State Mental Health Agency Information Systems, 2023

NRI's 2023 State Profiles

May 2024

Highlights Based on 46 States Responding to the SMHA IT Component of NRI's 2023 State Profiles

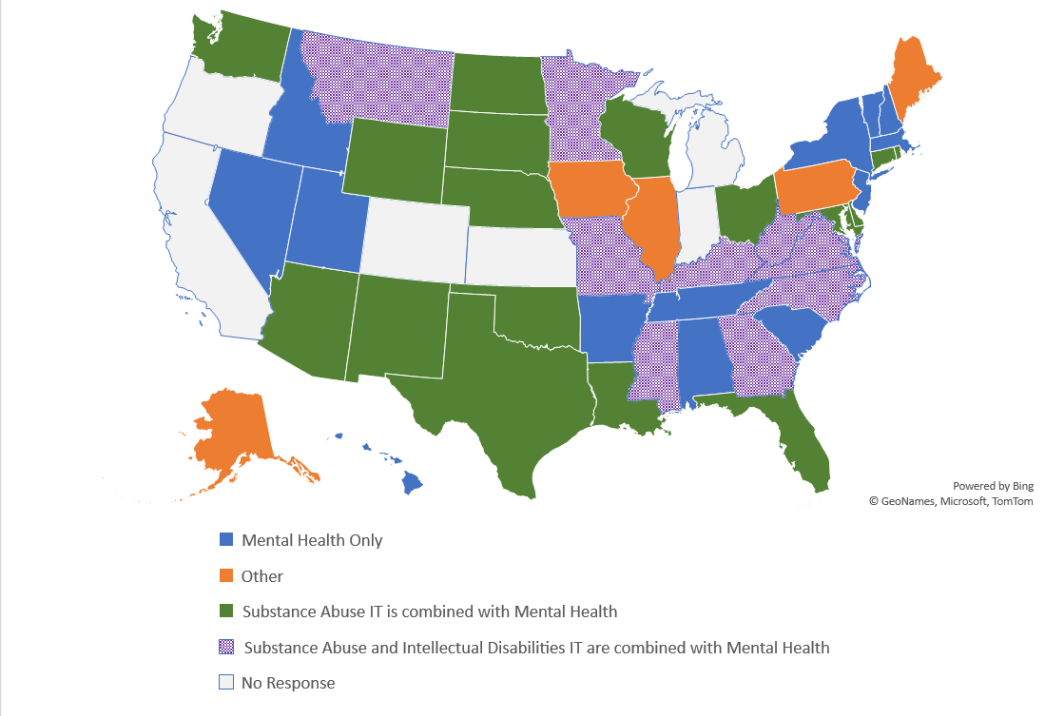
State Mental Health Agencies (SMHAs) are part of state government and are responsible for operating and funding services for adults with serious mental illnesses and children and adolescents with serious emotional disturbances. SMHAs serve as a safety net, providing mental health services to the most vulnerable individuals. SMHAs are also responsible for planning and developing comprehensive community-based mental health systems and serve key public health functions including mental health awareness and promotion and supporting behavioral health crisis services. In 2022, SMHAs provided services to more than 8.3 million persons (2 percent of the U.S. population) and spent more than $51 billion on these services.

SMHA Information Technology Systems:

Critical to the mission of SMHAs are monitoring the public mental health service system for service gaps; ensuring that persons with mental illness receive timely, appropriate, and needed services; reimbursing mental health providers for services provided; and building accountability performance targets and outcome measures. Having modern information systems that can count clients, measure outcomes, track system performance, facilitate care coordination, and at times even reimburse for services is fundamental to the SMHA's ability to fulfill these functions. Thus, information technology (IT) plays a major role in facilitating SMHA achievement of its core missions.

In most states, the mental health information system is combined with information systems that cover other disability services the SMHA is responsible for. In 18 states there is one data system that is used for both substance use treatment and mental health. In nine states, there is one data system that covers mental health, substance use disorders, and intellectual disability services, while 13 states operate data systems that only collect mental health data (Figure 1).

Figure 1: Types of Disability Services in the SMHA Information Management Systems, 2023



27
SMHAs have a combined Data system for MH & SUD

32
SMHAs Share Electronic Health Record (EHR) information between Providers

8
Have Pay for Performance Incentives with Providers

Behavioral Health Electronic Medical Record (EHR)

Thirty-two SMHAs report they are sharing EHR data between or across mental health providers to improve care across their service continuum.

- 20 SMHAs share EHR information through a Health Information Exchange
- 20 SMHAs share EHR information between state hospitals within the state
- 14 SMHAs share EHR information between community mental health providers and state hospitals
- 11 SMHAs share EHR information between different community mental health providers
- 9 SMHAs share EHR information between Managed Care Organizations and the SMHA system
- 8 SMHAs share ERH information between state hospitals, private psychiatric hospitals, and general hospital psychiatric units.

