Securing and Using the Right Data to Improve Your State’s Mental Health Block Grant Application: PART TWO

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Disclaimer

This webinar was developed [in part] under contract number HHSS283201200021I/HHS28342003T from the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (HHS). The views, policies and opinions expressed are those of the authors and do not necessarily reflect those of SAMHSA or HHS.
This presentation is the second of two parts focusing on the relationship between the planner and the data manager and between planning and data specific to the Mental Health Block Grant (MHBG).

Today’s presentation is structured to follow the WebBGAS format – planning steps and data tables for both the application and the Annual Report.

The next MHBG application will be a mini-application requiring only expenditure tables. These requirements will be briefly addressed.

The primary focus is on what is required and/or useful to include in each planning step and the required tables for the biennial application. It is understood that there will likely be some changes between now and September 1, 2019. However, the general structure and requirements will also likely be very similar to what is included here.
In Part One, we reviewed the data necessary and required for Block Grant reporting and for system management. The Planner(s) and the Data Manager(s) must work collaboratively:

- to identify data sources,
- to define data requirements,
- to monitor the quality of data, and
- to make system changes as necessary.

Not all data sources are located within your agency. Learn where they are and who owns that data.
Behavioral Health Services Information System (BHSIS) Agreements provide annual funding through SAMHSA to support the data collection and reporting for the block grant Implementation Report due December 1 each year.

- Uniform Reporting System Tables (URS) are MHBG requirements
- Client Level Data Reporting (MH-CLD or TEDS) are MHBG requirements

The key to accomplishing tasks associated with data collection for the block grant will be SAMHSA’s collaboration with the National Association of State Mental Health Program Directors (NASMHPD), the National Association of State Alcohol Drug Abuse Directors (NASADAD), and other state and community partners.
State Profile

Assurances/Certifications/Disclosure of Lobbying

Table 2 – State Agency Planned Expenditures
use allocation numbers in letter sent to Commissioner
MHBG and SABG tables remain separate in BGAS
use State’s fiscal year

Table 6 – Categories for Expenditures for System Development/Non-direct Service Activities

Section IV: Environmental Factors and Plan
Planning Council involvement and composition
Application – Big Picture

System description -  the good, the bad, and the ugly

Assessment of Need – overarching domains of access and quality

Priorities and Goals – where resources will be focused over the next two years

Each section should be complete in itself. The last two sections should clearly build upon the previous sections in a way that is clear and logical.
For each plan step, the following will be addressed:

- Brief description of requirements
- Potential data elements
- Sources of data
Must address five statutory criteria – Will be primarily in Step 1 -

**Criterion 1 – Comprehensive Community-based Mental Health Service System**
- organized community-based system of care for people with mental illness and co-occurring substance abuse problems
- focus on services and resources sufficient to support people living outside inpatient or residential locations to the maximum extent of their capability

**Criterion 2 – Mental Health System Data Epidemiology (Step 2)**
- Estimate of incidence and prevalence
- Quantitative targets and outcome measures
Step 1 – System Description – Statutory Criteria

Criterion 3 – Children’s Services
   Integrated system of services to address multiple needs of children
   Coordination with other service systems

Criterion 4 – Targeted Services to Rural and Homeless Populations and Older Adults
   Outreach and services to those who are homeless, live in rural areas, and older adults

Criterion 5 – Management Systems
   Available financial resources, staffing, and training for providers
   Training for emergency health service providers re SMI and SED
   Proposed allocation of block grant funding
# Statutory Criteria and WebBGAS

