Standardizing Organizational-level Behavioral Health Workforce Data Collection through a Minimum Data Set

August 2017

Phillip M. Singer, MHSA; Angela J. Beck, PhD, MPH; Jessica Buche, MPH, MA

KEY FINDINGS

A Minimum Data Set (MDS) can be useful in standardizing data collection methods to focus on a set of common data elements essential to informing a research question. In 2016, an MDS was developed to collect data from behavioral health providers on: demographics, occupation and area of practice, education, licensure and certification, and practice settings and characteristics.

Some key characteristics about the workforce are best collected from organizations, rather than individual workers. In 2017, the Behavioral Health Workforce Research Center used a collaborative process with consortium partners and key informants to develop an MDS focused on workforce data collection from organizations that employ behavioral health providers. The organizational-level MDS is constructed with three main themes to collect data elements related to: organizational characteristics, workforce characteristics, and payment mechanisms for services.

Collecting complementary data from both providers and organizations provides a more complete picture of workforce size and composition to inform behavioral health workforce planning efforts. Future research efforts should focus on identifying publicly available data to populate the organizational-level MDS and developing methods for primary data collection to address data gaps. In addition, it is important to develop an implementation plan for a variety of stakeholders that facilitates integration of organizational-level MDS data elements into human resources data collection.

CONTENTS:

BACKGROUND

The behavioral health workforce faces several pressing challenges. One such challenge is the lack of valid, accessible data to adequately inform workforce projections and address supply concerns.[1] Workforce data is often collected through two mechanisms: at the individual level (i.e., directly from the workforce), or at the organizational level from the organizations that employ the workforce.[2] Individual-level data collection generally yields the most comprehensive data about a worker's background, including their education, training, licensure, and experience; however, this method of data collection also has limitations. First, the field lacks a consensus definition of who comprises the behavioral health workforce, making individual-level data collection inconsistent across studies, as inclusion criteria varies. Second, there is no central repository with worker contact information, making it challenging to identify and reach all workers engaged in behavioral health services.[3] State licensing boards and professional credentialing bodies often have contact information for licensees and credentialed professionals, but that information is diffuse, varied, and sometimes inaccessible to external parties. Further, there is no mechanism by which workers without a professional license or certification, who encompass a large and potentially growing segment of the behavioral health workforce, can be readily identified. Third, there are certain types of data that individual workers would not have access to or would not be able to generalize to a larger grouping of the profession. For example, data related to payment mechanisms and types of behavioral health services delivered by the workforce would not be efficiently collected at the individual level.

In 2016, the Behavioral Health Workforce Research Center developed a behavioral health workforce Minimum Data Set (MDS) that facilitates standardized data collection at the individual level.[4] The Center defines *behavioral health workforce* to include all workers involved in prevention or treatment of mental health and/or substance use disorders. This report summarizes the development of an organizational-level MDS (Organizational MDS) as a complementary data collection tool for the behavioral health workforce. The focus and type of organizations that participate in the provision of behavioral health services vary considerably. An organization may focus on mental health, substance use disorders, preventative programs, drug courts, or a combination of the former. Further, the type of organizations can include large health systems and academic medical centers, community-based health centers, and treatment centers. Data collected at the organizational level provide an improved perspective on aggregate workforce size and composition trends, which complements the granularity of data inherent at the individual level.

METHODS

To inform the development of the Organizational MDS, the research team first identified peer-reviewed and grey literature covering behavioral health and general health care human resources from an organizational perspective.[5-10] For example, the Decision Support 2000+ information system, among other resources, provided insight into the types of data elements to collect at the organizational level.[11] Additionally, members of the BHWRC partner Consortium provided feedback on the necessary data elements and themes of an Organizational MDS.

Once the Organizational MDS was fully drafted, subject matter experts external to the BHWRC provided feedback as part of a preliminary pilot test to inform further refinement. Representatives from two behavioral health organizations served as key informants and participated in one hour phone interviews. The Organizational MDS was provided to the informants prior to their interview. During the interviews, the key informants provided feedback on data elements, data themes, logic, terminology, and ways to improve the workforce data collection process.

