

**Thursday, May 30, 2002 at 1:30 p.m. - 2:30 p.m.-  
Session: Plenary: MHSIP in the Grand Ballroom**

**MHSIP Decision Support 2000+ Liaison Group / Presenter: Jim Harvey, L.C.S.W.**

51st annual conference of the "2002 National Conference on Mental Health Statistics"  
May 28-31, 2002; Mayflower Hotel, 1127 Conn., Ave., N.W., Washington, D.C.  
Theme: "Convergence of Data Initiatives: Working Together on Data Infrastructure and Promoting Effective Use of Data."

---

## **MHSIP / DS2K+ LIAISON GROUP**

I am here to provide a few comments on the MHSIP / DS2K+ LIAISON GROUP.

I serve as the Mental Health Block Grant Planner for the State of Nebraska. I started with that assignment in 1998 when the Mental Health Block Grant started requiring performance measures.

At about that same time, Nebraska applied for and received a MHSIP State Reform Grant. We used that grant to develop and implement a Nebraska edition of the MHSIP Consumer Survey, a system of Performance Indicators, and related activities.

Via my role as grant manager, I started attending the Midwest User Group (MUG) meeting. Many of you may be aware that the Center for Mental Health Services sponsors Regional User Groups (RUGs) ... Northeastern, Southeastern, Midwest, and Western.

It was at one of the MUG meetings where I was introduced to DS2000+.

It was at the request of the MHSIP Policy Group that the MHSIP/DS2000+ Liaison group was formed. The purpose of the group is to provide a formal vehicle for advising the DS2000+ team on issues related to data standards for mental health, and to ensure that the DS2000+ address the needs of state and local mental health authorities and agencies.

It was via the Regional User Groups that some of the members of the MHSIP / DS2K+ LIAISON GROUP were recruited. I am representing a state point of view serving on that group.

## **If You Have Seen One State ... You Have Seen One State**

In attending MUG meetings, I have learned the phrase ...

“If You Have Seen One State ... You Have Seen One State”. (1)

To me, as an employee of the Nebraska Department of Health and Human Services, I know Nebraska organizes the mental health system differently than those in the other MUG states. As we in Nebraska look at other states’ approaches, we attempt to adapt things that can work in Nebraska.

If you look at a little history of the mental health system, it is no surprise that each state’s mental health system is different.

- 1773 - first public institution in British North American colonies devoted solely to the care and treatment of the mentally ill opened in Williamsburg, Virginia
- 1854 - President Franklin Pierce vetoes the "12,225,000 Acre Bill," which would have built public asylums at federal expense. (2)
  - this decision forced states to assume the lead responsibility for mental health services
  - That responsibility means each state has its own service and civil commitment structure.
  - No federal direct funding for mental health services until early 1960s.
- 1867 ... Nebraska became the 37<sup>th</sup> State on March 1, 1867.
- 1870 – Nebraska State Hospital for the Insane opened in Lincoln.
  - Prior to this, Nebraska residents needing psychiatric hospitalization were sent to Iowa.
  - At the end of the first biennial reporting period (Nov 30, 1872), there were a reported 116 patient admissions with an inpatient census of 49.

Since 1963, there has been a Federal presence in Mental Health. Today, this Federal presence includes addressing requirements under the Government Performance and Reporting Act (GPR). That leads us to issues around the “Uniform Reporting System” under the Federal Community Mental Health Block Grant which will be collecting performance measures from the 50 states and use the data to report to Congress.

Yesterday (May 29) at the "planners" meeting, Federal Officials outlined their proposals on the “Performance Partnership” ... moving the Mental Health Block Grant from voluntary reporting to mandatory reporting.

## **Why the Mental Health Statistics Improvement Program?**

The MHSIP grows out of a tradition of collaboration among individuals who are felt to have both insights about these data and rights to have their points of view considered. The program and its content have consistently been characterized by this openness to collegial input.

At the time FN-10 in 1989 was released, Cecil Wurster was working in Division of Biometry and Applied Sciences, National Institute of Mental Health. In serving on MHSIP / DS2K+ LIAISON GROUP, Cecil keeps the group on track in terms of incorporating the work completed in developing FN-11 workgroup.

MHSIP Consumer-Oriented Mental Health Report Card was released in April 1996. Now MHSIP Report Card Version 2 is being developed.

**MHSIP must be kept current ... updated on an ongoing basis ... changing as the needs of the field change. That brings us to “Decision Support 2000+”.**

### **DS2K+**

Now “Decision Support 2000+” is being developed. DS2K+ is considered a new conceptual model. It is intended to be one information system serving many purposes. People talk about the

- Core Components
- Stakeholders ... states, consumers, providers, others

If you visit the MHSIP web site, click on “Decision Support 2000+”. There you will find some interesting things. DS2K includes over ten areas with names like ...

- Population Data (new)
- Enrollment Data ... now Person Data Set ...
- Encounter Data
- Financial Data
- Human Resources Data
- Organizational Data
- Clinical Guidelines
- Data Collection Related to System Guidelines

- Performance Indicators and Report Cards (MHSIP Consumer-Oriented M H Report Card)
- Consumer Outcomes Measures (MHSIP Consumer-Oriented Mental Health Report Card)

DS2K+ includes MHSIP's tradition of openness to collegial input. You are actively encouraged to contact Sarah Minden or Marilyn Henderson with your comments, suggestions, feedback, and questions about DS2K+.

