

Treatment Episode Data Set (TEDS)

SUPPORTING STATEMENT

A. JUSTIFICATION

1. Circumstances of Information Collection

The Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Behavioral Health Statistics and Quality (CBHSQ) is requesting OMB approval for a revision to the Treatment Episode Data Set (TEDS) collection of client-level data submitted by states, the District of Columbia and the U.S. Territories (states) in the Treatment Episode Data Set (TEDS) as follows:

- 1) To continue collection of the existing (substance abuse) TEDS. TEDS is comprised of client-level substance abuse treatment data and was previously cleared as the TEDS data collection (OMB No. 0930-0335), which expires January 31, 2016.
- 2) To continue the collection of, and increase the number of states (currently six states in a pilot test) submitting client-level mental health treatment data to the Mental Health Treatment Episode Data Set (MH-TEDS) admissions and update/discharge data set as described in Attachment A1. The pilot study of MH-TEDS has been performed under the current TEDS clearance (OMB No. 0930-0335).
- 3) To begin/transfer the collection of Mental Health Client Level Data (MH-CLD), also described in Attachment A1 (transferred from OMB No. 0930-0168). Collection of MH-CLD data was previously approved as part of the Community Mental Health Services Block Grant (MHBG) and Substance Abuse and Prevention Treatment Block Grant (SABG) Application Guidance and Instructions (OMB No. 0930-0168), which expires June 30, 2018. (States may choose to submit to either MH-TEDS or MH-CLD data sets.)

TEDS and MH-TEDS/CLD are two of five components of the Behavioral Health Services Information System (BHSIS). The BHSIS data collections, including TEDS and MH-TEDS/CLD, are conducted under the authority of Section 505 of the Public Health Service Act (42 U.S.C. 290aa-4) and Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C. 300x-52(a)) to meet the specific mandates for annual information about public and private substance abuse and mental health treatment providers and the clients they serve.

Most of the BHSIS collections involve facility-level data systems, including the Inventory of Behavioral Health Services (I-BHS), which is an inventory of substance abuse and mental health treatment facilities, the National Survey of Substance Abuse Treatment Services (N-SSATS, OMB No. 0930-0106), and the National Mental Health Services Survey (N-MHSS, OMB No. 0930-0119). The N-SSATS and NMHSS are census surveys of treatment facilities. In contrast,

TEDS and MH-TEDS/CLD are client-level data systems that collect admission and update/discharge records from state substance abuse and state mental health agencies. Therefore, SAMHSA is requesting OMB approval for the combined TEDS and MH-TEDS/CLD client-level data collections.

The current (substance abuse) TEDS evolved from the Client Oriented Data Acquisition Process (CODAP), originally approved by OMB in 1975 (OMB No. 0930-0004), which was in operation from 1975 through 1981. When the Alcohol, Drug Abuse, and Mental Health Services Block Grant Program was implemented in 1981, CODAP was discontinued. It was reestablished in the late 1980s as the Client Data System (CDS), and was renamed the TEDS in 1995. TEDS is designed as a two-part, linkable system of admission and discharge records. The existing admissions portion of TEDS consists of a core of 19 demographic and substance abuse treatment variables and 17 supplemental items, and is based on information routinely collected by states from the facilities they fund.

In 2009, SAMHSA's Center for Mental Health Services (CMHS) tested the feasibility of collecting client-level data from the State Mental Health Authorities (SMHA). In 2010, the Center for Mental Health Services (CMHS) within SAMHSA announced new Data Infrastructure Grants (DIGs) that required states to submit client-level data by 2013. The DIGs were a vehicle through which states and territories received financial and technical assistance from SAMHSA to assist in their capacity-building effort to meet the Block Grant reporting requirements. This data initiative became MH-CLD and was under the MHBG and SABG Application Guidance and Instructions approval OMB No. 0930-0168).

