



MHSIP IN THE YEAR 2000 AND BEYOND

INTRODUCTION

Improving the quality of life and recovery of persons with mental disorders is the primary concern of the mental health services field. The use of public information is an essential means to accomplish this. For example, public information lets consumers, families and other decision makers know about the location and level of performance of service providers who seek to improve the quality of life of people with mental disorders. This is also the focal concern of the Mental Health Statistics Improvement Program (MHSIP). The present document is a description of a vision of MHSIP in the year 2000 and beyond, a MHSIP that is enhanced and better equipped to serve the field and address its concerns.

The MHSIP is a philosophical and conceptual framework about mental health data and their function in decision support. It provides a set of national standards for mental health information that assists the field in gathering the knowledge needed to respond to the rapidly changing environment in which the mental health system currently functions. Although MHSIP standards explicitly concern data for clinical, management and research use, the underlying objective of all derived information is the betterment of the lives of people with mental disorders.

With the support of the National Institute of Mental Health (NIMH), Division of Applied and Services Research (DASR), the National Association of State Mental Health Program Directors (NASMHPD) and the State mental health agencies, the MHSIP has witnessed recent and considerable progress in the adoption of its current data standards and system design concepts. The challenge of the future, however, cannot be ignored.

The fundamental goal of the MHSIP is to stimulate improved decision making in responding to the needs of persons with mental disorders. The MHSIP provides a national locus for the creation, maintenance and effective utilization of the information necessary for persons with mental health disorders to have the knowledge that they, their families, the public, service providers and policy makers need. The information is needed to ensure that:

- In meeting mental health needs, decisions are sound and accountable
- The services delivered to meet those needs are of high quality, continuous, coordinated and effective

A major assumption underlining the MHSIP is that the quality and scope of information are key to sound decisions. The mission of MHSIP is, therefore, to foster and enhance the quality and scope of information for decisions that will improve the quality of life and recovery of people with mental disorders.

Meeting the needs of persons with mental disorders has changed greatly since the initiation of MHSIP and is likely to continue to change in ways that cannot be anticipated. It is, however, clear that not only has the locus of mental health care shifted away from the state hospital environment and been dispersed among a variety of

service providers and settings, but the focus of the mental health care has shifted from an organizational base to a consumer based orientation, e.g., from services, by appointment, in an agency office to services, whenever and wherever needed. If MHSIP is to continue to be useful and provide leadership in the creation and utilization of data for decision support, it must change its focus from an organizational base to "persons with mental disorder" and it must actively seek out and involve the entire range of agencies, organizations and practitioners who currently respond to the needs of persons with mental disorders. In addition, MHSIP must develop the capacity for ongoing responsiveness to a rapidly changing mental health service environment. It is the MHSIP Ad Hoc Advisory Group's position that the public health model, described below, offers the most promise for guiding MHSIP into the 21st century.

To prepare for the year 2000, the MHSIP Ad Hoc Advisory Group and the NIMH must rededicate and expand their commitment to MHSIP and its mission. The MHSIP Ad Hoc Advisory Group must expand its scope of representation and its vision for what MHSIP needs to be. The NIMH needs to expand its commitment to MHSIP through dedicated staff and increased financial support.

The development of MHSIP has been accomplished by a few dedicated staff in the NIMH, limited but consistent financial support from the Institute and involvement of a select group of people, mostly from state mental health agencies. While these individuals and resources have provided continuity of leadership, general consensus and steady progress, this level of support is no longer adequate. It is especially inadequate in the face of the overwhelming needs for data within the mental health service system, among service system researchers and others interested in responding to the needs of persons with mental disorders. These data needs place demands upon MHSIP.

The MHSIP Ad Hoc Advisory Group has made a commitment to expanding its scope through the adoption of a public health approach and through ensuring more balanced representation in its group. To further carry out the mission of MHSIP and respond to the increasing and new demands, an organizational capacity beyond that currently available to MHSIP must be developed. This infrastructure is needed not only to support current activities, but also to prepare MHSIP to respond to the ever increasing demand of a changing mental health system.

PUBLIC MENTAL HEALTH PARADIGM

To fulfill its mission, MHSIP must be 1) consumer oriented, thereby addressing the wide-ranging scope and variability which characterize persons with mental disorders and the nation's many local service systems, 2) adaptive to new issues and programs over time, and 3) a vehicle for technology transfer, generalizing and disseminating knowledge gained.

The mission requires expansions into additional content areas and activities and, most basically, the adoption of a public health perspective. Under a public health perspective, the MHSIP will be able to: 1) enhance the quality and scope of information for decision making on behalf of persons with mental disorders, 2) address the areas of need and demand for service, the configuration and impact of service systems, and 3) foster the linkage of management information systems, policy analysis and decisions via data on patterns of service utilization, financing of care and quality/impact of care.

The public health model is an approach to health issues that encompasses demography, etiology of disorders, epidemiology, need assessment, service utilization, data systems, prevention and related policy analysis and policy development. This orientation assumes multiple and complex interrelationships among area characteristics, individual attributes, need and demand for services, organizational characteristics, area resources, treatment and results. It further assumes that there are organizational levels, referred to as auxiliary levels by the MHSIP, that accept the range of responsibilities implied by a public health model. A comprehensive public health model for

MHSIP would include population data, data on factors affecting need and demand for services, mental health services in the specialty system, mental health services outside the specialty system, generic services to persons with mental disorders, data on the quality and outcome of care and an organizational level where this range of information converges. It also implies a close interface with basic research so that the findings on causes of mental disorders and on effective treatment can be adaptively incorporated.

A public health paradigm will help to organize the relevant, critical information which is integral to the decision processes that can improve the quality of life and recovery of persons with mental disorders. The following are the ingredients of an information system based on a public mental health paradigm:

- Definitions of mental disorders
- Identification of people with mental disorders, i.e. epidemiology
- Relationships among area characteristics, individual attributes, prevalence of mental disorders, demand and use of services, i.e., need assessment
- Organization of service systems; health, mental health and other human services
- Delivery of clinical care within service programs
- Effects of services on the level of functioning and quality of life of persons with mental disorders
- Policy formulation that interacts with and integrates these elements
- Locations for the convergence and use of the information associated with the above

These ingredients do not have to be implemented all at once. They could, and should be prioritized in terms of importance and ease of incorporation and be implemented accordingly.

Areas in which the MHSIP must be developed to be compatible with a public health model

The implications of a public health model for the MHSIP are numerous, and should be viewed as extensions and enhancements of the Program, not as discontinuities. The advisory Group has identified three target areas that will advance the MHSIP toward implementation of a public health model: 1) expanded coverage, 2) enhanced data utilization in decision support, and 3) augmented system to include a person-based orientation.

