Children's Behavioral Health Plan Implementation
Data Integration Workgroup Report

EXECUTIVE SUMMARY

In recognition of the existing and growing behavioral health needs of children in the state, as well as the opportunity to leverage federal funding, DCF identified a need for furthering the implementation of the state's Behavioral Health Plan for Children originally approved in 2014, and established multiple workgroups, including the Data Integration Workgroup (workgroup). The workgroup identified the following four goals: (1) review existing state plans and activities in cross-agency data integration; (2) broaden state agency participation in the Office of Policy and Management's (OPM's) P20 WIN initiative; (3) identify key indicators and metrics of behavioral health system performance; and (4) make recommendations to Children's Behavioral Health Plan Implementation Advisory Board and the 12 state Department Commissioners for further follow-up and implementation.

The workgroup reviewed current state initiatives, in particular the P20 WIN initiative, which facilitates secure sharing of cross-agency data to support research and analysis of long-term outcomes. Based upon lessons learned across initiatives and the workgroup members' own experience in the field, the workgroup developed the following five recommendations. Follow-up on the recommendations should be overseen by the Children's Behavioral Health Partnership Implementation Advisory Board through an implementation workgroup that utilizes a transparent process with time-bound deliverables and reporting requirements.

Recommendation 1: All twelve state agencies involved in children's behavioral health in the state will commit to supporting P20 WIN, and ensure that the children's behavioral health system direct data requests, and relevant cross-system data requests, through P20 WIN.

Recommendation 2: The P20 WIN initiative should be resourced adequately to enhance its capacity to address behavioral health system requests in a timely manner.

Recommendation 3: Adopt the recommended framework and system-level indicators, and create an implementation plan for using the indicators to evaluate system-level achievements, gaps and "pain points" in the children's behavioral health system.

Recommendation 4: Pilot a behavioral health-related P20 WIN request that includes identifying the highest-need and highest-utilizers of the children's behavioral health system to inform development of targeted interventions for this group.

Recommendation 5: Adopt and implement the following practices to improve data integration efforts, and ensure organizational leadership involvement in developing data sharing agreements:
   a. Improve consistency in data definitions, and in the platforms and tools used for data collection and analysis across the behavioral health system to support data integration and reduce burden on providers and families;
   b. Consistently collect demographic and socioeconomic data in the behavioral health system; disaggregate and report on access, quality, and outcomes of care; and systematically engage in quality improvement to address any disparities identified;
   c. Develop and utilize family-level indicators to more effectively track service delivery and outcomes across the behavioral health system.

I. Background

Connecticut's Behavioral Health Plan for Children was part of the legislative response to the Sandy Hook tragedy and was developed with extensive input from families, providers, state agencies, researchers, community members, and other stakeholders. It was approved by the state legislature in 2014 and has provided a blueprint to ensure that the state's behavioral health system and its services promote well-being and meet the mental, emotional, and behavioral health needs for all children in the state.

More recently, in recognition of the existing and growing behavioral health needs of children in the state, as well as the opportunity to better align with federal and state funding priorities, leverage federal COVID relief funds and additional Mental Health Block Grant monies, DCF identified the need for collaboration across stakeholders to *further* support implementation of goals and objectives of the Plan and provide recommendations to its Implementation Advisory Board. A set of Workgroups were established to support this work, including the Data Integration Workgroup (workgroup). The workgroup's intent was to elevate and leverage current efforts related to data integration underway in the state and identify systems-level indicators to evaluate and address strengths and gaps across the system.

