

The Substance Abuse and Mental Health Services Administration (SAMHSA)

Treatment Episode Data Set (TEDS)

Supporting Statement A - Justification

Check off which applies:

- New
- Revision
- Reinstatement with Change
- Reinstatement without Change
- Extension
- Emergency
- Existing

1. Circumstances of Information Collection

The Center for Behavioral Health Statistics and Quality (CBHSQ) at the Substance Abuse and Mental Health Services Administration (SAMHSA) is requesting OMB approval for an extension with changes to the combined Treatment Episode Data Set (TEDS) data collections (OMB No. 0930-0335 and expires on December 31, 2024), submitted by states, the District of Columbia, and the U.S. Territories (hereinafter “States”):

- TEDS collects episode-level data on clients aged 12 and older receiving substance use treatment services from publicly funded facilities.
- Mental Health Client Level Data (MH-CLD) collects demographic, clinical, and National Outcome Measures (NOMs) data on clients receiving mental health and support services funded or operated by the State Mental Health Agencies (SMHAs).
- Mental Health Treatment Episode Data Set (MH-TEDS) is an alternative reporting method to MH-CLD. It collects episode-level data on all clients receiving mental health treatment services from publicly funded facilities. MH-TEDS data can be converted to MH-CLD format.

Under Section 505 of the Public Health Service Act (42 U.S.C. §290aa-4), CBHSQ is authorized to collect annual data on “the national incidence and prevalence of the various forms of mental illness and substance abuse.” CBHSQ is also authorized to collect data on the number and variety of public and nonprofit private mental health and substance use treatment programs and the number and demographic characteristics of individuals receiving treatment through such programs.

States, receiving fundings from SAMHSA’s Community Mental Health Services Block Grant (MHBG) and Substance Use Prevention, Treatment, and Recovery Services Block Grant

(SUPTRS BG),¹ utilize MH-CLD/MH-TEDS and TEDS data to meet the block grant reporting mandate and requirement, where:

- Section 1935(b)(3) of the Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C §300x-35(b)(3)) requires a State that receives a new grant, contract, or cooperative agreement, for the purposes of improving the data collection, analysis and reporting capabilities of the State, as a condition of receipt of funds, to collect, analyze, and report to the Secretary for each fiscal year subsequent to receiving such funds a core data set to be determined by the Secretary in conjunction with the States. Subsection (a) and subsection (b) authorize appropriations and allocations for technical assistance, national data case, data collection and program evaluation. TEDS assists SUPTRS BG for technical assistance, data collection, and program evaluation. “Data collection” is defined in this section as those activities that carry out the provisions of Section 505 of the Public Health Service Act, as well as data infrastructure development.
- Section 1942(a) of the Title XIX, Part B, Subpart III of the Public Health Service Act Public Health Service Act (42 U.S.C. § 300x-52(a)) requires the State, involved in a funding agreement for a grant, to submit a report containing information of the purposes for which the grant received by the State for the preceding fiscal year under the program involved were expended and a description of the activities of the State under the program.
- Section 1943(a) of the Title XIX, Part B, Subpart III of the Public Health Service Act Public Health Service Act (42 U.S.C. §300x-53(a)) requires the State, involved in a funding agreement for a grant, to annually provide for independent peer review to assess the quality, appropriateness, and efficacy of treatment services provided in the State to individuals under the program involved.
- Community MH Services BG and SAPT BG Application Guidance and Instructions FY 2024-2025 (OMB No. 0930-0168) requires states to identify the unmet service needs and critical gaps within the current system. The state’s priorities and goals must be supported by data-driven processes, including data that is available through a number of different sources such as SAMHSA’s TEDS. As part of the SUPTRS BG, states are also required to prepare and submit an annual report comprising of performance indicator tables to show progress made over time as measured by SAMHSA’s NOMS for substance use (SU) prevention, SUD treatment, and SUD recovery. SAMHSA collects and requires data annually from grantee SMHAs through the Uniform Reporting System (URS), MH-CLD, and MH-TEDS as part of the MHBG Implementation Report.

2. Purpose and Use of Information

Introduction and Background:

¹ Formally known as the Substance Abuse Prevention and Treatment Block Grant (SABG) and also known as the Substance Abuse Prevention and Treatment (SAPT) Block Grant Program.

