Planning Steps

Quality and Data Collection Readiness

Narrative Question:

Health surveillance is critical to SAMHSA’s ability to develop new models of care to address substance abuse and mental illness. SAMHSA provides decision makers, researchers and the general public with enhanced information about the extent of substance abuse and mental illness, how systems of care are organized and financed, when and how to seek help, and effective models of care, including the outcomes of treatment engagement and recovery. SAMHSA also provides Congress and the nation reports about the use of block grant and other SAMHSA funding to impact outcomes in critical areas, and is moving toward measures for all programs consistent with SAMHSA’s NBHQF. The effort is part of the congressionally mandated National Quality Strategy to assure health care funds – public and private – are used most effectively and efficiently to create better health, better care, and better value. The overarching goals of this effort are to ensure that services are evidence-based and effective or are appropriately tested as promising or emerging best practices; they are person/family-centered; care is coordinated across systems; services promote healthy living; and, they are safe, accessible, and affordable.

SAMHSA is currently working to harmonize data collection efforts across discretionary programs and match relevant NBHQF and National Quality Strategy (NQS) measures that are already endorsed by the National Quality Forum (NQF) wherever possible. SAMHSA is also working to align these measures with other efforts within HHS and relevant health and social programs and to reflect a mix of outcomes, processes, and costs of services. Finally, consistent with the Affordable Care Act and other HHS priorities, these efforts will seek to understand the impact that disparities have on outcomes.

For the FY 2016-2017 Block Grant Application, SAMHSA has begun a transition to a common substance abuse and mental health client-level data (CLD) system. SAMHSA proposes to build upon existing data systems, namely TEDS and the mental health CLD system developed as part of the Uniform Reporting System. The short-term goal is to coordinate these two systems in a way that focuses on essential data elements and minimizes data collection disruptions. The long-term goal is to develop a more efficient and robust program of data collection about behavioral health services that can be used to evaluate the impact of the block grant program on prevention and treatment services performance and to inform behavioral health services research and policy. This will include some level of direct reporting on client-level data from states on unique prevention and treatment services purchased under the MHBG and SABG and how these services contribute to overall outcomes. It should be noted that SAMHSA itself does not intend to collect or maintain any personal identifying information on individuals served with block grant funding.

This effort will also include some facility-level data collection to understand the overall financing and service delivery process on client-level and systems-level outcomes as individuals receiving services become eligible for services that are covered under fee-for-service or capitation systems, which results in encounter reporting. SAMHSA will continue to work with its partners to look at current facility collection efforts and explore innovative strategies, including survey methods, to gather facility and client level data.

The initial draft set of measures developed for the block grant programs can be found at http://www.samhsa.gov/data/quality-metrics/block-grant-measures. These measures are being discussed with states and other stakeholders. To help SAMHSA determine how best to move forward with its partners, each state must identify its current and future capacity to report these measures or measures like them, types of adjustments to current and future state-level data collection efforts necessary to submit the new streamlined performance measures, technical assistance needed to make those adjustments, and perceived or actual barriers to such data collection and reporting.

The key to SAMHSA’s success in accomplishing tasks associated with data collection for the block grant will be the collaboration with SAMHSA’s centers and offices, the National Association of State Mental Health Program Directors (NASMHPD), the National Association of State Alcohol Drug Abuse Directors (NASADAD), and other state and community partners. SAMHSA recognizes the significant implications of this undertaking for states and for local service providers, and anticipates that the development and implementation process will take several years and will evolve over time.

For the FY 2016-2017 Block Grant Application reporting, achieving these goals will result in a more coordinated behavioral health data collection program that complements other existing systems (e.g., Medicaid administrative and billing data systems; and state mental health and substance abuse data systems), ensures consistency in the use of measures that are aligned across various agencies and reporting systems, and provides a more complete understanding of the delivery of mental health and substance abuse services. Both goals can only be achieved through continuous collaboration with and feedback from SAMHSA’s state, provider, and practitioner partners.

SAMHSA anticipates this movement is consistent with the current state authorities’ movement toward system integration and will minimize challenges associated with changing operational logistics of data collection and reporting. SAMHSA understands modifications to data collection systems may be necessary to achieve these goals and will work with the states to minimize the impact of these changes.

States must answer the questions below to help assess readiness for CLD collection described above:

1. Briefly describe the state’s data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).

2. Is the state’s current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).
3. Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client-identifying information)?

4. If not, what changes will the state need to make to be able to collect and report on these measures?

Please indicate areas of technical assistance needed related to this section.

Footnotes:
Data Collection and Reporting System

The state's mental health database, Phoenix, has been successfully revised to accommodate SAMHSA-mandated client-level reporting as well as internal Bureau of Mental Health Services (BMHS) needs related to the Community Mental Health Agreement (CMHA). Much work has been done to improve the ability of the DHHS to mine the data necessary to inform program reporting and program compliance.

Activities related to the state’s response to the CMHA consume most SMHA data efforts. Quarterly data reports are posted that cite statistics on ACT, Supported Employment, and Mobile Crisis programs and utilization. Monthly data progress reports reflect the actions taken in each month, and month-over-month progress made in support of the Community Mental Health Agreement (CMHA) to allow the DHHS, the Community Mental Health Centers, and the Expert Reviewer for the CMHA.

The SMHA has contracted with an expert consultant who performs evidence-based practice fidelity assessments on ACT and Supported Employment. Fidelity Assessment reports help determine training needs, and the expert consultant provides training to address these to Community Mental Health Centers.

New Hampshire Hospital tracks psychiatric client-level episodes and treatment through its electronic record, the AVATAR system. The SMHA’s Phoenix system merges state hospital admission and discharge data with the AVATAR system to incorporate this information into Quality Service Reviews (QSR), required by the CMHA. Each of the ten Community Mental Health Centers receives a QSR annually for quality indicators agreed upon by the state and the plaintiffs named in the Agreement. A significant proportion of the QSR consists of client interviews in an effort to determine areas of improvement in a person-centered, meaningful manner.

Fragmented data reporting systems can present a challenge that the state is prepared for. In a stepwise fashion, the state is planning to build data bridges between the CANS and ANSA data that is being used to measure levels of functional improvement in all clients, not just the adults served by the CMHA. Use of the CANS & ANSA for program (ACT and MATCH, for starters) entry screening has been proposed by program leadership, and workgroups will be formed that will reinforce collaboration between the SMHA and its contractors. This is an area that is appropriate for technical assistance in implementation and practical application strategies.

Medicaid data will provide valuable information regarding the intersect between clients served by the Community Mental Health Centers and admissions to psychiatric units or emergency departments in hospitals other than the state psychiatric hospital.

None of these systems “speak” to one another completely, and difficulties are presented by some institutional resistance in addition to the resources required to design merging and reporting systems. Efforts are underway to consolidate these and other Public Health data systems, including the Bureau of Drug & Alcohol Services WITS system. Consolidated system-wide data reporting has emerged as a priority, spurred by the requirements of the CMHA and the need to support a system of care.