

*This is a compilation of questions asked of the SDICC and their recommended responses related to the December 1, 2004 reporting of the Basic and Developmental URS Tables. The questions are grouped by URS Table.*

**1. When are the URS Tables Due:**

**Answer:** The URS Tables are part of the Mental Health Block Grant Implementation Report, and therefore are due by December 1, 2004. Tables can be e-mailed to the NRI, data can be electronically entered into the URS Tables at [www.nri-inc.org](http://www.nri-inc.org) or copies can be mailed to CMHS. Mailed documents must be postmarked by December 1, 2004.

**2. Can we modify or update our URS data after we submit it (can we change the data after December 1, 2004?).**

**Answer:** Yes, states can modify their URS Tables after December 1, 2004 to correct errors or submit more recent data. However, states should submit some data to meet the December 1 deadline.

However, states should report as complete data as possible. After the December 1 data submission, the SDICC will prepare a set of output tables that will show your state's data and national (and some regional) averages. All states will be sent back a set of Output tables for review and correction before the URS data is considered final.

Please note that after the URS data are reviewed by your state, and the final set submitted formally to CMHS, the data will be made public by SAMHSA. You can look at the SAMHSA display of data for 2002 on the SAMHSA website at:  
<http://www.mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/URS2002.asp>

**3. Could you please provide clarification on the instructions for completing the FY2004 URS tables? The instructions state that all persons who received a mental health service, including screening, assessment and crisis services are to be included in the counts. Under the section on who not to include it states that all persons with a single diagnosis of substance abuse or mental retardation should not be included. This has resulted in some confusion on our part as we may have delivered a mental health crisis service or assessment service to a person who is in acute crisis. The end result may be an assessment that the person has a single diagnosis of substance abuse or mental retardation. Would this person be included in the URS tables or not?**

**Answer:** The intent of the directions was to make sure states aren't including all the people who are in their systems only getting Substance Abuse or Mental Retardation/Developmental Disability Services. The guidance was to help states where it has a State Department of MH plus MR and/or and SA to only report for their mental health programs.

A person who received a mental health crisis service or mental health assessment and who was thus registered in your data system as having received a mental health service, should be counted, even if they ultimately end up with a SA or MR diagnosis.

**Table 1: Profile of State Population by Diagnosis:** Federal Estimates of SMI for Adults and SED for Children, Current Year and three (3) years forward: Data to be provided by CMHS.

4. *This table indicates that CMHS will provide the data to states. Where is this data?*

**Answer:** For URS year 2 and year 3, the SDICC compiled this information from the US Census Bureau and developed state-by-state estimates for CMHS. CMHS then sent the data to states in August 2004. The tables are posted at <http://www.nri-inc.org/SDICC/SDICC.cfm>

5. *On all our data runs to report on the rest of the tables, we've been pulling data from State Fiscal Year 2004, which is between 7/1/03 and 6/30/04. I just wanted to affirm that Table 1 is compatible with the rest of our data even though it says "2003".*

**Answer:** The SMI and SED estimates are done for 2003, since that was the most recent data that the US Census Bureau has released with the age and income levels (by state) necessary for the calculations of SMI and SED using the Federal Estimation Methodology. The lack of this Census data projected 3-year out is the reason why there are no estimates 3-years out yet.

**Table 2: Profile of Persons Served, All Programs, by Age, by Gender, and Race/Ethnicity**

6. *The category "Other Race" has been eliminated this year from Table 2, Table 5, and the Developmental Tables. Where should we report people who are included in our state's database as "Other Race"?*

**Answer:** The category "Other Race" was dropped from the URS Tables this year to comply with Federal reporting guidelines for race/ethnicity. We are recommending that states report "Other Race" in the "Race Not Available" category. States may wish to add a footnote that describes how many of the persons reported in the "Race Not Available" category were identified as "other race."

**Table 3A: Profile of Persons Served in the Community MH Settings by Homeless Status:**

This table gathers information on two concerns: first, how many people were served in community programs, and second, how many of those served in the community were homeless at their last assessment?

