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Data Integration Workgroup
September 22, 2021 (9:00 am – 10:00 am)
Facilitators: Tim Marshall & Jeff Vanderploeg

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<u>Workgroup Goals:</u>
1. Review existing state plans and activities in cross-agency data integration
2. Broaden state agency participation in OPM P20Win initiative and/or related data integration initiatives
3. Identify key indicators and metrics of children's behavioral health system functioning across systems/payers
4. Make recommendations to Children's Behavioral Health Plan Implementation Advisory Board and the 12 state Department Commissioners for further follow-up and implementation

<u>Workgroup Meeting Cadence</u>
Monthly; up to 6 meetings

<u>Materials:</u>
1. Excel Spreadsheet: "Behavioral Health System Measures September 2021"
2. All current and past presentation materials are available on the workgroup website

<u>Meeting Objectives:</u>
1. Continue discussion of BH system indicators and metrics across systems/payers

<u>Agenda & Minutes</u>

1. **Welcome and Introductions (:02)**
   Jeff Vanderploeg welcomed the group to the 4th meeting in the Data Integration Workgroup, opened the meeting and reminded individuals that the meeting was being recorded.

2. **Overview of Meeting Agenda and Objectives (:03)**
   Tim Marshall overviewed what the workgroup had discussed over the past few meetings to provide context and set up for future meetings. He commented that the group is well into its third goal, and will soon look to prepare and develop a report. There are two more scheduled meetings, one each in October and November, and reviewing one or more drafts of a workgroup report is likely to be the primary activity. If the drafts need additional review, the group may schedule another meeting in December to complete its work.

3. **Data Elements for Monitoring Behavioral Health System Performance (:50)**
   Vanderploeg shared his screen to show the revised Behavioral Health System Measures Excel sheet. Vanderploeg explained how he has modified the Excel spreadsheet since the last meeting. The main changes involved: 1) reorganizing around the major categories/framework identified in the August meeting; 2) moving measures and metrics to fit under those categories, and; 3) highlighting "group endorsed" metrics in green and other metrics that were good fits (but not yet group-endorsed) in yellow. Framework/Categories include: need/prevalence/identification; access; quality; outcomes; workforce adequacy, and; costs. Additional context included examining all data from an equity lens, and incorporating the Area Deprivation Index (ADI) as appropriate. Finally, Vanderploeg noted that he had added the Youth Risk Behavioral Survey as another potential data source. He also noted that the current list of metrics was weak on ideas for measuring costs

   A participant noticed the CDCS (Contractor Data Collection System) was not listed although it had been discussed at the last meeting, so that source was added. From there, the group started with the identification, need, and prevalence measures. Marshall asked whether the Youth Risk Behavior Survey was in the wrong section, but Vanderploeg explained its placement under need and prevalence because the survey is administered to so many schools that it could approximate population level prevalence rates. The group noted that most measures and metrics, if administered to enough respondents, could do the same.

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A participant asked for further clarification around items are system-level rather than individual-level outcome metrics. The workgroup agreed on the importance of selecting items that have the potential to inform system-wide problems. Another participant suggested that some measures would be best reported by community-based providers, while others would be best reported by hospitals, and both should be incorporated.

Marshall asked that CHDI return to individual items that comprise the datasets mentioned (e.g., Youth Risk Behavior Survey, PIE, CSSD, others) to get more granular detail and information on specific items to be tracked. Another suggestion was made that the workgroup could recommend further support to DPH, who administers the YRBS, since they have historically struggled getting responses from a sufficient number of schools.

A participant asked that admission *and readmission rates* be included in the spreadsheet The group identified that some youth that frequently utilize the ED and inpatient hospitalization have high needs but do not always get the care they need. Vanderploeg noted that data development may be needed on this and other data suggestions, for any case in which there is not currently a systematic way to collect that data. Another participant suggested adding re-admission at 7 and 30 day post visit (ED and inpatient), which is a common HEDIS measure. Another participant suggested crafting a metric that could assess the extent to which youth "cycle" between different levels of care, but noted that it was unclear whether this was always indicative of appropriate or inappropriate quality or outcomes of care. Another participant suggested adding an item on rates of out-of-home placement, but noted that it would be important to note the reasons for out-of-home placement (which may require data development). Another suggestions was for including total inpatient days, as well as discharge delay from inpatient, which is currently tracked in Medicaid.