Twenty-three states have state laws providing extra confidentiality/privacy above the federal Health Insurance Portability and Accountability Act privacy protections.

Linking SMHA Client Information with Medicaid Data

Medicaid is the largest funding source for SMHA services, paying over $25.5 billion in FY 2022 for mental health services. Medicaid has its own unique data systems for enrollment and payment of service claims. To better understand mental health services, SMHAs are increasingly linking Medicaid data with other SMHA client information. In 2023, 77% of SMHAs (36 of 47 reporting) have access to Medicaid paid claims to analyze mental health services paid for by Medicaid.

- 25 SMHAs receive and analyze Medicaid Paid claim files from their Medicaid Agency
- 14 SMHAs have access to a state data warehouse (run by a separate state agency) that combines SMHA client data and Medicaid data
- 13 SMHAs have some other mechanism (such as an ASO, State University, or contractor) that links Medicaid data with SMHA data.
- 15 states are working with their State Medicaid agency to combine data systems.

32 SMHAs use these linked Medicaid SMHA data files for analyses of mental health services funded by SMHA and Medicaid sources. 27 SMHAs link the data systems for policy analysis, and 13 SMHAs use linked data to identify potential fraud and abuse.

Data Visualizations of Behavioral Health Services and Outcomes:

Most SMHAs (37 states or 80% of responding states) have developed data visualizations of behavioral health outcomes and client information. Eighteen states have data visualizations available to the public. (see Table 1).

Table 1: State Mental Health Agencies with Public Data Visualizations

State	Data Visualization Link
Florida	https://www.myflfamilies.com
Georgia	www.988ga.org
Hawaii	https://bh808.hawaii.gov/
Idaho	https://publicdocuments.dhw.idaho.gov/WebLink/Browse.aspx?id=2881&dbid=0&repo=PUBLIC-DOCUMENTS&cr=1
Kentucky	https://dbhdid.ky.gov/cmhc/qmot-surveys.aspx ;
Mississippi	https://www.dmh.ms.gov/news/olmstead/#progress-update
Montana	https://dphhs.mt.gov/interactivedashboards/DPHHSReportsandMetrics
Nevada	https://nvbh.org/dashboard/

New York	https://omh.ny.gov/omhweb/statistics/
Ohio	https://mha.ohio.gov/research-and-data/data-product-finder
Oklahoma	https://oklahoma.gov/odmhsas/research/statistics-and-data/dashboards.html
South Dakota	https://dss.sd.gov/docs/behavioralhealth/reports_and_data/State_Profile.pdf
Tennessee	https://www.tn.gov/behavioral-health/research/fast-facts.html
Texas	https://etss.hhs.texas.gov/t/IDDBHS-ODS/views/ER_AllTexasAccessDB/StoryAdultAdolescentJailTransport?%3Aembed=y&%3Aiid=3&%3AisGuestRedirectFromVizportal=y
Utah	https://sumh.utah.gov/data-portal-home/
Vermont	https://mentalhealth.vermont.gov/reports-forms-and-manuals/reports/results-based-accountability
Washington	https://hca.wa.gov
Wisconsin	https://www.dhs.wisconsin.gov/mh/county-services-dashboard.htm

Pay for Performance

Eight SMHAs use data to pay behavioral health providers based on performance measures identified by the SMHA. The table below describes state pay-for-performance initiatives and includes state contacts for these systems (see Table 2).