National-level data collection on admissions to substance use treatment was first mandated in 1972 under the Drug Abuse Office and Treatment Act, P.L. 92-255. The Client-Oriented Data Acquisition Process (CODAP), developed to collect admission and discharge data directly from federally funded drug treatment programs, was in operation through 1981 (OMB No. 0930-0004). CODAP was discontinued when the Alcohol, Drug Abuse, and Mental Health Services (ADMS) Block Grant Program was introduced in 1981. In 1988, the Comprehensive Alcohol Abuse, Drug Abuse, and Mental Health Amendments (P.L. 100-690) established a revised Substance Abuse Prevention and Treatment (SAPT) Block Grant and mandated federal data collection on clients receiving treatment for either alcohol or drug use. TEDS began in 1989 with the issue of three-year development grants to states.

In 2010, 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 build their capacity to meet the MHBG reporting requirements. This data initiative became MH-CLD.

During the same timeframe, as part of SAMHSA's initiative on Data, Outcomes and Quality, methods in which substance use and mental health 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, CMHS and CBHSQ collaboratively conducted a pilot study to examine the feasibility of states submitting client-level mental health data through TEDS. This data initiative became MH-TEDS. States may choose to use either MH-TEDS or MH-CLD as their reporting method.

Purpose of Information:

- TEDS and MH-TEDS Admission and Discharge/Update Data Elements (Attachment A)

TEDS and MH-TEDS provides episode-level data on clients receiving substance use treatment services from publicly-funded facilities and those receiving mental health and support services from facilities funded or operated by SMHAs, respectively. The TEDS system comprises two major components: TEDS-A (admissions) and TEDS-D (discharges/updates).

TEDS and MH-TEDS admission and discharge/update record include System Data Set, Minimum Data Set (MDS), Supplemental Data Set (SuDS), Discharge Data Set (DIS), and Mental Health Data Sets (i.e., Mental Health Admissions [MHA] and Mental Health Updates/Discharges [MHD]). MDS include demographic, substance use, and treatment characteristics. Each state is required to submit data for all MDS fields. Substance use

data in the MDS fields are optional for mental health. SuDS include psycho-socioeconomic characteristics or additional detail for MDS data fields. Except for those fields designated as NOMs, reporting of SuDS data fields is optional for both mental health and substance use. However, states are encouraged to report all SuDS fields available in the state data system.

- MH-CLD Basic Client Information (BCI) and State Hospital Readmissions (SHR) Data Elements (Attachment C)

MH-CLD provides demographic, clinical, treatment, and NOMs data of clients receiving mental health treatment and support services through SMHAs during a 12-month reporting period. Two data sets are submitted each reporting period: BCI data is due around December 1st of each year and SHR data is due around March 1st of the following year. 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 URS tables required for MHBG annual reporting.

- TEDS, MH-CLD, and MH-TEDS State Data Crosswalk and State Reporting Characteristics (hereinafter “Crosswalk”) (Attachment B and Attachment D)

SAMHSA recognizes that some state field definitions and/or categories may not exactly match those in TEDS and MH-CLD/MH-TEDS. The State Data Crosswalk contains specific information on mapping or translating the data elements, codes, and categories in the state system to the appropriate TEDS and MH-CLD/MH-TEDS data elements, codes, and categories. When state field definitions and/or categories cannot be mapped, this should be also documented in the State Data Crosswalk. This document also captures the contextual explanation on the state’s data characteristics, deviations, recent data changes, and anticipated changes in policy and data collection protocol that will affect future data reporting. States shall review the Crosswalk annually and submit a modified State Data Crosswalk if there are changes in the state data collection protocol and/or data system.

SAMHSA acknowledges that there are a number of reporting differences among states. While most Single State Authorities (SSAs) require facilities that receive state/public funding for providing alcohol and/or drug treatment services to report data to the SSAs, 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 client reporting practices also vary among states, where some states reported data on all admissions to all eligible facilities, and some reported only, or largely, admissions financed by public funds. Information similar to that provided in the TEDS State

Reporting Characteristics is proposed to be collected for MH-TEDS/MH-CLD. In the Crosswalk, states shall list and report annually on the state TEDS and MH-CLD reporting characteristics, framework, and scope, such as definitions of reporting eligibility, applicable facility/program types and which facilities and clients are included or excluded in the state's TEDS and MH-CLD/MH-TEDS reporting (see example in Attachment 1 and Attachment D).

Use of Information:

- Treatment performance measurement

SAMHSA uses the information provided in the Crosswalk to establish a consistent conversion of state data to the TEDS and MH-CLD/MH-TEDS database, to maximize comparability across states, and to produce standard national data. In addition, the State Crosswalk aids SAMHSA and other stakeholders (such as researchers) in the interpretation of individual state TEDS data.