The general framework for the MH-CLD collection involves a compilation of demographic, clinical, and outcome data of persons served by the SMHA within a 12-month period. States may choose Calendar Year or the State Fiscal Year, which differs from state to state, as a reporting period. Persons served is defined as all enrolled clients who received mental health and support services, including screening, assessment, crisis services, and telemedicine from programs provided or funded by the SMHA during the reporting period. Two data sets are submitted each reporting period: Basic Client Information (BCI) due December 1st of each year and State Hospital Readmissions (SHR) due March 1st of the following year. The MH-CLD consists of a core of 4 demographic variables, 10 clinical and treatment variables, 5 outcome variables, and 10 supplemental variables and is also based on information routinely collected by states from the facilities they fund. No personally identifiable information is collected.

During the same timeframe, as part of SAMHSA's initiative on Data, Outcomes and Quality, methods in which substance abuse (SA) and mental health (MH) data systems could be better integrated were explored. The primary objective was to collect policy-relevant data for decision

making while reducing the reporting burden for the states. As part of this effort, in mid-2010, under the BHSIS contract, contractors in collaboration with SAMHSA's CMHS and Center for Behavioral Health Statistics and Quality (CBHSQ) conducted a pilot study to examine the feasibility of states submitting client-level MH data through SAMHSA's Treatment Episode Data Set (TEDS). This data initiative became MH-TEDS.

TEDS is a compilation of demographic, substance abuse, mental health, clinical, legal, and socioeconomic characteristics of persons who are receiving publicly-funded substance abuse and/or mental health services. In some states, this may also include persons receiving privately-funded substance abuse services captured in state reporting. State administrative data systems, claims data, and encounter data are the primary data sources. Variables for MH-TEDS are the same as for TEDS (substance abuse) although substance abuse specific variables are not used for mental health clients.

States are given the option of reporting to either of the MH-CLD or MH-TEDS systems. Both systems feed into, and pre-populate, the Uniform Reporting System (URL) tables required for SABG and MHBG applications.

States are under a contractual arrangement with SAMHSA that provides each state with an average of \$75,000 per year for substance abuse TEDS activities (the exact amount is determined by a formula that takes into account the population of each state) and \$137,362.64 and \$61,813.17 per year for states and territories, respectively, for MH-TEDS/CLD activities. The states use that money, in part, to convert their client-level data to the TEDS and MH-TEDS/CLD formats and to send the data to SAMHSA. For instances in which the data elements cannot be cross-walked into the TEDS and MH-TEDS/CLD response categories, there is an "other" coding option to allow for differences between state variables and SAMHSA variables. Data elements for TEDS/MH-TEDS are listed in Attachment A1 including several data elements used to calculate performance measures for the Substance Abuse Prevention and Treatment (SABG) Block Grant or for the Community Mental Health Services Block Grant (MHBG). Data elements for MH-CLD are also listed in Attachment A1.

TEDS and MH-TEDS/CLD include admissions to all drug abuse, alcoholism, and mental health treatment facilities in the United States, the District of Columbia, and the territories that receive public funds through the state substance abuse and mental health agencies or are monitored for administrative purposes through those agencies. MH-TEDS/CLD also includes usage of various mental health recovery services. Because TEDS and MH-TEDS are compilations of data from the state administrative systems, the scope of facilities included in TEDS and MH-TEDS/CLD are affected by differences in state licensure and accreditation practices and disbursement of public funds. For example, some state substance abuse and/or mental health agencies regulate

private facilities and individual practitioners, while others do not. In some states, hospital-based substance abuse and mental health treatment facilities are not licensed through the state substance abuse and/or mental health agencies. In general, facilities reporting TEDS and/or MH-TEDS/CLD data receive state alcohol, drug, and/or mental health agency funds (including Federal Block Grant funds) for the provision of alcohol and/or drug treatment and/or mental health services. Thus TEDS and MH-TEDS/CLD does not include all admissions to substance abuse treatment and mental health treatment services but comprises a significant proportion of admissions. Most states are able to report all admissions to all eligible facilities, although some report only substance abuse admissions financed by public funds. Eligible mental health facilities report all admissions to their facilities regardless of funding source. States may report data from facilities that do not receive public funds, but generally do not because of the difficulty in obtaining data from these facilities. TEDS and MH-TEDS/CLD generally do not include data on facilities operated by Federal agencies, including the Bureau of Prisons, the Department of Defense, and the Veterans Administration. However, some facilities operated by the Indian Health Service are included.

