

CMHS/SAMHSA Data Infrastructure Grants/ Uniform Reporting System Regional Conference Call Report

February 9, 2011

Group 1 – Northeast at 11 AM

Group 2 – Midwest/Southeast at 2 PM

Group 3 – Western/Pacific/Territories at 4 PM

Meeting Facilitator: Olinda Gonzalez, Ph.D (CMHS)

Meeting Summary Prepared by State Data Infrastructure Coordinating Center (SDICC) at NRI

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Agenda:

1. Update/Summary on status of approved client level indicator reporting and pending data elements.
 - a. Discussion of length of time in service data element proposal
 - b. Discussion on responses to client identifier framework
 2. Review draft timeframe and plan for state technical assistance
 3. Announcements—reminder that Continuation Applications are due by March 4th
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1. Update/Summary on Status of Approved Client Level Indicator Reporting and Pending Data Elements

Dr. Gonzalez reported that the SAMHSA has approved moving forward with the DIG client level data reporting framework outlined in the document distributed prior to the December cycle of DIG regional calls: "CMHS Current Considerations for Mental Health DIG Client Level Reporting." SAMHSA is continuing to review the alignment of data standards across its three centers (CMHS, CSAT, and CSAP) and some measures (such as military status) are being deferred until a consistent SAMHSA wide operational definition is available.

Ted Lutterman and Bernadette Phelan (NRI) reviewed the status of three particular groups of data elements.

- a. **(1) Mental Health Diagnoses and (2) Substance Abuse Problems:**
 - i. **Mental Health Diagnoses:** The Mental Health Client Level Pilot Study conducted last year tested the reporting of up to six mental health diagnoses. Results of the client level pilot found that while many mental health consumers had more than one diagnosis listed, that the number of diagnoses dropped off greatly after three diagnoses. Therefore the recommendation for DIG reporting is to collect up to three mental health diagnoses (using either DSM or ICD coding).

Discussion among the three DIG regional calls identified that all SMHAs collect psychiatric diagnoses, but SMHAs have several concerns about the completeness of their diagnostic data. Concerns raised by SMHAs included:

- Several states indicated that they only carry one diagnosis in their client level files
- In some states diagnoses are collected at admission and discharge, but no update is reported while clients remain in service
- Large numbers of consumers may have missing diagnoses
- Substance abuse is not a Medicaid eligible service in some states and as a result, few substance abuse diagnoses are listed on Medicaid paid claims

ii. **Substance Abuse Problems:** The identification of consumers with a substance abuse problem was tested in the Mental Health Client Level Pilot. Several states have reported that they do not collect substance abuse diagnoses and other states have indicated that they are missing substance abuse diagnoses for substantial populations of treated consumers (particularly consumers with Medicaid payment in states where Medicaid will not pay for substance abuse services). As a result of these limitations, the DIG Client Level framework recommends the use of a Substance Abuse Problem data element that would have a limited set of response categories:

- Yes, person had a substance abuse problem/diagnosis
- No Substance abuse problem/diagnosis
- Unknown
- Not Collected

With these reporting categories, states that collect substance abuse problems using a “flag” type of data element (for example a “Yes/No” data element for if a consumer has a substance abuse or a Substance Abuse problem checklist (such as a list of “Drugs of Abuse”) could use the Substance Abuse Problem data element to identify consumers with substance abuse problems. States that carry substance abuse diagnoses (using either ICD or DSM coding systems) could also identify persons with substance abuse problems by the existence of a substance abuse code and then would complete this variable accordingly (e.g., if a consumer has a diagnosis of “cocaine dependence” then the Substance Abuse Problem data element would be completed as “Yes, person had a substance abuse problem/diagnosis”).

The discussion with the states identified that most states do maintain either substance abuse diagnoses and/or a substance abuse identifying data element. Several states reported they now screen all mental health patients for co-occurring disorders and have a data element that records the existence of a substance abuse problem. However, several states cautioned that they are concerned that providers

may still be under reporting both substance abuse diagnoses and substance abuse problems.

- b. **Use of SMHA Existing Non-PHI Client Identifiers for DIG Reporting:** During a prior round of DIG Regional Calls, several states reported that the Client Identifier (Client ID) maintained by the SMHA meets all the HIPAA requirements as a non-PHI data element. These states asked if their own client ID was already non-PHI, could they use that state Client ID for reporting DIG Client data to SAMHSA.

Dr. Gonzalez of CMHS and NRI staff worked with the SAMHSA Health Information Technology expert to see if states could use their existing non-PHI client IDs for reporting. SAMHSA has reviewed the issue and agrees that non-PHI state IDs can be used for DIG reporting. SAMHSA has asked that CMHS and NRI require any electronic transmissions of client data to use an encryption process. NRI will provide both FTP and e-mail encryption options for states to submit such data. A one page memo addressing this issue in more detail was e-mailed via the DIG Listserve prior to the February Regional Calls (see attachment "General Framework in The Use of (non-PHI) Unique Client IDs").