The availability of consistent, state-level, and cross-year data allows SAMHSA to assess the impact of programs and changes over time, and to permit states to assess their progress in improving quality as well as develop benchmarks for planning purposes. SAMHSA and program Project Officers can use the information to identify states where improvements are being made and states where assistance may be needed to improve client outcomes. 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

SUPTRS BG (OMB No. 0930-0168) requires each state to assess and identify the unmet service needs and critical gaps in the state's current behavioral health systems during the planning process. States use data collected through TEDS to report aggregate number of admissions and discharges in substance use disorder treatment in their state (Plan Table 3). SAMHSA may use TEDS data to pre-fill the required SUPTRS BG Treatment Performance Measures (Tables 14-20) in the states' annual reports, which had previously been completed by states (Attachment 2).

Similarly, MH-CLD/MH-TEDS provides the data to pre-fill the URS Tables, which are part of the state's Implementation Report used in the MHBG reporting process (URS Tables 2A, 2B, 2C, 2D, 3, 4, 4A, 5A, 5B, 14A, 14B, 14C, 15, 20A, 20B) (Attachment 3).

- Publicly available information

The TEDS and MH-CLD annual report and public use data files are publicly available to behavioral health service providers; researchers; the public; and federal, state, and local governments, where information is used for analysis of substance use/mental health patterns and other trends in the treatment system (see Section 16 for details). MH-CLD/MH-TEDS data are presented in annual webinars to the states in conjunction with the URS reporting. Additional webinars and presentations are presented to SAMHSA project officers and leaders. Other users include Congress, Federal agencies, and offices such as the Office of National Drug Control Policy (ONDCP), SAMHSA’s Block Grant administrators, state legislatures and agencies, local communities, and organizations.

Proposed Revisions:

- Proposed changes to TEDS/MH-TEDS

- Add a combined TEDS/MH-TEDS State Crosswalk to map the data elements, codes, and categories in the state system to the appropriate TEDS/MH-TEDS data elements, codes, and categories; to obtain contextual information, including state data collection protocol and reporting capabilities and data footnotes; and to collect information on the state TEDS/MH-TEDS reporting characteristics, framework, and scope.
- Add Fentanyl and Xylazine in the list of Detailed Drug Code to improve the comprehensiveness and greater details of the substance recorded.
- Remove the term “Crack” from the existing option of “Cocaine/Crack” under the “Substance Use” data field.
- Revise existing “Gender” data field to “Sex” and add “Sexual Orientation” and “Gender Identity” (SOGI) as optional reporting data fields to provide inclusive measures. These revisions align with both SAMHSA’s efforts in enhancing behavioral health equities among diverse populations and the latest OMB approved BG Reporting requirement (OMB No. 0930-0168). All SUPTRS BG tables which collect/report SOGI orientation information have been updated and OMB approved.
- Revise terms with negative connotations to non-stigmatizing terms. Examples include changing the word “abuse” to “use,” “detoxification” to “withdrawal management,” and “Medication-Assisted Opioid Therapy” to “Medications for Opioid Use Disorder.” These revisions align with the current edition of The Diagnostic and Statistical Manual of Mental Disorders (5th ed., American Psychiatric Association, 2013), and the White House Office of National Drug Control Policy 2017 Memo on “Changing Federal Terminology regarding Substance Use and Substance Use Disorders.”

- o Original “TEDS and MH-TEDS/MH-CLD Admission and Update/Discharge Data Elements” form with combined TEDS/MH-TEDS and MH-CLD data elements is separated into two documents to be more user friendly and improve clarity. Data elements are reorganized in the order of the code number to facilitate clearer mapping. Other minor modifications are made to enhance language consistency and clarity. For example, all “SABG” are updated to “SUPTRS BG.”
- Proposed changes to MH-CLD
 - o Add the MH-CLD State Crosswalk to map the data elements, codes, and categories in the state system to the appropriate MH-CLD data elements, codes, and categories; to obtain contextual information, including state data collection protocol and reporting capabilities, and data footnotes; and to collect information the state MH-CLD reporting characteristics, framework, and scope.
 - o Revise existing “Gender” data field to “Sex” and add SOGI as optional reporting data fields to provide inclusive measures. These revisions align with both SAMHSA’s efforts in enhancing behavioral health equities among diverse populations and the latest OMB approved BG Reporting requirement (OMB No. 0930-0168). All MHBG tables and related URS tables which collect/report SOGI information have been updated and OMB approved.
 - o Add a new “School attendance status at admission or start of the reporting period” as a required data field to assess the changes and outcomes of clients receiving mental health treatment and support services through SMHAs.
 - o Add optional reporting tables for Type of Funding Support, Mental Health Block Grant-Funded Services, and Veteran Status.
 - o Replace existing data elements “Substance Use Problem” and “Substance Abuse Diagnosis” with non-stigmatizing terms of “Substance Use Disorder” and “Substance Use Diagnosis” to help reduce stigma and support treatment for substance use disorders. These revisions align with the current edition of The Diagnostic and Statistical Manual of Mental Disorders (5th ed., American Psychiatric Association, 2013), where “abuse” has been replaced by “use.” These revisions also align with the White House Office of National Drug Control Policy 2017 Memo on “Changing Federal Terminology regarding Substance Use and Substance Use Disorders.”
 - o Data Elements are reorganized in the order of the code number to facilitate clearer mapping. Make minor modifications to MH-CLD data elements to enhance language consistency and clarity.