Developments and successes of the current MHSIP have been confined almost exclusively to a relatively small area embraced by the public health model, viz, mental health organizations operated or funded by State mental health agencies (SMHAs). Historically, this was the initial and exclusive focus of the MHSIP. In the most recent revision to MHSIP materials, i.e., FN-10, after deliberating alternatives (see chapter 11), the organization focus was retained, but broadened to embrace a fuller complement of organizations.

The first implication of the public health model is that the MHSIP must systematically expand the scope and coverage of mental health organizations that are involved in the implementation and use of materials generated by the Program.

The Advisory Group has contemplated how sectors of the mental health service system other than the SMHA-affiliated sector can be enfolded. A MHSIP based on a public health model must minimally have as its scope of coverage:

A. The public mental health sector--largely organizations operated or funded, in whole or part, by the SMHA which provide mental health services to persons with mental illness.

B. Other specialty mental health sectors--organizations specializing in mental health services to persons with mental illness, but affiliated differently from those above. Private psychiatric hospitals and psychiatric units in general hospitals are such organizations.

C. Other health and human service sectors--organizations that are not specialty mental health settings, but which are actively involved in providing services to persons with mental illness, including mental health (e.g., by the primary care system), health, and generic services.

Implicit in each of these sectors is an auxiliary level. This can be a SMHA, a corporate owner, a governmental level other than an SMHA, etc., that has an oversight, assistance, or reimbursement relationship with the organizations. For both the organizations and auxiliary levels associated with each of the described sectors, there must be pertinent activities, products, and communications. With NIMH support, the MHSIP has achieved some degree of success in the adoption of FN-10 data standards and system design concepts in the first sector noted above. However, the next decade must also demonstrate some degree of success with the other sectors described. In Appendix A projects have been identified that will advance this cause.

A second implication of a MHSIP based on a public health model is the need to reinforce decision support by showing how standard data content enhances decisionmaking.

Pursuit of this implication takes two forms. The first of these is quite basic. The MHSIP must offer the field content standards that are relevant to the decisions that follow from the public health orientation. Current standards are targeted primarily to managerial and broad clinical decisions. Not only must the MHSIP move to develop content standards in additional areas covered by a public health model (e.g., minimum items that should be considered in a needs assessment, analysis of policy differences, etc.), but it must retain its investment in the information domains it has already articulated. Thus, new content must be incorporated, while the current content is maintained.

The other step for the MHSIP follows from these content standards. The MHSIP must translate the standards into data-based information that is supportive of decisionmaking. At present, this type of decision support is incorporated into the MHSIP solely as a philosophy. That is, ample reinforcement is given throughout FN-10 for the use of discrete and integrated data content by managers. However, the evidence is largely anecdotal. Only the briefest glimpse is provided in the chapter on financial data for how individual items of content can be systematically associated with one another to yield concrete pieces of information that have usefulness to decisionmakers. Time constraints and an explicit decision not to overburden the document led to the exclusion of work that would have produced similar examples for the other content areas.

In appendix A projects have been identified that will move the MHSIP in these directions:

A. Develop and promulgate data content standards for content areas covered by a MHSIP based on a public health model

B. Provide compelling demonstrations for the translation of data content standards into data-based information and demonstrations for how this information assists decisionmakers to improve the system of care.

These activities are intended to generate conceptual materials and stimulate demonstrations of actual applications of MHSIP content to decisions regarding program performance.

The third, and final, area for MHSIP development is to place increased emphasis on the individual as a potential level of analysis.

In part, this emphasis is currently in the MHSIP--the integration of data within an organization depends critically on the patient/client (as well as staff persons) as a focal point. However, a MHSIP based on a public health model must make this emphasis more explicit and uniform, but also extend the concept outside the confines of administrative information systems to include clinical and research uses.

Decisions intended to improve the quality of life and recovery of persons with mental illness ultimately depend on an ability to aggregate, integrate, and analyze data at the individual level. This does not mean the individual is the sole level of analysis. The organization, auxiliary, and system levels continue to be pertinent also. However, even at these levels, there are times when individual level data will need to be combined into meaningful categories to describe performance and understand patterns.

Persons may be receiving services in any of the three sectors noted earlier. A person-oriented level of analysis makes it possible to examine the service experiences of persons in different sectors, as well as over time. It also entails persons with mental illness who are in need of services and not receiving them. This requires that the MHSIP enfold basic epidemiologic principles of case identification, incidence and prevalence.

As FN-10 frequently notes, a person-focus is extremely valuable in permitting decisionmakers to construct groups of patients with particular clinical profiles or who experience different career paths in the service delivery system. Either by epidemiologic methods of case identification or by using routine data accumulated by information systems, these groups can be analyzed. For example, some of the service paths may be more successful than others, producing faster recovery, longer tenure in the community, or demonstrating beneficial gains on some other measure.

This will require a systematic consideration for how data can be shared across organizations, across sectors, and over time, while protecting the rights to privacy of individuals. If such data can be aggregated, they will operationalize a public health model within the MHSIP. In addition, such data capacity will be of value to a wide range of decisionmakers and will facilitate a common goal of improved care and recovery for persons with mental illness. Appendix A describes projects that will advance this area of the MHSIP.

These major areas for development within the MHSIP are intended to yield a Program that reflects a public health model. The areas and their relationships are summarized in the following figure. Arrows have been added to the figure to show directions in which the current MHSIP content and system concepts must move to achieve a public health model.

(Graphic not available)

Operational steps to achieve a MHSIP compatible with a public health model

To develop a comprehensive information system that is compatible with a public health orientation, the MHSIP must systematically engage in new operations. In so

doing, it is important not to forsake the stakeholders who have been loyal and historical allies in advancing the MHSIP.

The following operational steps are an attempt to specify a general action and associated objectives intended for each action. Flowing from these objectives are specific tasks and projects, briefly noted in the following materials, and more thoroughly documented in Appendix A.

OPERATIONAL STEP 1: Solidify accomplishments

Background. The Federal grants to support State implementation of MHSIP-consistent decision support systems are an initial commitment to work toward the managerial and research benefits promised by integrated decision support systems. Activities during the first year of grant award have made it apparent that additional work is needed to achieve implementation. This translates into other products that are required, supplementary activities to reinforce implementation, and the need to sustain interest and implementation as the initial grants expire.

