State Epidemiological Outcomes Workgroup (SEOW)
April 19, 2017, UCONN Health Offices at the Exchange, Suite 173
MEETING MINUTES

Chair: David Gregorio, UCONN Health

Participants: Karyn Backus, DPH; Alexandra Gorski, UCONN Health; Dawn Grodzki, DMHAS; Connie Heye, Office of Early Childhood; Eugene Interlandi, DOT; Celeste Jorge, DPH; Carol Meredith, DMHAS**;** Christine Miskell, SERAC; Stephanie Moran, DMHAS; Michelle Riordan-Nold, CT Data Collaborative; Melissa Sienna, DCF; Bonnie Smith, UCONN Health; Jennifer Sussman, UCONN Health; Jane Ungemack, UCONN Health; Smruti Vartak, UCONN TSRC; Janice Vendetti, UCONN Health; Sandra Violette, DOC; Sara Wakai, Center for Public Health and Health Policy; Susan Wolfe, DMHAS.

Via phone: Anthony Dias, CT Hospital Association; Mary Lyon, CT Hospital Association; Scott Newgass, SDE; Eleni Rodis, DMHAS; John Suchy, Liquor Control.

MEETING NOTES

	Agenda Item	Discussion	Outcome/Action
I.	Welcome and Introductions (David Gregorio)	In-person attendees and phone participants introduced themselves and were welcomed and the goals of the meeting were discussed. A sign in sheet was circulated for in-person participants.	• A sign in sheet will be available at each meeting to track attendance, and a call-in number will be provided for those who need it. • Goals and objectives will be formulated and revisited over time.
II.	DMHAS Update (Carol Meredith)	STR grant, not competitive, so hoping to hear soon about the award, collaboration w DCF, Judicial, DOC, 5.5 million, 21st Century Cures grant Recently completed a suicide prevention grant for 25+ Using data to perform gaps analysis, and support applications Hoping to use data from SEOW process to set priorities for prevention block grant. Awaiting data analysis from CPES to identify substances, risk factors, behaviors SPF Rx grant to raise awareness of prescribing practices through CPMRS Data from DCP.	

		Piggybacking on initiative of DPH (CDC) targeting same goals and populations. Working together to integrate efforts. DCP data will tie this together. ADPC (3 subcommittees), Tx, Prevention, Recovery to develop recommendations. Prevention looking to provide info to prescribers, updating state website on opioids (revamping, more interactive, get the word out). Prevention Week May 14-20, Conference 5/15. 4 agencies to integrate medical records in PDMP. How can SOEW interface with DMHAS efforts and ADPC recommendations? SEOW role could be to identify block grant funding priorities	
III.	Discussion of data analytics supporting hospitals to manage data quality and address population health in the CHIME database. (Anthony Dias, Mary Lyons, CHA)	CHA processes data from the hospitals in the state. Utilization quality and population health. Mary Lyon process data (analytics) Administrative claims data for a very long time. CHA sequestered by DSS to collect Medicaid data on behalf of hospitals. Real time, (3 second lag), ongoing . Several datasets provided to the State: Office of Healthcare Access (OCHA), pt admission discharge data. 116 data fields representing all hospitals including newborns. Dx, demographics, procedure codes, revenue codes, payor data, for inpt d/c's. Past year expansion to outpt surgery, freestanding ambulatory surgery center provide data directly to OCHA, hospital surgery. Patient identifiers for use by OCHA, semiannual basis. CHS provides data on all invasive procedure. Annual reporting, 10 reports of hospital utilization data, text and data files as well as narrative reports to OCHA. Case mix by DRG or demographics. DPH mandate: annually requires hospitals to provide ED encounter data, patient specific fields for morbidity/mortality and other study. ED admissions and discharges, some overlap in inpt and ED databases (non-admissions vs those that become inpt admissions. DPH identifiers for youth that are not included in OCHA inpt dataset. OCHA has remote access to DPH dataset through secure VPN connection. No patient characteristics. Also delivered as a dataset to OCHA. Claims based data after discharge vs. Medicaid feed is different and broader. The feed begins at patient registration, through in-hospital transfer, discharge, will generate events w demographics, etc. CHA receives this event information as a transaction type. CHA provides this data to CHN which process and analyzes for DSS purposes.	