3. Use of Information Technology

All TEDS and MH-CLD/MH-TEDS data are submitted electronically. The Data Submission System (DSS) allows the states to run automated edit checks prior to final submission. TEDS

and MH-CLD/MH-TEDS processing results and data quality feedback reports are returned to the states electronically. It is anticipated that further enhancements will be made to enhance error reporting to facilitate the improvement of state data quality.

Increased use of Information Technology (IT) is being made to enhance quality control and improve feedback to the states. States receive quarterly feedback reports and data quality profiles with all data discrepancies or issues. States are required to review, provide feedback, and/or resolve data inconsistencies.

4. Efforts to Identify Duplication

Consultation with states and other federal agencies involved in the development of TEDS and MH-CLD/MH-TEDS 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-CLD/MH-TEDS are components of the Behavioral Health Services Information System (BHSIS) impose no extra burden on small businesses. States, for their own administrative purposes, require reporting of client treatment information from substance use treatment facilities and mental health and support service facilities. States extract the TEDS and MH-CLD/MH-TEDS data from these existing state data systems and submit 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-CLD/MH-TEDS data were discontinued or conducted less frequently, valuable up-to-date information on substance use 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)

SAMHSA is requesting an exemption and additional time for TEDS and MH-TEDS/MH-CLD to implement modifications to the race and ethnicity data classification, required by the revised Statistical Policy Directive No. 15: Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity (SPD 15) effective on March 28, 2024.

In the “Revisions to OMB's Statistical Policy Directive No. 15” Federal Register Notice (FRN) published on March 29, 2024 (89 FR 22182), OMB acknowledges that, *“certain programs that involve interconnected data across multiple agencies or offices, or that rely on data collected and provided by non-Federal entities, may take longer to implement than programs like statistical surveys,”* and *“agencies may use the detailed categories employed by the U.S. Census Bureau's most recently fielded American Community Survey.”*

States utilize the data collected under this information collection (IC) request to meet SAMHSA’s block grants reporting mandate and requirement. There is a need to align the race and ethnicity data classification with the OMB approved Combined Block Grant Application (OMB No. 0930-0168), managed by SAMHSA’s CMHS and Center for Substance Abuse Treatment (CSAT). Race and ethnicity data elements from TEDS/MH-TEDS and MH-CLD are used to calculate performance measures and to enable states to meet application and reporting requirement for the SUPTRS Block Grant and for the MHBG. BGs are proposing and anticipating the reporting of revised SPD 15 categories of race and ethnicity starting December 1, 2027, during the FY2028/2029 MHBG and SUPTRS BG Reports period.

Data collected under this information collection request are submitted by SSAs and SMHAs. It takes longer for non-federal entities (SSAs and SMHAs) to implement revisions related to race and ethnicity, considering SSAs and SMHAs often abstract and compile data from multiple state external and internal data sources. Adoption of the revised SPD 15 categories of race and ethnicity will require changes at the provider and the State systems levels. These changes can take between 18 to 24 months to implement due to the individual nature of the States’ subcontract agreements and the number of the State systems involved in gathering these data.

There is also a need to align the race and ethnicity data classification with the Census Bureau’s implementation schedule because Census Bureau data are used in the TEDS and MH-CLD key measurement and national outcome reporting. For example, TEDS reports client characteristics of substance use treatment admissions and discharges by race and by ethnicity. Rates per 100,000 populations are calculated using the U.S. Census Bureau Annual State Resident Population Estimates and the American Community Survey (ACS). Population estimates are adjusted to obtain estimated counts for race and ethnicity by applying the ACS distribution ratios for these subgroups to the Census totals reported. MH-CLD provides data on the race and ethnicity of clients receiving mental health and support services, and cross-tabulate demographic categories with NOMs such as employment and living situation. Clients with mental health diagnoses are presented as rates per 100,000 population, where ACS data is drawn for estimating by race and ethnicity. MH-CLD reporting applies U.S. and Puerto Rico Census population distribution ratios to ACS estimates to generate population estimates for children (ages 0 to 17) and adults (ages 18 and older). Census Bureau announced its final decision on November 5,

2024 that it would implement the updated standards in the 2027 data collection cycle. This means the first ACS 1-year estimates produced using the updated standards is planned for release in September 2028.