The workgroup was comprised of stakeholders from hospitals, the state's behavioral health partnership, community-based provider agencies, child and family advocacy organizations, and state agencies (Department of Mental Health and Addiction Services (DMHAS), Office of Policy and Management (OPM), Office of the Child Advocate (OCA), Department of Social Services (DSS), as well as DCF). A full list of workgroup participants is included as Attachment 1. The workgroup was tasked with accomplishing the following four goals:

1. Review existing state plans and activities in cross-agency data integration
2. Broaden state agency participation in OPM's P20 WIN initiative
3. Identify key indicators and metrics of behavioral health system performance
4. Make recommendations to the Children's Behavioral Health Plan Implementation Advisory Board and the 12 state Department Commissioners for further follow-up and implementation

The subsequent sections of the report provide additional information on Workgroup process, achievement of each of the goals above, and the Workgroup's recommendations for consideration by the Advisory Board and the twelve state Department Commissioners. Note that the recommendations outline the critical steps the state will need to make to improve data integration and support ongoing systems improvement in children's behavioral health. For these recommendations to be fully realized, an implementation and evaluation plan will need to be developed with details regarding roles, processes, and accountability structures.

II. Workgroup Process and Accomplishments

The Workgroup held six monthly meetings between June and November, 2021. To support the first two identified Workgroup goals, the initial two meetings in June and July of 2021 included presentations on Connecticut's existing plans and activities in relation to data integration. OPM in particular is leading three of the state's efforts regarding data integration: the State Data Plan, the Open Data Portal, and P20 WIN. Connecticut's data plan has three goals: (1) improve relevance of the open data portal and related tools; (2) ensure the data lifecycle promotes equity, particularly racial equity; and (3) improve use of data in informing decision-making. To highlight some of the most relevant and mature data

integration initiatives in the state, two efforts were discussed in detail: P20 WIN and 500 Familiar Faces (also known as the Governor's Task Force on Housing and Supports for Vulnerable Populations).

P20 WIN

P20 WIN is a Connecticut initiative aligned with the state's broader efforts to improve efficiency and effectiveness of government and services. The vision of P20 WIN is to *inform sound policies and practices through the secure sharing of critical longitudinal data across the participating agencies to ensure that individuals successfully navigate supportive services and educational pathways into the workforce.*

A request may be submitted for a multi-agency data match through a P20 WIN standardized process. The request is reviewed by the agencies providing the data, and if approved, the cross-agency data is matched by the Department of Labor (DOL). The requestor is provided with the data, along with conditions regarding strict data utilization, security, and destruction protocols. One of the key components of the initiative is the inclusion of a data governance structure with an executive board setting the strategic direction and research agenda, a data governing board establishing policies and approving and denying requests, and data stewards responsible for the operation of the initiative.

At the time of the presentation to the workgroup, the following organizations had committed to data sharing through P20 WIN: Office of Early Childhood (OEC), State Department of Education (SDE), University of Connecticut (UCONN), Connecticut State Colleges and Universities (CSCU), Connecticut Conference of Independent Colleges (CCIC), Office of Higher Education (OHE), Connecticut Coalition to End Homelessness (CCEH), DCF, DSS, and DOL.

As the number and diversity of organizations that contribute data to P20 WIN grows, so will the knowledge and capacity gained through analyses of integrated data. In particular, as it relates to the workgroup's charge, the contribution of data across the twelve state agencies that have a role in children's behavioral health has the potential to greatly increase the state's understanding of the relationship between behavioral health efforts related to prevention, early identification, intervention and treatment, and individuals and families' long-term outcomes across systems and into adulthood. Workgroup members noted that there is sometimes inconsistent interpretation of statutes related to privileged information between behavioral health clinicians and clients and how these relate to data sharing. To encourage full participation, it would be beneficial to offer agencies and providers clarity on what is allowable and to reinforce how the P20 WIN process maintains security and privacy of data.

500 Familiar Faces

Connecticut's 500 Familiar Faces (500 FFs) project identified individuals and families involved in multiple systems within the state who experience homelessness and is an example of the type of data integration efforts that P20 WIN can support. Project partners—DSS, DCF, DMHAS, the Governor's Office, OPM, Beacon Health Options, Judicial Branch, Court Support Services Diversion (JBCSSD), Department of Correction (DOC), and CCEH—intended to use these results to improve the services these individuals receive, including integration of a trauma-informed, strengths-based, person-centered approach to service delivery. The project required a multi-agency data match to identify individuals and families meeting the criteria of multi-system involvement and homelessness and analyses to identify patterns of system involvement and levels of need. The results of the project included the finding that a higher proportion of individuals than expected experienced involvement in at least five systems and had high levels of need (as identified by the given system) in at least two of these systems.

