

## VII. Requirements for Organizational Data

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### **What is the Intended Purpose or Function of this Component?**

The organizational data component of the information system should include sufficient information to capture the many types of structural and financial arrangements that exist in mental health care today. In the 21<sup>st</sup> century, the organizations that manage and provide mental health services represent a spectrum of public, private, and joint public and private enterprises. Financing is derived from private (e.g., commercial insurance, self-pay) as well as public sources including Federal, State, and local funds. The complexity of mental health organizations requires that a broad array of data be collected, including information about the type of facility, its size, location, ownership, and funding .

Organizational data should serve the needs of all stakeholder groups. Consumers and advocates want to locate mental health programs that deliver the kinds of services they seek as well as identify gaps in services or in geographic access to services. Payers and administrators are interested in tracking changes in the number of consumers served within the organization as a whole and by particular programs in it. Researchers and policy makers are concerned with charting the course of a rapidly evolving mental health care field and identifying service needs and barriers to quality care. As in the case of human resources data, organizational data are maximally useful when linked to other data such as enrollment, encounter and financial data.

### **What Information is Required to Accomplish this Purpose?**

The organizational component of the information system provides information about the structure, financing, and functions of a mental health organization. A mental health organization is “any administrative and functional structure of one or more service-providing units and a group of persons within this structural entity, defined by law, charters, license, contract or agreement to provide mental health services to persons for the purpose of preventing, identifying, reducing, or stabilizing mental disabilities” (Leginski et.al., 1989).

Mental health organizations are engaged in actual service delivery— in contrast to organizations that do not, themselves, provide services, but are responsible for the administrative, financial, or regulatory activities related to service provision such as Federal agencies that pay for mental health services, State Mental Health Authorities, county funding administrations, third party payers, accreditation and certification agencies, as well as free-standing utilization management companies and administrative services only (ASO) organizations. These “auxiliary level agencies”, together with service providing organizations, constitute a traditional mental health system (Scott, 1986; Leginski et.al, 1989).

Over the last decade, the boundaries between provider level and auxiliary level organizations have become blurred such that the traditional distinctions between payer and provider and between public and private are no longer clear. The organizational component of an information system, when linked to the encounter, financial, and human resources components, must be able to capture a reasonably complete picture of the organization. Information from these databases should be sufficient to answer

questions about the nature of the entity to which an organization belongs (e.g. a managed behavioral health care organization, an HMO, a local mental health authority) , the type of facility (e.g. psychiatric hospital, residential treatment center, outpatient mental health clinic), the type of services it provides (e.g., crisis intervention, case management, utilization management), the volume of services delivered (e.g., number of admissions, number of discontinuations), and its finances (e.g., revenues, expenditures, incentives and degree of risk), and its human resources (see section on human resources data set) .

Table 1 lists candidate data elements for the organization component of the information system. This level of detail is essential in view of the complexity of organizational structures today. The data should be collected periodically to reflect changes in operation, funding, or other parameters. In order to maximize the usefulness of organizational data, a unique identifier for the organization is essential. As mentioned in regard to human resources, HCFA is devising a method to create identification numbers for all health claims payers and providers and the mental health field should work with HCFA to coordinate efforts. Indeed, the mental health field has been using the organization-level unique identifiers developed by the CMHS National Reporting Program (NRP) for many years and these could serve as a foundation for a nationwide system. Given the complicated nature of this task, it is suggested that the proposed mental health information system use the identifiers developed for the National Provider Identifier and Payer ID.

## Who Provides the Information?

Currently, organizational data are collected by the Federal, state and local governments as well as by private systems of mental health care. The Federal government through the Survey and Analysis Branch of the Center for Mental Health Services conducts a complete enumeration survey of all specialty mental health organizations and separate psychiatric services of non-Federal general hospitals on a biennial basis. It collects these data with the assistance of the State Mental Health Authorities, the National Association of State Mental Health Program Directors, the American Hospital Association and the National Association of Psychiatric Healthcare Systems.

Prior to 1986, the Inventory of Mental Health Organizations and the General Hospital Mental Health Services Inventory (IMHO/GMHS) were conducted independently, with significant duplication of effort. Since that time, a common core form with separate versions for specialty mental health organizations and general hospitals with separate psychiatric services has been developed. This newer version allows for comparisons across types of organizations. The survey covers outpatient mental health clinics, psychiatric hospitals, general hospitals with separate psychiatric services, VA medical centers, Federally funded community mental health centers, residential treatment centers for emotionally disturbed children, and “all other mental health organizations” including multi-service mental health organizations and free-standing partial care organizations (Center for Mental Health Services, Appendix D). The current 1998 and proposed 2000 surveys include managed care organizations in addition to the usual categories of mental health organizations and are moving to sampling organizations as well as internet-based data collection.

