

VI. Requirements for Human Resources Data and

VII. Requirements for Organizational Data

Denise Noonan

Summary

Both the human resources and organizational data sets serve as basic building blocks of the mental health information system. They tell us who is performing services and in what kinds of settings. The human resources data set describes the demographics, qualifications, size and distribution of the work force. This information is especially important in view of the fact that behavioral health care delivery is labor intensive and personnel costs typically constitute the largest share of overall expenditures. The organizational data set includes information about the type, size, location, ownership and funding for a mental health organization. It should be sufficiently broad to capture the variety of structural and financial models that have emerged over the past decade.

Human resources and organizational data must meet the needs of a variety of stakeholders who want to know whether the behavioral health workforce is qualified, culturally competent, and sufficient in numbers to serve the designated population as well as the nature of the organizations that comprise the delivery system. Linkages between human resources and organizational data and other components of the information system, such as enrollment, encounter and financial data, allow stakeholders to plan, manage and evaluate behavioral health care services. As organizational and financial models of behavioral health care delivery are continuously evolving it is particularly important to be able to track changing human resource needs as well as impacts of change on type of services available, use of services, and quality of care.

Many of the items recommended for inclusion in the human resources and organizational data sets are collected periodically by the government, private sector, and professional societies. Valid comparison of data across sources is hampered by lack of uniform definitions of items and variation in data collection procedures. In addition, the absence of unique identifiers for individual providers and organizations presents a major barrier to aggregation of data. Until the issue of unique identifiers for consumers, clinicians, and organizations is resolved, the linkages between elements of the information system will not be maximized.

Work must proceed in a number of areas to refine the human resources and organization domains of the prototype:

- Develop national unique identifiers for behavioral health care clinicians
- Further develop national unique identifiers for behavioral health care organizations.
- Develop standard definitions for common terms such as provider/clinician, sponsor, payer, organization, plan, and facility.

- Develop standard data definitions and codes for the major disciplines, training or occupations of all direct and nondirect service staff.
- Develop standardized question formats, response categories, and timing of data collection.

VI. Requirements for Human Resources Data

Denise Noonan

What is the Intended Purpose or Function of this Component?

The purpose of the Human Resources component of the mental health information system is to specify the domains of data in each area that are necessary to describe providers of service. The data can be used alone or linked to other types of data for purposes of planning, managing, and evaluating behavioral health care services. The data elements should be selected to meet the information needs of a variety of stakeholders including consumers and advocates, public and private payers, administrators, providers, policy makers, and health care researchers. The challenge with this component of the information system, as with all of the others, is to gather enough data to get meaningful information, but not so much that the process creates undue burden on those who provide, collect, or analyze the data.

Human resources data provide information regarding the demographic characteristics, qualifications, size, and distribution of the mental health work force. Data elements should be chosen so that when they are combined with other data (e.g. enrollment, encounter) questions such as the following could be answered:

- What are the qualifications of personnel who deliver particular services such as utilization management, case management, emergency care or inpatient care?
- Does the work force possess the skills necessary to provide quality care to the population it serves including the ability to speak languages other than English?
- Do the demographics of the work force reflect the demographics of the population served with regard to racial and ethnic background?
- Are there skews in the distribution of the workforce (such as a large proportion of managers approaching retirement age or the least experienced clinicians caring for consumers with the most complicated conditions) that require administrative attention?

Human resources data are useful both at the level of the organization and aggregated across organizations to create a picture of the mental health workforce. This information is particularly important since personnel costs constitute at least 75% of mental health care expenditures (Leginski, et.al, 1989). Personnel costs are high because these services are labor intensive and require skilled providers to deliver them. Important public policy questions regarding access to care, availability and delivery of services, and training of mental health providers cannot be addressed unless this information gap is closed.

To date, information on mental health personnel is gathered by a number of entities, such as professional societies, licensing boards, and payers, each of whose agenda drives the type of data collected. The Federal government has directed efforts towards collecting better human resources data at both the organizational (Leginski, et.al, 1989) and encounter levels (Manderscheid &

Henderson, 1995). Uniform data collection at the encounter and organizational level would allow data to be aggregated at the national level to provide a comprehensive picture of the workforce. A national provider database would be extremely valuable for answering questions regarding the supply and distribution of various types of providers throughout the country.