The intended pilot of a multi-agency service delivery model was delayed because of COVID-19; nevertheless, project collaborators seized the opportunity to learn from the project, and identified best practices along with recommendations to improve service coordination. This type of data integration offers the opportunity to better serve individuals and families by providing a more holistic, coordinated, and less siloed approach to care, and to achieve better outcomes through a more efficient, less costly service delivery model.

Opportunities for Improvement

In an effort to promote ongoing improvement in the state's data integration efforts, the workgroup highlighted lessons learned from various initiatives, and identified several practices to be adopted across state agencies. One of the primary lessons learned was the importance of leadership involvement. Data sharing agreements can be extremely challenging, and are often more time-consuming than the actual data analysis and reporting. Without organizational leadership prioritizing the work required to share data, the work can be significantly delayed. In addition to leadership involvement, it is also important to have staff at agencies with the technical expertise to effectively support data integration efforts.

Consistency in data collection and analysis practices was also identified as a challenge. State agencies and other entities utilize a variety of tools and platforms for collecting and analyzing data, including different data collection fields, instruments and databases, statistical software packages, and varying protocols for public accessibility of data. This presents challenges for data sharing even when there is a common interest in doing so. Agencies regularly collect demographic data; however, the categories of data vary substantially, including categories of race and ethnicity, and the inclusivity of gender identity. This degree of variation is particularly salient in light of the imperative to promote health equity and address health disparities. Compounding this challenge is the increasing percentage of individuals with *missing* demographic data.

Multiple state efforts are underway to improve data collection consistency across agencies, and P20 WIN is developing a data governance manual to support this. Specific to demographic data, the recent passage of Public Act No. 21-35, *An Act Equalizing Comprehensive Access To Mental, Behavioral And Physical Health Care In Response To The Pandemic*, requires the Office of Health Strategy to develop standards for agencies collecting health data to improve their categories of race and ethnicity and increase alignment between individuals' self-identification and available demographic categories. Improved consistency in data practices would also reduce the burden on providers who often are required to enter data on multiple platforms for different state agencies with varying operational definitions for the same fields.

In addition to consistent collection of demographic data, it is important that the data then be *utilized* to identify any areas of inequity across system indicators. Data should, as often as possible, be disaggregated by race and ethnicity in particular, but also by sex, gender, and age, as well as by geographic and socioeconomic indicators. Use of a social deprivation index (a composite of multiple variables) is one example of a socioeconomic indicator that may be applied to identify possible disparities. Disaggregation by these factors is critical to promoting health equity and addressing disparities. When possible, the intersection of two or more variables should be included in analyses to identify variation in needs and outcomes with respect to intersectionality of race, ethnicity, sex, gender, age, geography and/or socioeconomic status.

The last area of practice the workgroup identified was the need for a family indicator. Most services capture adult or child information, but generally not both, and generally do not nest child-related data within family structures. The complex nature of families (e.g., they may extend beyond a single household or address, they may include more than two parents, they change in composition over time, etc.) presents challenges for accurately capturing families within datasets even when intentional efforts are made to do so. The state is engaged in multiple projects that have the goal of adding a family-level indicator, and will seek guidance from other states and countries where these efforts have been successful. It is of note, however, that while various state efforts have demonstrated commitment to utilization of a family indicator, there is no single state agency assigned this responsibility; therefore, ongoing collaboration and coordination across stakeholders is critical to the success of these efforts.

