

State Indicator Pilot Agenda

Conference Call

January 8, 2001

1. Roll Call: Ron Manderscheid: AZ, CO in late, CN, DC, IL, IN, MO no, NY, OK, RI no, SC, TX, UT, VT, WA. Ron asked us to think about what to do about having added so many indicators; do we need to focus on several more intensively, rather than list all?

2. Report on State Indicator Pilot Operational definitions-Ted Lutterman--focused most action in last months re: 22 state comments on uniform reporting initiative. A reduced set may be recommended to OMB with others held back for more study. Using 16-state effort to come up with core definitions, e.g., living situation and criminal justice contact. Wherever there was a definition agreed on under 16-state project, it was used; otherwise supplemented definitions. Three levels of tables identified: requested data, developmental, optional for states to report. Revised set of tables must go to OMB again for review, so may not be available till after February 1. Olinda and Ron will monitor and make available to 16 states. Reporting burden reduced 65-70%.

3. Diagnosis modification decisions- Bernadette Phelan--received 12 responses (WA collects no diagnostic information. Two of 8 recommendations accepted at last conference call. Survey then sent to 16 states. Seven of 11 states approved change in "alzheimer" category label; some offered alternatives--"Dementia, delirium and other related disorders due to medical conditions." Inclusion of 311-depression and mood disorders--all approved. Eight of 11 states approved sub-categories for mood disorders, depression, etc. RM suggested letting those who want to break out categories can do so, and those who do not want to can submit the basic categories (except penetration will use the old categories, since many have already reported year 2 data). Question re: combining panic disorder and agoraphobia--this is a small # in most reporting states. It was proposed by AZ to put these codes into the 'anxiety' category and the group agreed. Question re: re-grouping adults with major mental illness by adding 297 and 298, but exclude 296.9 (mood disorder, NOS--questionable whether it's justifiable as a major mental illness)--this item was tabled. Children with major mental illness was also tabled. Bernadette, RM and OG will discuss and make recommendation.

4. Calculating Age Categories-continued discussion-Nancy Callahan--overall states are doing a variety of methods--some calculate as of admit, at midpoint of year (e.g., for penetration rate) etc. Some recommended looking at individual indicator (through the workgroups) to decide which age calculation should be used, with midpoint generally being the preferred method--though CO and others said it is inconsistent with their state's historical use. Vijay: unless states intend to re-calculate age across all their

indicators, they may want to keep the age calculation they are using now. RM: this is like the differences in state fiscal year. NC: as we make recommendations, some calculation methods are preferred and we can educate states about possible methods and why they produce different results. Each indicator workgroup can make a recommendation re: which method is most appropriate for each indicator. States may continue to use a different-from-recommended method and that will be footnoted in any table. NC will work with each workgroup to ensure there are not too many different methods recommended across the workgroups.

5. Update on 16 State data reporting on penetration rates, readmissions, and consumer surveys--Olinda González--a separate, private page will be developed on the MHSIP website to all posting of completed penetration rate, 30-day re-admission and other indicators to allow states to have a month to review and comment and add comments/footnotes on their own data submitted. This would then be transferred to NRI State Profile System. The group agreed to do this. VG asked for specific topics to respond to. OG: states could talk about specific areas where there may be state-to-state variation that would explain data differences, e.g., differences in the organization of state inpatient systems. VG: this needs to be done for every indicator and it would be helpful to have a guideline for comments. Create a list of possible areas that would create variation so people can respond to them for each indicator as it is finalized.

6. National Statistics Conference--State Indicator Pilot presentations and abstract entries--UT, CN, Nancy Callahan and others have submitted individual abstracts. RM encouraged others to submit, even though the date has passed. RM wants a group presentation made that might include something from the MH, US, 2000 article; the BG reporting needs; other parts of the 16-state project. Judy Hall, Bernadette Phelan, Deb Kupfer, Nancy C. will work with OG and RM.

7. Group discussion (special report) Living Situation indicator - Nancy Callahan--sent outline of recommendations, separating adults in supported housing. Can use as an outcome measure by looking at change over time. Two components: where is the person living (structure) and support needed to live in that situation (this applies most to private residence, since others imply support). This does not address who they live with (spouse, parent, etc). For children, foster home would be separate from other 24-hour residential care, since it is a preferred arrangement for children. Recommendation is to collect at admission, periodically thereafter (1X, 2X/yr), and at discharge. VG asked about distinguishing therapeutic foster care, since it's an evidenced-based practice recommended by the Surgeon General. There is a category for TFC on the child survey. Group agreed to add the two categories. Question: should this be defined by "where lived most of the last 30 days" or by some other criterion? Most states collect point-in-time data--where the person is at the time the question is asked. It was agreed this would be the preferred method, with footnotes when this method is not used. John McGrew asked whether the taxonomy allowed much room to show change, since many people will fit in the 24-hour care category and will not move from it. Question raised re: whether to assume anyone living with a family is getting support. "Home-like" setting was discussed: 3 people or less, 4 people or more, would be one way to sub-divide 24-

hour care, but different states have different licensing and cut-offs, so would not be reportable.

