MHSIP Retreat:

Role and Function of Public Mental Health Agencies–Data Implications

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Community-MH

State mental health agencies are increasingly becoming contractors for services, rather than direct providers of services. In the 1990s, the percentage of SMHA budgets devoted to community-based mental health services has passed state hospitals and now approaches 57% of SMHA budgets. In the larger population states, the funding of community mental health services is frequently sub-contracted to county or multi-county mental health organizations. In small and medium population states, the provision of community mental health services is usually provided by community mental health centers that directly contract with the SMHA. Most of the approximately one dozen states that operate community mental health programs are either privatizing or examining privatization of community mental health agencies.

Non-traditional services are becoming much more common. Most States have embraced the goal of promoting "recovery" among consumers and are funding a variety of new programs to help support recovery. Consumers are using self-help programs, club houses and Assertive Community Treatment (ACT) programs that are often not delivered in traditional CMHCs. Instead, services are delivered where consumers live, work, and play. Existing MHSIP (FN-10) standards do not speak to these newer types of integrated and non-traditional services. With the development of the MHSIP Consumer-Oriented Mental Health Report Card and its Consumer Survey, MHSIP provided valuable leadership to the field in compiling information on consumer's perceptions of access, appropriateness, and outcomes for mental health care. Increasingly, community mental health information systems are focusing on consumer identified measures of recovery, empowerment, and personhood.

Community mental health agencies report having to work with an increasing number of different payors with multiple reporting requirements. Increasingly, payors are requiring community programs to be accredited by a national organization in order to receive payments. The need to become accredited has staffing and MIS implications.

The information system implications are that more and more states are monitoring the performance of mental health systems they fund but do not operate. In large states, data comes into the SMHA filtered through county government/organizations. In many states, these community agencies also are linking mental health services with other human service providers (VR, housing, education, juvenile justice,

criminal justice, etc) that are outside the mental health system. Thus, community-based systems put more burdens on providers to report on aspects of consumers' lives that are more outside agency control than is the case in hospital environments.

State Psychiatric Inpatient Programs

The number of state hospitals and their size have undergone large decreases in the 1990s. In many states, there are half the number of state hospital beds today than there were 10 years ago. However, more of the hospitals are JCAHO accredited and HCFA certified than ever before. With the increased accreditation, State hospitals now are required to produce comparable performance indicator data. Both the production of meaningful, comparable data and the utilization of performance indicator data will be major issues for state hospitals in the 21st Century.

In addition, new legal challenges to the use of state hospitals–such as an ADA case currently pending before the U.S. Supreme Court, the movement of sexual offenders into state hospitals, a new generation of very expensive antipsychotic medications, and a new focus on abuses of seclusion and restraint–are focusing attention on aspects of state hospitals not well addressed by current MHSIP data standards. Meeting these emerging issues will require the integration of hospital critical incident reporting, pharmacy databases and more information on the legal and functional statuses of patients.

Managed Care:

State mental health agencies are increasingly moving to implement the principles of managed care, such as utilization review and rate setting, in the operation of their existing mental health systems. The momentum to contract out Medicaid mental health managed care to private managed care companies has drastically slowed or reversed. A number of states that had been planning to implement Medicaid waivers for mental health have withdrawn or not implemented approved waivers. Instead, more states seem to be trying to use managed care principles within their public systems. The increased use of contracted mental health services, by both community mental health agencies, and managed care organizations may increase the demands for information to monitor and assess the quality of mental health services being provided. Thus, SMHAs are shifting from delivering services to contracting and monitoring the performance of others in delivering these services. These shifts will result in many more demands being placed on information systems to provide data to help monitor care and to comply with new practice guidelines.

Accreditation Organizations:

In the absence of Federal leadership, the accreditation organizations are setting data standards for mental health. NCQA, with the HEDIS report card, has set data standards for reporting performance indicators for managed care that include limited mental health specifications. The JCAHO, through the ORYX requirements, is requiring all psychiatric hospitals to report comparable data. The NASMHPD Research Institute's new ORYX reporting system (which has 45 participating states) has established *de facto* mental health data standards for state psychiatric hospitals in reporting such issues as seclusion, restraints, use of new medications, medication errors, elopements, injuries, and new legal status codes.

Federal Agencies:

Federal attention to mental health data standards has largely vanished. NIMH funds millions of dollars of mental health research without any encouragement or requirement of common mental health data standards. CMHS and SAMHSA conduct demonstration programs and "knowledge development" projects without using MHSIP standards. Whereas in prior years, meetings of the MHSIP Policy Group

included representatives from a number of program areas within NIMH, and then CMHS (survey and reports, planning, demonstration programs), and occasionally members of HCFA, and the MHSIP was used to advise the Federal Government on various surveys and data requirements, today that focus has largely been lost. Only representatives from the CMHS Survey and Analysis branch attend MHSIP Meetings, and even the Survey and Analysis Branch rarely uses the MHSIP for "advice" on surveys (either content of surveys, approaches, or priorities for different areas of surveys).