Now the DS2000+ Prototype is being developed.

### **MY PERSPECTIVE ON MHSIP/DS2K LIAISON GROUP**

As a State level person, I need to deal with the practical aspects of implementation.

RESULT: To me, DS2K+ serves as a data dictionary ... a reference document ...

In that respect, DS2K+ helps to establish a common language and data standards across the Mental Health System.

It provides for data standards reflecting generally accepted of concepts in the mental health field, approaches to measuring various items, establishing common terms and definitions and much more.

The first meeting of the MHSIP / DS2K+ group was in February 2001, State representatives raised serious issues on Health Insurance Portability and Accountability Act of 1996. We were interested in seeing DS2K+ develop strategies on integrating material from the HIPAA. The DS2K+ team has provided an excellent start in this area ... keeping it current will be challenging.

I expect that as the DS2000+ Prototype is developed, we will see:

- SECURITY / PRIVACY / CONFIDENTIALITY – The security / privacy / confidentiality issues are very important. As the DS2K prototype is developed, it provides an opportunity to demonstrate the operational meaning of security / privacy / confidentiality. To me this means we not only meet the technical requirements of the law but also the spirit of those laws. The records need to be protected from unauthorized access and unauthorized use. Strict penalties need to be invoked for failure.

The security / privacy / confidentiality issues are very important. Given how the HIPAA issues were addressed, I am confident on how the DS2K+ team will do a good job of addressing these issues. To me, this is both a current concern and future concern. After the current people on the DS2K+ team move on, the new group needs to also take this issue seriously. How will the security / privacy / confidentiality issues be addressed on a sustainable basis both today and in the future.

- BURDEN – As development of DS2K moves forward, I am concerned about what the burden will be on States and Providers. Each time at the Federal Level additional requirements are made additional burden flows down to the States, then to the providers. The “Burden” can range from
  - very easy, no additional effort, part of routine practice ... up to
  - very difficult, labor intensive plus difficult to gather reliably.

The Federal Officials proposals on the “Performance Partnership” with mandatory reporting has the potential to create serious reporting burdens.

- MENTAL HEALTH / SUBSTANCE ABUSE – As development of DS2K moves forward, I hope we see better coordination between the federal offices addressing mental health and substance abuse issues. For example, the Nebraska Department of Health and Human Services contract section covering the non-Medicaid funded Behavioral Health services contains 113 data fields covering:
  - Demographics,
  - Standard admission status,
  - Mental Health Adults,
  - Mental health children / adolescents, (0-18),
  - SUBSTANCE ABUSE services as well as
  - GAMBLERS ASSISTANCE PROGRAM (NEW)
- CONSUMER ACCESS TO DATA REPORTS – the DS2K application includes features providing consumer access to the data. The degree of access may need to be limited due to the issues noted above on security / privacy / confidentiality. These need to be recognized. However, at the same time, I believe the consumer access to the data has the potential to

improve the Mental Health System at both the micro and macro levels. So, suitable reports designed for individual consumers as end users needs to be included.

Earlier today one speaker talked about the importance of “knowledge is shared ... information flows freely.” He also talked about how safety is respected.

### **In Summary ...**

Data standards can be used to help communicate across the field.

- MHSIP Community ...
- MH Block Grant Community ...
- Other mental health stakeholders
- Discussion on expanding it to include Substance Abuse ...

### **... THANK YOU ...**

brief bio sketch for program booklet.

James S. Harvey, LCSW  
Nebraska Department of Health and Human Services  
Office of Mental Health, Substance Abuse and Addiction Services  
Lincoln, NE

Mr. Harvey has worked for the State Mental Health Authority since 1980. Currently his duties include serving as the state planner for the federal Mental Health Block Grant, staff for the Mental Health Planning and Evaluation Council, planning for disaster mental health response, and related duties. He wrote Nebraska's first MHSIP grant and served as project manager for recently completed MHSIP State Reform Grant. He is the Project Director for the Nebraska Mental Health Data Infrastructure Grant.

Mr. Harvey's background includes a Master of Social Work Degree. He is a Licensed Mental Health Practitioner (# 665) and Certified Master Social Worker (#16). He is trained as a mediator under the Nebraska Office of Dispute Resolution and is affiliated with "The Mediation Center: Resources for Collaborative Decision Making" in Lincoln, NE.

HHS Office of Mental Health, Substance Abuse and Addiction Services  
P.O. Box 94728  
Lincoln, NE 68509-4728  
work phone: 402-479-5125  
e-mail: [jim.harvey@hss.state.ne.us](mailto:jim.harvey@hss.state.ne.us)

(1) an expression by Richard DeLiberty, Indiana Division of Mental Health

(2) -- 1854 - President Franklin Pierce vetos the "12,225,000 Acre Bill," which would have built public asylums at federal expense.

Source: Madness and Government: Who Cares for the Mentally Ill? By Henry A. Foley and Steven S. Sharfstein: © 1983; ISBN 0-88048-001-7; Page 7

Also under the CHRONOLOGY OF EVENTS (page xviii)

Also referred to as the "Indigent Insane Bill".