<table>
<thead>
<tr>
<th>Mental Health Statutory Criteria/Requirements</th>
<th>WebBGAS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Comprehensive Community-based Mental Health Service Systems</td>
<td>Planning Step 1: Assess the Strengths and Needs of the Service System to Address the Specific Populations, Including ESMI, Environmental Factors and Plan 1, 4, 5, 10, 17, 19, 20, and 21</td>
</tr>
<tr>
<td>2. Mental Health System Data Epidemiology</td>
<td>Planning Step 2: Identify the Unmet Service Needs and Critical Gaps with the Current System and Table 1</td>
</tr>
<tr>
<td>3. Children’s Services</td>
<td>Planning Step 1, Environmental Factors and Plan 19</td>
</tr>
<tr>
<td>4. Targeted Services to Rural and Homeless Populations</td>
<td>Planning Step 1</td>
</tr>
<tr>
<td>5. Management Services</td>
<td>Planning Step 1, Tables 2–6, Environmental Factors and Plan 10</td>
</tr>
<tr>
<td>6. Independent Peer Review</td>
<td>Independent Peer Review</td>
</tr>
<tr>
<td>7. Public Comment</td>
<td>Public Comment</td>
</tr>
</tbody>
</table>
Step 1: Assess the strengths and organizational capacity of the service system to address specific populations (SMI and SED)

Overview of state system – how it is organized at state and local levels

Role of SMHA relative to other state agencies

Description of regional, county, tribal, and local entities that provide services

Description of service recipients by demographics including racial, ethnic, and sexual gender minorities, American Indian, Alaskan Native
Step 1 – System Description – BGAS Requirements

Organization of Public System
Where is the State Mental Health Authority (SMHA) located – Org chart of State Agencies

How are MH services administratively organized – Org chart of SMHA

Description and location of state hospital(s) – how many beds of what kind located where – narrative and map

Description and location of community provider system – what kind of agencies located where – narrative and map

Description of mental health services provided by other state agencies, local governmental entities, and tribes

Advocacy groups – list by agency and area of focus
Examples of System Descriptors

Service Recipients

- Numbers and rates/1000 served in hospitals and communities – state data system –
- State/community hospital readmissions – state data system, hospital association
- Numbers served by others – child welfare, juvenile justice, corrections, private sector – other data systems
- Use of ESMI set-aside – number of programs using which model, number served, outcome measures – state data system
- Use of Child set-aside – number of programs, number served, outcome measures – state data system
- Number served in rural areas – number of transportation recipients by service area - state data system
- Number of homeless present/served – annual survey of street homeless, numbers with mental illness, number served who were homeless at time of admission
- Number served by demographic characteristics with focus on diverse racial, ethnic, and sexual gender minorities, American Indian, Alaskan Native
Services Provided

Number and location of specialty services – narrative and map

Number served by provider type – state data system

Number served in state hospitals and communities over time – state data system

Number of recipients by service category – outpatient, residential, inpatient – state data system

Number of recipients by specific service type – EBPs, Peer Support, Case Management, different levels of residential service – state data system
Step 1: System Description – BGAS Requirements

Workforce

Number of staff by type of position (clinician, case manager, residential worker, peer specialist, etc., psychiatric manpower shortage areas – survey and/or state data system

Number and type trained for delivery of EBPs – survey and/or data system, training records

Number and type trained for specific clinical techniques – survey, training records

Number and type trained to provide services to those with co-occurring disorders – survey, training records

Number of staff/recipient in urban and rural areas
Training

Sources of training – on-line, on-site, state-sponsored, federal technical assistance – state and local training received/provided

Training provided by community providers/state to emergency health personnel – training records, training sites

Training needed – clinical techniques, COD, EBP, data reporting, performance improvement, deficiencies identified through certification/licensure – state system
Financial Resources

Current expenditures by funding source – state, Medicaid, Block Grant, other – state financial system

Other state agency expenditures – other state agency financial systems – ask for it

Budget increases/decreases – state financial system

Private insurance coverage of services to those with mental illness – private insurers – ask for it
Identify the unmet service needs and critical gaps within the current system

Needs assessment process should be data driven.