**Table 3B: Profile of Persons Served in State Psychiatric Hospital and Other Inpatient**

**Settings by age by gender:** This table gathers information on the numbers of persons served in state psychiatric hospitals, other inpatient settings, and residential treatment center for children.

**Table 4: Profile of Adult Clients by Employment Status by age by gender:**

7. *Table 4 on employment says: "Data should be reported for clients in non-institutional settings at time of discharge." Am I correct in interpreting that to mean that only people who have been discharged should be counted in this table? What if a person has been discharged more than once?*

**Answer:** The focus of this table is on the most recent known employment status of persons being served in the community. States should report the last employment status available (either last status reported for clients currently in services or the status at discharge for those no longer in service. If a person has been discharged multiple times during the year, only report their employment status at their last discharge. This is the same language used in prior URS cycles.

**Table 5: Profile of Clients by Type of Funding Support by age by gender:** Table gets number of clients whose services were paid by Medicaid, by non-Medicaid sources, or who's care is paid for by both Medicaid and other sources

**Table 6: Profile of Client Flow and Turnover:**

8. *The Excel table has a place to input counts of adults and of children. However, there is no place to indicate the clients that have no age identified. Because the formula summing the children and adult counts does not factor in the NA's it is providing an incomplete total for the program. Is this how the spreadsheet was intended to operate or should I override the formula to input a complete total for each program?*

**Answer:** Please override the formula in the Total to put in the total and add a footnote in the comments section that details by age were not completely available.

9. *Table 6 asks for RTC data for children 17 and under. As would be reported on table 3b, we serve some persons in RTCs who are transitioning to adult programs. Should we change table 6 so that they would be included?*

**Answer:** Please only report persons under age 18 in Table 6 and add a footnote on how many people aged 18 to 21 were served, but not reported?

10. *For reporting LOS in table 6 are we to only include FY04 stays? For example, if a patient was admitted to a long term care psych. hospital on 7/1/00 and is discharged on 1/1/2004, should the LOS include all days from 2000 - 2004 (1280 days) or just days since the beginning of FY04 (185 days)?*

**Answer:** The intent is to report the entire length of stay for an episode (not just the days in 2004). If someone had been in the hospital for 3 year and was discharged the first day of the reporting year, the intent is not to show a LOS of 1 day (the 1 day in the reporting year) as opposed to the 3 years of stay in the prior years.

**Table 7: Profile of Public Mental Health Service Expenditures and Sources of Funding: CMHS indicated in the Federal Register that this data will come from the NRI's SMHA Revenue and Expenditure Study.** Data for the tables are from the NRI's annual revenues and expenditures study. The NRI is currently commencing compilation of FY'2003 data. For URS Year 2, FY'2002 data was used from the NRI study for all 50 states, plus DC.

The NRI is working on completing the FY'03 version of the Revenues and Expenditures Study (which is the source used for URS Table 7). Although the FY'03 R/E data was due November 19th, we still have a number of states which have not yet submitted this data and who will be getting us the data after December 1.

We also run a number of data edits (consistency between years, outliers among states, and between tables within FY'03) and will be sending a draft of the R/E data back to the states before it is considered final. Our goal is to have the R/E cleaned up and "final" by the February National DIG meeting.

**Table 8: Profile of Community Mental Health Block Grant Expenditures for Non-Direct Service Activities**

*11. We provide training to community providers using some of the MH Block Grant funds. Where should we report these expenditures on Table 10?*

**Answer:** Please include Training expenditures under the "Technical Assistance" row on Table 10. You may also wish to add a state Comment/footnote that describes the training you provide.

**Table 9: Public Mental Health Service System Inventory Checklist:**

*12. The definitions have psychosocial rehab but Table 9 refers to psychiatric rehab (and doesn't list psychosocial). What is the definition of psychiatric rehab?*

**Answer:** Please use the definition of psychosocial rehab for psychiatric rehab on Table 9.

*13. We have received mixed results concerning the ACT and MTT services, because the definitions are so closely linked. How can we differentiate between them?*

**Answer:** Mobile Treatment Teams (MTT) are a much broader concept of treatment teams that may include Assertive Community Treatment (ACT), but also include many other treatment programs that don't meet ACT specifications. For next year, we will recommend replacing the ACT definition in the "Data Definitions" document with the Table 16 Evidence-Based Practice definition of ACT (which is more detailed). We recommend you use the Table 16 ACT definition to help focus on what is an ACT program. Then other mobile treatment programs that don't meet the ACT definition would fall into the MTT category. In some states, that there are mobile treatment programs (MTTs) that lack the full multi-disciplinary team of ACT (e.g., they may not have a psychiatrist) or that are not 24/7 or otherwise don't have essential elements of ACT. These should all be reported as an MTT, but not as an ACT program.