Objectives:

- Maintain incentives
- Develop resource materials
- Enhance networking
- Advance MHSIP implementation

Exemplary projects:

- Complement current data sets with items specific to children and youth
- Institute a second generation of grants to States to develop applications of system content implemented during the award period of the initial grants
- Test a MHSIP bulletin board
- Pursue formative evaluation of the extent to which MHSIP has had a beneficial impact on care, clients, and/or communities
- Finalize a definition for a person with severe and persistent mental illness

OPERATIONAL STEP 2: Strengthen knowledge

Background. The size, range of expertise and fragmentation that characterize the stakeholders who are involved in generating and using mental health statistical data present an especially complex challenge to the MHSIP. To date, persons from State mental health agencies have been the primary advisory constituency and the focus for adoption and implementation of MHSIP recommendations. The MHSIP must systematically expand the scope of stakeholders involved in its development, implementation and use so that input is more robust and representative, the value of MHSIP recommendation is internalized by a wider audience, implementation of content and system design standards for mental health data is expanded, and system operations are less subject to vicissitudes of funding and staff turnover.

Objectives:

- Achieve compatibility
- Increase skills
- Broaden the scope of stakeholders
- Evolve a new management specialty level

Exemplary projects:

- Obtain inputs from Medicaid and the Joint Commission on Accreditation of Health Organizations (JCAHO) regarding the compatibility of MHSIP recommendations for meeting information requirements associated with these agencies
- Design and institute training opportunities around technical topics associated with a MHSIP compatible with a public health model
- Develop professional training sites and professional opportunities for persons who can be thought of as chief information officers/information resource managers within mental health settings
- Reconfigure the Ad Hoc Advisory Group and consider additional mechanisms for obtaining inputs

OPERATION STEP 3: Stimulate Uses

Background: Current and future development of the MHSIP depends on resources sufficient to maintain involvement and compelling, rational evidence of the value of MHSIP recommendations. As implementation advances, an increased number of opportunities will be evident that permit analysis and use of integrated data systems. Such analysis and use has three benefits: it is self-reinforcing, provides opportunities to embrace additional constituents and highlights potential new directions for development.

Objectives:

- Promote management applications
- Promote and support research activities
- Link public and academic sectors

Exemplary projects:

- Demonstrate the relevance of MHSIP recommendations to a managed care model
- Demonstrate a variety of effectiveness measures that can be derived from MHSIP content
- Reconceptualize the operations of the National Reporting Program on mental health statistics to incorporate the receipt of integrated data files
- Develop additional materials that foster uses of integrated data, e.g., performance indicators

OPERATIONAL STEP 4: Incorporate emerging areas

Background: The field of mental health and the MHSIP exist within a complex, open system that interacts with numerous other health and human service systems. Furthermore, the environment of all these systems is dynamic and changing at an unprecedented pace. To reflect and be responsive to the changing environment of mental health and to be true to both the mission of MHSIP and its values, there is a need to expand MHSIP concepts into new areas that ensure that they are contemporary and relevant.

Objectives:

- Expand MHSIP to encompass a public health model
- Expand MHSIP to include emerging knowledge and target groups
- Incorporate new program directions

Exemplary projects:

- Enfold new and expanded organizational coverage
- Design and assess mechanisms that would allow the capture, or use, or service data to persons with mental illnesses in non-specialty mental health sectors.
- Explore possible of data standards and system design for an approach to need assessment.

THE NEED FOR SUPPORT AND FOR AN INFRASTRUCTURE

An infrastructure, i.e., institutional support and functions required for continued operations, is necessary to ensure the future of MHSIP. With appropriate resource support, past accomplishments will be secured and the program will gradually evolve toward a public health paradigm. Without support and an infrastructure, MHSIP will not be able to respond to the field and to issues of public accountability (e.g., concerning compliance with legislation and the use and impact of public funds). It might also miss opportunities for working with other sectors, such as other public agencies (NIDA, NIAAA, NCHS), accreditation and financing agencies (JCAHO, HCFA), provider organizations (NAPPH, NCCMC, nursing) and professional organizations (APAs, NASW, ANA).

It is critical that MHSIP move to capitalize on the progress made in the past 15 years by securing resource support. An infrastructure needs to be created that is capable of carrying out the many functions currently performed and those that will be added as demand for information expands. In the absence of such a structure, it will be difficult for MHSIP to expand in the needed direction, or even maintain its current gains. It will be especially difficult, because, even at the present, there are insufficient staff dedicated to MHSIP-related activities and because most of the current financial support (i.e., the MHSIP implementation grants) is time limited.

The infrastructure is to provide a national locus of support for the creation, maintenance and effective utilization of mental health information. It should either be located within, or be closely associated with NIMH, in order to remain credible with the states and with the field. This focal point of MHSIP is to foster a sense of collective ownership and collaborative responsibility by all stakeholders. It must have adequate resources, authority, connectedness and linkages with other organizations and be empowered to act on behalf of MHSIP.

Currently, MHSIP information is derived mostly from state operated and funded mental health organizations and, to a lesser extent, the rest of the specialty mental health system. Once expanded to reflect a public health paradigm, a greater degree of support will be required. A dedicated organizational structure with senior and specialty staff and with financial resources will be needed to assure both maintenance of accomplishments and further developments.

Four major functions need to be performed to assure the success of MHSIP. First and foremost is leadership. NIMH has provided the leadership for MHSIP since its inception and must continue in that role. The three other major functions can be performed by NIMH, and/or by other forms of infrastructure. These consist of the management of MHSIP, the financing of MHSIP and research using MHSIP-consistent data. In greater detail, these include the following:

- Providing continuous, broadly-based leadership and advocacy for MHSIP-related activities
- Facilitating increased participation in MHSIP by various components of the specialty mental health sector
- Ensuring needed linkages with other organizations - public as well as private
- Providing oversight and management of MHSIP activities
- Making possible the linkage of MHSIP to mental health planning activities, to services research and to decision making in the mental health field generally
- ensuring needed financial support for MHSIP
- Establishing a stable minimum core set of coordinated resources to support the day-to-day activities needed for the implementation and expansion of MHSIP
- Enabling new types of resource development for MHSIP activities - including private funding
- Promoting the use of MHSIP standards and information in treatment and services research
- Promoting technology transfer and dissemination of knowledge gained through research and policy studies

Specific activities, such as monitoring and evaluation, operation of a clearinghouse, and certification of software and of vendors could be structured within the domain of the MHSIP infrastructure organization. This broad mandate, however, will entail material requirements, capacity and national credibility.

To perform even some of these needed functions, there must be assured commitment of senior, specialty and support staff, and of lasting financial resources. These can be accomplished through a number of optional approaches to infrastructure.