What Information is Required to Accomplish this Purpose?

There is substantial variability in the type and amount of information collected regarding human resources. Standardization of these data by means of commonly used definitions and codes for a minimum data set would enhance its usefulness. Furthermore, the size of the human resources data set can be kept at a minimum by avoiding duplication of data elements collected for other components of the information system and by eliminating data that would have limited usefulness in cross-site comparisons because they are so specific to a particular organization.

The human resources component of the information system should provide descriptive data on the nature of the workforce currently providing mental health services or administratively supporting their delivery. These would include full and part time staff engaged in direct or indirect care under a contractual agreement. There is disagreement in the field as to whether information should also be collected on volunteers, trainees, and others who deliver services as well as support staff. Many would argue, however, that it is impossible to obtain a complete and accurate picture of what resources are required to deliver services without such data. Typically, human resources data are collected at the level of the organization and describe the workforce along a number of dimensions including its size, distribution within the organization, professional training, quality, and productivity.

Work on the human resources component of the information system has been ongoing since the 1980's when specific data elements were recommended in the MHSIP Data Standards for Mental Health Decision Support Systems (FN10) (Leginski, et. al., 1989). For the past 15 years, the Human Resources Workgroup (initially sponsored by NIMH and now by CMHS) has addressed the issues of noncomparability of human resources data across the professions by bringing together representatives of the four major mental health disciplines— psychiatry, psychiatric nursing, psychology, and social work— through the American Psychiatric Association, the American Psychological Association, the National Association of Social Work, and the Council of Psychiatric Nursing Organizations as well as representatives from the American Counseling Association, the Association of Marriage and Family Therapists, the Commission on Applied and Clinical Sociology, the Health Resources and Services Administration, the International Association of Psychosocial Rehabilitation, and the National Commission on Counselor Certification (Dial et al., 1990; Dial et al., 1992; Peterson et al., 1996). The minimum data set developed by the Human Resources Workgroup is currently used by many of these national organizations; its most recent refinement, including a list of key variables and their descriptions, as well as guidelines for data collection, is presented in *Mental Health United States 1998* (Pion, et al, 1998).

Core Data Elements

The core data elements for mental health and substance abuse providers described by the Human Resources Workgroup cover demographic characteristics, educational characteristics, credentials, employment characteristics, involvement in managed care, and characteristics of clients served (Pion, et al; 1998) (see Table 1). Each element covers a range of information:

- Demographic characteristics include information on age, gender, and race/ethnicity. These data are particularly useful for training institutions in their attempts to be responsive to the needs of the population served by mental health professionals. Health services researchers are interested in the impact of provider age, gender and race/ethnicity on the effectiveness of interventions.
- Educational characteristics include the type and field of the highest degree earned, the institution granting the degree, the year in which the degree was granted and the primary professional identification of the respondent. These data provide some information on the experience, training and qualifications of mental health professionals. It is especially important to understand the roles various practitioners are playing, whether their training has prepared them for these roles, and how these roles are shifting with changes in the field.
- Credentials are obtained by asking about State and disciplinary recognition as a mental health provider or proficiency in specialties or subspecialties. This information is an important indicator of quality of the workforce, since providers must demonstrate some level of competence in order to be credentialed. Data on specialization is particularly helpful in assessing the availability of clinicians to subpopulations needing specialized mental health services.
- Employment characteristics include employment status, numbers of positions held, employment settings, work activities, relationship to employer(s), and zip codes of primary service delivery settings. This information is essential for the purpose of describing who is providing what service in what setting(s) at a particular moment in time, but it is also useful for examining trends in employment related to market conditions or other factors.
- Involvement in managed care settings is assessed by asking about the respondent's affiliations with a variety of models of managed care and income earned through these affiliations.
- Characteristics of clients served include age, gender, race/ethnicity, and diagnostic group. While it would be preferable to collect much more extensive information in this area, issues regarding patient confidentiality, accuracy of responses, and respondent burden preclude doing so. Even these basic data are useful for informing issues such as the cultural competence of the workforce and the availability of appropriately trained personnel to meet the needs of particular groups of clients.