Since TEDS is a secondary data system compiled from data collected by states for their own purposes, there are a number of reporting differences among states for substance abuse clients. The state definitions of reporting eligibility and state data system reporting characteristics for the TEDS data elements are shown in the table included in Attachment A2. MH-TEDS/CLD is also a secondary data system compiled from data collected by states for their own purposes. All states report on demographic characteristics, clinical characteristics, and outcomes of persons served by the SMHA within a 12-month window. These persons served include all enrolled clients who received mental health and support services, including screening, assessment, crisis services, and telemedicine from programs operated or funded by the SMHA during the reporting period.

2. Purpose and Use of Information

Major products and uses of the TEDS and MH-TEDS/CLD data are highlighted below:

TEDS provides client-level data on drug use patterns among admissions to treatment, including primary drug of abuse, age at first use, mode of administration, and frequency of use, which are useful in tracking changing patterns of drug use and treatment need. Client discharge data in TEDS has allowed the analysis of treatment length of stay and treatment completion, potentially important factors in treatment outcome studies.

MH-TEDS/CLD provides client-level data on mental health admissions to and continuation in treatment, including demographic, socioeconomic, legal, clinical, and outcome data of persons

served by the State Mental Health Authorities (SMHAs) within a 12-month window. Persons served include all enrolled clients who received mental health and support services, including screening, assessment, crisis services, and telemedicine from programs provided or funded by the SMHAs during the reporting period. Data collected, using either MH-TEDS or MH-CLD has allowed analysis of continuation of treatment and changes in status, also potentially important factors in treatment studies.

Treatment performance measurement - The data elements in TEDS and MH-TEDS/CLD allow SAMHSA to analyze change in several outcomes measures. Change in status or behavior in aggregate, as measured by the National Outcome Measures (NOMs), either for substance abuse or for mental health, can be used to assess states' progress in documenting the outcomes of substance abuse treatment and/or mental health treatment services interventions.

The availability of consistent, state-level, cross-year data allows SAMHSA to assess the impact of programs and changes over time, and permits states to assess their progress in improving quality as well as develop benchmarks for planning purposes. This information can, in turn, be used by State Project Officers to identify states where improvements are being made, and states where assistance may be needed to improve client outcomes between admission, update, and discharge. Technical assistance resources can then be targeted to those areas where improvements are needed, and states that have used effective intervention strategies can be tapped to share their processes and expertise with other states.

Relief of burden on states - TEDS provides the data to pre-fill the SABG application performance measurement forms (Tables 16-22) previously completed by states. Attachment A3 provides the SABG application Tables 16 – 22. Similarly, MH-TEDS/CLD provides the data to pre-fill the Uniform Reporting System (URS) Tables (OMB No. 0930-0168) which are part of the state's Implementation Report used in the MHBG application process (Tables 2A and 2B, Table 3, Table 4, Table 14, Tables 15 and 15a, Tables 19A and 19B, Tables 20A and 20B). In addition to these tables, MH-TEDS can also populate URS Tables 5A and 5B; these two tables cannot be populated using MH-CLD. Attachment A4 provides an example of these URS tables used in the MBGH process.

The TEDS annual report and public use data files are used by states to compare their experience with the rest of the country. It is anticipated that an MH-TEDS/CLD annual report and public use data files will be produced when the data are sufficient to provide national statistics. The annual reports and public use files are/will be used by policy makers and researchers for analysis of drug use patterns and other trends in the treatment system and mental health patterns and trends. TEDS public use files are available for analysis on the interactive SAMHDA website (<http://datafiles.samhsa.gov>).