Comparison of state numbers to national numbers and to similar states – state data system, NRI, URS, NOMS, Behavioral Health Barometer, CDC Behavioral Risk Factor Surveillance System, Agency for Healthcare Research and Quality Healthcare Cost and Utilization Project

- Rates in treatment in hospitals and community providers
- Numbers served in hospitals and community providers by demographics
- NRI estimate of SMI and SED prevalence compared to number served
- NSDUH estimate of any mental illness compared to number served in all systems
- Consumer Satisfaction Survey data trends
- 30 and 180 day hospital readmission rates
- Number of suicides per 1000
- Morbidity and mortality
- Consumer Outcomes
Comparison of state numbers to its baseline – trend data – state data system – on-site reviews

- Increases/decreases over time in the elements listed above
- Number and location of EBPs by type – state data system, local providers
- Assessment of fidelity to EBP models – onsite reviews – external evaluators
- Number of staff by category – clinical, peers, case managers, etc. – survey, state data system

Number of psychologists/social workers/psychiatrists/1000 – identified manpower shortage areas – licensure boards, HRSA

- Number served in rural areas compared to state average and to urban areas
- Number who were homeless at admission
- Number served by demographics
- Medicaid # served and revenue
Non-quantitative identification of need

Federal/state lawsuits over system issues

Natural/man-made disasters

Governor/legislative priorities

Input from Planning Council and constituent groups

Town Hall meetings

Surveys
Drawing Conclusions

What does it all mean?

Why are the numbers the way they are?
  political imperatives
  budget cuts/increases
  federal grants
  training
  staff recruitment

What factors need to be addressed to change the numbers in the direction you want?
The acquisition and analysis of data present an opportunity for the planner and data manager to work collaboratively.

Have all providers submitted all the data? No? The planner needs to address the deficiency with the provider – what sanctions can and should be imposed.

Is there a technical issue that the data manager needs to address?

Are there known factors that would influence trend data?
Changes in coding
Changes in providers
Services added/deleted
Step 3: Prioritize State Planning Activities – BGAS Requirements

*Step 3: Prioritize state planning activities*

Address core federal goals and aims

Address required target populations – SMI and SED

Clearly based on identified need/gap in the system which may come from either Step 1 or 2.

Should be limited in number due to global nature
Chances are that there are more needs/gaps than can realistically be addressed in two years. A rationale should be given for selecting the priority areas.

**Access Examples**
- Are rural areas significantly disadvantaged in rates in treatment?
- Are there EBPS that have not been implemented at all or in certain areas of the state? (This could also be a quality measure.)
- Is there a trend where certain demographics are being increasingly or decreasingly served – elderly, gender, LGBTQ and in what geographic areas?
- What community services are needed to improve 30 and 180 day state hospital readmission numbers?
- Are child and adolescent services available in all geographic areas? What types of services are missing from where?
- Are total numbers served in communities and state and local hospitals in line with national data or data from comparable states?
- What do other state agencies and advocacy organizations complain most about?
Quality Examples
Are there sufficient peer support specialists, case managers, psychiatrists, etc. to meet caseload standards?

Has person-centered planning, trauma informed care, data reporting, etc. been identified as a deficiency by the certification/licensure process or by analysis of data reporting?

What are consumer satisfaction scores over time and what should be done to maintain/improve the scores?

What degree of fidelity do EBPs have to the model?

How are outcome data trending? Why?
Step 4: Develop goals, objectives, performance indicators, and strategies

Sets the expectations for the system for the next two years

Should represent focus areas where the most time, attention, and resources will be spent

Should be based on consistent, accurate, and complete data where Baseline, Year 1, and Year 2 indicators can be measured

Note the state’s fiscal year and whether data have to be estimated for the baseline and annual performance indicators

Issues that may impact data consistency/accuracy/completeness should be identified

There may be more than one goal per priority, more than one strategy for each goal, and more than one performance indicator for each strategy. Only one is required.
Planning Table Instructions

Instructions for completion of the Planning Tables are provided in the MHBG application and provide baseline data for measuring performance of your state/territory against MHBG goals.