Unique Provider Identifier

Establishing a unique provider identifier is a critical step in the mental health field being able to achieve an accurate accounting of who is delivering services. A unique identifier is particularly essential when data are aggregated across organizations. The identification number would make it possible to recognize individuals who provide services in more than one setting and to track migration of providers over geographic areas or from one type of service setting or clientele to another.

Passage of the Health Insurance Portability and Accountability Act (HIPAA) in 1996 mandated the establishment of a standard health care provider identifier that will be applicable to all health plans and health care clearinghouses that conduct electronic transactions related to health claims, health plan enrollments and disenrollments, and health plan premium payments.

In fact, the Health Care Financing Administration (HCFA) has been working since 1993 to develop a national system for identifying and uniquely enumerating health care providers. A workgroup consisting of representatives from the public and private sectors, specialty groups, standards groups and others reviewed the existing identifiers, found them inadequate and proposed a National Provider Identifier (NPI). The NPI is an 8-position alphanumeric identifier that will allow for the distribution of approximately 20 billion unique identifiers. The NPI would not contain embedded intelligence that would describe the health care provider; rather, this information would be stored in a database called the National Provider File. An NPI would be assigned to each “individual, group or organization that provides medical or other health services or supplies” (www.hcfa.gov). Under the proposed HCFA system, a health care provider is someone who “is licensed, certified, or otherwise authorized to perform medical services or provide medical care equipment or supplies...” (www.hcfa.gov); the definition does not include those who provide indirect services such as administrative or housekeeping staff. If the NPI system is used in the mental health field, the list of providers will need to be expanded to include paraprofessionals, outreach workers, consumers and any others who provide direct services, as well as providers of indirect services.

Enumeration of health care providers for the National Provider System would need to be completed in phases over several years due to the volume of providers. Even when the process is complete, there will be providers who do not conduct any of the electronic transactions stipulated in HIPAA and who will not be enumerated. It is likely that human resources data collected by the Federal government, private and public payers, and mental health organizations will need to be supplemented by data from other sources to provide a complete picture of the resources available in the field. Practitioners in independent practice, individuals who provide services outside traditional organizational structures, e.g. pastoral counselors, school psychologists, peer counselors, and professionals engaged in non-service mental health-related endeavors may not submit bills to payers and may not appear in organizational data bases. Information from these individuals will need to be gathered by surveys conducted by regulatory and oversight bodies and professional organizations and societies (Pion et al., 1998).

A unique provider identification number would eliminate duplicated data and allow for tracking of trends over time. Maximum comparability of data from all sources can be achieved by specifying core data elements for mental health providers that would be adopted by all relevant disciplines. Cross-walking capability is also enhanced by standardized question formats, response categories, and timing of data collection (Pion et. al., 1998). The Human Resources Workgroup is building consensus regarding information that can be collected via membership surveys.

Who Provides the Information?

Information on individual providers of mental health services is available from a number of sources, including:

- employers of mental health workers;
- payers of services such as government agencies and private insurers;
- regulatory and licensing boards;
- professional organizations and societies; and
- health services researchers.

Human resources data must be collected at points of entry into a system or organization; at specified intervals to detect changes in training, job function, hours, and compensation; and at exit from the system or organization. The data are typically reported by the individual on forms provided by the data collector for that purpose. Ideally, the stable parts of the record are automated to reduce paperwork and only those items that have changed since the last reporting period need to be updated. In the future, a national provider file may obviate the need for repeated collection of any stable items and authorized users could access the data, or subsets of it, from a central data bank.

Currently, a provider who works in more than one setting will submit information to multiple entities. For example, a psychiatrist may be a part-time employee of an HMO, a participating provider in a number of behavioral health care carve-out panels, and an attending staff member of a psychiatric inpatient unit in a general hospital. A national provider survey including all of the sites would count the psychiatrist three times. With a unique national provider identification number, the psychiatrist would appear only once in the database.

