CHILD AND ADOLESCENT HEALTH CENTERS
QUARTERLY REPORTING DATA ELEMENTS DEFINITIONS
EFFECTIVE October 1, 2019

Content Relevant to: E3 Enhancing & Expanding Emotional Health Models

Number of Unduplicated Users (clients) by Demographic Designation per quarter

Definition of an Unduplicated User:

An unduplicated user is an individual who has presented themselves to the E3 Program for service with the mental health provider (minimum Master's prepared and licensed mental health provider), and for whom a record has been opened. Opening a record includes documenting an assessment, diagnosis and treatment plan. Once per year, the user is counted to generate the number of unduplicated clients utilizing the E3 services for that year.

Age Range	Female	Male	Total
0-4			
5-9			
10-17			
18-21			

Number of Unduplicated Users (clients) **by Race** per quarter

White
Black/African-American
Asian
Native Hawaiian or Pacific Islander
American Indian or Alaskan Native
More than One Race

Number of Unduplicated Users (clients) **by Ethnicity** per quarter

Arab/Chaldean
Hispanic or Latino

Definition of a Visit:

A visit is a significant encounter between an E3 provider and a new (unduplicated) user or established (duplicated) user. Each visit should be documented as appropriate to the visit and provider (i.e., visits include an assessment, diagnosis and treatment plan documented in the medical record and/or other documentation appropriate to the visit). A user will likely have multiple visits per year.

Total Visits by Provider Type per quarter

*Mental Health Provider must be minimum Master's prepared and licensed. Mental Health Provider visits are counted as "face to face" contacts.

*Telehealth Visits can be tele-conferencing and tele-phonic. Telehealth visits should be counted when using this mechanism during visit.

Note: Telehealth visits should be counted only once, as a Telehealth visit.

Do not count as a visit with BOTH the mental health provider AND a Telehealth visit.

Visits by Type per quarter

Count the visit by type of session provided. If the client was seen individually, count as an individual visit. If the client was seen in a therapeutic group, count as a group visit. If a client receives both individual and therapeutic group services, count both visit types.

QUALITY INDICATORS REPORT DEFINITIONS

For each of the following Quality Measures, report the **YTD NUMBER** each quarter. Each quarter, your data will likely be equal to or greater than, the previous quarter. Note that this is different than the quarterly reporting elements, where data is reported **by quarter** for that specific quarter only.

Number of Unduplicated Clients Ages 10-21 Years with an Up-to-Date Depression Screen

Report the number of unduplicated clients up-to-date with depression screening. This information could come directly from a behavioral health screener or risk assessment, so the number screened (flagged) for depression may equal or be very close to the number of behavioral health screeners and/or risk assessments completed. (Note this is not the same as a depression **assessment** conducted by a provider.) Do not double count clients who were screened (flagged) for depression using behavioral health screen or risk assessment and who also completed a specific depression screening tool (e.g., Beck's, PHQ-9, etc).

Number of Clients Age 12 and Up with a Positive Depression Assessment (Diagnosis of Depression)

Report the number of clients (age 12 and older) with a diagnosis of depression according to the score on the depression screening tool ***and*** psychosocial assessment by the provider. Exclude the following: a) those who are already receiving documented care elsewhere, and b) those who are referred out of the E3 site for treatment.

Number of Clients Age 12 and Up with a Diagnosis of Depression who have Documented, Appropriate Follow-Up

Report the number of clients from the denominator who receive treatment at the E3 site who have all of elements of an appropriate follow-up plan: a) had a psycho-social assessment completed by 3rd visit (includes suicide risk assessment/safety plan), b) had a treatment plan developed by 3rd visit, c) treatment plan reviewed @ 90 days (for those on caseload for 90+ days), and d) screener re-administered at appropriate interval to determine change in score.

For the following two quality measures, please note that you are NOT expected to administer BOTH a behavioral health screen AND a risk assessment to each client. You only need to administer one tool or the other as appropriate for age, developmental level and need. Please report the number of behavioral health screens and/or risk assessments provided to your clients:

Number of Unduplicated Clients Ages 5-21 Years with at least one Up-to-Date Behavioral Health Screen in the annual year.

Report the number of clients that receive an annual Behavioral Health Screen as appropriate for age and developmental level. This may include clients that are UTD because they completed the Behavioral Health Screen in a previous fiscal year *but* are being seen in the E3 site in the current fiscal year.

Examples of **appropriate** screening tools (to use) **include but are** not limited to Pediatric Symptoms Checklist (17 or 34), Strength and Difficulties Questionnaire.

Number of Unduplicated Clients with an Up-to-Date Risk Assessment / Anticipatory Guidance

Report the number of clients that are complete with an annual risk assessment or anticipatory guidance, as appropriate for age and developmental level. This may include clients that are UTD because they completed the risk assessment/anticipatory guidance in a previous fiscal year *but* are being seen in the E3 site in the current fiscal year.

BILLING REPORT DEFINITIONS

Reported on annual basis only, as requested:

Enter the **dollar amount in claims submitted for services** provided during the current fiscal year (October 1- September 30), regardless of whether or not the claims were paid during the fiscal year.

Enter the **dollar amount received in revenue** during the current fiscal year (October 1-September 30), regardless of whether or not revenue resulted from claims filed during the fiscal year.

For each of these entries, you will be entering data by:

Medicaid Health Plan/Medicaid (from a drop-down menu)

Commercial

Self-Pay

Other

Note that the Estimated Percent of Claims Paid and Unpaid (based on dollar amount, not on number of claims) and Payor Mix will be auto-totaled.

5 Most Common Reasons for Rejection of Submitted Claims

Select the five most common reasons for rejection of submitted claims from the dropdown menu according to best-fit category.

DIAGNOSES AND PROCEDURE CODES AND FREQUENCY

Reported on annual basis only, as requested:

Mental Health Problem Diagnoses – Top 5 diagnoses from the mental health provider

CPT codes – Top 5 CPT codes - both the code and the name of procedure