Metrics that approximate whether children are matched to the appropriate treatment was identified as a need. In addition, the group agreed that, in general, the development of measures and metrics for the behavioral health system should be oriented toward identifying gaps and "pain points" in the system that could inform system development efforts. As an example, the workgroup identified that children with intellectual and developmental disabilities are often underserved because there are insufficient services available to this population. Furthermore, the group identified that the system is set up to address episodic behavioral health needs, and tends to be less appropriate for youth with chronic, long-term needs.

Another participant suggested looking at the all-payers claims database (from the Office of Health Strategy) as a potential data source, if the group is interested in capturing the needs of all children regardless of insurance type. Participants indicated that understanding which services are and are not covered by various payers speaks to the adequacy of the service array. Insufficient and unaffordable (e.g., deductibles, co-pays) insurance coverage sometimes results in a service being provided because it is covered, not because it is most appropriate to the child's needs.

Finally, in terms of data collection logistics, it was noted that some of the smaller providers without EHRs or adequate technological capacities may not be able to participate in data collection relevant to monitoring the system, which is a challenge that needs to be overcome. Another participant suggested comparing data to national standards or benchmarks whenever possible, to determine where Connecticut stands.

These changes and other recommendations were reflected in the updated Excel spreadsheet that was being shared on screen during the meeting.

4. **Wrap Up and Next Steps (:05)**

Vanderploeg and Marshall asked that the group, between now and the October meeting, think about what is needed to wrap up this group. The group agreed that reviewing a draft report of proceedings and recommendations was an appropriate next step for the remaining two meetings. The group was reminded that

their recommendations would be passed forward to the Children's Behavioral Health Plan Implementation Advisory Board, and the 12 state agency commissioners named in relevant legislation.

There being no further business, the meeting was adjourned at 10:00 a.m. The next meeting dates are October 27 and November 17.

5. **Chat Box:**
   From Julianne from CJR to Everyone: 09:09 AM
   Contractor Data Collection System from JBCSSD
   Do ACES have a place here?

   From Cheri Brown to Everyone: 09:22 AM
   Are Chronic ED visitors tracked here? The discussion was a tad confusing for me to follow.

   From Alison Meyers to Everyone: 09:31 AM
   Bed tracking is a great addition, thank you

   From Julianne from CJR to Everyone: 09:31 AM
   agreed

   From Cheri Brown to Everyone: 09:34 AM
   It's not just prescribers, and hospital providers, in my opinion. It is home providers, properly trained and supported .
   And proper Respite Care.

   From Eva Kaufman to Everyone: 09:39 AM
   Commercial insurances can have prohibitively costly deductibles and co-pays - some families don't accept the recommended level of care due to concerns about large fee balances

   From Lauren Schempp to Everyone: 09:41 AM
   Agree with Eva. Private insurance also refuses to pay for a lot of children's behavioral health level of cares. They also have very restricted length of stays for other levels of care like PHP/IOP. It's a huge barrier.

   From Elisabeth Cannata to Everyone: 09:44 AM
   so in addition to "what was recommended - what was the reason for something else implemented...e.g. "insurance barrier, no opening, not available in that geographic location...

   From Alison Meyers to Everyone: 09:53 AM
   I have to drop off the call. Thank you for the great discussion. I agree that this data needs to point to the gaps in our BH system here in CT. Would it be possible for me to receive the updated spreadsheet prior to Friday morning for my review with our behavioral health leadership team?

   From Julianne from CJR to Everyone: 09:54 AM
   I believe the data is October 27?

   From Jeff Vanderploeg to Everyone: 09:56 AM
   Oct. 27 from 9-10am