MINIMUM DATA SET ELEMENTS

The full Organizational MDS is presented in the Appendix. Collectively, eleven data elements are grouped into three categorical themes: organizational characteristics, workforce characteristics, and payment mechanisms for services (Table 1).

Table 1. Summary of Organizational Minimum Data Set Themes and Elements for Behavioral Health Organizations

MDS Theme	Data Elements
Organizational Characteristics	▪ Organizational Location ▪ Primary Focus of Services ▪ Organizational Setting ▪ Organizational Integration ▪ Patient Populations Served
Workforce Characteristics	▪ Number of Employed and Contract Workers and FTEs ▪ Number of Behavioral Health Workers Who Separated from Organization ▪ Number of Retirements from Organization
Payment Mechanisms for Services	▪ Managed Care Arrangements Present in Organization ▪ Type of Payment Sources for Behavioral Health Services ▪ Payment Arrangements to Compensate Behavioral Health Services

KEY INFORMANT FEEDBACK

The qualitative work conducted in the process of developing this MDS yielded several important concepts related to workforce research. First, key informants stated that the Organizational MDS could help inform workforce data collection for a variety of different entities and emphasized the need for standardized data across government agencies, accrediting bodies, national organizations, and provider organizations. For example, key informants summarized how government data sources provide some information on the licensed professionals in mental health clinics such as psychiatrists, counselors, and social workers; however, a large portion of the workforce, including aides, technicians, and peer specialists are not licensed. Monitoring workforce supply and demand for these professions across organizations, states, and regions is difficult. Additionally, key informants reported that turnover is especially high for many non-licensed professionals, so a focus on retirement age and eligibility for this segment of the workforce may not be as useful, as these workers tend to leave jobs, and often the field, before retirement age. This adds to the importance of understanding the differential factors that impact staffing patterns and projections for the breadth of behavioral health occupations. Finally, key informants stressed the need for putting a system in place that reduces the burden on organizations to implement workforce data collection using an MDS.

CONCLUSIONS

The Organizational MDS is an important complement to the individual-level MDS; collectively, they provide the data elements needed to generate a full profile of the behavioral health workforce. Key informants and Consortium partners recognize the value of an MDS in ensuring standard data collection efforts across the varied types behavioral health provider organizations. Workforce data can be used to identify areas of maldistribution of behavioral health professions, make profession-specific projections for future need or professional shortages, and highlight professions that require additional recruitment and retention efforts.

The behavioral health workforce is expansive, which is beneficial in meeting the needs and providing services to a diverse patient population. However, this diversity presents challenges when it comes to standardizing methods for regular monitoring of the workforce. Adoption of an MDS is one strategy for addressing this limitation but requires resources to implement. The findings of this project indicate that the idea of instituting a consistent data collection mechanism is a viable one; future work will focus on an implementation strategy for utilizing MDS data elements in organizational human resources data collection to yield better data that will help to inform behavioral health workforce planning efforts and meet the care needs of those seeking behavioral health services.

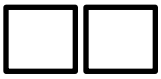
References

1. Hoge M, Morris J, Daniels A, Stuart G, Huey L, Adams N. An action plan for behavioral health workforce development. *Cincinnati, OH: Annapolis Coalition on the Behavioral Health Workforce.* 2007.
2. U.S. Department of Health and Human Services. Health Resources & Services Administration Data Warehouse. 2017; https://datawarehouse.hrsa.gov/. Accessed July 24, 2017.
3. Heisler EJ, Bagalman E. The mental health workforce: A primer. 2013.
4. Beck AJ, Singer PM, Buche J, et al. *A Minimum Data Set for the Behavioral Health Workforce.* 2016.
5. Stanhope V, Choy-Brown M, Barrenger S, et al. A comparison of how behavioral health organizations utilize training to prepare for health care reform. *Implementation Science.* 2017;12(1):19.
6. Nysenbaum JB, Bouchery E, Malsberger R. Availability and usability of behavioral health organization encounter data in MAX 2009. *Medicare & medicaid research review.* 2014;4(2).
7. Nysenbaum J, Morris E, DeSantis R, et al. ASSESSING THE USABILITY OF 2011 BEHAVIORAL HEALTH ORGANIZATION MEDICAID ENCOUNTER DATA. 2016.
8. Zayas LE, McMillen JC, Lee MY, Books SJ. Challenges to quality assurance and improvement efforts in behavioral health organizations: A qualitative assessment. *Administration and Policy in Mental Health and Mental Health Services Research.* 2013;40(3):190-198.
9. Lauriks S, de Wit MA, Buster MC, Arah OA, Klazinga NS. Composing a core set of performance indicators for public mental health care: A modified Delphi procedure. *Administration and Policy in Mental Health and Mental Health Services Research.* 2014;41(5):625-635.
10. Teich JL, Melek SP. Characteristics of managed behavioral health care organizations in 1996. *Psychiatric Services.* 2000;51(11):1422-1427.
11. Henderson MJ, Minden SL, Manderscheid RW. *Decision Support 2000+.* Rockville, Maryland: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration;n.d.