Infrastructure options

There are at least seven distinct models of infrastructure, as well as an eighth, mixed model. These range in terms of the degree of federal participation and investment of fiscal and human resources. Not all these options can equally address the challenges of a public health model. This is because the scope of coverage, orientation toward decision support and person focus required for a public health model will necessitate a critical level of resources, authority and connectedness with the field.

Some options also involve different degrees of acquisition of functions to be performed, e.g., coordination of activities, communication with stakeholders, etc. NIMH and DASR involvement, however, should be maintained in all cases, at the very least by dedicating senior staff and funds.

The generic models, in terms of governmental role are:

- A. Fully federal
 - 1. National, or an ADAMHA Center for ADM statistics
 - 2. NIMH unit, e.g., a division
 - 3. DASR unit, e.g., a branch
 - 4. DASR staff and funds
- B. Non-federal
 - 5. Non-governmental entity (such as a resource center) funded by NIMH (and others) - with broad-based advisory structure
 - 6. Non-governmental entity created by major public and private sector stakeholder
 - 7. Membership organization - individuals and agencies
- C. Mixed
 - 8. Governmental and non-governmental entity

The first option, i.e., a National Center of ADM Statistics will require the most extensive federal involvement. The Center would be conceptually similar to the National Center for Health Statistics, within the Center for Disease Control (CDC). The advantages of a center on the Agency level are that it will integrate ADM data and information, which are intrinsically highly related and ensure some stability and commitment of resources for the functions to be performed. In comparisons with all other options, this will also involve the greatest commitment of federal resources.

The second level of federal commitment, Model 2, could be in the form of a Division within NIMH. This level will be quite appropriate to a public health model data and information program. It will also require significant amount of fiscal and human resources.

A third model is a branch within DASR. The functional requirements of an infrastructure for MHSIP suggest the need for a significant amount of resources, formalized in terms of organizational structure and budget. The locus of the branch within DASR would be a good fit. It will provide for historical continuity and for easy interface with the NRP.

An alternative to a branch within DASR, is the full-time dedication of at least 2 senior staff in the Office of the Director, DASR, and funds to acquire the performance of the needed functions. This option represents a departure, in terms of reduced direct federal involvement. It might be easier to accomplish due to restrictions on the number of positions and on hiring and, as a form of privatization, provide for greater flexibility.

The next three options represent a major departure in terms of federal involvement and consist of new, quasi-public organizations. These options are qualitatively different. They represent reduced federal stakes for the benefits of privatization, flexibility and opportunities for fund raising, both from federal and non-federal authorities.

A quasi-public, non federal option can take several forms in terms of ownership, membership and sources of funding. It could be a non-governmental resource center with an advisory structure. The Mental Health Policy Resource Center is an example of this type of model. An entity created and owned by public and private sector stakeholders is another option, as is a membership organization, such as the American Psychiatric Association and the American Public Health Association. A mixed governmental and non-governmental model can also be created.

Quasi-public, non-federal models share some advantages and disadvantages. On the positive side, quasi-public organizations are free of bureaucratic requirements and,

therefore, can be more efficient and effective than governmental agencies. Unlike governmental organizations, they are also free to raise funds, e.g., from private foundations. There are also disadvantages to such options. A quasi-public MHSIP will require that NIMH relinquish the leadership role it has played in the development and shaping of the program. Another disadvantage is that it will take a new organization a long time to establish its credibility in the field, which might hinder the development and implementation of MHSIP.

Acquisition options to accomplish infrastructure objectives

Acquisition of infrastructure functions to be performed can also take several forms. Acquisition could be narrow or broad in their scope. They could include some functions and not others, or cover varying proportions of function, i.e., some tasks and not others. All acquisitions could be from one organization, or from multiple organizations. Finally, acquisitions could involve various mechanisms, such as cooperative agreements, grants, contracts, or a combination of all three.

SUMMARY

The evolving environment of the mental health field and the mental health service delivery systems necessitates the enhancement and expansion of MHSIP. A public health paradigm is being proposed as the most suitable model to meet current and anticipated information needs for clinical intervention systems, management and research. This approach is consumer-based, true to the values subscribed to by the MHSIP and offers a rational and systematic direction for future development.

Support is needed to secure past accomplishments of MHSIP and to enable the program to develop in the desired direction. The Advisory Group has identified the need for an infrastructure and for functions to be performed, which will require organizational definition and dedicated staff and funds. The infrastructure could take several forms that range in degree of federal involvement and dedicated resources. Not all infrastructure options, however, permit the accomplishment of the public health paradigm the Advisory Group has endorsed. The functions identified by the Advisory Group could also be performed via combinations of in-house staff activities and methods of acquisition.

The needed infrastructure will enable MHSIP to respond to the field and to critical issues of public accountability. It will make possible collaboration with other public agencies, with accreditation and financing agencies, with provider organizations and with professional organizations and it will make possible the broader application of MHSIP principles and procedures. This will facilitate the greater availability and use of data on mental health needs, services and programs for both research and for decision making.

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Appendix M

Details on Projects Would Advance the MHSIP

Toward Compatibility with a Public Health Model

OPERATIONAL STEP 1: Solidify accomplishments

Background The Federal grants to support State implementations of MHSIP-consistent decision support systems are an initial commitment to work toward the managerial and research benefits promised by integrated decision support systems. The activities during the first year of grant award have made it apparent that additional work is needed to achieve implementation. This translates into other products that are required, supplementary activities and incentives to reinforce full implementation, and the need to sustain interest and implementation as the initial grants expire.

Objectives:

- Maintain Incentives
- Develop resource materials
- Enhance networking
- Complete current standards
- Advance MHSIP implementation

1. Solidify accomplishments

Issue: Those implementing the MHSIP recommendations report a considerable need for materials that can be used in orientation and training about the conceptual, technical, and content recommendations of the MHSIP. The desire is to reach a broader range of constituencies and audiences, especially at the provider level.

Response:

1.1A. Develop training, orientation, and education materials that make the MHSIP of FN-10 accessible to wider audiences.

1.1B. Develop and pilot test sample curricula appropriate to adult education formats

Mechanism:

1.1A. Task force to develop a plan and itemize materials needed

Task forces or individual professional services contracts to develop the materials within the plan

1.1B. Requests for applications to develop such sample curricula, test, and evaluate their differential effectiveness or Request for proposal to award a competitive contract (open market or 8a set-aside) to do as above.

Infrastructure:

Program staff to develop the charge, the contract statement of work.

Project officers to monitor the activity in a knowledgeable, proactive manner.

A sponsorship site to handle offerings and administrative issues around this training

A cadre of trainers, perhaps developed via a training-of-trainers approach nested within the grant/contract, available for hire.

