

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

July 29, 2010

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. No Cost Extensions due July 30, 2010**
- 2. Participants' Evaluation of the DIG Annual Meeting**
- 3. Employment Workgroup**
- 4. Optional Modules: Veterans, Health & Mental Health, and Children's EBPs**
- 5. Status of Plans for State Comment on Remaining Client-Level Data Elements**
- 6. Grant Announcements**

Information on No Cost Extensions: Requests due Friday, July 30

Gwen Simpson and Olivia Cline Thomas, representatives from the SAMHSA Office of Grants Management, were on the call to answer any questions regarding the No Cost Extensions due to SAMHSA on Friday, July 30, 2010. Requests for No Cost Extensions are due to the Office of Grants Management 60 days prior to September 30 (July 30). Please email Olivia Cline Thomas with your requests (Olivia.ClineThomas@samhsa.hhs.gov). A formal, revised notice of grant award will be sent approving No Cost Extensions.

Formal award letters will be issued for the next cycle of Data Infrastructure Grants near the end of September, at the latest. The Office of Grants Management is aware that this late notice may cause problems with states trying to issue new contracts, pay salaries, etc, and will strive to get the grant award letters out to states as soon as possible.

Participant Evaluation of the DIG Annual Meeting

The DIG Annual Meeting was held on June 24 and 25, 2010. Participants were requested to complete an evaluation form and provide feedback on how the meeting can be improved in the future. Fifty-nine participants filled out the evaluation form. The majority of those filling the form out were State DIG Data Representatives (23), State DIG Planners (12), and State DIG Coordinators (10). Ninety-one percent of all participants indicated the overall meeting was either "good" or "excellent." The Poster Session

was the highest rated session for the third consecutive year. Many participants indicated they would have liked more time for discussion, especially during the Workgroup Breakout Sessions. On the call, there was a difference of opinion on the structure of the meeting in conjunction with the National Conference and the Olmstead meeting. Some participants liked having all three together, while other states indicated the weeklong series of meetings made it difficult for more than one state representative to attend. It was also recommended that the meeting planners do a better job at monitoring the Question and Answer periods after each session. Participants also suggested ideas for potential topics:

- Research methods and setting benchmarks
- Impact of healthcare reform, and how this may influence the use of the block grant funds
- Collecting statistics on consumers with co-occurring diagnoses and how they benefit from both the mental health and substance abuse block grants
- How to gather statewide data and market the data effectively to legislators to influence change
- More information on children and families
- Minimum reporting requirements for evidence-based practices
- Block Grant Application requirements
- Introduction to the Block Grant for those present who are new to the project

Employment Workgroup

The Employment Workgroup Session differed from the other two sessions in that it was designed to generate issues important to the states as they revise their employment targets in light of the current economic recession. Representatives from Ohio and Massachusetts were present to share their experiences. Due to the recession, Ohio was forced to close their State Outcome System and has been looking at other sources, such as employment agencies and benefit applications, to measure the effects of the recession on employment. Massachusetts has made employment one of the critical outcomes of treatment by integrating the goal with consumers' treatment plans. Massachusetts' SMHA believes that this will be beneficial, and hope to be ready to employ a more systematic way to set block grant targets in the next several years.

Three discussions ensued after the Ohio and Massachusetts shared their perspectives.

1. A common definition of employment is needed across the states. The difficulty in deciding upon a common definition is whether the perspective should be from the economic side (e.g., people are employed and earning income), or the therapeutic side (e.g., the movement of people from not in the labor force, unemployed, employed in other ways, etc.).
2. There is need for guidance on what is the best source of employment data. Collaboration with employment agencies is important (e.g. Vermont receives data from the employment agency). There is also a question regarding at which level targets should be set, whether it be at the aggregate level or a finer breakdown (e.g. setting targets as to how many people should be fully-employed, part-time employed, or across a persons' treatment period).
3. Use of other analytical methods in addition to trending employment, such as a comparison with general population to show differences in probability of getting employed.

The workgroup is currently waiting for guidance from CMHS on how to move forward. There are currently no meetings planned about this topic until guidance from CMHS is received. However, this workgroup meeting did show the potential demand for technical assistance about setting targets.

Three New URS Reporting Tables that CMHS is preparing to send to OMB for approval for URS reporting (starting in 2011) were discussed: Veterans, Health & Mental Health, and Children's EBPs

1. Returning Military Service Members, Veterans and their Families:

The Veterans Workgroup has been meeting since December of 2009 to develop a table for inclusion in the URS tables beginning in either 2011 or 2012. The proposed table would collect information about the various initiatives and programs offered by SMHAs through the use of block grant funds that are targeted towards current military, veterans, and their families. There is a wide variation and this checklist will be used to determine what is actually happening at the state level.

The reason for including this table as part of the URS is that SAMHSA would like to collect this information through the Block Grant annually. The final version of the table was sent to the DIG Listserv on July 28, 2010. Updates to the newest version of the table are described below:

- States do not want this table to ignore the needs of other military veterans, including those who served in the first Gulf War, and even in Vietnam. SMHAs have found that the current conflicts in Iraq and Afghanistan are triggering PTSD in some of these veterans. To address these populations, the table now asks if the SMHA offers services to ANY veteran, as well as specifically asking if the services target returned veterans and those currently deployed. This addresses the concern that the first draft of the table focused exclusively on those veterans serving in the current OIF/OEF conflicts.
- States indicated that it was impossible to provide a breakdown of figures by program/service initiative. The modified (optional) Table 6 within the document now asks for an actual or estimated count of how many are actually receiving services, screening, or outreach on an aggregate level.