<u>Identification of Indicators and Metrics</u>
The workgroup met from August through October to achieve the third workgroup goal of identifying key indicators and metrics of behavioral health system performance. Their collaborative process included: (1) consideration of a comprehensive list of indicators compiled from a wide range of state and national children's behavioral health initiatives; (2) development of a framework for capturing the overarching components of the behavioral health system to guide selection of indictors; (3) selection of specific indicators within the identified framework that will most effectively demonstrate system-level achievements as well as gaps or "pain points" and; (4) identification of specific data sources for each of the selected indicators. It is worth noting that the workgroup was charged with identifying primarily *system-level* indicators that could help monitor and evaluate system performance, as opposed to making recommendations around individual-, family-, or program-level outcomes.

The workgroup recommended that system-level indicators be categorized using a framework reflecting critical areas of the children's behavioral health system:

Need, Prevalence and Identification → Access → Quality→ Workforce → Cost → System Outcomes

The table below lists the system-level indicators and potential data sources associated with each, organized by the framework categories. As with individual and program-level data, all security and privacy regulations and protocols must be strictly followed. In some cases, the data elements are collected by certain systems, or in particular settings, which presents opportunities for expansion. In other cases, the recommended indicator is not known to be collected anywhere in Connecticut's system; nevertheless, the workgroup identified the variable as important for evaluating overall system functioning. In some cases where the data source is missing, new data collection tools and collection methods will need to be developed.

System Indicator	Potential Data Source
NEED, PREVALENCE AND IDENTIFICATION	
Relevant risk areas of the Youth Risk Behavior Survey (e.g., substance use, depression)	Collected at schools (Department of Public Health)
Calls/Episodes of Care to Mobile Crisis Intervention Services	Provider Information Exchange (PIE) (DCF)
Emergency Medical Services transports for BH needs	
Rate of developmental screening	Medicaid (DSS) in primary care settings
Rate of behavioral health screening	Medicaid (DSS) in primary care settings; Integrated Care for Kids (InCK)
Rate of positive trauma screens in primary care	CT State Health Improvement Plan (SHIP)
Physical health comorbidities with BH conditions	
Positive suicide screening results	

Rates of depression	
Rates of disruptive behavioral disorder	PPCPRSG; HEC
Rates of high school students who feel loved and supported	CT Kids Scorecard; SHIP
Needs of special populations, e.g., children with developmental disabilities, autism spectrum disorders, etc.	
Rates of need across social determinants of health	
ACCESS	
Outpatient utilization rate	
Utilization rates and total days in ED	CT Behavioral Health Partnership (BHP)
ED discharge delay	CTBHP
Rate of inpatient utilization, and discharge delays	CTBHP
Inpatient bed availability (available, staffed, private and publicly operated)	Hospitals; CTBHP
Availability and wait lists across levels of care	
Rates of referrals from one level of care to another	PIE
Availability of service needed vs. service referred	
Utilization of service following referral	
BH services covered/available by insurance carrier	Ins Provider Report Cards
Insurance affordability (deductibles, co-pays)	
Rates of cancelled appointments/no-shows	
Treatment barriers (e.g., distance to appointment, internet coverage for telehealth, etc.)	
QUALITY	
Services meet individual needs	
Referrals and connections-to-care	PIE (DCF)
Percent of services that are evidence-based	
Fidelity to evidence-based treatments (EBT)	EBT Database
Matching service/EBT to child need/acuity	EBT Database
Rates of children with multiple episodes across intensive LOCs	
WORKFORCE	
Percent of providers who meet quality and access criteria	CT SHIP
Percent of organizations adopting CLAS standards	CT SHIP
Adequate supply of BH workforce (by categories of various BH workforce job titles)	CT SHIP
Availability of prescribers (CAP, APRN, etc.)	
COST	
Actual cost of delivering service	
Reimbursement rates across insurance types	
Out of pocket expenses for families	
SYSTEM OUTCOMES[1]	
Rate of ED utilization and suicide risk	Medicaid; PCMH (DSS)
Total annual inpatient bed days annually	Medicaid (DSS)
Rates of hospital ED BH readmission (7 and 30 days)	CT SHIP
Follow-up after Hospitalization for Mental Illness	Healthcare Effectiveness and Data Information Set (HEDIS)[2]
Referrals to EDs from schools	
Juvenile detention and arrest rates	CSSD

[1] System outcomes will also be inclusive of need and prevalence rates trended over time.
[2] The National Committee for Quality Assurance (NCQA). Retrieved from https://www.ncqa.org/hedis/.