The possibility of a MHSIP-based Applied Training Institute (modeled after the Applied Statistics Training Institute of NCHS) or Staff College should be considered.

Resources:

1.1A.

\$21,000 in contract funds to support 3 meetins for plan development.

\$60,000 for materials development

\$30,000 for printing

.25 FTE

1.1B.

\$30,000 to develop curricula, case studies, lesson plans, workbooks, materials, etc. per topic area

\$70,000 additional to pilot test and make improvements

\$15,000 additional to evaluate differential effectiveness of two approaches

\$100,000 additional to develop a training-of-trainers approach and a cadre of trainers (this cost would not be repeated for each topic area, an economy of scale applies)

.4 FTE

Timeframe: 1.1A. Short term: by FY 1994

1.1B. Curricula--Short term: by FY 1994

Remainder--Mid term: by FY 2000

Issue: Communication within the field-especially those involved with MHSIP implementation-about issues of relevance to MHSIP content, implementation, and use needs to be more efficient, timely, and accessible.

Response: 1.2 Develop a computer bulletin board that allows for more flexible, rapid, and efficient communication among principals in the field.

Mechanism: Professional services contract for a pilot demonstration and testing of a limited number of bulletin board functions (e.g., grant administration notices; relevant meetings; corrections/new considerations for items in FN-10; a vendor/hardware/software section; a query and answer section).

Infrastructure: Program staff to develop the statement of work

Project officer to monitor the activity in a knowledgeable, proactive manner

If effective, a sponsorship location to house and maintain the bulletin board

Resources: \$10,000 for a procurement to develop and pilot test

\$10,000 annually for maintenance and support

\$ 5,000 every other year to develop, pilot, and add additional functions

.1 FTE

Timeframe: Demonstration and, if successful, start up--Short term: by FY 1994

Added functions--Mid term: by FY 2000

Issue: It is apparent from grant applications and progress in the first year of award that by the end of the award period, most States will have made only partial progress toward achieving the level of integration advocated by the MHSIP. Failure to stimulate and support additional progress could mean the loss of expertise to the field and regression in the implementation of integrated systems.

Response: 1.3 Develop a second generation grant program

Mechanism: Request for applications, with set aside funds. In the RFA, support is possible for:

- demonstrating the managerial/research payoff of gains made under the initial implementation grant
- the extension of MHSIP content and concepts to additional areas such as planning, children and adolescents, consumer and family empowerment, agendas for human resource development
- enhancing the degree of integratability within the existing system

States and corporate entities would be eligible.

Infrastructure: Cadre of states or corporate entities that have crossed some threshold of integratability in their systems.

Program staff to develop the RFA and process and review applications

Project officers to monitor the grants

Opportunities for grantees to meet and exchange findings

Resources: \$16 million for grants: \$4.0 million in initial year, escalating to \$5 million annually for 2 years, and dropping to \$2.0 million in the fourth year

\$300,000 annually for technical assistance supplement to grantees and others dealing with these issues

\$40,000 annually for site visits

3.0 FTE

Timeframes: Short term: by FY 1994

Issue: The activity stimulated by the NIMH grants to States to implement integrated decision support systems represents a substantial new investment of effort and resources by both the Institute and the States. It would be desirable to determine the extent to which these activities have altered the situation within States in terms of data retrieval and analysis capabilities and positioned the NIMH to benefit from better data in areas such as the National Reporting Program, Block Grant reporting, or PAL research grant applications involving these data bases.

Response: 1.4 Design a formative evaluation of the benefits that have accrued to the States and NIMH from the initial grant program.

Mechanism: Request for proposal or a sole-source research contract with an organization such as the Institute of Medicine that examines the feasibility of a formal evaluation and lays out issues in design and execution methodology, if appropriate.

Infrastructure: Program staff to develop the RFP

Project officer to monitor developments in a knowledgeable, proactive manner.

Resources: \$400,000 in contract funds

.5 FTE

Timeframe: Short term: by FY 1994

Issue: FN-10 cannot carry the entire weight of documentation for MHSIP recommendations in the area of mental health information systems. The need for supplements to and extensions of its content were apparent even while it was being developed.

Response: 1.5 Make the content of FN-10 also applicable to children and youth

Mechanism: Task forces

Infrastructure: Program staff to develop the statements of work or RFA

Project officers to monitor developments in a knowledgeable, proactive manner.

Resources: \$15,000 for minor content revision

\$30,000 to assess the feasibility and value of the revised content by two agencies responsible for children's mental health

\$75,000 for a more ambitious revision that deals with children's mental health services occurring in different human service departments/organizations

\$12,000 to publish a new monograph dealing with the latter

.25 FTE

Timeframe: Short term: by FY 1994

Issue: A major gap exists in the MHSIP's ability to operationally specify individuals with severe and persistent mental illnesses.

Response: 1.6 Finalize the recommendations for the dimensions to be considered in characterizing persons with severe and persistent mental illness and develop additional content areas needed to facilitate the application of the definition viz, operational definitions for the factors that contribute to a definition of disability and that are compatible with determinants used by the Social Security Administration.

Mechanism: Professional services contract to finalize the recommendations for an operational definition.

Task force to develop additional content items necessary to implement definition.

Small procurement to pilot test the new data content.

Resources: \$10,000 for professional services contract

\$50,000 for task force

\$36,000 for two pilot sites

.5 FTE

Timeframe: Operational definition--Short term: by FY 1994

Proposed content modifications/revisions--Short term: by FY 1994

Pilot test initiated--Short term: by FY 1994

OPERATIONAL STEP 2: Strengthen knowledge

Background. The size, range of expertise, and fragmentation that characterize the stakeholders who are involved in generating and using mental health data presents an especially complex challenge to the MHSIP. To date, persons from State mental health agencies have been the primary advisory constituency and the focus for adoption and implementation of MHSIP recommendations. The MHSIP must systematically expand the scope of stakeholders involved in development, implementation, and use so that input is more robust and representative, the value of MHSIP recommendations is internalized by a wider audience, implementation of content and system design standards for mental health data is expanded, and system operations are less subject to vicissitudes of funding and staff turnover.

Objectives:

- Achieve compatibility
- Increase skills
- Broaden the scope of stakeholders
- Evolve a new management specialty level

2. Strengthen knowledge

Issue: Knowledge of the recommendations of the MHSIP is currently best developed among State mental health agency personnel. Many other sectors involved with specialty mental health services remain unaware of the relevance of the MHSIP.

Response: 2.1 Request and support review of the recommendations of the MHSIP by selected Federal and non-Federal agencies (e.g., Health Care Financing Administration, Joint Commission of the Accreditation of Health Care Organizations, National Association of Private Psychiatric Hospitals, National Association of Community Mental Health Centers) in terms of the value of the content and system design from the reviewer's perspective.

