Testimony
Department of Human Services
Human Services Interim Committee
Representative Chuck Damschen, Chairman
June 19, 2014

Chairman Damschen and members of the Human Services Committee, I am JoAnne Hoesel, Director of the Division of Mental Health and Substance Abuse with the Department of Human Services. I am here today to provide information on a potential central data depository for all public and private behavioral health data, including the estimated cost to implement a repository.

The Division of Mental Health and Substance Abuse, in its role as state mental health and substance abuse authority, collects, reports, and submits data from publicly funded mental health and substance abuse providers. I have provided this information to you in the past, most recently April 2014 which focused on client trend data. Current reporting federal requirements drive the collection, reporting, and analysis of data. Data details have also driven the electronic health record design.

In considering how data collection could be expanded to include private providers to secure a behavioral health data repository, questions for consideration are offered:

1) What information is needed? What do we want to know? What decisions need to be made and supported by data?
2) What existing statutory authority exists?
3) What method(s) can be used to gather the data?
4) What is provider capacity to generate and report the data?
5) What provider support, training, and assistance would be needed?

6) What remedies are available to address challenges that will occur?

The public system serves as the safety net, providing mental health and substance abuse services to the most vulnerable individuals in North Dakota. Efforts dating back to the 1970's describe an ongoing and evolving process to collect, report, and analyze data collection for publicly funded programs. As these processes matured and information technology resources evolved, reporting has improved. In 2004, the Substance Abuse Mental Health Services Administration (SAMHSA) implemented specific national outcome measures to be measured across all SAMHSA-funded programs. The outcomes focus on measures of client functioning. Client functioning measures describe changes in how clients manage their illnesses and live in communities. Client functioning data includes the extent clients are employed, stay in school, have involvement with criminal justice, have a safe and stable place to live, have social connections to and support from others. Two main data sets are in place for the public system 1) Treatment Episode Data Set (TEDS) and 2) Uniform Reporting System (URS) for reporting tied to the substance abuse and prevention block grant and the mental health block grant funding.

In 2010, the U.S. Department of Health and Human Services (HHS) was charged by Congress to develop a National Quality Strategy (NQS). Using the NQS as a model, SAMHSA developed the National Behavioral Health Quality Framework (NBHQF). The six NQS goals are: evidence-based practices, person-centered care, coordinated care, healthy living for communities, reduction of negative life events, and cost reductions. The impact of each of those goals is being tracked via a set of core behavioral health quality measures across three targets or domains. The Division works closely with the National Association of

Alcohol and Drug Addiction Directors (NASADAD) and the National Association of State Mental Health Program Directors (NASMHPD) to track the development of the NBHQF and its impact to the Department's technology systems and need for staff training and technical assistance.

Existing North Dakota statutory authority to collect service and client data differs between mental health and substance abuse services. The Division licenses all substance abuse treatment programs in North Dakota. This licensing includes both public and private programs and within that role the North Dakota Administrative Code indicates that programs must collect data as prescribed by the Department.

In the area of mental health services, the Department's authority, through North Dakota Century Code, is limited to the human service centers, the state hospital, and contracted services. The data collected is that of the public-funded mental health system.

In considering what data may be needed and how it may be used, we designed three data level tiers which I believe will provide a framework for the committee's decision making. Each level tier is tied to data purpose and intended use and each level require varied resources for successful implementation.

Tier One provides service detail on who was served, what were the issues, what service was provided.

1. Total number of people served
2. Referral source
3. Gender of those served
4. Age of those served

5. Primary drug used and/or presenting problem
6. Primary diagnosis
7. Military involvement
8. Service provided to the client

Tier One would guide decisions tied to the state's service needs, service capacity, service trends, and workforce training needs.

Tier Two includes the Tier One elements but adds data elements that describe the functioning changes of the clients served and more detail on what services were provided.

1) Client Living arrangement
2) Client Employment status
3) Client Criminal justice involvement
4) Client's Social Connection
5) Client's hospitalization occurrences
6) Evidence-based programs provided

Tier Two adds data elements tied to **service outcomes** and would be collected at least at admission and discharge in order to determine change.

Tier Three includes data from the first two tiers but adds data collection after discharge. The same data is captured but is collected at a later date to measure sustained illness management. This tier is the most labor-intense and data-rich.

The Department is not able to provide cost projections at this time but is hopeful that the information provided will assist the committee as it moves forward with their decision on a data repository. The Department would need to have additional guidance (via answers to the questions posed earlier in this testimony) and understand which

tier-level of data is expected in order to provide a cost estimate for establishing a data repository. The Department has experience in this area and is interested and committed in providing assistance and information to the committee.

Thank you.

Sources: World Health Organization, SAMHSA, Institute of Medicine, Office of Inspector General.