Individuals who do not provide direct service but whose work supports the administrative structure of the organization and contributes to its performance are included in the human resources database of the organization. These would include volunteers, trainees, and anyone who delivers services under a contractual arrangement with a mental health organization, such as an attending physician. Information on this segment of the workforce would be collected at the level of the organization, just as it would be for direct service staff.

Who Uses the Information that is Produced?

Human resources data serve multiple purposes for many stakeholders. When human resources data are linked with encounter, financial, and outcomes data, important questions can be answered about the productivity of different types of staff, the clientele served by different professions, the impact of years of experience on effectiveness, and costs associated with treatment by various groups.

Stakeholders may use human resource data in a number of ways, including the following.

- Organizations collect these data to fulfill basic management tasks such as recruiting employees, complying with licensing and accreditation standards, and anticipating increasing or decreasing demand for staff. Organizations also use human resources data to make reports to funding agencies, respond to inquiries from governing bodies or provide indications of quality for marketing purposes.
- Payers of services such as government agencies and private insurers collect data on providers for credentialing, accountability, and quality control initiatives.

- Regulatory and oversight bodies such as licensing boards, accrediting groups, and Federal agencies require data on mental health professionals for credentialing, planning, policy implementation, and monitoring.
- Consumers and their advocates use human resources data to identify trends in health care delivery, to assess quality of care, and to make choices among health plans.
- Policy makers conduct analyses regarding training, supply, employment, and utilization of mental health providers.
- Professional organizations and societies conduct surveys of their memberships to advance their initiatives.
- Health services researchers pursue studies of the mental health workforce to address questions related to practice patterns, employment characteristics, demographics and the like.

How Ready Are These Components for Inclusion in the Information System?

With the exception of unique identifiers, many of the items recommended for inclusion in the human resource and organization data components are already available and are being collected by the government, private sector, or professional societies (Pion et al., 1998). The challenge is to ensure that the items are clearly defined and specific enough so that valid comparisons across settings are possible.

The level of detail required to provide meaningful information in the human resource area has at times been problematic. Personnel have perceived questions about racial and ethnic background as intrusive and potentially divisive or prejudicial. Early versions of the human resource component of the MHSIP Data Standards dropped some items due to concerns that they might be offensive or interfere with completion of the instrument (Leginski, 1989). Similarly, while it would be useful to gather detailed information about salary, fringe benefits, and degree of risk, many respondents might perceive such inquiries as intrusive.

The question of how broadly to define the mental health workforce also needs resolution. In addition to direct service providers, there are many individuals whose work supports the delivery of care, including volunteers, consumers, pharmacists, and administrative support staff. While the true cost of service delivery cannot be calculated without including these groups, their inclusion in a human resources database may not be necessary.

What Future Efforts are Required for Readiness?

The development of national standard data definitions and codes is crucial to the facilitation of comparisons across mental health care organizations. While substantial progress has been made, a number of key steps remain:

- Develop national unique identification numbers for organizations and their staff.

- Determine which staff will have unique identification numbers. The National Provider System includes only direct service providers, and does not cover the entire universe of direct and non-direct providers of mental health services.
- Develop standard data definitions and codes for types of services delivered in mental health care systems to ensure that the entire array of services offered by an organization are represented in the data.
- Develop standard data definitions and codes for the major disciplines, training or occupations of all direct and non-direct service staff.
- Develop standardized question formats, response categories, and timing of data collection.

Table 1**Human Resources Data Elements¹**

Data Element	Definition	Ready for Prototype
Social Security Number *	Social Security Number	Yes
Unique Provider Identification Number *	Unique Provider Identification Number (UPIN) assigned by the Health Care Financing Agency for use in submitting Medicare and Medicaid bills	No
Staff Unique Identifier ⁺	For all staff. A unique identifier that corresponds to a staff member independent of the organization reporting. May be the same as the Provider ID.	No
Date of Birth * ⁺	Staff member's date of birth (mm/dd/yyyy)	Yes
Sex * ⁺	Staff member's gender (male/female)	Yes
Race and Ethnicity * ⁺	The US Census Definition (all that apply) <ul style="list-style-type: none">• African-American or Black• American Indian or Alaskan Native• Asian or Pacific Islander• Hispanic• White• Other (specify) If Hispanic: <ul style="list-style-type: none">• Mexican American• Puerto Rican• Other Hispanic (specify)	Yes

¹ The data elements listed in this table are taken from two sources which are identified as follows: *Pion et al., 1998 and ⁺ Leginski et al., 1989 (FN-10).