MH-TEDS/CLD data are presented in annual webinars to the states in conjunction with the URS reporting. Additional webinars/presentations are presented to SAMHSA project officers and leaders. These data are/will be used by states, policy makers, researchers, and project officers for the analysis of mental health patterns and trends in the treatment services system.

The data from the MH-TEDS/CLD populate the URS tables, a requirement for the MHBG. These tables are used in the MHBG application process. These tables are posted to the SAMHSA website and are used by SMHAs to compare their experience with the rest of the country. These data are also used by policy makers and researchers for analysis of NOMs and other characteristics of clients within the state mental health systems and their associated trends.

Users of BHSIS data include Congress, Federal agencies, and offices such as the Office of National Drug Control Policy (ONDCP), SAMHSA's Center for Substance Abuse Treatment (CSAT) Block Grant administrators, SAMHSA's Center for Mental Health Services (CMHS) Block Grant administrators, state legislatures and agencies, local communities, organizations(e.g., the National Association of State Alcohol and Drug Abuse Directors (NASADAD), National Association of State Mental Health Program Directors (NASMHPD)), and researchers.

Planned Changes:

No changes are planned for the substance abuse TEDS data collection. There are no changes in the variables collected for MH-TEDS/CLD. The only changes includes transfer of the MH-CLD collection, previously collected through the Data Infrastructure Grants (DIGs) in support of the MHBG (OMB No. 0930-0168) and the implementation of MH-TEDS beyond the pilot stage.

3. Use of Information Technology

All TEDS and MH-TEDS/CLD data are submitted electronically. An on-line submission system allows the states to run automated edit checks prior to final submission. TEDS and MH-TEDS/CLD processing results and data quality feedback reports are returned to the states electronically. It is anticipated that further enhancements will be made to decrease burden to the states by making data submission requirements more flexible and enhancing error reporting and correction capabilities.

Increased use of Information Technology (IT) is being made to enhance quality control and improve feedback to the states.

4. Efforts to Identify Duplication

Consultation with states and other federal agencies involved in the development of TEDS and MH-TEDS/CLD confirms that no other federal agency or private organization collects client admission or discharge data on a national level.

5. Involvement of Small Entities

The TEDS and MH-TEDS/CLD components of the BHSIS imposes no extra burden on small businesses. States, for their own administrative purposes, require reporting of client treatment information from substance abuse and mental health treatment facilities. States extract the TEDS and MH-TEDS/CLD data from these existing state data systems and forward them to SAMHSA.

6. Consequences if Information Collected Less Frequently

Legislation requires that information provided by BHSIS be collected each year. If collection of TEDS and MH-TEDS/CLD data were discontinued or conducted less frequently, valuable up-to-date information on substance abuse and mental health treatment utilization and client characteristics would not be available on a timely basis for the range of BHSIS users.

7. Consistency with the Guidelines in 5 CFR 1320.5(d)(2)

The data systems fully comply with the guidelines in 5 CFR 1320.5(d)(2).

8. Consultation Outside the Agency

A Federal Register Notice published on August 11, 2015 (80 FR 48116) solicited comments on TEDS, MH-TEDS/CLD. One comment (with SAMHSA's response) was received from New York State and is included as Attachment 8.

SAMHSA also consults outside the agency through periodic meetings with state substance abuse data representatives, the State Mental Health Authorities, and other organizations.

Contact with the state.

Over the past three years, SAMHSA held a series of interactive webinars and conference calls with state and territory data representatives to seek their advice on data reporting issues and explain procedural changes from a DIG (grant) reporting system to the MH-TEDS/CLD (contract) reporting system. Three webinars of specific interest were 1) Launching the

Behavioral Health Treatment Data System, a series of regional webinars during the week of November 14, 2013, attended by a total of 163 participants from all of the states and territories; 2) De-duplication of Client Records on April 13, 2015, attended by 65 participants from 38 states and territories; and 3) 2014 Mental Health Data Collection Results, on June 15, 2015, attended by 89 participants from 41 states and territories. (The participants at the November 2013, April 2015, and June, 2015, webinars are listed in Attachments A5, A6, and A7, respectively.)