The inventories used by the Federal government are brief, so as to reduce burden on the respondent; nonetheless, the response rate is not as high as desired. Standardized data collected at the level of the organization and made available to the Federal government could reduce the need for surveys. Data gathered by the organization itself would be far more detailed than that reported to the Federal

government so as to satisfy the requirements of payers, licensing and accrediting bodies, and regulatory bodies. Standardization of question formats, response categories and timing of data collection would enhance cross-walking capability to national survey data bases.

## **Who Uses the Information that is Produced?**

One goal of organizational data is to support the management functions of a mental health organization. Managers of mental health organizations use these data to determine service utilization patterns, acquire information about revenues and expenditures, and compare their program statistics with those of similar organizations.

Organizations such as Federal Government agencies, State Mental Health Authorities, insurance payers, and accrediting bodies use organizational data to describe the various types of organizations within their scope of interest or responsibility. By linking organizational data to other databases, these entities can produce information to guide decision making and other activities in areas such as funding, licensing, or advocacy.

Another reason to collect organizational data is to paint a comprehensive picture of mental health organizations in the United States. Policy makers and advocates use aggregate organizational data to determine the availability of resources and volume of services, examine trends, and identify gaps in service. In recent years, they have been particularly interested in using these data to explore the impact of health care reform and restructuring delivery and financing of mental health care.

## **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 organization data component of the information system are already available and are being collected by Federal and state governments and by private sector organizations. The challenge is to ensure that the items are clearly defined and specific enough so that valid comparisons across settings are possible.

## **What Future Efforts are Required for Readiness?**

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, several important steps remain to be taken:

- Coordinate **HCFA** efforts to develop unique identifiers with existing mental health identifiers (Health Care Financing Administration, 1998).
- Develop a typology of arrangements for organizing and financing mental health services and locate it within the broader context of healthcare organizational and financial arrangements.

- Link efforts to specify a mental health organizational data set with similar efforts in other sectors of the human service system to ensure cross-system compatibility.

**Table 1****Organization Data Elements <sup>1</sup>**

| <b>Data Element</b>   | <b>Definition</b>   | <b>Ready for Prototype</b> |
|---|---|----------------------------|
| Organization Identifier   | Federal ID Number or National Provider System ID Number   | No                         |
| Organization Location   | P.O. Box number or street number and name, city or town, State, zip-code  | Yes                        |
| Clinician Identifier<br>(link to human resources data set)        | Federal ID Number or National Provider System ID Number   | No                         |
| Clinician Location<br>(link to human resources data set)          | P.O. Box number or street number and name, city or town, State, zip-code  | Yes                        |
| Type of Facility  | The category that best characterizes its general type: <ul style="list-style-type: none"><li>• Psychiatric hospital</li><li>• Psychiatric unit of a general hospital</li><li>• Organization providing residential services</li><li>• Outpatient mental health clinic</li><li>• Mental health partial or day hospital</li><li>• Multi-service mental health organization</li><li>• Consumer-run mental health organization</li><li>• FQHC (Federally Qualified Health Clinic)</li><li>• Other mental health organization</li></ul> | Partial                    |
| Name of Director  | Last name, first name, middle initial, degree. The director of the organization is generally the individual regarded as accountable for the performance of the organization.  | Yes                        |
| Telephone Number of the Director                                  | Area code, 7-digit number, extension  | Yes                        |
| Locations of Directly Operated Service Sites and Program Elements | The address of each site directly operated by the organization and an indication of its program elements.   | Yes                        |

<sup>1</sup> Some of the data elements listed in this table are contained in the human resources, financial, and encounter data sets. In a fully-operational integrated information system, these data would be drawn from those data sets for analyses pertaining to organizational issues.

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**Table 1****Organization Data Elements <sup>1</sup>**

