Data Integration Workgroup
September 28, 2022 (1:00 pm – 2:00 pm)
Facilitators: Scott Gaul, Manisha Srivastava, and Beresford Wilson

Workgroup Goals:

1. Finalize onboarding of state agencies to P20 WIN and develop a data integration framework that uses P20 WIN to identify service utilization patterns among children with multi-system involvement **and identify opportunities to improve the behavioral health system.**
2. Finalize a children's behavioral health data dashboard and implementation plan that supports ongoing system improvement and reduction of health disparities.

Workgroup Meeting Cadence
Quarterly; up to 5 meetings

Materials:

1. PowerPoint presentation

Meeting Objectives:

1. Identify next steps and priorities for system dashboard
2. Provide Feedback on Revised P20 WIN Project

Agenda & Minutes

1. **Welcome and Introductions (:02)**
   Beresford Wilson welcomed everyone to the Data Integration workgroup and then facilitated introductions.

2. **Overview of Meeting Agenda and Objectives (:03)**
   Scott Gaul reviewed the workgroup agenda and the above objectives.

3. **Dashboard Priorities and Next Steps (:25)**
   Aleece Kelly (CHDI) shared a PowerPoint that reviewed previously agreed-upon indicators and associated data sources/opportunities for disaggregation [note that this information was shared via email in advance of the meeting]. A goal of today's meeting was to gather feedback and input that would help staff produce a mock-up of a sample of dashboard indicators to bring back to the group. The workgroup reviewed the information on the PowerPoint.

   The group had a discussion on the pros and cons of using the Youth Risk Behavior Survey (YRBS) data within the dashboard. The upsides include the data being public and the opportunity for longitudinal analysis and comparison with other states/national rates. The downsides being that the data is only available every two years and includes only a small sample of schools. Recent legislation mandates that schools requested to participate do complete the survey which should lead to more robust datasets to pull from. **A participant asked if there was a question in the survey related to whether or not the youth sought services to help them with their needs.** Staff will follow up.

   Several of the data sources for other indicators would require data sharing agreements or formal data requests. The group noted that there is a shortage of throughput-related indicators outside of ED and inpatient utilization and delays. These are available mostly from the bed report that the hospital association collects which is not publicly accessible data. There is data on ED awaiting inpatient and inpatient availability, but limited data on inpatient awaiting community services. Each service type and organization are different with how they track waitlists, and typically there isn't a formal list. There are a number of services that aren't supposed to carry waitlists. In PIE there is a data element but there isn't an episode opened until the individual is in services. A

youth may also be referred to multiple programs to increase the chance of getting into one, and so it the data would be duplicated across children.

The workgroup reviewed the remaining indicators. In regard to the indicator for out-of-pocket costs, this could be requested through the All-Payer Claim database, however data related to actual cost vs. reimbursement will be a challenge to attain. Population outcomes the group identified the rate of suicide attempt, rate of inpatient utilization and the number of ED visits for behavioral health needs.

Wilson asked if there have been any discussion regarding juvenile justice (JJ)-involved youth (CSSD data) as an indicator. The group discussed that we could not include CSSD data within the P20 WIN project because CSSD is not currently a participating P20 WIN agency. There could, however, be an indictor added to the system dashboard that includes information on juvenile justice-involved youth. The group agrees this is a critical population among youth with behavioral health needs. The group also acknowledged there may be challenges or additional steps needed to receive CSSD data. If there are significant challenges getting the data that would inform the system, this is an opportunity to inform a *data development* agenda. Kids get stuck in juvenile detention as well as the ED. At least one data point should be added to include the youth that are involved with the JJ system. Scott Gaul, shared a link that there is a dashboard through JJPOC, that is looking into juvenile justice outcomes and disparities, and OPM is currently working with CSSD.

From Scott Gaul shared resources from JJPOC: 1) Recommendations on system measures: https://towyouth.newhaven.edu/ioyouthrecommendations/ and 2) overview of planned dashboard from last year: https://towyouth.newhaven.edu/wp-content/uploads/2021/11/JJPOC-11.18.21-PowerPoint-FINAL-2.pdf. There will be an update at the October JJPOC meeting with more detail.

In conclusion, the workgroup recommended that staff select indicators with available data to develop a mock dashboard. It would be best to start with the data sources that don't need a data sharing agreement, and consider the access to *disaggregated* data.

4. **Behavioral Health Cross-Agency Data Integration Project Design (:25)**

At the last meeting the workgroup discussed a complex proposal for the P20 WIN project that integrate data across multiple state agencies. Following the meeting, some challenges were identified in regard to the timeline for completing the project and informing system improvement. As a reminder, these efforts are constrained by agencies that are already participating in P20 WIN. Staff are bringing a revised proposal for the project that narrows the scope and number of agencies that would be requested to supply data for this project, and would be feasible to complete within a shorter timeframe. This proposal looks at children being screened in a primary care setting. Are there potentially disparities in the proportion of children receiving screenings and those who, after screening positive, receive services? The project would use DSS Medicaid data and PIE data.

A participant asked if there would be a challenge with the fact that PIE includes children across insurance types. Staff acknowledged that the project would need to exclude children who receive screenings and/or services who are covered by private insurance. Facilitators offered that there would be a system to match children from the DSS data with the PIE data. The process involves matching name and birth date and possibly other identifiers, and will successfully match most children but not all. The group discussed the issue that screenings are not the highest reimbursable service, and as a result the proportions that are actually receiving services may be smaller. The group also explored whether it would be helpful to look at youth who are receiving services in PIE but didn't screen during a well child visit. We would want to see that all children get screened and all children have a well visit. It will be important to identify when the well child visits are available, when do the screenings fall off. Per AAP recommendations, that a behavioral health screening happens at every child well visit. It would be helpful to use the project to look at trends of well child visits and screenings, and especially assess what occurs during times of transitions in childhood.

5. **Wrap Up and Next Steps (:05)**
   Manisha thanked everyone for their active participation in today's workgroup meeting. The workgroup developed a lot of great questions to move the work forward.

6. **Adjourn**
   Beresford Wilson adjourned the meeting at 2:00pm.

   Next meeting Date: December TBD

   Chat box: All comments in the chat were included in the minutes.