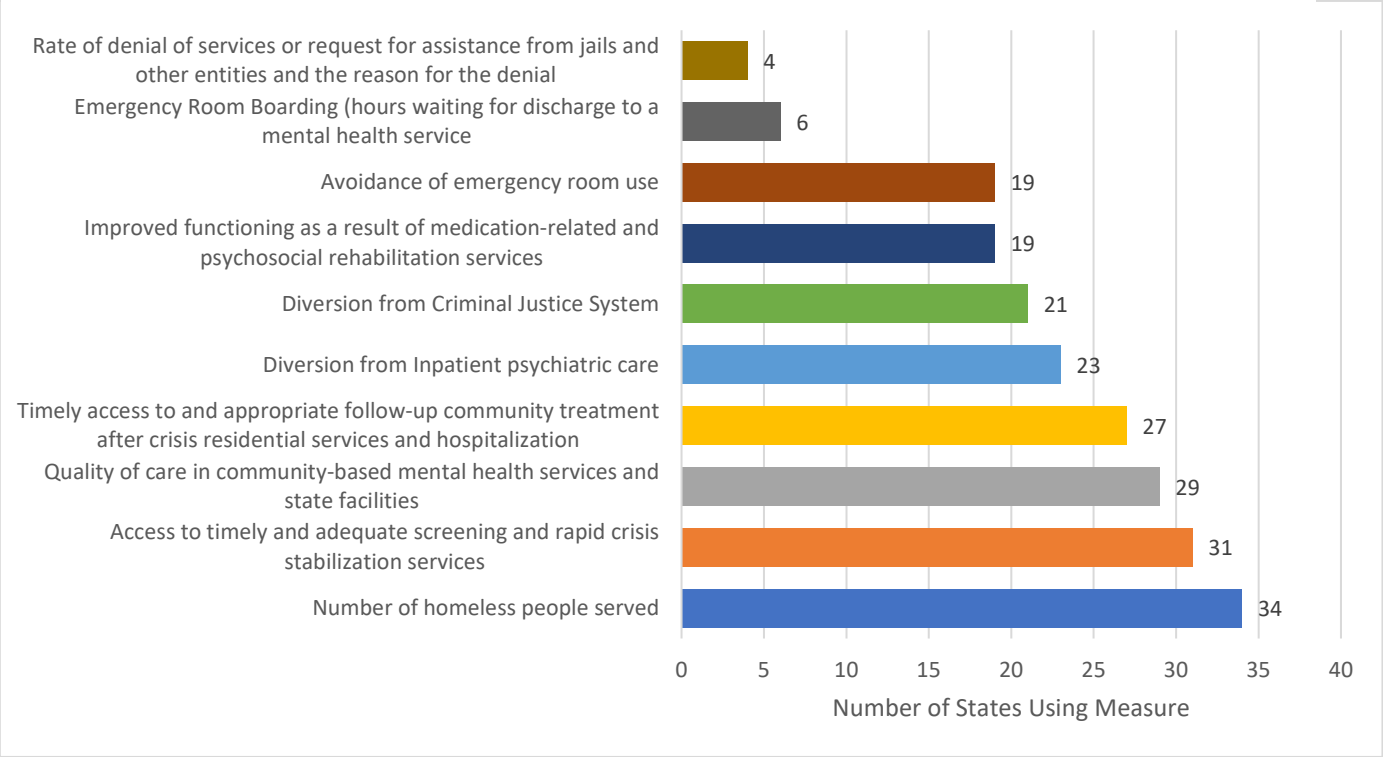
Table 2: States with Pay for Performance Initiatives and State Contact Persons

State	Information about State Pay for Performance	State Contact for information about Pay for Performance System
Arizona	The MCOs are the recipient of the pay for performance program. However, they also have the discretion to utilize similar metrics with contracted providers.	Margaret.Hackler@azahcccs.gov
Delaware	Incentive payments if clients and organization meet certain metrics, no justice involvement, no inappropriate hospitalization, adherence to recovery plan, etc.	Jessica.Crumbacker@delaware.gov
Kentucky	CMHCs - % crisis follow-ups within 30 days; in-reach contacts for referrals from personal care homes within 14 days; readmission rates to psychiatric hospitals; rates of SMI & SED peer support services; rates of children with SED receiving targeted case management; 7 services per TEDS episode lasting more than 30 days; % of outpatient SUD treatment services lasting more than 30 days; % of reported prevention activities meeting CSAP Strategy; accurate reporting/crisis reporting for IDD populations Facility Operators - seclusion rates; restraint rates; readmission rates; staffing levels; staff injury reduction; documentation of multiple anti-psychotic use; active treatment rates in ICFs; transitions from ICFs to community.	stephanie.craycraft@ky.gov jenniferc.moore@ky.gov
Maine	Currently the measure is annual screening of people who are prescribed atypical antipsychotic medications for prediabetes or diabetes.	Jessica.benson-yang@maine.gov
Minnesota	CCBHC Measures	lisa.l.blacker@state.mn.us
Missouri	CCBHC required measures for the CCBHC Demonstration are completed annually. These include suicide risk assessment measures for adult and youth, follow-up from hospitalization for adult and youth, Antipsychotic medication adherence, and engagement in substance use treatment.	Jason.Jones@dmh.mo.gov, Director of Research and Statistics.
Oklahoma	Outpatient Crisis Service Follow-up within 8 Days; Inpatient/Crisis Unit Follow-up within 7 Days; Reduction in Drug Use; Engagement in Treatment; Medication Visit within 14 Days of Admission; Access to Treatment; Improvement in Interpersonal; Improvement in Medical/Physical; Improvement in Self Care/Basic Needs; Inpatient/Crisis Unit Readmission within 6 Months; Outpatient Peer Recovery Support Services; and Access to Treatment (Children).	Mark Reynolds, mark.reynolds@odmhsas.org
Vermont	Vermont's Value-Based Payment Measures include client satisfaction, clinical service delivery, and monthly service measures: https://mentalhealth.vermont.gov/sites/mentalhealth/files/doc_library/Appendix%20I%20-%20VBP%20Measures%20-%20DAs%20%28CY2023-FINAL%29.pdf	stephen.devoe@vermont.gov

Outcome Measures Used by SMHAs:

SMHAs are tracking a variety of measures about the impact of mental health services. Figure 2 below shows the number of states reporting they track specific measures.

Figure 2: Number of States Tracking Behavioral Health Outcome Measures



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