APPENDIX: ORGANIZATIONAL MINIMUM DATA SET

Organizational Characteristics

1. In what state is your organization located?



2. What is the ZIP code of your office location? (If your organization has several office locations, please report the zip code of the main office.)

3. Which of the following is the primary focus of your organization's prevention and/or treatment services? (Select all that apply.)

   - Mental health
   - Substance use disorder
   - Recovery oriented systems of care/peer center
   - Corrections
   - Drug court
   - Mental health court
   - Veterans court
   - Re-entry programs
   - Jail diversion (Pre-adjudication programs)
   - Preventative program
   - Primary care
   - Oral health
   - Other (please specify) _____

4. Which of the following settings best describes your organization?
   - Health Care Facility (Inpatient) (e.g. Hospital, Hospice, Long-Term Care Facility Substance Use Disorder)
   - Health Care Facility (Outpatient) (e.g. Community Health Center, Primary or Specialist Medical Practice, Independent Group Practice, Independent Solo Practice)

- Educational Setting (e.g. College/University Counseling/Health Center, School-based Mental Health Center)
- Business/Private Sector (Business/Industry, Employee Assistance Program/Company, Professional/Trade Association)
- Substance Use Disorder Treatment Center (e.g. Substance Use/Addiction Treatment Center, Methadone Clinic, Detox Facility, Recovery Support Services)
- Government Agency (e.g. Veterans Facility, Child Welfare Agency, Social Service Agency, Public Assistance Agency, Correctional/Criminal Justice Facility (adult or juvenile), Public Health Department, Drug Court)
- Managed Care Organization (Domestic or International)
- Licensed Mental Health Center
- Community-based Mental Health Centers
- Other (please specify) _____

5. **Which of the following best describes the level of primary care-behavioral healthcare integration supported by your organization?**
   - **Minimal collaboration**: mental health and other healthcare providers work in separate facilities, have separate systems, and rarely communicate about cases.
   - **Basic collaboration at a distance**: providers have separate systems at separate sites, but engage in periodic communication about shared patients, mostly through telephone and letters. Providers view each other as resources.
   - **Basic collaboration onsite:** mental health and other healthcare professionals have separate systems, but share facilities. Proximity supports at least occasional face-to-face meetings and communication improves and is more regular.
   - **Close collaboration in a partly integrated system:** mental health and other healthcare providers share the same sites and have some systems in common such as scheduling or charting. There are regular face-to-face interactions among primary care and behavioral health providers, coordinated treatment plans for difficult patients, and a basic understanding of each other's roles and cultures.
   - **Close collaboration in a fully integrated system:** mental health and other healthcare professions share the same sites, vision, and systems. All providers are on the same team and have developed an in-depth understanding of each other's roles and areas of expertise.
   -
6. **Which of the following client/patient population(s) does your organization serve? (Select all that apply.)**
   - American Indian or Alaskan Native
   - Asian or Asian American
   - Black or African American
   - Native Hawaiian or Other Pacific Islander
   - White
   - Hispanic/Latino/a
   - Children (under 13 years)
   - Adolescents (13-17 years)
   - Adults (18-64 years)