In considering the need to collaborate with non-Federal entities and to align with the Census Bureau for the MHBG and SUPTRS BG Reports, SAMHSA requests additional time to adopt revisions to the race and ethnicity data collection for TEDS/MH-TEDS and MH-CLD. SAMHSA would like to request adoption of these changes starting December 1, 2027, in alignment with timelines anticipated by the MHBG and SUPTRS BG – still well within the five-year adoption time frame set out by the Office of Management and Budget. In the interim, SAMHSA is working closely with states and their partners to provide the necessary guidance, technical assistance, and other resources to ensure successful adoption of SPD 15 as efficiently and effectively as possible.

8. Consultation Outside the Agency

In accordance with 5 CFR 1320.8(d), on October 11, 2024, a 60-day notice for public comment was published in the Federal Register (88 FR 82616). One comment was received.

SAMHSA also consults outside the agency through periodic webinars/meetings with SSA representatives, SMHA representatives, and other organizations.

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-CLD/MH-TEDS 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-CLD/MH-TEDS.

9. Explanation of Any Payment or Gift to Respondents

SSAs and SMHAs receive monetary support through on-going BHSIS state agreements (see Section 14 for more details).

10. Assurance of Confidentiality

Client data: Client-level data are submitted to TEDS and MH-CLD/MH-TEDS by the states. MH-CLD data are already de-identified when submitted by the states. 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 state behavioral health data systems. Records received into TEDS and MH-CLD/MH-TEDS are stored with the HHS Amazon Web Services (AWS) cloud environment. Data access is limited only to authorized personnel. In preparing TEDS and MH-CLD/MH-TEDS public use files, SAMHSA 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.

The privacy of individually identifiable information contained in patient records at specialized substance use 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 42 CFR Part 2 Final Rule announced in February 2024 includes the modification that permits disclosure of records without patient consent to public health authorities, provided that the records disclosed are de-identified according to the standards established in the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

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 A), the following statement is included: “The client-level mental health data will be afforded the same level of confidentiality protections as substance use data in accordance to 42 CFR, Part 2.”

TEDS and MH-CLD/MH-TEDS data systems: The contractor that maintains BHSIS data systems, including TEDS and MH-CLD/MH-TEDS, undergoes Security and Authorization procedures conducted by SAMHSA’s Office of Management, Technology and Operations/Division of Technology Management (OMTO/DTM) periodically. The most recently completed Security Authorization (Authorization to Operate [ATO]) for the BHSIS program, including TEDS and MH-CLD/MH-TEDS, was approved at the moderate level by SAMHSA’s Information Security on October 10, 2023. The latest security status reports for the system were submitted on August 30, 2024. The SAMHSA IT Clearance Officer stated: “The information system is authorized without any significant restrictions or limitations. This security authorization is my formal declaration that adequate security controls have been implemented in the information system and that a satisfactory level of security is present.”

11. Questions of a Sensitive Nature

TEDS, MH-TEDS and MH-CLD data collection does not involve asking questions directly of clients. Information on a client’s substance use 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 information is then sent to the state. Information about individual client admissions is periodically extracted from these state records and sent to SAMHSA.

12. Estimates of Annualized Hour Burden

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

Type of Activity	Number of Respondents	Responses per Respondent	Total Responses	Hours per Response	Total Burden Hours	Wage Rate	Total Hour Cost
TEDS Admission Data	52	4	208	55	11,440	\$30.28	\$346,403
TEDS Discharge/Update Data	52	4	208	55	11,440	\$30.28	\$346,403
TEDS State Data Crosswalk	52	1	52	12	624	\$53.21	\$33,203
MH-CLD BCI Data	35	1	35	105	3,675	\$30.28	\$111,279
MH-CLD SHR Data	34	1	34	35	1,190	\$30.28	\$36,033
MH-CLD State Data Crosswalk	35	1	35	24	840	\$53.21	\$44,696
MH-TEDS Admissions Data	19	4	76	55	4,180	\$30.28	\$126,570
MH-TEDS Discharge/Update Data	19	4	76	55	4,180	\$30.28	\$126,570
MH-TEDS State Data Crosswalk	19	1	19	40	760	\$53.21	\$40,440
State Total			6657		38,329		1,211,597

Basis for Burden Hour Estimates:

- TEDS (Admission Data, Discharge/Update Data, and State Data Crosswalk)

Based on the most recent inputs collected in April 2024 from nine states (with highest, median, and lowest total TEDS data file record count in 2022 data submission), the national average burden hour across states is estimated to be 55 hours for each quarterly

submission (a total annual burden of 11,440 hours) of TEDS admission data and TEDS discharge/update data files respectively. State quarterly data submission involves activities including, but not limited to, compiling data, abstracting data from state external and internal data source, running preliminary data report, communication with providers to clear data errors, cleaning data, running data report and validation, uploading and submitting data, data issue follow-up and corrections.