CMHS needs to send the proposed table to the Office of Management and Budget (OMB) for approval as part of the Block Grant Guidance Package. It is important to note that this is a draft version of the table and is not to be completed by the states until it receives OMB approval. The earliest CMHS will request states to complete this table is in the December 2011 round of reporting.

Participants on the Regional calls discussed the point that each state is different in terms of how veterans receive services. For example, many states' VA systems are the exclusive providers of service to veterans, or the VA is charged with collecting data on veterans. However, some states are reaching out to provide services to veterans, military service members, and their families, and the purpose of this table is to allow those states to receive credit for these efforts. Participants also indicated that the amount of funds from the Block Grant to provide such services may be quite small, and the burden of reporting this table may end up being overwhelming to SMHAs. The participants cautioned that it is

important to keep in mind which funding streams are used to provide certain services when determining whether this will be an optional or mandatory table.

2. Health and Mental Health Survey Module

For nearly a year, the Health Survey Module workgroup has been developing the best way to add optional health questions to the MHSIP Adult Consumer Survey. This is a necessary endeavor as consumers in the public mental health system have a higher rate of physical impairment than the overall public health population (especially in rates of smoking, obesity, diabetes, and heart disease, among others). This workgroup was represented by Jay Yoe of Maine and Tim Connor of Wisconsin at the Workgroup Sessions of the 2010 DIG Annual Meeting. Verda Rana of NRI also presented and shared the results of the pilot with data from eight states.

For the pilot, states used seven health questions from the BRFSS and added them to the end of the MHSIP Adult Consumer Survey. This proved to be an easy and inexpensive way to identify the health problems experienced by mental health consumers. The workgroup found that the methodology worked, and did not experience a reduction in MHSIP survey response rates.

The workgroup recommends that the seven basic questions be added as an optional health module. This would allow states to compare results with other states, as well as between years. The workgroup also recommends having these questions for at least two consecutive years to establish benchmarks and identify trends. A proposed optional URS Table for states to submit health module results was prepared for SAMHSA to include in as part of its Block Grant Guidance Package to OMB. The new Health module URS table would strictly be an optional table for states that want to add these questions. Participants on the call expressed support for collecting this data.

Several states on the call shared their experiences with adding the questions to their surveys:

- Nebraska contracts with the same group that does their BRFSS, and has a separate group to conduct the data analysis. It has proven to be a fairly simple, non-burdensome process to add the seven questions, even though the data collection has been limited to only asking 50 items. This has forced the state to remove some items from the Consumer Survey; however, having support from the Commissioner and others throughout state government have made this a simpler task. This has proven to be a particularly important addition as it shows the links between medical conditions and mental illness, especially in light of health care reform.
- Maine has had a lot of success in adding health questions in a number of state areas. The focus on physical health, and the collection of health information, has enabled the SMHA to get mental-health into the public health picture by having mental health-related measures included in district public health profiles, as well as information into the interactive BRFSS website. The state is currently looking to add depression and anxiety questions to the tobacco survey, and a depression screen on the web-based universal health screening tool. Two state-funded grants that look at how to better integrate health and mental health services resulted from these data.

3. Children's Evidence Based Practice: New Optional Table for reporting Additional Children's EBPs

A third table prepared by the Children's EBP Workgroup (and reviewed last year through the DIG Regional Calls) will be included in the Block Grant Guidance package to OMB. The current EBP table (Table 16) only captures three children's EBPs that are all targeted towards children small populations of severely ill children. It became clear that states are providing many other children's EBPs, but were not able to report and get credit for offering these services in the existing URS tables. In 2008, Jeanne Rivard of NRI worked with a Workgroup to develop a table that captured which EBPs states were offering to children. The group developed a checklist that identifies which EBPs states were offering, and allows states to indicate how many children receive each service on an aggregate level; demographic data are not collected. The draft of this table is posted on the NRI website at www.nri-inc.org/projects/SDICC/work_groups.cfm

Status of Plans for State Comment on Remaining Client-Level Data Elements

NRI and CMHS have been exploring options for an efficient way to gather state feedback on the remaining Client-Level Data Elements for future DIG reporting. NRI and CMHS are working to set up an online forum that allows states to provide feedback on each data element. We are currently consulting with the IT departments of both entities to determine which method will be most appropriate. As soon as the forum is established, an email will be sent out to the Listserv encouraging participation and feedback. The forum will allow states to post comments for each data element.

SAMHSA TEDS Pilot Study Of Client Level Data:

The Office of Applied Studies is initiating a feasibility study. This was mentioned in the new DIG RFA Substance Abuse pilot being carried out by SAMHSA. There will be a review/pilot of a few states who have integrated SA/MH data systems and joint programs. The study will look at two or three measures that are included in the NOMS and how feasible it will be to report them using the TEDS. We will let you know in the future as it develops. There is federal interest at SAMHSA for data integration where it also maintains the quality and integrity of the programs we already have.

New DIG Grant Announcement Awards

SAMHSA has completed processing of new DIG grant applications (to be awarded before Oct 1). About 10 states will need to shore up their "terms and conditions" section. Dr. Gonzalez of CMHS will be calling those ten states within the next week. If your state needs to address or modify anything on your application, please respond to Olinda's requests as soon as possible to avoid any delays.

Electronic Health Records:

There are no new changes or major issues related to Electronic Health Records. However, OMC is planning to hold regional meetings with consumers on their desires and needs around security and confidentiality as they relate to EHRs. For those of you that would like to receive regular information out of OMC on the various activities occurring in or around your state, Olinda will send out the address to access and to register for the announcements.