Mechanism: Interagency agreements with Federal agencies and professional services contracts with non-Federal agencies

Infrastructure: Program staff to develop the statements of work

Project officers to monitor developments in a knowledgeable, proactive manner.

Representatives within the targeted agencies who are thoroughly familiar with the agencies' histories in data collection, agency needs for data, and current data collection/retrieval capabilities.

Resources: Interagency agreements: \$50,000 each

Professional services contracts: \$25,000 each

.25 - 1 FTE

Timeframe: Short term: by FY 1994

Issue: Clinical and management professionals generally function in mental health organizations with the belief that documentation for a management information system and clinical records detracts from service provision. In addition to an understanding of the value of uniform and comparable data across sites, they need a better understanding of such relationships as:

- the contribution of high quality data to treatment planning,
- the effect of their productivity and documentation on the economic health of their organizations, and
- data as a demonstration of accountability to consumer/constituency/organizational needs

Response: 2.2 Introduce a curriculum module into the apprentice-level training of mental health clinical and management professionals that provides an understanding of the role and uses of data, and their obligations to provide and apply this resource.

Mechanism: Contract or grant to develop and pilot test a prototype curriculum that could be tailored to relevant professional training experiences at graduate level. The curriculum could also be modified for adult education formats.

Infrastructure: If the prototype is successful, full support from NIMH to require its inclusion in any approved clinical training grant

To reach audiences who have completed professional training, a sponsorship site to handle offerings to various audiences

Program staff to develop the statement of work or RFA

Project officers to monitor developments in a knowledgeable, proactive manner

Resources: \$750,000 for grant or contract

.2 FTE

Timeframe: Mid term: by FY 2000

Issue: Over the years, NIMH has evolved a tacit concept of the type of professional who is involved with data systems. This concept has variously emphasized the skills of being a statistician, a clinical director, computer hardware expert, financial management consultant, human resource manager, system designer/developer, researcher/evaluator, change agent, and member of the senior management team. Although many of those who have worked with NIMH and the MHSIP have accommodated these shifting emphases, other fields--such as general hospital administration and corporations involved with manufacturing--have moved to acknowledge and codify a specialty profession that embraces most of these emphases.

Response: 2.3 Assist the mental health services field to identify a new management level profession that can be characterized as a Chief Information Officer (CIO) or an Information Resource Manager (IRM).

Mechanism: RFA for training applications to develop a series of training programs/sites to produce IRMs/CIOs for mental health settings.

Infrastructure: Program staff to develop the RFA

Project officers to monitor developments in a knowledgeable, proactive manner.

Field acceptance of such a profession, i.e., employment opportunities

Professional opportunities for such individuals to network, attend meetings, acquire additional skills, publish, etc.

Resources: \$1 million initial set aside for RFA (2 sites)

If successful, \$500,000 for one additional site

.2 FTE

Timeframe: Mid term: by FY 2000

Issue: The perspective represented by the Ad Hoc Advisory Group of 1990 is basically that of the State operated/funded mental health service system. To ensure that the MHSIP is representative of the field, and to nurture implementation of MHSIP recommendations in other mental health sectors, there must be opportunities to gain knowledge about the inputs and concerns of other stakeholders.

Response: 2.4 • Revise the membership guidelines of the MHSIP to include representation of system perspectives in addition to those of the States.

- To broaden input and provide more opportunities, consider additional differentiation of Advisory Group functions along such lines as a MHSIP policy steering group, technical implementation group, research and management applications group, etc.
- To permit the functioning of the MHSIP with a degree of stability and independence consistent with its collaborative foundations, develop a mechanism similar

to the IRG chairperson's grants that will support convening of meetings, accommodate on-site expenses, support write-ups of minutes, etc.

Mechanism: Revised membership guidelines, including the possibility of various constituencies voting on their representatives.

Chairperson grant.

Infrastructure: Additional constituencies that recognize the value of MHSIP-style approaches and wish to be active in shaping them and promoting the adoption of MHSIP products among the constituency they represent.

Approval from NIMH grants/contracts re the chairperson grant mechanism.

Resources: If membership is expanded, an additional \$5,000 annually per added individual.

\$60,000 annual chairperson grant.

.05 FTE for contact/negotiation with additional constituencies

.5 FTE for management/documentation of various group activities

Timeframe: Short term: by FY 1994

OPERATION STEP 3: Stimulate uses

Background: Current and future development of the MHSIP depends on resources sufficient to maintain involvement and compelling, rational evidence of the value of MHSIP recommendations. As implementation advances, an increased number of opportunities will be evident that permit analysis and use of integrated data systems. Such analysis and use has three benefits: it is self-reinforcing, provides opportunities to embrace additional constituents, and highlights potential new directions for development.

Objectives:

- Promote management applications
- Promote and support research activities
- Link public and academic sectors

3. Stimulate uses

Issue: Voluntary use of and compliance with the recommendations of the MHSIP currently lacks a compelling positive consequence.

Response: Document the measurable consequences of MHSIP adoption and expand the range of stakeholders who ascribe to MHSIP principles with project that:

3.1A. Achieve compatibility between the MHSIP recommendations and the standards and specifications of HCFA's Medicaid Management Information System (MMIS).

3.1B. Achieve compatibility between the MHSIP recommendations and the standards for performance indicators and information systems applied by the Joint Commission on the Accreditation of Health Organizations (JCAHO).

3.1C. Reconceptualize the operations of the Survey and Reports Branch such that data collection and report generation are based on the receipt of integrated data recommended by the MHSIP.

Mechanism: 3.1A. Establish an interagency agreement between DBAS, NIMH and HCFA for the latter to review the recommendations in FN-10 and determine what modifications, if any, are needed so that MHSIP-based systems would be in compliance with the specifications for a MMIS and other system specifications of HCFA.

3.1B. Contract for JCAHO review of MHSIP content to determine the extent to which the content meets their needs for performance indicators for mental health organizations and for the extent to which a MHSIP compatible MIS in a provider setting would be viewed an organization asset by JCAHO, e.g., in a site review or reflecting an ability to generate a range of performance indicators.

3.1C. Establish an ad hoc Advisory Group for the Survey and Reports Branch that assists in systematically reorienting the National Reporting Program to benefit from the existence of integrated decision support systems.

Infrastructure: Program staff and representatives in the field who can represent MHSIP content authoritatively.

Project officers to monitor developments in a knowledgeable, proactive manner.

Representatives from providers, auxiliary levels, and research knowledgeable about integrated information systems and the provision of such data to the national level.