Table 1**Human Resources Data Elements¹**

Data Element	Definition	Ready for Prototype
Primary Professional Identification * +	<p>Self-selected category that best reflects the major discipline, training, or profession for which staff member has been trained or hired (rank all that apply)</p> <ul style="list-style-type: none">• Activity therapist (e.g., art, music, dance, recreational, or occupational therapist)• Counselor (e.g., clinical mental health, rehabilitation, school, substance abuse, vocational counselor)• Marriage and family therapist• Nurse (other than a psychiatric nurse)• Physician (other than a psychiatrist)• Psychiatric nurse• Psychiatrist• Psychologist (e.g., clinical, counseling)• Psychosocial rehabilitation specialist• School psychologist• Social worker• Sociologist (e.g., applied or clinical)• Other mental health professional (specify) <p>Leginski et al., 1989 include: mental health worker with less than a bachelor degree; schoolteacher; public, hospital, or business management/administration; speech therapist; dietician; pharmacist or assistant; dentist or dental assistant; other physical health professional or assistant; medical records administrator or technician; other worker (support, maintenance, administration).</p>	Partial
Employment Primary Professional Discipline *	Whether staff member is employed in the primary professional discipline ranked #1 in each of primary setting and secondary setting	Yes
Degrees Earned * +	<p>Although question formats may vary, the minimum data elements should include type of degree, field of degree, year of receipt, and the institution awarding the degree.</p> <ul style="list-style-type: none">• Doctorate (e.g., MD, PhD, ScD, JD, EdD, DO)• Master's Baccalaureate• Less than baccalaureate (e.g., AA or RN)• Other (specify) <p>Pion et al., 1998 include the field of the degree (e.g., clinical psychology, social work or sociology), year degree was degree awarded, and name of the institution awarding the degree (Name, City, State/Province, Country, Name of Dpt)</p> <p>Leginski et al., 1989 include education level: less than high school diploma or GED, high school diploma or GED, some college, associate degree, bachelor degree</p>	Partial

Table 1**Human Resources Data Elements¹**

Data Element	Definition	Ready for Prototype
Credentials for Practice * +	<p>Whether staff member is currently licensed, registered, or certified to practice in his/her profession by one or more of the 50 states, the District of Columbia, or US territories.</p> <p>Pion et al., 1998 asks respondents to indicate the specialties of the current licensure, registration, or certification, the states in which they are valid (e.g., clinical psychology, school counseling, or occupational therapy), to be specific, and not to use initials or abbreviations:</p> <ul style="list-style-type: none">• Licensure (specialty/state(s))• Board certification (MDs only) (specialty/state(s))• Other certification (specialty/state(s))• Other registration (specialty/state(s)) <p>Pion et al., 1998 also asks respondents to indicate any additional practice-related credentials and the full name of the credentialing body (e.g., Diplomate in Clinical Psychology by the American Board of Professional Psychology).</p>	Partial
Employment Status * +	<p>Staff member's current employment status (check one):</p> <ul style="list-style-type: none">• Employed (by an organization or individual or self-employed)• Student (trainee, intern, resident, postdoctoral fellow, other trainee)• Retired and not employed (if self-employed, do not answer)• Not currently employed• Other (specify) <p>Leginski et al., 1989 suggest, in addition, the following:</p> <ul style="list-style-type: none">• Salaried, payroll (full- or part-time)• Paid under contractual arrangement• Volunteer• Attending <p>Pion et al., 1998 also ask:</p> <p>If not employed: is respondent currently looking for work? (yes/no)</p> <p>If employed: what are the number of hours per week respondent typically works for pay? [If time period is atypical due to illness, vacation, or other circumstances, typical hours worked per week are reported]</p> <p>If employed: is respondent currently seeking employment in addition to current job or position? (yes/no)</p>	Yes

