2024 SAMHSA Technical Specifications and Resource Manual](#).

Depression Remission at Six Months (DEP-REM-6)

Measurement period: period for which data are required for reporting purposes

Numerator measurement period: Begins four months after the beginning of the Measurement Year and extends eight months past the end of the Measurement Year; this allows capture of remission in the period 4 to 8 months after an Index Event Date that may occur at any point during the Measurement Year (6 months (+/- 60 days)). This equates to a four-month window around the six-month calendar date from the Index Event Date (+/- 60 days)

Denominator measurement period : 12-month reporting period from January 1 – December 31

Figure 1. Visual of Measurement Year, Measurement Periods, and Index Event Dates for Remission at Six Months

	Index screening may be 7 days before first possible IED																			
Months:	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
	MY																			
	Denominator MP: 12 mo MY																			
	Numerator MP: 6 mo +/- 60 days after IED																			
If IED=x, R may be measured:	x				R	R	R	R	R											
If IED=x, R may be measured:		x				R	R	R	R	R										
If IED=x, R may be measured:			x				R	R	R	R	R									
If IED=x, R may be measured:				x				R	R	R	R	R								
If IED=x, R may be measured:					x				R	R	R	R	R							
If IED=x, R may be measured:						x				R	R	R	R	R						
If IED=x, R may be measured:							x				R	R	R	R	R					
If IED=x, R may be measured:								x				R	R	R	R	R				
If IED=x, R may be measured:									x				R	R	R	R	R			
If IED=x, R may be measured:										x				R	R	R	R	R		
If IED=x, R may be measured:											x				R	R	R	R	R	R

Key: IED: Index Event Date; MY: Measurement Year; MP: Measurement Period; R: Six Month Remission may be measured, depending on date, 4-8 months after IED (6 months (+/- 60 days)).

DEP-REM-6 Stratification

Age

12-17 years

18+ years

Payor

Medicaid

Non-Medicaid (including dual MK/MC)

Ethnicity

Hispanic or Latino

Not Hispanic or Latino

Unknown

Race

American Indian or Alaska Native

Asian

Black or African American

Native Hawaiian or other Pacific Islander

White or Caucasian

More than one race

Unknown



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Q&A and Peer Learning Discussion

Submitted Questions/Future Topic Discussions?

- Future sessions will include:
 - Presentations from peer clinics on successful strategies for particular metrics
 - Overview of data use in the community needs assessment
 - Using/interpreting the metrics dashboard
 - Other ideas?



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Resources

OHA References and Resources

- [OHA CCBHC Website](#)
- [Clinic-Led Metric FAQs](#)
- [Data Reporting Template](#)
- [Clinic-Led Metric Screening Tool Requirements](#)
- [Community Needs Assessment Template and Guidance](#)

External References and Resources

- [SAMHSA Quality Measures Technical Specifications Manual](#)
- [SAMHSA Quality Measures Guidance, Updates, and Webinar Series](#)
- [SAMHSA CCBHC Quality Measurement FAQs](#)
- [National Council for Mental Wellbeing](#)

CCBHC Provider Resources

- OHA website: <https://www.oregon.gov/oha/HSD/BHP/Pages/CCBHC-Information-for-Providers.aspx>
- Data and Reporting
 - Please send questions to Katy.Holmquist@oha.oregon.gov and Gina.Turrini@oha.oregon.gov
- Program Requirements
 - Please send questions to ccbhc@oha.oregon.gov
- Cost Reporting
 - Please send questions to ccbhccostreporting@oha.oregon.gov

Thank you!

You can get this document in other languages, large print, braille or a format you prefer free of charge. Contact the OHA CCBHC team at CCBHC@oha.oregon.gov.

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