A restructured, redesigned NRP

Resources: 3.1A. \$250,000 Interagency agreement

.2 FTE

3.1B \$600,000 Contract

.25 FTE

3.1C \$25,000 annually supplement to SRB budget to conduct pilot tests/feasibility studies of advisory group recommendations prior to their internalization

Timeframe: 3.1A. Short term: by FY 1994

3.1B. Short term: by FY 1994

3.1C. Advisory Group-Short term: by FY 1994

Restructured, redesigned NRP--Mid term: by FY 2000

Issue: Conferences are an opportunity to gain rapid familiarity with the state-of-the-art, share ideas and developments with fellow travelers, and are catalysts that stimulate attendees to introduce innovations when they return home. Most of the meetings that a MHSIP constituency has an opportunity to attend, e.g., the NASMHPD Research Institute meeting and the National Conference on Mental Health Statistics, focus on mental health services research based on ad hoc study designs, specially negotiated administrative arrangements with small numbers of organizations, and de novo data collection. The opportunity-and MHSIP tradition-of presenting management and research analyses drawn from ongoing data systems has been increasingly de-emphasized in the National Conference forum.

Response: 3.2 Develop and sponsor sets of Conferences that are separate but equal and focus on different traditions in mental health services research.

Mechanism: Hold annual National Conferences on Mental Health Services Research based on traditional research models

Hold annual National Conferences on Mental Health Statistics based on analyses from ongoing integrated decision support systems

Foster other traditions of analysis via small procurements in such topic areas as epidemiology/prevalence and the linkage with service use; management and policy analyses at provider and auxiliary levels.

Infrastructure: Constituencies that had better than an intuitive understanding of these traditions and actively pursued activities under one or more of the areas

Outlets for disseminating reports and information from such meetings; special publication series, journal numbers, etc.

Staff, either within DBAS or in a sponsorship location outside Government, to manage the activities, handle contracts, etc.

Resources: \$150,000 annually for each of the identified national conferences

\$30,000 annually to initiate one special analysis in another area

\$35,000 to print papers, statistical notes, or series reports derived from these activities

.5 FTE

Timeframe: Short term: by FY 1994

Issue: If the MHSIP emphasizes the individual as a complementary focus of analysis and simultaneously expands the scope of coverage to additional service delivery sectors, questions will inevitably arise about the extent to which MHSIP recommendations are adequate to meet these challenges.

Response: 3.3 Assess the match between the data needs under a managed care approach and the data recommendations of the MHSIP and suggest resolutions, if needed

Mechanism: A professional services contract or task force

Infrastructure: Program staff to develop the statement of work

Project officers to monitor developments in a knowledgeable, proactive manner. Pilot sites where complex data sharing agreements do not present an unreasonable impediment to implementation

Resources: \$25,000 professional services contract; or \$60,000 task force support

\$6,000 to publish supplement to FN-10

.25 FTE

Timeframe: Short term: by FY 1994

Issue: A major gap exists in the MSHIP's silence on addressing the effectiveness aspect of the management knowledge model that guides the content of FN-10.

Response: 3.4 Demonstrate a variety of effectiveness measures that can be drawn from ongoing data bases and from relatively simple additions of measures/scales that programs could consider, e.g., continuity of care linkages, relapse rates, symptom relief measured via the BPRS, control of problem behaviors via special incident/risk management reporting, work/school performance via attendance/stability, etc.

Mechanism: Research and development contract

Infrastructure: Program staff to develop the RFP

Project officer to monitor developments in a knowledgeable, proactive manner.

Resources: \$350,000

.25 FTE

Timeframe: Short term: by FY 1994

Issue: It is axiomatic within the MHSIP and MHSIP-consistent data systems can serve as a source of quality data for hypothesis-based research studies. However, the academically based community either finds that there are an insufficient number of collaborations between service-based and academic researchers in which ongoing high quality, integrated data bases serve as a meeting ground.

Response: 3.5A Based on accomplishments supported by the research capacity grants to States that are compatible with the MHSIP content, support a special research monograph that includes a consideration of the opportunities and challenges for academic researchers to work with ongoing data bases.

3.5B Support research demonstration grants that combine:

- a PAL focus,
- data derived from ongoing data systems,
- a particular target group emphasis (children, severely mentally ill, heavy users, etc.),
- an emphasis on impacts and outcomes of services, and
- interest in policy research and development

Mechanism: 3.5A Professional services contracts to develop appropriate content/chapters.

3.5B An RFA with set aside funds or a competing grant supplement to the Centers for Research on the Organization and Financing of Care for the Severely Mentally Ill

Infrastructure: Program staff to develop the statements of work and the RFA

Project officers to monitor developments in a knowledgeable, proactive manner.

Sites, both service and academically based, capable of performing.

Resources: 3.5A \$30,000 for PSCs

\$18,000 for printing

.25 FTE

3.5B \$1,000,000 set aside research funds

.25 FTE

Timeframe: Initiate within short term: by 1994

Products within mid-term: by 2000

Issue: Data collected by the Implementation Task Force Indicated that the priority need among sites interested in implementing the recommendations in FN-10 related to materials on how the resulting data could be of use to decisionmaking, particularly decisions related to management actions affecting mental health organizations. Although FN-10 uses numerous examples to demonstrate the managerial benefits of an integrated decision support system, they are anecdotal. The MHSIP needs to accumulate evidence that such systems enable managers to pose and analyze complex questions and to realize measurable benefits.

Response: 3.6A Demonstrate the derivation of performance indicators from FN-10 content; sponsor training/orientation; collect data to generate performance indicator data to be used for comparisons

3.6B Accumulate a set of management-oriented case studies that can be presented in a form similar to that of a research article: problem/hypothesis, method, results, benefits and applications. Publish as a special issue of a professional journal or issue a special monograph.

Mechanism: 3.6A Task force to develop a representative rationale for performance indicators and develop needed content.

Grant or contract to develop and offer training in the generation and use of performance indicators that can be used to assess issues of service adequacy, efficiency, accessibility, and impact; can also include exemplary or national data collection around performance indicators to produce sample results or norms for comparisons

3.6B Competitive contract

Infrastructure: 3.6A Program staff to develop the statements of work or RFA

Project officers to monitor developments in a knowledgeable, proactive manner.

A sponsorship site for training and handling administrative matters, if it becomes ongoing and integrated with training/orientation noted above.

Capacities within the Survey and Reports Branch to receive/generate additional reporting of performance indicator data

3.6B Program staff to develop the statements of work or RFA

Project officer to monitor developments in a knowledgeable, proactive manner.