- Older Adults (over 64 years)
- Homeless
- Rural
- Suburban
- Urban
- Native American Reservation
- Working Poor/Unemployed
- Suicidal
- Other (please specify) _____

Workforce Characteristics

7. **How many of the following workers did your organization employ or contract to provide mental health or addiction services as of December 31, 2016?**

   Please report total number of workers and Full-time Equivalent workers (FTEs) for each occupation. FTE refers to the ratio of the number of paid hours in a period by the number of working hours in that period, as defined by your organization. [A full-time employee is counted as 1.00 FTE; an employee who works part time at 50% of the normal work hours for the position would be counted as a 0.50 FTE.] Please round your answer to the nearest 0.50 FTE. The FTE total should be less than or equal to the total number of workers.

Occupation	Employed Workers (non-contract)		Contract Workers	
	Number of Workers	Number of FTEs	Number of Workers	Number of FTEs
Aide/Technician				
Behavioral Health Specialist				
Case Manager				
Community Health Worker				
Licensed Counselor				
Forensic Mental Health/Forensic Services Worker				
Health Navigator				
Marriage and Family Therapist				
Nurse				
Peer Support Worker/Recovery Specialist				
Physician				
Physician Assistant				
Psychologist				
Psychiatric Pharmacist				
Psychiatric Rehabilitation Practitioner				
Social Worker				
Sociologist				

Other occupation, please specify_____				
TOTAL				

8. **During calendar year 2016, how many behavioral health workers separated (voluntarily or involuntarily) from your organization?**

Occupation	Number of Workers
Aide/Technician	
Behavioral Health Specialist	
Case Manager	
Community Health Worker	
Licensed Counselor	
Forensic Mental Health/Forensic Services Worker	
Health Navigator	
Marriage and Family Therapist	
Nurse	
Peer Support Worker/Recovery Specialist	
Physician	
Physician Assistant	
Psychologist	
Psychiatric Pharmacist	
Psychiatric Rehabilitation Practitioner	
Social Worker	
Sociologist	
Other occupation, please specify_____	
TOTAL	

9. **How many of the behavioral health workers who separated from your organization during calendar year 2016 did so due to retirement?**

_____

Payment Mechanisms for Services

10. **Which of the following managed care arrangements are present in your organization? (Select all that apply.)**
    - Salaried staff member of an HMO which is responsible for both general and behavioral health care
    - Salaried staff member of an HMO responsible solely for behavioral health care
    - Member of a group practice that is a contracted network provider to an HMO
    - Member of a group practice that is a contracted network provider to a behavioral health care firm
    - Independent practitioner who is a contracted network provider to an HMO
    - Independent practitioner who is a contracted network provider to a behavioral health care firm
    - The organization does not have any involvement in a managed care arrangement

11. **What kinds of payment source(s) are used for direct provision of behavioral health services in your organization? (Select all that apply.)**
    - CHAMPUS (Civilian Health and Medical Provider of the United States)
    - Medicaid HMO
    - Medicaid Waiver Program
    - Medicaid – another managed care arrangement
    - Medicare HMO
    - Medicare PPO
    - Other Federal funding
    - State, county, or city funds
    - Private fee-for-service/individual's insurance plan
    - Preferred provider private insurance plan
    - HMO, private insurance plan (not Medicare or Medicaid HMO)
    - Consumer's on funds (out-of-pocket dollars from client of family)
    - TriCare
    - Veterans Affairs Contractor
    - Other _____

12. **What payment arrangement(s) are used to compensate your behavioral health services at your organization? (Select all that apply.)**
    - Fee for service (i.e., a bill is submitted for each service provided)
    - Fee for service with a withholding (i.e., a portion of the fee is withheld and paid only at the end of the year based on some type of performance criteria)
    - Fixed rate per case (i.e., a set amount of dollars for each consumer treated without regard to intensity or length of treatment; services are not reimbursed separately)

- Capitation payment (i.e., a payment based on the population of consumers for whom you or your organization has agreed to provide services if services are needed)
- Consumer self-pay
- Salary
- Unpaid or no funding source
- Other (please specify) _____