Meeting 04-17-2015: Children's Behavioral Health Data and Quality Team

Data and Quality Team website: https://www.dshs.wa.gov/bhsia/division-behavioral-health-and-recovery/data-and-quality-team

Agenda Item & Lead(s)	Discussion and Outcomes	Action to be taken by whom/when
Action Items from Last Meeting • New membership list • Updated charter • Revisions to Measures of Statewide Performance • DOH rep	• Updated membership and charter will be put on the website. Website link above. • A new Population Reference Figure to illustrate behavioral health needs of children and youth was distributed. It is another way of viewing the information in the Measures of Statewide Performance. • Carol Dean (formerly Miller) is the DOH rep to this committee. Although she is unable to attend the meetings she does read the minutes and attends all statewide FYSPRT meetings.	All agreed this additional look was additive and should be added to the Measures document. Raetta shared that she had taken the other figures to her RSN Quality Committee and a very informative discussion about ways to display data ensured. There was some discussion re displaying data for Transition Age Youth, 15-21.
Additional Measures to Consider Katie Weaver Randall, DBHR • Linkage with 1519/5732 measurement work (to develop accountability measures for DSHS/HCA) • Discussion of 30-day readmission measure Goal: to provide information to bring to the 5732/1519 workgroup about how to think about aligning work and how the 30-day measure for children/youth is similar/different than for the adult population?	1519/5732 workgroups devised measures to include in contracts as well as accountabilities for QI for Behavioral Health services. The focus has been on adults and we need to weigh in as to whether these are of value for the child system. Consensus was that the 30-day rehospitalization measure is very important and challenging for children's services. Because of few children's hospitals, children/youth don't generally get admitted to a neighborhood hospital and may enter through various routes so it is hard to track them. Some hospitals are willing to share admission information, others are not. Children/youth might get to a more appropriate service setting, e.g., if the provider agency/RSN knew that hospitalization was in process or recently occurred. Another issue is that youth might get admitted to hospitals with private insurance which runs out after 3 days. When that happens they get Medicaid coverage – so there is data re a Medicaid hospital admit. However, upon discharge there is no Medicaid coverage	RDA will review available data to understand what is occurring and what best to capture to inform this measure. Included will be admission types, readmissions after discharge, state date of the hospitalization, inpatient settings, e.g., CLIP, CSTS, Community hospitals and other as available data warrants. They will bring these data back to the committee in June for review. It was pointed out that these data would be used to monitor how well we were doing. Improvements would need to be implemented at the local level.

	and so data re subsequent services, readmission is not available. The question was raised whether inpatient substance abuse treatment should be included in these measures? They're separate measures for adults.	
Measures of Statewide Performance Barb Lucenko, Bridget Lavelle Goals: Continue discussion on latest ideas/ recommendations for indicator(s) and come up with next steps. • Continuing discussion of Goals 6.1"The system provides a comprehensive and accessible array of services for children, youth and families" and 6.2 "The system is characterized by accessibility and equity in access to care for children, youth and families.	Further discussion about "services". Can we capture those in the community vs. office based? Is there sufficient workforce, network adequacy to provide services? EQRO looks at requests for specialty services, services out of network. RSNs track second opinions. A question was raised re where to requests for services come from. And after a request is made, what is the delay in accessing that service? Families report significant barriers in accessing services not offered by the provider agency, especially psychiatry. The approach seems to be to say no rather than query re request and educate re what the services are, what benefit might be obtained. RSNs authorize varying codes for different services so across state comparisons are difficult. For youth with intensive needs all coding should be under WISe, but for others crisis stabilization codes allowed in one RSN, for example, may not be allowed in another RSN. The availability of psychiatrists by county was reviewed. It was noted that ARNP access was not included. Qualis reports no standard measures for provider capacity.	Share the statewide Gaps Analysis re EBPs at next meeting. Not possible to discern location of services (rural, urban, school, home, phone (e.g., PALS line), distance, time of travel, etc). Katie will ask push this forward as a new data requirement and include this in Encounter Data Validation.
First Quarter 2015 Cross-System Data from the BHAS Bridgette, Barb, & Kathy Goals: Practice Identifying cross-system strengths and concerns.	Initial BHAS data on numbers of CANS screens, Referral Source types, screening outcomes and Clinican-Reported Cross-System Involvement were presented and discussed. One-third of referrals came from RSNs which is to be expected as the first thing RSNs did when implementing WISe was transfer intensive youth already receiving services. We expect this to decrease over time. The 2nd most frequent was Children's Administration (any type), then self-family (which might have originated elsewhere, e.g., schools, medical providers, as parents are often referred to services).	There is a need to differentiate where in Children Administration the referrals are coming from – and what the screening outcomes recommends. A change order has been negotiated with RCR to delineate BRS versus non-BRS services – and whether the assessments are coming with referral to, during or discharge from BRS services.
Next meeting – May 15, 1-3pm Agenda: WISe Quarterly Longevity Reports	Nate Israel will walk the committee through the BHAS Longevity Reports within a Transformational Collaborative Outcomes Management (TCOM) framework.	