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| <b>Data Element</b>                                    | <b>Definition</b>   | <b>Ready for Prototype</b> |
|--|---|----------------------------|
| Type of Ownership or Control                           | For profit (individual, partnership or corporation, state-local government, state government, county or city government, district/regional authority)<br><br>Not-for-profit (religious organizations, Federal government, Other)  | Yes                        |
| University or College Affiliation                      | Various affiliations exist with universities or colleges: <ul style="list-style-type: none"><li>• Operated by a college or university</li><li>• Offers professional services provided by a college or university</li><li>• Provides placements for clinical trainees</li><li>• Operates a clinical training program</li><li>• None</li></ul>  | Yes                        |
| Total Revenue and Support (link to financial data set) | Operating revenue and support: first- and third-party revenue (includes client fee payments, insurance payments, Medicare, Medicaid)<br><br>Operating revenue and support: all other sources (includes grants, matches, allocations, appropriations, purchase-of-service agreements, service contracts, etc., from State, Federal, municipal, and other sources)<br><br>Non-operating revenue and support (includes revenue and support not related to the delivery of mental health services such as gifts, capital gains, interest, research grants, etc.)<br><br>Total revenue and support | No                         |
| Number of Hours of Operation Scheduled Per Week        | Number, rounded to nearest whole hour, usually scheduled each week.   | Yes                        |

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| <b>Data Element</b>  | <b>Definition</b>   | <b>Ready for Prototype</b> |
|--|---|----------------------------|
| Relation to the State Mental Health Agency                                   | <p>The relationship the provider has with the state regarding operation and funding.</p> <p>Operated by:</p> <ul style="list-style-type: none"> <li>• State Mental Health (MH) Agency</li> <li>• State agency other than MH</li> <li>• Other than state agency</li> </ul> <p>Receives funds:</p> <ul style="list-style-type: none"> <li>• Directly from State MH agency, exclusive of Medicaid</li> <li>• Indirectly from State MH agency through an intermediary</li> <li>• Directly or indirectly from a State agency other than State MH agency, exclusive of Medicaid</li> <li>• Does not receive funds from any State agency, exclusive of Medicaid</li> </ul> | No                         |
| Admissions   | Total number of admissions of clients for the reporting year.   | Yes                        |
| Discontinuations   | Total number of clients discharged or otherwise leaving the rolls of the organization during the reported year.   | Yes                        |
| Number of Hot-Line Phone Calls   | Number of phone calls received by a dedicated telephone line, which is used as a crisis hotline, for emergency counseling, or referral resources for callers with mental health problems, during the reporting year.  | Yes                        |
| Total Full-Time Equivalents by Type of Service                               | Total number of staff hours attributed to each type of service/program element for the reporting year.  | Partial                    |
| Number of Consumers on Rolls by Type of Service (link to encounter data set) | Total number of consumers on the rolls or census of each type of service directly operated by the organization at the end of the reporting year.  | Partial                    |
| Number of Beds Set Up and Staffed by Type of Service                         | The number of beds set up and staffed by type of service at the end of the reporting year.  | Partial                    |

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**Table 1****Organization Data Elements <sup>1</sup>**

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| <b>Data Element</b>  | <b>Definition</b>  | <b>Ready for Prototype</b> |
|--|--|----------------------------|
| Number of Consumers Days or Units Provided By Type of Service (link to encounter data set) | The number of consumer days provided by types of service during the reporting year.  | Partial                    |
| Types of Services Provided   | <p>Intake, Diagnostic, and Screening Services</p> <ul style="list-style-type: none"><li>• Intake/screening</li><li>• Diagnostic evaluation</li><li>• Information and referral services</li></ul> <p>Treatment Services</p> <ul style="list-style-type: none"><li>• Individual therapy</li><li>• Family/couple therapy</li><li>• Group therapy</li><li>• Collateral services</li><li>• Electroconvulsive therapy</li><li>• Medication therapy</li><li>• Activity therapy</li><li>• Behavioral therapy</li><li>• Mobile treatment team</li><li>• Psychiatric emergency walk-in</li><li>• Telephone hotline</li><li>• Substance abuse detoxification</li><li>• Other substance abuse services</li></ul> <p>Rehabilitation Services</p> <ul style="list-style-type: none"><li>• Vocational rehabilitation services</li><li>• Educational services</li><li>• Psychiatric rehabilitation</li></ul> | Yes <sup>2</sup>           |

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2 These data elements are currently in use in the CMHS Survey of Mental Health Organizations and general Hospitals with separate psychiatric services.

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**Table 1****Organization Data Elements <sup>1</sup>**

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| <b>Data Element</b>                      | <b>Definition</b>  | <b>Ready for<br/>Prototype</b> |
|--|--|--------------------------------|
| Types of Services<br>Provided, Continued | Support Services <ul style="list-style-type: none"><li>• Case management services</li><li>• Legal advocacy</li><li>• Drop-in center</li><li>• General support</li><li>• Intensive residential services</li><li>• Supportive residential services</li><li>• Housing services</li><li>• Respite residential services</li><li>• Foster care</li></ul> Program for Assertive Community Trial (PACI) or<br>Continuous Treatment Team Program (CTTP) |                                |

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## References

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