**Table 10: Profile of Agencies Receiving MH Block Grant Funds Directly from the State MH Agency:**

No Questions received:

**Table 11: Summary Profile of Client Evaluation of Care: MHSIP Adult Consumer Survey and YSS-F Child/Adolescent Survey Results:**

*14. We conduct both the YSS-F (Family Survey) and the YSS (child self-report) survey. The URS Table 11 instructions recommend the reporting of the YSS-F. Where should we report YSS results?*

**Answer:** Please only report the data from the YSS-F in this table. Testing demonstrates that the results from the YSS-F are different from the results from the YSS; therefore, it is not recommended that the results of the two surveys be combined.

States that have conducted the YSS are encouraged to report on the results in the “Comments” section of Table 11.

**Table 12: State MH Agency Profile:** This table collects contextual information on the data reported by SMHA in earlier Basic Tables, plus information on Co-occurring MI/AOD clients.

*15. What does "AOD" stand for? I think "MI" is "mental illness".*

**Answer:** AOD means Alcohol and Other Drug Abuse (which some people prefer over the term Substance Abuse--since it explicitly includes Alcohol abuse).

## Developmental Tables:

**Table 13: Unmet Need for Mental Health Services (or Untreated Prevalence of Mental Health):** Note: CMHS committed to developing a standardized methodology that could be used to provide these estimates for states.

### *Issues Identified*

The Unmet Need/Untreated Prevalence workgroup started to work on this table in 2003, but tabled action until the new National Co-morbidity Study (NCS) was available. This workgroup will reconvene during the next cycle of URS activities to recommend how this table can be calculated.

**Table 14: Adults Served with Serious Mental Illness and Children Served with Serious Emotional Disturbances:**

16. *Table 14 seems close in design to Table 2-A, which asks for State/Community data. Table 14's instructions are not as clear to me. Does Table 14 request both State/Community data or just that of the Community (Public Mental Health System)?*

**Answer:** Table 14 is designed to mirror Table 2A and 2b, but for only those persons who meet the definitions of Adults with Serious Mental Illness or Children with Serious Emotional Disturbances. Table 14 asks for the numbers of persons who meet the Federal definitions of SMI and SED, but if you can only report for those who meet a unique State definition, that is okay, but please note what definition you used. The intent is for states to report both persons served in state hospitals and community programs on this table.

**Table 15: Living Situation:** This Developmental Table compiles information on the living situation at the last assessment for consumers using 9 different living situations.

17. *For individuals 65 and older that were living in a Foster Home, I noticed on the Excel template that the cell is blacked out. Are we not supposed to report these individuals living in foster homes for that age group? If not, can you tell me where they should be included? I can understand the reason for blacking out the Children's Residential Treatment for this age group but not the foster home.*

**Answer:** This has been unblocked out (e.g., you may report foster care for older adults).

**Tables 16-17: Evidence-Based Practices:**

18. *There are columns in each table requesting the Total Unduplicated N. Should we report the total unduplicated N that received any of the EBPs or should this be the Statewide total Unduplicated N (w/SMI or SED)?*

**Answer:** The columns for Total Unduplicated on Table 16 are to compile information on the total number of persons with either a SMI or SED in your state. These columns are designed to be the denominators for calculations of the use of the specific EBPs within the state: e.g.,

to calculate what percent of adults with SMI received ACT or what percent of children with SED received MST.