Also, in the day-to-day operations of the contract, the BHSIS contractor is in frequent communication with the states, receiving considerable feedback on the details of the state data systems and how potential changes in TEDS and MH-TEDS/CLD would impact their systems. SAMHSA makes efforts to accommodate state suggestions, taking into account the multiple state data systems that must crosswalk their data elements into TEDS and MH-TEDS/CLD.

In addition, the Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation (ASPE) has reviewed this OMB request.

9. Payment to Respondents

State substance abuse and mental health agencies receive monetary support through on-going BHSIS state agreements.

10. Assurance of Confidentiality

Client-level data: Client-level data are submitted to TEDS and MH-TEDS/CLD by the states. When submitted by the states, MH-CLD data are de-identified; therefore, there are no confidentiality concerns for MH-CLD data. For TEDS and MH-TEDS, the responsibility for assigning facility and client identifiers resides with the individual states. Client identifiers consist of unique numbers within facilities, and, increasingly, unique numbers within state behavioral health data systems. Records received into TEDS and MH-TEDS/CLD are stored in secured computer facilities, where computer data access is limited through the use of key words known only to authorized personnel. In preparing TEDS and MH-TEDS/CLD public use files, a contractor conducts a disclosure analysis of the data. Client and facility identifiers are removed, certain variables are recoded, and cells are collapsed or otherwise masked as needed to ensure that individuals cannot be identified.

[Note: The privacy of individually identifiable information contained in patient records at specialized substance abuse facilities receiving any form of federal assistance is protected by 42 CFR Part 2 (OMB No. 0930-0092)]. The term "federal assistance" is broadly defined to include federal tax exempt status, Medicare certification, and federal financial assistance in any form,

ensuring applicability to virtually all state-supported facilities reporting TEDS data to their state agency. The regulations stipulate the conditions under which records may be disclosed for research purposes and the security procedures that must be followed to protect the records.

The privacy of MH patient records is not protected under the 42 CFR, Part 2. There is no equivalent law that protects MH patient records except HIPAA, state laws, and related federal laws. However, under the BHSIS Agreements with the individual states (Section C, No.1), the following statement is included: “The client-level mental health data will be afforded the same level of confidentiality protections as substance abuse data in accordance to 42 CFR, Part 2.”

TEDS and MH-TEDS/CLD data system: The contractor-maintained DASIS/BHSIS data systems, including TEDS and MH-TEDS/CLD, underwent Security and Authorization procedures conducted by SAMHSA’s Office of Management, Technology and Operations/Division of Technology Management (OMTO/DTM) in July 2011. The SAMHSA IT Clearance Officer stated:

“After a careful review of the document submitted by Synectics I found that the Submission of the *IT Security Plan Document*: [a] is reasonable, [b] responds to SAMHSA/CBHSQ’s IT Requirements, [c] adequately meets all SAMHSA and Federal Security Plan Requirements of the Project [i.e. The plan accurately addresses the security requirements for an overall Low Level Rated System], and [d] it is acceptable to the Division of Technology Management (DTM).”

The contractor-maintained BHSIS data systems, including TEDS and MH-TEDS/CLD are currently undergoing an update of these Security and Authorization procedures. Additionally, the first of two Disaster Recovery/COOP/Contingency Plan tests was completed on January 17, 2015. Based on the findings of the first contingency test, a second test was conducted on May 9, 2015. The findings of the second test indicated that all IT systems were adequately backed up by fully operational redundant systems.

11. Questions of a Sensitive Nature

None of the BHSIS components involves asking questions directly of clients. Information on a client’s substance abuse and mental health history, which is of a sensitive and personal nature, is collected in the normal course of admission to a treatment facility. Client-level information is then sent to the state. Information about individual client admissions is periodically extracted from these state records and sent to SAMHSA for addition to the TEDS and MH-TEDS/CLD files.