Table 1**Human Resources Data Elements¹**

Data Element	Definition	Ready for Prototype
Number of Separate Paid Positions *	Number of different employment positions currently held (e.g., if respondent works part-time in a drug abuse clinic and also has a part-time independent practice, this should be reported as two positions. If respondent has two different job titles such as Associate Professor and Director of the Student Counseling Center, these are also two separate positions.)	Yes
Employment Setting(s) *	<p>From the list below, the category that best describes the employment setting of the respondent's primary and secondary paid positions:</p> <ul style="list-style-type: none">• Academic setting (universities, 4- and 2-year colleges, professional schools)• Hospitals, including public, for-profit, and nonprofit (general, psychiatric, rehabilitation, other specialty population hospitals)• Other residential health care settings (nursing homes, residential treatment centers, group homes, half-way houses, rehabilitation settings, other transitional settings)• Clinics, rehabilitation, and other outpatient settings (community mental health centers, freestanding mental health outpatient clinics, health maintenance organizations, specialized health service clinics such as substance abuse or pain clinics, other ambulatory health or mental health settings, freestanding rehabilitation agencies)• Home health agency• Individual independent practice• Group independent practice• Other (business and industry, schools and school systems, criminal justice systems, Federal, State, and local agencies, other social service agencies, other settings not mentioned above)• Number of hours worked in last typical work week	Yes

Table 1**Human Resources Data Elements¹**

Data Element	Definition	Ready for Prototype
Work Activities *	<p>Total number of hours that respondent worked in primary paid position, and total number of hours worked in all paid positions combined.</p> <p>For the past week, number of hours spent in specific work activities in primary paid position and in all of positions combined:</p> <ul style="list-style-type: none">• Direct care (diagnostic assessment, evaluation, medication prescription and management, treatment)• Clinical supervision of staff and trainees• Clinical/community consultation and prevention (not involving direct care)• Educational activities (teaching or courses or professional workshops, curriculum development, course evaluation)• Management and administration (policy or program development and review, personnel administration, recruiting, budgeting)• Research (basic and applied)• Other activity not mentioned above (e.g., scholarly writing) <p>Typical work week? (yes/no)</p> <ul style="list-style-type: none">• If no, number of hours worked in primary position in a typical week	Yes
Zip Code(s) Service Settings*	First 5 digits of zip code of residence and primary and secondary paid positions as well as for services provided in other settings	Yes

Table 1**Human Resources Data Elements¹**

Data Element	Definition	Ready for Prototype
Relationship to Employer(s) *	<p>Financial arrangement to employer(s) for primary and secondary positions:</p> <ul style="list-style-type: none">• An employee of an organization (e.g., responsible through a supervisor for attaining company goals; paid by company resources)• Self-employed (including group independent practice association, and private practice, consulting) <p>Percentage from the following payment arrangements:</p> <ul style="list-style-type: none">• Fee for service (i.e., a bill is submitted for each service provided)• Fee for service with a withholding (i.e., a portion of fee is withheld and paid only at end of year based on some type of performance criteria)• Fixed rate per case (i.e., a set amount of dollars for each consumer treated without regard to intensity or length of treatment; services are not reimbursed separately)• Capitation payment (i.e., a payment based on the population of consumers for whom respondent or organization has agreed to provide services if services are needed)• Consumer self-pay• Salary• Other (specify)	
Involvement in Managed Care Arrangements *	<p>Number of affiliations respondent has with each of the following types of managed care arrangements (in any setting); whether any income is received from each of these arrangements. Includes both being a salaried provider in a centralized health maintenance organization (HMO) and contracting with a behavioral healthcare firm that supplies referrals under a reduced fee for service arrangement and also carries out utilization review of cases:</p> <ul style="list-style-type: none">• As a salaried staff member of an HMO which is responsible for both general and behavioral healthcare• As a salaried staff member of an HMO responsible solely for behavioral healthcare• As a member of a group practice that is a contracted network provider to an HMO• As a member of a group practice that is a contracted network provider to a behavioral healthcare firm• As an independent practitioner who is a contracted network provider to an HMO• As an independent practitioner who is a contracted network provider to a behavioral healthcare firm• Other types of managed care arrangements (specify)	Yes