**Table 18: Use of New Generation Atypical Antipsychotic Medications:**

19. *The definition of new generation medications provided in Table 18 does not include Abilify (aripiprazole). Abilify is included in the list of atypical antipsychotics reported monthly as an Oryx indicator. If we do have anyone with a diagnosis of schizophrenia receiving this medication, should we include or exclude these counts for Table 18?*

**Answer:** The intent of this table is to gather information about the use of new “atypical” medications for persons with schizophrenia. The focus on “new” medications means there will regularly be new medications coming out that can be reported here. It is okay to report on additional atypicals on Table 18 if they are being used in your state, but that it would be good for you to list them in the comments. E.g., "Rhode Island data also includes Abilify (Aripiprazole) in its reported atypical antipsychotics medications."

20. *On table 18, are columns 5 and 6 (labeled "STATE MENTAL HEALTH") the aggregation of columns 1 & 3 and 2 & 4 respectively?*

**Answer:** The State MH Agency System columns (5 and 6) on Table 18, are NOT the sum aggregations) of the State Hospital and Community Columns. Since many consumers are served in both state hospitals and community programs, the intent of the State MH Agency System columns were to get an unduplicated count on the use of Atypical Medications across the state. This requires some unduplication of consumers between hospitals and community systems (unless there is no movement from the hospital into the community).

**Table 19: Outcomes:**

**Tables 20a, 20b, and 21: Readmissions within 30 and 180 Days of Discharge:** These Developmental Tables compile information on readmissions within 30 and 180 days to state hospitals for civil patients (table 20a), and forensic patients (table 20b) and to any inpatient hospitals (table 21). Data is compiled by age, gender, race, and ethnicity.

21. *Does the count of readmissions within 180 days include the count of readmissions within 30 days?*

**Answer:** The 30 days should be counted within the 180 days. I.e., it is readmissions within 0 to 180 days.

22. *How can we calculate 180-day recidivism when the URS tables have to be completed less than six months after the report period? I.e., Table 20A wants numbers for 180-day recidivism 5 months after the end of our fiscal year, but we need 6 months of data to calculate the same.*

*The alternatives are to report older data (this table only, all tables???) or re-define recidivism (which also means publishing conflicting statistics in our FBG report versus on the State Governor's Web site.*

*If we use calendar year '03 data instead of fiscal year '04 data, this table will contain stat's based on a different time frame then the other tables. If we use calendar '03 to report all tables, then A) we won't be providing the most current information and B) the URS Tables will conflict with the data we report in the Goals section elsewhere in the report.*

**Answer:** The workgroup that worked on the 30 day and 180 day readmissions issue explicitly discussed the issue of how to measure 180 day readmissions given the December 1 reporting period. The workgroup's recommendation, which was discussed on all the DIG Regional Calls and with CMHS was that reporting 180 day readmissions would require the use of a different time period for reporting Table 20/21 than other DIG tables. The workgroup and CMHS did not want to specify what specific timeframe states should use (CY or FY), but asked states to report the time period they wanted to.

See below from the workgroup report: The time period for reporting:

The workgroup discussed the need to look beyond a 12-month window in order to calculate the percent of persons who have a readmission. To calculate readmission rates for persons discharged in the last month of a year the calculation must look beyond the discharge year in order to give persons discharged during the last month 30 days or persons in the last 6 month a chance to be readmitted within 180 days (for example to calculate readmission rates for the year January 1, 2002 to December 31, 2002, you would need to look at readmissions that occurred through January 2003 in order to give people discharged during December 2002, 30 days to have a readmission).

It was pointed out, that with URS reporting due by December 1, 2003, that states cannot report on all persons discharged from July 1, 2002 to June 30, 2003 (the most common state FY) and then follow readmissions through December 30, 2003 and meet the reporting requirements. This may result in states needing to calculate this indicator based on the calendar year 2002 or use the prior fiscal year. The workgroup does not want to specify a specific time period for a state to use for the calculation of the discharge cohort. Each state should use the 12-month time frame that works best for them.

**Recommended Action:** The table should acknowledge that the number of discharges reported on these tables (Table 20) would probably not be the same as the number of discharges reported on Basic Table 6, since Table 20 needs to use data from an earlier time period to allow persons 180 days to experience a readmission.