Given the relative absence of Federal interest in developing and using comparable data standards, MHSIP shifted its focus to public mental health systems–primarily state systems. This focus on state systems has led to the development of the largely successful MHSIP Consumer-Oriented Mental Health Report Card and 12 years ago, of FN-10 data standards. However, despite wide State acceptance of many of the MHSIP recommended indicators, the MHSIP Consumer-Oriented Mental Health Report Card has not found much acceptance by either private industry or local mental health providers–many of whom seem to see the MHSIP Consumer-Oriented Mental Health Report Card as a "state indicator set".

Furthermore, with the focus on public delivery systems outside the Federal government, the Federal contributions to the MHSIP effort are drastically reduced. Where MHSIP once had several ongoing implementation and project task forces, each with a paid facilitator/staff person, now task forces limp along with limited funding and no paid coordinator/facilitator. The result is that MHSIP is frequently looked to as the source of mental health data standards and data for public mental health and expected to be current, but not given the resources to meet that mission. The result is a series of no-win situations for MHSIP–it gets expectations it cannot possibly meet with its lack of resources and lack of support.

Federal funding of MHSIP activities, although substantial in terms of grants to states, remain focused on efforts aimed at helping "others" (such as states and local mental health programs) implement comparable standards, not at Federal reporting. In the past few years, most CMHS "MHSIP" funds have been spent on state grants to implement existing standards, with no real commitment of Federal funds to MHSIP Policy Group-identified priority areas of updating and developing new standards.

While CMHS and SAMHSA have largely ignored the updating of data standards for mental health, other Federal efforts that are not mental health specific are threatening to impose "general health" data requirements on mental health systems that may adversely affect mental health information systems. HCFA’s proposed electronic data records standards could become the *de facto* standards for all electronic billing records–despite their absence of many important mental health codes.

The traditional focus of MHSIP has been on MIS systems that often lack direct applicability to (1) billing systems, (2) clinical decision systems, or (3) critical incident reporting systems. It could be argued that these three data systems are now driving much of the public and systems demands for information. (1) Billing systems are the focus of major federal (NCHS and HCFA) efforts to develop common standards for electronic billings. (2) managed care systems and medical professionals are recognizing that to get the highest quality data, the data needs to be directly accessible and useful to the treatment staff who are supplying the data. Traditional MIS systems do not include electronic medical records or even MIS data packaged to help clinicians provide better services. (3) Critical Incident Reporting: major exposés and scandals about the excessive use of seclusion and restraint, problems with medication side-effects or the use of expensive new psychiatric medications are not covered by MHSIP’s traditional MIS focus. However, these are all areas about which Congress, advocates, and others are looking for information.

If the mental health community feels the need for a common voice in setting mental health data standards (which is not something I really hear from much of the MH community), then maybe the MHSIP approach needs to be re-evaluated. One approach would be to promote the development of a

national mental health data committee that is broadly represented by all sectors of the mental health community. This new committee would be formally charged with reviewing all SAMHSA data related activities (including surveys, planning, demonstration, programs, etc) to use uniform language and definitions. Second, this committee could be a central focus for all other Federal data policies related to mental health information. This committee would probably be very different from the current MHSIP Policy Group–it would have to include a broad range of representatives of all the MH field.

Topical subcommittees/advisory groups could be constituted under the umbrella mental health data committee. One such subcommittee could be similar to the current MHSIP Policy Group and would focus on "Public MH Systems", another committee could be on electronic medical records, or private sector information systems. The key would be to have broad Federal support that the committee would make policy and advise the Federal Government on MH data standards. Second, the committee and its subcommittees would have staffing and resources to convene workgroups, task forces, and to have recommendations implemented by Feds and to direct resources to States and local governments to help them implement them.

One key is to identify a mission for MHSIP–or any MHSIP-like successor–that is consistent with the needs and desires of the people the group purports to advise. If the Federal government does not think it needs any "advice" on mental health data policy, then the MHSIP should stop purporting to "advise" the Federal Government and focus on other needs. If there is no willingness to base mental health information policy on the advice of any outside organization, then MHSIP should not include in its mission statement any such functions. If there is no federal role for MHSIP, then maybe a different funding scheme needs to be developed that focuses on particular state, local, or private information needs.