Table 1**Human Resources Data Elements¹**

Data Element	Definition	Ready for Prototype
Source(s) of Payment for Provision of Direct Services *	Funding sources that consumers may use to pay for direct services (all that apply) and percentage of reimbursement from each source: <ul style="list-style-type: none">• CHAMPUS (Civilian Health and Medical Provider of the United States)• Medicaid• Medicaid which is HMO• Medicaid which is another managed care network (e.g., PPO, POS)• All other Medicaid• Medicare• Medicare which is HMO• Medicare which is PPO• Other Federal funding• State, county, or city funds• Private fee-for-service/individual's insurance plan (e.g., major medical plan such as Blue Cross/Blue Shield or Aetna without a preferred provider arrangement or HMO; may include utilization review)• Preferred provider private insurance plan• HMO, private insurance plan (not Medicare or Medicaid HMO)• Consumer's own funds (out-of-pocket dollars from client or family) Other (specify)	Yes

Table 1**Human Resources Data Elements¹**

Data Element	Definition	Ready for Prototype
Provision of Direct Services to Special Populations *	Total number of consumers treated by respondent during most recent typical week of practice.	Yes
	Percentage of consumers with certain characteristics to whom respondent provided direct services during the last typical week: <ul data-bbox="516 653 1179 1318" style="list-style-type: none">• Children (individuals aged 10 years or younger)• Adolescents (individuals aged 11-17 years)• Adults (individuals aged 18-64 years)• Elderly (individuals aged 65 years and older) • Individuals• Couples• Groups• Families (parents, relatives, and/or children as a unit)• Community prevention services • African-American or Black• American Indian or Alaskan Native• Asian-American or Pacific Islander• Hispanic (Cuban, Mexican American, Puerto Rican, or other Hispanic)• White• Other (specify) • Male• Female.	
	Using DSM-IV diagnostic categories, provision of services during the most recent typical week to consumers with any of the following disorders (all that apply): <ul data-bbox="516 1476 1198 1881" style="list-style-type: none">• Adjustment problems, family and/or relationship problems, or academic problems• Affective disorders (bipolar disorder, major depression)• Anxiety disorders• Dually diagnosed individuals (i.e., individuals with a mental health and substance abuse diagnosis, a mental health and mental retardation diagnosis, or a mental retardation and substance abuse diagnosis)• Mental retardation and other developmental disorders• Organic brain disorders and syndromes• Personality disorders (borderline disorders, antisocial disorders)• Schizophrenia or other major psychoses	

Table 1**Human Resources Data Elements¹**

Data Element	Definition	Ready for Prototype
Provision of Direct Services to Special Populations Continued	<ul style="list-style-type: none">• Substance abuse (alcohol abuse or dependency, drug abuse)• Disorders usually first diagnosed in infancy, childhood, or adolescence (other than mental retardation or developmental disabilities)• Other mental health problems not listed above• Other general health problems (specify)• Unable to specify	
Languages Other than English **+	Whether staff member can provide direct services to consumers in any language other than English (yes/no/specify) Pion et al., 1998 includes the percentage of consumers to whom respondent provided direct services that required use of languages other than English in the past time period	Yes
Staff Separation Date +	If applicable, the month during which the relationship or affiliation between the individual and the organization was terminated	Yes