12. Estimates of Annualized Hour Burden

The total estimated annual burden on the states for activities associated with TEDS and MH-TEDS/CLD is: 59 respondents, 723 responses, and 5,898 hours.

The estimated annual burden for the separate TEDS activities is as follows:

Type of Activity	Number of Respondents (States/Jurisdictions)	Responses per Respondent	Total Responses	Hours per Response	Total Burden Hours	Wage Rate	Total Hour Cost
TEDS Admission Data	52	4	208	6.25	1,300	\$40	\$52,000
TEDS Discharge Data	52	4	208	8.25	1,716	\$40	\$68,640
TEDS Crosswalks	5	1	5	10	50	\$40	\$2,000
MH-CLD BCI Data	30	1	30	30	900	\$40	\$36,000
MH-CLD SHR Data	30	1	30	5	150	\$40	\$6,000
MH-TEDS Admissions Data	29	4	116	6.25	725	\$40	\$29,000
MH-TEDS Update/ Discharge Data	29	4	116	8.25	957	\$40	\$38,280
MH-TEDS Crosswalks	10	1	10	10	100	\$40	\$4,000
State Total	59		723		5,898		\$253,920

Basis for Burden Hour Estimates:

TEDS and MH-TEDS/CLD admission and discharge data: TEDS and MH-TEDS/CLD do not impose any burden on facilities because the information that facilities provide to states is sought by states for their own administrative purposes.

For TEDS, the minimum data set merely serves to standardize items, categories, and definitions across states. The 52 states and jurisdictions are estimated to spend 6.25 hours each compiling and checking the admissions data and submitting it to SAMHSA an average of 4 times per year (on a schedule determined by each state.) Fifty states, the District of Columbia, and Puerto Rico are expected to submit TEDS admissions data, for a total burden of 1,300 hours. Similarly, the states are expected to spend an average of 8.25 hours each compiling and checking the discharge data and submitting it to SAMHSA an average of four times per year. Fifty States, the District of Columbia, and Puerto Rico are expected to submit discharge data, for a total burden of 1,716 hours per year.

States may choose to submit data to either the MH-CLD or the MH-TEDS system. While the majority of states currently submit data to MH-CLD, it is expected that states will gradually transition to submitting data to MH-TEDS.

Averaged over three years, it is estimated that 30 states, jurisdictions, or territories will submit to MH-CLD. It is estimated that they will spend 30 hours each compiling, de-identifying, and checking the Basic Client Information (BCI) admissions/update/discharge data one time per year for submission by December 1, for a total burden of 900 hours per year. Similarly, 30 states are expected to spend an average of 5 hours each compiling, de-identifying, and checking the State Hospital Readmission (SHR) data each year for a total burden of 150 hours per year.

For MH-TEDS, 29 states, jurisdictions, or territories are estimated to spend 6.25 hours each compiling and checking the admissions data and submitting it to SAMHSA an average of 4 times per year (on a schedule determined by each state) for a total burden of 725 hours. Similarly, states are expected to spend an average of 8.25 hours each compiling and checking the update/discharge data and submitting it to SAMHSA an average of four times per year for a total burden of 957 hours.

TEDS and MH-TEDS/CLD Crosswalks: States provide a crosswalk, documenting state data definitions and their translations into the appropriate TEDS and MH-TEDS/CLD data items. Updates are submitted only when there is a change to report. An average of 5 states are expected to submit new TEDS crosswalks each year and 10 states are expected to submit new MH-TEDS/CLD crosswalks each year as they revise their data systems, for a total burden of 150 hours per year.

Basis for Hour Costs:

Based on information gained in discussions with the states, and using adjustments for inflation, it is estimated that salaries for the state staff responsible for handling submission of TEDS and MH-TEDS/CLD admission and discharge data and maintenance of the crosswalks will average \$40 per hour.