Adults in supportive housing is an evidenced-based program and NC provided recommendation to use. NC will write up all comments and re-report.

8. Individual workgroup up-date reports:

-children's survey/children's indicator survey to States- Randy Koch/Molly Brunk-- conference call this morning re: 5 proposed child indicators. School performance--no reporting states are currently collecting; would be burdensome to get directly from schools. Discussed using 'school performance' from the youth services survey and expand to include attendance, behavior and school performance. Might also link to school performance data and look at C-CAR and CAFAS data. UT has found providers question whether parents know about school performance, and expect kids to distort information. RM: could correlate actual performance with perceptions where both are collected. Adding items to YSS/FSS would require more testing; some states are just starting their YSS and will include when items have been written (IN, OK). Living in a family-like setting is recommended for living situation or YSS. Therapeutic foster care can be collected from YSS or self-report living situation data. Fewest states (incl OK) said they could report services in natural settings, so decided not to use. Some states are collecting CJS involvement, but nothing consistent, so recommended to include in YSS.

a. Atypical Medications - Jocelyn Letourneau, RI --all but one state has reported with dates for probable reporting--summary will be distributed.

b. Seclusion and Restraint and other hospital indicators- Ted Lutterman --awaiting discussion between CMHS and NRI

c. Stakeholder Participation in Planning - Donna Stimpson, CT --revisions to survey completed and will be reviewed by planner subcommittee Jan 11, then distributed with expected return from all states by Feb 13 with analysis in Feb and Mar. Suggestion made to send to data people for them to give to planners in some states.

d. Substance Abuse - Jack Wackwitz, CO--Deb reported 12 of 16 states have reported and all can, in theory, report co-occurring SA disorders. Some have a common SA/MH data system or common ID system; others can match data.

e. Recovery - Vijay Ganju, TX--states are in process of working with technical workgroup to define what will happen at focus groups in each state, how meetings will be transcribed, summarized and analyzed. VG created a budget which CMHS, HSRI, NTAC agree funds are available to cover costs. WA and UT have joined other states.

- f. Functioning and Symptoms - Mary Smith, IL--OG says Mary will be sending out responses to questions re: email she sent out previously, then follow-up with email requesting data on instruments.
- g. ACT/SE - John McGrew, IN--status quo from last time; states are collecting data on a pilot with expectation of report in two months.
- h. Criminal Justice - Lucille Schacht, NRI--one state added and another dropped for 6-7 states reporting; now collecting data
- i. Mortality - Craig Colton, UT--more phone calls made this month to invite more states to participate
- j. Living Situation - Nancy Callahan
- k. Employment - Denny Geertsen, UT--progress on conceptual plan; two states will pilot linking MH and employment security data; another option will be to collect data through existing data systems in 6 categories where there is commonality across states. Collect data at admission, discontinuation, then periodically thereafter for 18-64 year olds; also collecting definitions.
- h. Link to Physical Health - Deb Kupfer, CO/Jack Wackwitz--Deb waiting for 2 pilot states to report; 3 have reported. Will get info from YSS as well. CO has sent mail out survey to 8000 clients piloting questions. MO will survey in Spring. Others may get info by matching to Medicaid data system.
- l. 30 and 180 Day Readmissions - Sudha Mehta, NY--data from 14 states and expects data from others soon, then will work on formatting for FY and CY 98-99.
- m. Contact within 7 Days - Steve Davis, OK--states need to send or re-send data; OK will contact and remind states this week.
- n.. Costs - Nancy Callahan --7 state states have submitted data, 2 states will not be able to provide data at this time, others are working on it. VT will be using states' data in an intrastate report. Waiting on other states to report; will send out all states' data as it comes in.
- o. Adult Consumer Survey - Judy Hall, CO--has not received new survey data recently, so asked for recent survey data to be sent. Deb Kupfer is added to work group.
- p. Penetration Rates - John Pandiani, VT--has received penetration data from 10 states and utilization from 6 states and others are working to prepare data.
- Notification to Final Report Workgroup that a meeting will be set up in near future. OG will organize a call with 10 volunteers.

Group agreed we would pick a few indicators to focus more attention on at the next call and not talk about all indicators.