Table 2

Additional Human Resources Data Elements

Data Element	Definition
Country of Highest Degree	Name of Country
Private Practice Maintained	The individual maintains a private practice in this profession (yes/no/not applicable).
University or college Affiliation	The individual is affiliated with a university or college to teach or conduct research at that institution (yes/no/not applicable).
Participation in Job-related or Career Development Training	The individual has participated in any of the following types of training intended to improve job performance, acquire additional skills, or satisfy a continuing education expectation: <ul style="list-style-type: none">• In service training, i.e., sponsored by the organization, usually onsite and during work hours• Extracurricular, i.e., sponsored by another organization, usually offsite, and release time from work may or may not be granted• None
Income from Organization	Actual or estimated income for annual salary or reimbursement received from this organization, including overtime and bonuses, and excluding fringe benefits.
Fringe Benefits Value	Estimated percentage of the person's salary from the organization that the fringe benefits represent. These include contributions to retirement funds, health insurance, or life insurance payments, education benefits, participation in profit sharing, shares of stock, etc.
Year of Degree	A 4-digit code for year in which the highest degree was granted.
Primary Job Function	The assigned category that best describes the major function the organization expects the person to perform on a day-to-day basis: <ul style="list-style-type: none">• Direct or adjunctive clinical service• Consultation, education, or prevention• Administration or management• Other job function (all other job functions in organization not covered above)
Experience	Prior to current employment or affiliation with the organization, total number of years worked in mental health. (If 6 months or less, round down; if more than 6 months, round up.)

Sources: Mental Health Statistics Improvement Program, Draft for FN-11

References

Center for Mental Health Services. *Mental Health, United States, 1998*. Manderscheid, R.W., and Henderson, M.J., eds. DHHS Pub. No. (SMA) 99-3285. Washington, DC: Supt. of Docs., U.S. Govt. Print. Off., 1998.

Dial TH, Tebbutt R, Pion GM, Kohout J, VandenBos GR, Johnson M, Schervish PH, Fox JC, and Merwin EI. Human Resources in Mental Health. In: Manderscheid, RW and Sonnenschein, M.A., eds. *Mental Health, United States, 1990*. DHHS Pub. No. (ADM) 90-1708. Washington, DC: Supt. of Docs., U.S. Govt. Print. Off., 1990. pp.196-215.

Dial TH, Pion GM, Conney B, Kohout J, Kaplan KO, Ginsberg L, Merwin EI, Fox JC, Ginsberg M, Staton J, Clawson TW, Wildermuth VA, Blankertz L, and Hughes R. Training on Mental Health Providers. In: Manderscheid RW and Sonnenschein MA, eds. *Mental Health, United States, 1992*. Washington, DC: Supt. of Docs., U.S. Govt. Print. Off., 1992. pp.142-163.

Health Care Financing Administration. Health Insurance Reform: Standards for Electronic Transactions; National Standard Health Care Provider Identifier; Proposed Rules. *Federal Register*, Volume 63, No. 88, May 7, 1998.

Leginski WA, Croze C, Driggers J, Dumpman S, Geertsen D, Kamis-Gould E, Namerow MJ, Patton RE, Wilson NZ, Wurster CR. Data Standards for Mental Health Decision Support Systems. DHHS: Pub. No. (ADM) 89-1589. Washington, DC: Supt. of DOCS., U.S. Govt. Print. Off., 1989.

Manderscheid RW and Henderson MJ. Federal and State Legislative and Program Directions for Managed Care: Implications for Case Management. Rockville, MD: U.S. Center for Mental Health Services, 1995.

Peterson, DP, West J, Pincus HA, Kohout J, Pion GM, Wicherski MM, Vandivort-Warren RE, Palmiter ML, Merwin EI, Fox JC, Clawson TW, Rhodes KK, Stockton R, Amrose JP, Blankertz L, Dwyer KP, Stanhope V, Fleishcer MS, Goldsmith HF, Witkin MJ, Atay JE, and Manderscheid RW. An Update on Human Resources in Mental Health. In: Manderscheid RW and Sonnenschein, M.A., eds. *Mental Health, United States, 1996*. Washington, DC: Supt. of Docs., U.S. Govt. Print. off., 1996.

Pion G, Merwin E, and Human Resources Workgroup. Core Data Elements for Mental Health and Substance Abuse Providers: Needed Information for Improving the Healthcare System. In Center for Mental Health Services. *Mental Health, United States, 1998*. Manderscheid RW and Henderson MJ, eds. DHHS Pub. No. (SMA) 99-3285. Washington, DC: Supt. of Docs., U.S. Govt. Print. Off., 1998.