13. Estimates of Annualized Cost Burden to Respondents

There are no capital or start-up costs associated with TEDS and MH-TEDS/CLD, and maintenance and operational costs imposed by TEDS and MH-TEDS/CLD are minimal.

14. Estimates of Annualized Cost Burden to the Government

(a) BHSIS Contract: The annualized cost to the Government for the TEDS and MH-TEDS/CLD component of the BHSIS contract, excluding payments made to the states under the state agreements (see A14.b), is estimated to be \$3.2 million, which includes:

- management of all aspects of TEDS and MH-TEDS/CLD, from working with states to develop crosswalks to receipt and checking of TEDS and MH-TEDS/CLD data, providing feedback to the states, and compilation of the data into a master file;
- management of the integrated computer systems that maintain the TEDS and MH-TEDS/CLD components of BHSIS including the TEDS and MH-TEDS/CLD data collection and editing process, and other data administrative functions, such as data security; and
- preparation of annual data reports, analytic files, public use files, NOMS performance management files, webinars, and web-only data tables.

(b) State agreements: The costs for contracts with states for their preparation and submission of the TEDS and MH-TEDS/CLD data to SAMHSA are approximately \$11.4 million annually. For TEDS, each state receives \$27,000 plus an additional amount based on the state population for an average of \$75,000 per year for each state. For MH-TEDS/CLD, each state receives \$137,362.64 and each territory receives \$61,813.17 per year. This is expected to remain unchanged for the next three years.

(c) Monitoring: The cost for monitoring the TEDS and MH-TEDS/CLD component of the BHSIS contract and carrying out related work includes salaries and travel to meetings for 2 FTEs, for a total of approximately \$304,000.

Total annualized cost to the government is \$14.9 million.

15. Changes in Burden

Currently there are 3,066 total burden hours for TEDS. SAMHSA is requesting 5,898 total burden hours. There are no changes in burden for the substance abuse TEDS portion of the collection (3,066 hours). The increase of 2,832 hours is due to a program change of the following: 1) transferring 1,050 hours from the MH- CLD portion of the collection from the block grant application procedures (OMB No. 0930-0168), and 2) the addition of MH-TEDS

resulting from an increase in the number of states reporting to MH-TEDS above the pilot phase with a burden of 1,782 hours.

16. Time Schedule, Publication and Analysis Plans

a. Time Schedule

The annual cycle of activities is as follows:

<u>TEDS and MH-TEDS/CLD Tasks *</u>	<u>Completion Date</u>
Compilation of TEDS data	Ongoing
Publication of national admission report for 2014 data year	January 2016
Public use admission data file for 2014 data year	January 2016
Pre-populated Block Grant Tables for 2014 data year	February 2016
MH-CLD SHR data submission	March 2016
Publication of state admission report for 2014 data year	May 2016
Publication of discharge report for 2014 data year	May 2016
Public use discharge data file for 2014 data year	May 2016
Freeze the 2014 file for 2015 reports	October 2016
MH-CLD BCI data submission	December 2016

*TEDS and MH-TEDS/CLD activities for subsequent years will be on a similar schedule.

b. Analyses and Publications

The TEDS and MH-TEDS/CLD data will be disseminated in the following manner:

- **TEDS National Report** -- TEDS admissions data are included in an annual report that provides information on persons in substance abuse treatment for each of the major drug categories by age, race, and sex, and includes detailed cross tabulations on persons in treatment. The report is available in hard copy and on the SAMHSA website.
- **TEDS State Report** -- TEDS admissions data are compiled into an annual report that provides detailed treatment statistics for each of 52 reporting states and jurisdictions. The report is available in hard copy and on the SAMHSA website.
- **TEDS Discharge Report** -- TEDS data for linked admissions and discharges are compiled into an annual report that highlights treatment statistics on length of stay in treatment and completion of treatment for each major type of care and for the major client demographic categories within each type of care. The report is available in hard copy and on the SAMHSA website.