Plan Table 1: *Priority Area and Annual Performance indicators*

Plan Table 2: *State Agency Planned Expenditures*

Plan Table 6: *Non-Direct Services System Development*
# Plan Table 1: Priority Area and Annual Performance Indicators

<table>
<thead>
<tr>
<th></th>
<th>Priority Area:</th>
<th>Priority Type (SAP, SAT, MHS):</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Population(s) (SML, SED, ESML, PWWDC, PP, PWID, EIS/HIV, TB, OTHER):</td>
<td></td>
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<tr>
<td>4</td>
<td>Goal of the priority area:</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Objective:</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Strategies to attain the objective:</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Annual Performance Indicators to measure achievement of the objective:</td>
<td></td>
</tr>
<tr>
<td>Indicator #1:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a)</td>
<td>Baseline measurement (Initial data collected prior to and during SFY 2018):</td>
<td></td>
</tr>
<tr>
<td>b)</td>
<td>First-year target/outcome measurement (Progress to the end of SFY 2018):</td>
<td></td>
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<tr>
<td>c)</td>
<td>Second-year target/outcome measurement (Final to the end of SFY 2019):</td>
<td></td>
</tr>
<tr>
<td>d)</td>
<td>Data source:</td>
<td></td>
</tr>
<tr>
<td>e)</td>
<td>Description of data:</td>
<td></td>
</tr>
<tr>
<td>f)</td>
<td>Data issues/caveats that affect outcome measures:</td>
<td></td>
</tr>
</tbody>
</table>
Plan Table 2

<table>
<thead>
<tr>
<th>ACTIVITY (See instructions for using Row 1.)</th>
<th>A. SAIG</th>
<th>B. MIBG</th>
<th>C. Medicaid (Federal, State, and local)</th>
<th>D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)</th>
<th>E. State funds</th>
<th>F. Local funds (excluding local Medicaid)</th>
<th>G. Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Substance Abuse Prevention* and Treatment</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>a. Pregnant Women and Women with Dependent Children*</td>
<td>$</td>
<td></td>
<td>$</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>b. All Other</td>
<td>$</td>
<td></td>
<td>$</td>
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<td></td>
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</tr>
<tr>
<td>2. Primary Prevention**</td>
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<td>$</td>
<td>$</td>
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</tr>
<tr>
<td>a. Substance Abuse Primary Prevention</td>
<td>$</td>
<td></td>
<td>$</td>
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<td></td>
</tr>
<tr>
<td>b. Mental Health Primary Prevention***</td>
<td></td>
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<tr>
<td>3. Evidence-Based Practices for Early (10 percent of total award MIBG)****</td>
<td></td>
<td>$</td>
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<tr>
<td>4. Tuberculosis Services</td>
<td>$</td>
<td></td>
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<tr>
<td>5. Early Intervention Services for HIV</td>
<td>$</td>
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<td>$</td>
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<tr>
<td>6. State Hospital</td>
<td></td>
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<tr>
<td>7. Other 24-Hour Care</td>
<td>$</td>
<td></td>
<td>$</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>8. Ambulatory/Community Non-24 Hour Care</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>9. Administration (excluding program / provider-level MIBG and SAIG must be reported separately)</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>10. Subtotal (Rows 1, 2, 4, 5 and 9)</td>
<td>$</td>
<td></td>
<td>$</td>
<td></td>
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<td></td>
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<tr>
<td>11. Subtotal (Rows 3, 6, 7, and 8)</td>
<td>$</td>
<td>$</td>
<td>$</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>12. Total</td>
<td>$</td>
<td>$</td>
<td>$</td>
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</tr>
</tbody>
</table>
For FY17 there was a shift in the methodology for completing URS Table 2 (MHBG Table 7). It changed from relying on expenditure data reported in the annual NRI State MH Agency-Controlled Revenues and Expenditures Study (R/E) to states completing this table directly as part of their URS reporting.

The resulting data greatly underreported the funds expended by states (-$18.4 billion between FY15 – FY17).