- c. **Length of Time in Service:** Feedback were received from states on the length of time in service proposal. Given the variability in state data and reporting capacity, responses received from the three regional groups differed from receiving a firm support of the proposed method to raising concerns on the ambiguous approximation of the time in service using the proposed method. CMHS/NRI will continue to refine the proposal based on the feedback received from states and progress of this work will be communicated through the DIG listserv. The following is a summary of the discussions:

- Options:
 - report length of time in service by levels of care, i.e. state hospital, community-based programs, acute inpatient, etc.
 - report the number of episodes instead of length of time in service
 - report by counting the number of days for each service event (how do we handle services provided at the same time?)
 - use EBP as a measure for intensity of service
 - use a scale for the length of time in service such as 1-6 months, 7-10 months, etc.
 - report length of time in service from the start date of treatment episode
- Concerns:
 - Some states do not use 'episodes'; they have claims data but cannot distinguish specific treatment episodes.
 - The proposal may result to overstatement of the length of time in service in situation where there is a gap in service during the reporting period.
 - Claims data are reliable but the following issues may complicate their use:

- States observe a lag time for the submission of claims by providers. This lag time can be as long as 2 years ... in which case it can understate the time in service.
- Given the lag time, it may appear that a person did not receive a service (due to absence of a claim/encounter) when in fact they did.

NRI will continue to work with CMHS and the states over the next month to finalize the data elements included in this report

2. **Timeframe for DIG Client Level Activities in 2011:** Ted Lutterman and Olinda Gonzalez reviewed an updated timeline for DIG Client Level activities during 2011. The revised timeline now includes the DIG Annual meeting in mid-late June 2011 in conjunction with the SAMHSA Block Grantee's Meeting.

1. **End of February 2011:** completion of draft operational definition of data elements due for initial reporting in December 2011.
2. **Mid-March 2011:** completion of draft Instructions Manual which includes the data dictionary, file layout, coding convention, and data edits for use in DIG Client Level reporting. A copy will be distributed to States for review prior to the Regional User Group meetings. The expectation is that States share and discuss the draft Manual to other staff who will be involved in the development of the state crosswalk and data extraction. From their discussion, states can make a list of questions, clarifications, reporting issues, etc. to send to CMHS and/or discuss at the User Group meetings.
3. **April-May 2011:** Four (4) CMHS Sponsored Regional User Group meetings will be held. At this time, CMHS/NRI will give a walkthrough of the Instructions Manual, discuss questions, clarifications, reporting issues raised by States, and provide preliminary training of SMHA staff in preparing and submitting client level data and data crosswalk.
4. **June 2011:** National DIG Meeting in conjunction with CMHS/CSAT/CSAP SAMHSA Joint National Block Grantee Conference. Discuss the final Instructions Manual, training/technical assistance available, progress in the discussion of other data elements such as the CJ, Education, etc., and other reporting issues.
5. **Summer 2011:** States start to submit their State Data Crosswalk that maps SMHA data systems to the CMHS/SAMHSA DIG Client Level data elements for review.
6. **Summer 2011:** Upon approval of the State Data Crosswalk, States begin to submit Client Level Test Files (50 to 500 cases) to verify SMHA extraction, coding, and transmission of client level data
7. **November 2011:** States start to extract their complete data files and submit to CMHS/NRI for processing. This action assumes that the test file was successful. State reports are due by December 1.

8. **Ongoing throughout 2011:** CMHS will work with states through workgroups to develop recommendations for NOMS and other measures that are not currently operationalized (Criminal Justice, School Attendance, Military Status, and others).

Several states asked about the expectation of reporting of URS tables by December 1st of 2011 if states submit client level data for some of the measures. CMHS is strongly encouraging states to both report client level data in 2011 and to also report all URS tables. After 2011, the intent at this time is to allow states that submit client level data to NOT report those URS tables that can be completed by client level data (e.g., states submitting client level data including employment status and living situation would not be required to report URS Tables 2, 4, 14, and 15).

3. **DIG Grant Continuation Applications:** Dr. Gonzalez reviewed the requirements for states to submit DIG Continuation Application by March 4, 2011. If States need of any assistance in completing the technical and budget application requirements, please contact Olivia Cline-Thomas, Grants Management Specialist at olivia.clinethomas@samhsa.hhs.gov or by phone at (240-276-1413). States are encouraged to copy Dr. Gonzalez at olinda.gonzalez@samhsa.hhs.gov. If there are questions on the application narrative or programmatic concerns, please feel free to contact Dr. Gonzalez by the e-mail above or at 240-276-1762.
4. **Next Month's Regional DIG Calls:** Dr. Gonzalez reported the next round of DIG Regional Calls will be held in March 2011. The data and time of the calls will be sent out via the DIG list serve.

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