- **TEDS State Summary Tables** -- State Summary Tables for each state, including one for each year since 1992 through the most recent complete year, are available on the SAMHSA website.
- **Mental Health Client Level Data Reports** – MH-TEDS/CLD data (admissions/update/discharge) will be compiled into an annual report that provides treatment statistics nationally and for the reporting states and jurisdictions.
- **MHBG Application Tables** – NOMS data from MH-TEDS/CLD are pre-populated in the MHBG URS Tables 2A, 2B, 3,4,14, 15, 15a, 19A, 19B, 20A, 20B. Data from MH-TEDS is also used to populate Tables 5A and 5B.
- **SABG Application Tables** -- NOMS data from TEDS are pre-populated in the SABG application performance measurement Tables 16-22.
- **State TEDS Quarterly Feedback Reports** -- Each state receives a quarterly report containing TEDS data tables for that state, along with technical notes about the data.
- **Public Release Data Files** -- Public release data files of TEDS data are available for downloading and on-line analysis at the Substance Abuse and Mental Health Data Archive (SAMHDA) website, (www.datafiles.samhsa.gov). It is expected that public use files for MH-TEDS/CLD data will be available when data are sufficient for national estimates.
- **Uniform Reporting System (URS)** tables are posted to the web (www.samhsa.gov/data).
- **Annual webinars** to states, project officers, and SAMHSA leaders concerning reporting and data are available on the BHSIS Resource Center.
- **Other reports** -- Selected data from TEDS and MH-TEDS/CLD are included in other statistical compilations, including, for example, *Healthy People*, the *National Healthcare Quality and Disparities Reports*, and the *National Drug Control Strategy*. In addition, analytic reports presenting TEDS and MH-TEDS/CLD data are/will be included in a SAMHSA weekly short-report statistical publication series. About 12 - 15 TEDS reports have been published annually since the series began in 2001. They are available on the SAMHSA website.

In the TEDS annual reports, SAMHSA describes the limitations of TEDS in terms of differences in state reporting by publishing the table included in Attachment 2, which provides the key characteristics of state data collection systems and their TEDS reporting practices. The table includes state-by-state coverage of various facility and client types in the state reporting. The accompanying descriptions in the reports indicate that the scope of facilities included in TEDS is

affected by differences in state licensure, certification, and accreditation practices, and disbursement of public funds. Similarly the reports describe the client reporting practices and indicate that about 60 percent of states reported data on all admissions to all eligible facilities, although some reported only, or largely, admissions financed by public funds. Other differences in state practices covered in the description are the mix of services offered by the states, which can have an effect on overall state admission rates. Also, the publications describe SAMHSA and state processes for reviewing the data.

While reporting of MH-TEDS/CLD data has been primarily through webinars, information similar to that provided in the TEDS reports including coverage and state data collection differences are included. Differences in state practices are covered in the descriptions on data. Differences between MH-TEDS and MH-CLD are described; currently, tables from the two systems are reported separately to avoid comparing data that, while similar, have different bases.

17. Display of Expiration Date

All TEDS and MH-TEDS/CLD data collections materials will display the OMB number and expiration date.

18. Exceptions to Certification Statement

There are no exceptions to the certification statement. The certifications are included in this submission.

B. COLLECTIONS OF INFORMATION EMPLOYING STATISTICAL METHODS

No statistical methods are employed in this data collection.

LIST OF ATTACHMENTS

Attachment A1	TEDS and MH-TEDS/CLD Admission and Update/Discharge Data Elements
Attachment A2	Table of TEDS Reporting Practices by State
Attachment A3	SABG Application Tables 16 – 22
Attachment A4	MHBG Application URS Tables 2A, 2B, 3, 4, 5A, 5B, 14, 15, 15a, 19A, 19B, 20A, 20B
Attachment A5	Participant Lists for November 2013, Launching the Behavioral Health Treatment Data System webinar series
Attachment A6	Participant List for April 2015, De-duplication of Client Records webinar
Attachment A7	Participant List for June 2015, 2014 Mental Health Data Collection Results
Attachment A8	Comment from Federal Register 60-day Notice