Resources: 3.6A \$60,000 for developmental work

\$10,000 to publish results in a monograph

\$100,000 for training

\$1 million for data collection and normative indicator results

.5 FTE

3.6B \$250,000 for competitive contract

\$15,000 for printing of an NIMH monograph

.33 FTE

Timeframe: 3.6A All developmental work--Short term: by FY 1994

Remainder of 3.6A and 3.6B--Mid term: by FY 2000

OPERATIONAL STEP 4: Incorporate emerging areas

Background: The field of mental health and the MHSIP exist within a complex, open system that interacts with numerous other health and human service systems. Furthermore, the environment of all these systems is dynamic and changing at an unprecedented pace. To reflect and be responsive to the changing environment of mental health and to be true to both the mission of MHSIP and its values, there is a need to expand MHSIP concepts into new areas that ensure that they are contemporary and relevant.

Objectives:

- Explore public health developments
- Expand MHSIP to include emerging knowledge and target groups
- Incorporate new program directions

4. Incorporate emerging areas

Issue: The MHSIP has been developed largely by the public mental health system. Although representative of NCHS and NAPPH participated in some task forces, MHSIP could be considerably strengthened through endorsement and implementation in major segments of the specialty mental health system, such as private psychiatric hospitals and psychiatric units in general hospitals.

Response: 4.1 Endorsement by and planned implementation of MHSIP in private psychiatric hospitals and psychiatric units in general hospitals

Mechanism: Negotiate agreements with NAPPH and AHA

Infrastructure: Inclusion of NAPPH and AHA representatives in the MHSIP Advisory Group or key, active task forces

Capacity within the organizations represented by these agencies to implement MHSIP recommendations or report out data compatible with the MHSIP

Staff capacity to handle additional data

Resource: \$250,000 subcontract funds within the IMHO/GHMHS contract to sustain their active involvement in supplying MHSIP-consistent data

.05 FTE for the negotiations

.25 FTE for additional data (much of the organization data is already received)

Timeframe: Agreement--Short term: by FY 1994

MHSIP implementation in private psychiatric hospitals and psychiatric units in general

hospitals--Mid term: by FY 2000

Issue: The purpose of the mental health system and its data systems is to serve clients, their families and communities and bring about improvement in quality of life. To that end, the MHSIP should be both organizationally and consumer-based. The MHSIP must produce information about the characteristics and total service needs of all persons with mental disorders, especially those whose service needs involve other sectors of health or human services.

Response: 4.2 Expand MHSIP content to include data standards to reflect generic services provided to persons whose service needs involve mental health and other sectors of health and human services. Such groups may include SPMI, elderly, people with multiple diagnoses, children and youth, AIDS patients and individuals who are HIV positive.

Mechanism: A contract to conduct a feasibility study of recording generic services needed and received by persons with mental illnesses. If feasibility is demonstrated, convene task forces, as needed and appropriate to the groups specified above, to develop the standards and suggest models for required processes

Infrastructure: Program staff to develop the statement of work or RFP

Project officer to monitor the feasibility study

At least one site to conduct the feasibility study

Task forces (conditional on results of feasibility study) to develop standards and models

Capacities to receive/generate generic services data

Resources: \$60,000 for the initial task force

.5 FTE for a project officer

\$100,000 for feasibility study

\$30,000 annually for each task force formed around a target population

1 FTE for designing accommodations for the receipt and processing of additional data

.5 FTE for handling of additional data generated, thereafter

Timeframe: RFA and pilot--Short term: by FY 1994

Remainder--Mid term: by FY 2000

Issue: Appropriate management of complex systems requires a routine and systematic approach to planning for systems growth, realignment and retrenchment. Such planning requires a public health orientation specifically based on data that describe area characteristics, populations and factors affecting need and demand for services.

Response: 4.3 Develop suggested content standards and guidelines for data collection/systems models for data on social area characteristics, need assessment and area resources. Develop models for integrating results with data on organizational characteristics, treatment rates, mental health and generic services, and service quality and outcomes to produce needed public health/mental health information.

Mechanism: A competitive contract (open market or 8a set aside) to develop a model and prepare a monograph

Infrastructure: Program staff to develop to RFP

Project officer to monitor developments in a knowledgeable, proactive manner

States capacity to produce the information

Pilot sites to test and refine model

Resources: \$250,000 to develop models, prepare monograph and prepare a training workbook

1.0 FTE

Timeframe: Initiation--Short term: by FY 1994

Final product--Mid term: by FY 2000

Issue: More mental health services are provided outside the specialty mental health system than within it. Recent policy trends (e.g., OBRA) and emerging data (e.g. mentally ill in jails and prisons) suggest an increasing need for the MHSIP to consider the data and system design implications of these developments.

Response: 4.4 Expand MHSIP to cover mental health services provided outside the specialty system to include, at a minimum, primary health care, nursing facilities and correctional systems

Mechanism: Professional services contracts or use of a logistical support contract to convene a panel of experts and representatives of the various systems to prepare a report of analyzing the extent of mental health services in these sectors and, if appropriate, recommending actions and next steps.

Possibility of one or more contracts to conduct in-depth analysis, prepare a design for expanding MHSIP coverage, and pilot testing the recommended design.

Infrastructure: Staff to prepare the statements of work

Project officer to monitor developments in a knowledgeable, proactive manner.

Contract (conditional on panel recommendations)

Capacity to receive and handle additional data

Resources: 1.0 FTE, development and pilot

\$60,500 over 18 months for panel

\$125,000 per sector to be covered in a development and pilot test contract

1.0 FTE, if there is a commitment for ongoing additional data from these sectors

Timeframe: Panel report--Short term: by FY 1994

Design and partial implementation of expansion--Mid term: by FY 2000 (conditional)

Issue: Sound information systems are dynamic, open, interactive systems that respond to both changing environmental and informational needs. Any change has to be carefully evaluated to balance new needs against desired stability and continued comparability of available data. The MHSIP needs to have a formal, standing mechanism that assesses when change in data content or system design is advised and proposes appropriate actions.

Response: 4.5 Adopt a formal mechanism that permits the MHSIP to stay attuned to desirable changes in content or design

Mechanism: Professional services contract to consider a variety of options and make a recommendation

Implementation of the recommendation

Infrastructure: Program staff to develop the statement of work

Project officer to monitor the activity in a knowledgeable, proactive manner

Possibility of an additional oversight group or a person/organization capable of periodic objective analysis of inputs

Resources: \$10,000 contact to develop options

.1 FTE

\$30,000 potential annual commitment to an addition oversight group or

\$25,000 biennially for an analysis of received inputs

Timeframe: Short term: by FY 1994