Presence of protective factors/resiliency	PPCPRSG
Rates and total days of out of home placement by age	
Needs met at discharge	DCF PIE

III.   Workgroup Recommendations[3]

The Data Integration Workgroup arrived at the following recommendations to present to the Children's Behavioral Health Plan Implementation Advisory Board and the twelve state Department Commissioners for further follow-up and implementation. Follow-up on the recommendations should be overseen by the Children's Behavioral Health Partnership Implementation Advisory Board through an implementation workgroup that utilizes a transparent process with time-bound deliverables and reporting requirements.

Recommendation 1: All twelve state agencies involved in children's behavioral health in the state will commit to supporting P20 WIN, and ensure that the children's behavioral health system direct data requests, and relevant cross-system data requests, through P20 WIN.

Recommendation 2: The P20 WIN initiative should be resourced adequately to enhance its capacity to address behavioral health system requests in a timely manner.

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Recommendation 4: Pilot a behavioral health-related P20 WIN request that includes identifying the highest-need and highest-utilizers of the children's behavioral health system to inform development of targeted interventions for this group.

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IV.   Next Steps – Implementation and Monitoring

The first round of workgroup activities correspond to the first stage of implementation: exploration. Following this stage is installation, early implementation, and full implementation. [4] To make progress

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[3] The workgroup reached consensus on many of the issues raised in regard to need as well as the recommended BHUC and CSU model components included in this report. That does not mean, however, that each workgroup participant explicitly endorsed each of the report's recommendations. Through a process of intensive review and open debate, the included set of recommendations emerged.

[4] National Implementation Research Network. What Are Implementation Stages. Retrieved from What Are Implementation Stages | NIRN (unc.edu).

on the recommendations of this workgroup, and begin to collect and report on the system-level indicators identified by the workgroup, it is essential that each of the recommendations be translated into an implementation plan to provide the state with specific action steps. The implementation plan will be inclusive of (but not exclusive to) the following components:

- A MOU to be signed by the twelve state agencies to support and utilize P20 WIN, inclusive of requirements regarding leadership involvement.
- Confirmation/final identification of all data sources for system-level indicators.
- Operational definitions of the identified system-level indicators and any associated methodological considerations for use in analyses.
- Plans for system-level data collection, analysis, reporting, and distribution of findings including roles, and responsibilities.
- Assessment of capacity across state agencies and providers to support system-level data collection, and identification of technical assistance, technology, and financial resources needed to support full implementation.
- Assessment of consistency in data definitions and data collection across state agencies and processes for improving consistency.
- Plans for implementation and evaluation of a behavioral health data integration pilot project, including identification of lead agency(ies).
- Evaluation plan for assessing effectiveness of collection and reporting of system indicators and data integration efforts.

The workgroup members recommended that an ongoing workgroup be formed to develop this implementation plan, with composition inclusive of families/consumers, state agencies, community-based providers, the behavioral health partnership, and hospitals. The workgroup will need clear goals and objectives, a timeframe for completing the implementation plan, and resources to pursue the recommended activities. The workgroup should engage in their work with accountability and transparency, and regularly report to the Children's Behavioral Health Plan Implementation Advisory Board. Adoption of the recommendations in this report, supported by the development of an implementation and evaluation plan, will result in significantly increased capacity for data-driven decision-making and the capacity to systematically evaluate and improve system-level outcomes.

Attachment 1: Workgroup Participants

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