States are estimated to spend an average of 12 hours each, for a total annual burden of 624 hours, in responding to the annual TEDS Crosswalk. States conducted activities such as research, gathering, compiling, reviewing, updating, and verifying information requested in the Crosswalk.

- MH-CLD (BCI Data, SHR Data, and State Data Crosswalk)

States may choose to submit data to either the MH-CLD or the MH-TEDS system. Thirty-five states currently submit data to MH-CLD (one state reports BCI data only as they do not operate any state hospitals). Based on the most recent inputs collected in April 2024 from nine states (with highest, median, and lowest total MH-CLD data file record count in 2022 data submission), the national average burden hour across states is estimated to be 105 hours (a total annual burden of 3,675 hours) for the annual submission of MH-CLD BCI data submission and 35 hours (a total of 1,190 hours) for the annual MH-CLD SHR data submission respectively. State annual data submission involves activities including, but not limited to, extracting data from different data systems, compiling and cleaning data, reconciling client status updates, testing data, reviewing validation results from the CLD system and making revisions and corrections, maintaining and modifying code, and final data submission.

States are estimated to spend an average of 24 hours each, for a total annual burden of 840 hours, in responding to the annual MH-CLD Crosswalk. States conducted activities such as reviewing MH-CLD requirements, consulting with subject matter expert, communication with providers, data system vendors, and contracted partners, determining state changes to data collection, holding meetings for discussion, combining information, reviewing and editing crosswalk to record any changes in data collection.

- MH-TEDS (Admission Data, Discharge/Update Data, and State Data Crosswalk)

Based on the most recent inputs collected in April 2024 from six states (with highest, median, and lowest total MH-TEDS data file record count in 2022 data submission), the national average burden hour across states is estimated to be 55 hours (a total annual burden of 4,180 hours) for the quarterly submission of MH-TEDS admission data and

MH-TEDS discharge/update data files respectively. State quarterly data submission involves activities including, but not limited to, compiling data, data extraction from multiple data sources, communication with providers and/or program staff to correct data errors at source, data file preparation and cleaning, reviewing data for accuracy and data quality, testing data and correct errors before submission for processing, and final data submission.

States are estimated to spend an average of 40 hours each, for a total annual burden of 760 hours, in responding to the annual MH-TEDS Crosswalk. States conducted activities such as reviewing and developing the data set to comply with MH-TEDS format, reviewing and updating new service or service codes, including any changes and providing explanation or definition in the comment area of the Crosswalk.

Basis for Hour Costs Estimates:

Based on information provided by states in April 2024, state staff who are responsible for TEDS, MH-TEDS and MH-CLD data submission are usually data and health information analysts. Based on the latest data from the Bureau of Labor Statistics' *Occupational Outlook Handbook* (accessed May 1, 2024), the national median wage for this level is \$30.28 per hour, taking into consideration the wide variety of facility types and sizes. Staff responsible for developing, maintenance, and updating the crosswalks is generally mid- to senior-level staff, often the Medical and Health Services Managers, who earn a median hourly wage of \$53.21 per hour.

13. Estimates of Annualized Cost Burden to Respondents

There are no capital or start-up costs associated with TEDS and MH-CLD/MH-TEDS. Information that facilities provide to states is sought by states for their own administrative purposes. Maintenance and operational costs imposed by TEDS and MH-CLD/MH-TEDS are minimal.

14. Estimates of Annualized Cost Burden to the Government

Contract Cost:

(a) BHSIS Contract: The annualized cost to the Government for the TEDS and MH-CLD/MH-TEDS component of the BHSIS contract, excluding payments made to the states under the state sub-contracts (see A14.b), is estimated to be \$3.3 million, which includes:

- management of all aspects of TEDS and MH-CLD/MH-TEDS, including but not limited to working with states to develop crosswalks, receiving and validating TEDS and MH-CLD/MH-TEDS 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-CLD/MH-TEDS components of BHSIS including the TEDS and MH-CLD/MH-TEDS data collection process, and other data administrative functions, such as data security;
- preparation of annual data reports, analytic files, public use files, NOMS performance management files, webinars, and web-only data tables; and
- monitoring of the TEDS and MH-CLD/MH-TEDS component of the BHSIS contract and carrying out related work includes salaries and travel to meetings.