Table 2 is expected to reflect expenditures by revenue source for all individuals/services reported in the URS data set. If clients from community providers receiving services paid for by Medicaid, for example, are reported in the URS Tables and are part of the state’s MHBG Plan, then expenditures for these services should be reported.
# Planning Table 6

<table>
<thead>
<tr>
<th>Activity</th>
<th>A. MHBG</th>
<th>B. SABG Treatment</th>
<th>C. SABG Prevention</th>
<th>D. SABG Combined</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Information Systems</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>2. Infrastructure Support</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>3. Partnerships, community outreach, and needs assessment</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>4. Planning Council Activities (MHBG required, SABG optional)</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>5. Quality assurance and improvement</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>6. Research and Evaluation</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>7. Training and Education</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>8. Total</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>
Implications for Planner/Data Manager Relationship

The planner must identify the data elements used to describe and assess the service system.

The data manager must understand what can be provided in the existing data system, what changes might be needed, how long it will take, and how to get data from other systems.

The planner and data manager must be familiar with national data sets and understand whether/how the state system is the same as/different from the national data sets in order to make legitimate comparisons.

Comparison to similar states may give a more realistic view.
Data managers may work with multiple EHR systems used by local providers, health information exchanges and other data sources.

Technical issues related to data sharing and privacy (HIPAA) must be addressed and resolved.

What, When and How is data shared?
- Business Associate Agreements and other data sharing agreements
- HIPAA compliance
- 45 CFR compliance

Data Dictionary and Crosswalks between data elements and code sets from all data sources must be developed and maintained in order to report client level data.
SAMHSA requires an annual implementation report, due December 1, in order to determine to what extent the state/jurisdiction has implemented its goals and strategies proposed in the MHBG application.

**Required**

- WebBGAS Tables
- URS Tables for the most current fiscal year
- Client Level Data files for the most current fiscal year
  - MH-CLD
  - TEDS
Goal Achievement – Table 1

Enter Year 1 data to compare to baseline

Did you obtain the projected target? If no, why?
   Man-made or natural disasters
   Budget changes
   Changes in leadership/focus
   Data acquisition issues – accuracy, timeliness

Do you need to revise/eliminate the goal, strategy, or performance indicator?
Implementation Report Requirements

Report Domains

Expenditure – generally the responsibility of the planner to get numbers from the finance people

Population and Services – generally the responsibility of the data manager using the community and hospital data sets or other identified external data sets

Performance Indicators and Accomplishments – generally the responsibility of the data manager using the community and hospital data sets as well as Consumer Satisfaction Surveys
## Implementation Report Expenditure Tables

<table>
<thead>
<tr>
<th>Report</th>
<th>URS Table #</th>
<th>BGAS Table #</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Agency Expenditure</td>
<td>7</td>
<td>2a</td>
</tr>
<tr>
<td>State Agency ESMI Expenditure</td>
<td>NA</td>
<td>2b</td>
</tr>
<tr>
<td>Set-aside for Children</td>
<td>NA</td>
<td>3</td>
</tr>
<tr>
<td>Expenditure for Non-direct Service Activities</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>Agencies Receiving Direct Block Grant Funding</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>MOE for Statewide Expenditure</td>
<td>NA</td>
<td>6</td>
</tr>
</tbody>
</table>
These tables permit comparison to national data, similar states, and state trend data assuming your data system acquires comparable data.

<table>
<thead>
<tr>
<th>Report</th>
<th>URS Table #</th>
<th>BGAS Table #</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Population by Diagnosis</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Persons Served, All Programs by Age, Gender, and Race/Ethnicity</td>
<td>2A and 2B</td>
<td>8A and 8B</td>
</tr>
<tr>
<td>Persons Served in the Community, State Hospitals, and Other Settings</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td>Clients by Type of Funding Support</td>
<td>5A and B</td>
<td>10A and B</td>
</tr>
<tr>
<td>Client Turnover</td>
<td>6</td>
<td>11</td>
</tr>
<tr>
<td>State Mental Health Agency Profile</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>Persons with SMI/SED Served by Age, Gender, and Race/Ethnicity</td>
<td>14A and B</td>
<td>13 A and B</td>
</tr>
<tr>
<td>Persons Served in the Community, State Hospitals, and Other Settings for Adults with SMI and Children with SED</td>
<td>15A</td>
<td>14</td>
</tr>
</tbody>
</table>
These 14 tables include measures of client characteristics over time as well as point in time. The National Outcome Measures (NOMS) come from these tables.

<table>
<thead>
<tr>
<th>Title</th>
<th>URS Table #</th>
<th>WebBGAS Table #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Clients by Employment Status</td>
<td>4</td>
<td>15A</td>
</tr>
<tr>
<td>Adult Clients by Employment Status by Primary Diagnosis</td>
<td>4A</td>
<td>15B</td>
</tr>
<tr>
<td>Social Connectedness and Improved Functioning</td>
<td>9</td>
<td>16</td>
</tr>
<tr>
<td>Summary Client Evaluation of Care</td>
<td>11</td>
<td>17A</td>
</tr>
<tr>
<td>Consumer Evaluation of Care by Race/Ethnicity</td>
<td>11A</td>
<td>17B</td>
</tr>
<tr>
<td>Living Situation</td>
<td>15</td>
<td>18</td>
</tr>
<tr>
<td>SMI and SED Receiving Specific Services</td>
<td>16</td>
<td>19</td>
</tr>
<tr>
<td>SMI and SED Receiving EBP for ESMI</td>
<td>16A</td>
<td>19A</td>
</tr>
<tr>
<td>Adults with SMI Receiving Specific Services</td>
<td>17</td>
<td>20</td>
</tr>
<tr>
<td>Criminal Justice or Juvenile Justice Involvement</td>
<td>19A</td>
<td>21</td>
</tr>
<tr>
<td>Change in School Attendance</td>
<td>19B</td>
<td>22</td>
</tr>
<tr>
<td>Non-forensic Readmission to any State Hospital – 30 &amp; 180 days</td>
<td>20A</td>
<td>23A</td>
</tr>
<tr>
<td>Forensic Readmission to any State Hospital – 30 &amp; 180 days</td>
<td>20B</td>
<td>23B</td>
</tr>
<tr>
<td>Non-forensic Readmission to Psychiatric Inpatient – 30 &amp; 180 days</td>
<td>21</td>
<td>24</td>
</tr>
</tbody>
</table>
Collaboration and communication between planners and data managers year round.

The fiscal year for most states is different than the federal fiscal year –July 1 through June 30. Time crunch for those whose FY ends at a different time. Alabama FY runs October 1 through September 30 leaving only 2 months to clean and clarify data.

Trial runs of reports and data to be used should be conducted on regular schedule, quarterly for example, and reviewed in order for early identification of errors or anomalies. Analyze data and take any corrective action.

Data collected from outside state agencies (Corrections, labor, education) must reflect consumer’s situation for the same time period MH services are provided.
The information contained in the application and Implementation Report provide a feedback loop that accomplishes the following:

• The data from all sources used in the application to describe the system, to assess needs, and to set priorities, goals, strategies, and performance indicators set the parameters for what will be reported in the Implementation Report.

• The performance data included in the Implementation Report should be used to either request a modification to the application or to set the parameters for the acquisition of data for the next application.

• The Implementation Report findings should be discussed with the Planning Council to solicit input on possible changes to the application or the priorities, goals, etc. for the next application.

• Planning Council and other non-quantitative sources of data will influence what data are gathered and what is given priority in the application….then the cycle starts all over again.
Feedback Loop

- MHBG Implementation Report
- CLD
- Review Implementation Report
- Meet with Planning Council
- Modify/update goals/strategies for next MHBG application cycle

**Set Goals/Strategies**

- MHBG Application process
- gather/analyze existing data to assess system needs

**Implement Strategies**

- Data collection infrastructure in place
- Interim monitoring
- Data analysis

**Measure and Report Performance against Goals**

**Adjust Goals and/or Strategies**

- MHBG Implementation Report
- URS Tables
- CLD
Questions

Please address any follow-up questions to the following:

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