(b) State agreements: The costs for contracts with states for their preparation and submission of the TEDS and MH-CLD/MH-TEDS data to SAMHSA are approximately \$11.3 million annually.

SAMHSA Staff:

The cost for multiple federal staff's time spent on monitoring the contract, overseeing TEDS, MH-TEDS, and MH-CLD data collection and operation, conducting quality control of data files and reports, reviewing and drafting analytic reports, designing and implementing ad hoc analysis and assessment is estimated to be approximately \$823,000 annually. The cost estimate is based on proportionate annual rates of:

- one GS 12 staff (spending 20% of their time);
- four GS 13 staff (each spending 100% of their time);
- five GS 14 staff (four of which spending 20% and one spending 50% of their time); and
- one GS 15 staff (spending 25% of their time).

The 2024 mid-point grade level annual rates for GS 12 to GS 15 (Step 5) are \$112,425, \$133,692, \$157,982, and \$185,824 for SAMHSA headquarter federal staff in Maryland.

Total annualized cost to the government is \$15.4 million.

15. Changes in Burden

SAMHSA proposes a new annualized total burden of 38,329 hours to states, reflecting an increase of 32,431 hours from the prior estimate of 5,898 burden hours in 2021. Proposed change in the burden hours is due to the following:

TEDS data collection efforts

- SAMHSA increases and provides a more accurate estimate on the average burden hours per response for the TEDS Admission Data collection (increased from 6.25 hours to 55 hours per response), TEDS Discharge/Update Data collection (increased from 8.25 hours to 55 hours per response), and TEDS Crosswalks (increases from 10 hours to 12 hours per response), based on the latest inputs and feedback from states in April 2024. New estimates also reflect a more comprehensive list of activities that states conducted for the information collection (details in Section 12).
- Due to the proposed changes of TEDS data elements along with the newly added State Reporting Characteristics, states are expected to update their State Crosswalk. This leads to a total of 52 responses and submission of TEDS Crosswalk, compared to the prior estimate of 5 states submitting updated TEDS Crosswalk annually.
- Changes in the burden hour estimate for TEDS data collection account for a subtotal of 20,438 burden hours' increase from the 2021 estimates.

MH-CLD data collection efforts

- SAMHSA increases and provides a more accurate estimate on the average burden hours per response for the MH-CLD BCI Data collection (increased from 30 hours to 105 hours per response) and MH-CLD SHR Data collection (increased from 5 hours to 35 hours per response). MH-CLD Crosswalks burden hour estimates are newly added (24 hours per responses). All updated burden hour estimates are based on the latest inputs and feedback from states in April 2024. New estimates also reflect a more comprehensive list of activities that states conducted for the information collection (details in Section 12).
- The number of states that chose MH-CLD as their reporting method is also updated to 35 states from the prior 30 states (one state does not submit SHR data because this state does not have state hospitals), based on the most recent MH-CLD data submission for Reporting Year 2023.
- Changes in the burden hour estimate for MH-CLD data collection account for a subtotal of 4,655 burden hours' increase from the 2021 estimates.

MH-TEDS data collection efforts

- SAMHSA increases and provides a more accurate estimate on the average burden hours per response for the MH-TEDS Admission Data collection (increased from 6.25 hours to 55 hours per response), MH-TEDS Discharge/Update Data collection (increased from 8.25 hours to 55 hours per response), and TEDS Crosswalks (increases from 10 hours to 40 hours per response), based on the latest inputs and feedback from states in April 2024. New estimates also reflect a more comprehensive list of activities that states conducted for the information collection (details in Section 12).

- The number of states that chose MH-TEDS as their reporting method is also updated to 19 states from the prior 29 states, based on the most recent MH-TEDS data submission for Reporting Year 2023.
- Due to the proposed changes of MH-TEDS data elements along with the newly added State Reporting Characteristics, states are expected to update their State Crosswalk. This leads to a total of 19 responses and submission of MH-TEDS Crosswalk, compared to the prior estimate of 10 states submitting updated MH-TEDS Crosswalk annually.
- Changes in the burden hour estimate for TEDS data collection account for a subtotal of 7,338 burden hours’ increase from the 2021 estimates.

16. Time Schedule, Publication and Analysis Plans

a. Time Schedule

The annual cycle of activities is as follows:

<u>TEDS and MH-CLD/MH-TEDS Tasks*</u>	<u>Completion Date</u>
Compilation of TEDS data	Ongoing
TEDS Quick Statistics	Quarterly
TEDS State Quarterly Feedback Reports and Data Quality Profiles	Quarterly
SUPTRS BG Application Tables	Quarterly
MH-CLD BCI data submission	December
MH-CLD SHR data submission	March
Publication of the MH-CLD annual reports	May
Public use MH-CLD data files	May
URS Annual Webinar	June
Publication of TEDS annual reports	August
Public use TEDS data files	August
Publication of MH-CLD short reports	August
MH-CLD/MH-TEDS Annual Webinar	September
Freeze the TEDS file for annual report	October
Publication of TEDS short reports	November
MHBG Report Tables	November

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

b. Analyses and Publications

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

- **Compilation of TEDS data** – TEDS is a repository of national data on clients admitted to and discharged from substance use treatment programs. Each participating state reports a minimum set of data at monthly or quarterly intervals and may also report supplementary data items that are available.
- **TEDS Quick Statistics** – Quarterly updated admissions and discharges data on clients aged 12 years and older by primary substance use, sex, age, race, and ethnicity.
- **TEDS State Quarterly Feedback Reports** – Each state receives a quarterly report containing TEDS data tables for that state, along with technical notes about the data.
- **SUPTRS BG Application Tables** – NOMs data from TEDS are pre-populated in the SUPTRS application performance measurement tables (see details in Section 2 and Attachment 2). The report is available on the SAMHSA website, (<https://www.samhsa.gov/grants/block-grants/block-grant-application>).
- **MH-CLD BCI data submission** – The BCI is an unduplicated data file in which each record corresponds to one person who is assigned a unique client identifier and contains clients’ demographics, clinical attributes, and outcomes.
- **MH-CLD SHR data submission** – The SHR is a duplicated data file in which each record corresponds to the number of times a client was discharged from a state hospital within the 12-month reporting period.
- **Publication of MH-CLD Annual Reports** – MH-CLD annual report presents the total number of clients receiving mental health treatment services by demographics, NOMs and the top five mental health diagnoses for children (ages 0 - 17) and adults (18 and older) by geographical distribution. The report is available on the SAMHSA website, (<https://www.samhsa.gov/data/>).
- **Public Use MH-CLD data files** – Public release data files of MH-CLD data are available for downloading and online analysis at the Substance Abuse and Mental Health Data Archive (SAMHDA) website, (www.datafiles.samhsa.gov).
- **URS Annual Webinar** – States, project officers, and SAMHSA leaders are presented reporting period data.

- **Publication of TEDS Annual Reports** – TEDS annual report presents the total number of admissions to and discharges from substance use treatment services by demographics, NOMs, morbidity status, and the top six primary substances by geographic distribution. The report is available on the SAMHSA website, (<https://www.samhsa.gov/data/>).
- **Public Use TEDS data files** – Public release data files of TEDS data are available for downloading and online analysis at the SAMHDA website, (www.datafiles.samhsa.gov).
- **Publication of MH-CLD short reports** – Selected MH-CLD data are included in statistical compilations of short reports.
- **MH-CLD Annual webinars** – States, project officers, and SAMHSA leaders are presented reporting period data.
- **Freeze the TEDS file for annual report** – TEDS data is extracted, processed, and cleaned for the annual report.
- **Publication of TEDS short reports** – Selected TEDS data are included in statistical compilations of short reports.
- **MHBG Report Tables** – Data from MH-CLD/MH-TEDS are pre-populated in the MHBG URS performance measurement tables (see details in Section 2 and Attachment 3). The report is available on the SAMHSA website, (<https://www.samhsa.gov/data/data-we-collect/urs-uniform-reporting-system>).

In the TEDS annual report, SAMHSA describes the total number of admissions to and discharges from substance use treatment services in the reporting period by demographics, NOMs, morbidity status, and the top six primary substances by geographic distribution.

In the MH-CLD annual report, SAMHSA describes the total number of clients receiving mental health treatment services in the reporting period by demographics, NOMs and the top five mental health diagnoses for children (ages 0 - 17) and adults (18 and older) by geographical distribution.

17. Display of Expiration Date

All TEDS and MH-CLD/MH-TEDS 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 A	TEDS and MH-TEDS Data Elements
Attachment A1	TEDS and MH-TEDS Data Elements - Track Changes
Attachment B	TEDS and MH-TEDS State Crosswalk
Attachment C	MH-CLD Data Elements
Attachment C1	MH-CLD Data Elements - Track Changes
Attachment D	MH-CLD State Crosswalk

Supplement:

Attachment 1	TEDS State Reporting Characteristics
Attachment 2	SUPTRS Application Tables 14 - 20
Attachment 3	MHBG Report URS Tables