		Karen Backus, DPH, births and deaths, have worked with OCHA and Family Health data sets. How is data quality addressed? There are a series of conditions to determine missing fields (content standard not met) flagged. Hospitals can resubmit the data electronically or correct it. Relationship of certain fields are checked. Logic checks (data rel'ps, etc.), data completion (reasonable amount of cases received based on flow). Process to ensure no duplicate entries. Does CHA do anything about geocoding and address? Some areas of the state not able to be geocoded. Some towns grouped especially smaller towns. OCHA mentioned legislation that will expand OCHA's data sharing. What is that about? Follow-up on this. *How can open data portal and/or ctdata.org make this data more usable? What are the barriers to this?* JU: *Interest in alcohol or drug related overdoses, geocoding those, demographic profiles of those cases. How can we access? Can special requests be made? Is it part of standardized reporting?* DPH or OCHA databases, based on dx and procedure codes, demographic data available? Family Health Dataset has indicators. *Can we access from DPH or CHIME/CHA? Key to understanding dimensions of substance use and other health problems. Can special requests be made? Of whom? Who would be the person to talk to?* Some towns grouped especially smaller towns. Smruti Vartak, UCONN Crash, made a request of Human Investigation Committee (IRBish) of DPH to make a request for dataset w indicators (Separate agreements w individual hospitals to supplement OCHA data). Aggregate published reports published by OCHA. Family Health reports are health based no event based. *CM: how to access reports? DG: Can hospitals access data from other hospitals?* Some data available for comparison. Nothing detailed, aggregate benchmarks only. *JU: Healthcare field changing dramatically, based on move to systems. Q about urgent care centers. If hospital system has urgent care centers, are those data being entered into CHIME?* If operating under the hospital license, then yes. If independent or dr based, then no. *CM: Mentioned three sets of data from OCHA. Clarify?* *DG: Challenges in data access and use, have made in-roads, that's why we come.* DSS: Medicaid pop and cost reporting. A report required for Medicaid patients w hospital acquired condition. Change in reimbursement structure had ended the need for that report.	

IV.	Overview of the Connecticut Data Collaborative (CTDC)and the ctdata.org website (Michelle Riordan-Nold, CTDC)	About the CT DATA COLLABORATIVE: Public private partnership that advocates for public availability of open and accessible data. Mission has evolved. Data Collaborative began w policymakers frustrated w the lack of usable data, early childhood data. MOUs and data sharing agreements to enable sharing. Executive Order 39 changed that. CTDC works with communities and Tyler works w agencies. How different from Open Data Initiative? Making data usable, based on community needs and requests. Help get data out of datasets and make it usable and available "liberation" of data and increase data literacy. Example Secty of State database business licensure. Received data on a CD and had to pull it into something usable. DCP asked for access to this data for investigations. Traffic stop data (made searchable), library data patron usage (geocoded) CT Data Academy to increase data literacy in state and local governments and municipalities, nonprofits, to use their own data, strengths weaknesses, limitations. Work w Open Data Initiatives. Free monthly data basics trainings, open to public, data indepth training series (3 part course, piloting in Fairfield), data in person (meet up in Hartford) and monthly data calls (ctdata.org/academy). InfoEd example, edsite, data by county but not aggragable to state. CTDC built a data scraper to enable aggregation. Next data conference in June. Broadly and well attended, soliciting ideas for panels and workshops. *JU: great conference, broad constituency, policy sectors, etc.* Staff of two recently expanded to four. Looking for ideas. *CM: Customized consultation options? To make sense of data?* Yes, example library data. No in-house capacity to look at their data. *To what extent does the layperson use ctdata and its services.* Example of a schoolteacher who used data. Recently unemployed person attended training. No good sense of who is using the services. Promotion could be better. Small staff has prevented that but is expanding. *JU: What about hits to the website? Has it expanded? CPES has contracted with CTDC to maintain a prevention data repository. PFS grantees, ex., looking for town level data. Agencies w individual needs at the community level.* Nonprofits applying for grants. *DG: as a public health professional, encouraging to think upstream, there are graduates of MPA, MPH who go to work in those community environments. Examination of evidence bases for approaches, CTDC may be able to do a better job of increasing data capacity at the student level (partner w educational inst.)* *How do you build interprofessionalism (cross pollination) into data work at that level. JU, SEOW has that purpose*.	

		Walk through the system. SB 1031 to codify EO 39 dies in committee. Included it in larger bill, section 4 of the bill would have mandated agency participation. It would have taken the language of the EO and put it into legislation for when governor changes. Sustainability. S/A Tx Admissions example Provide raw and metadata (suppression rules, etc.) *JU: Can we use community types or other subgroups to avoid suppression rules? Community Health Foundation community types?* Not with the data as it is, but possible. *KB, need record level data to be able to do that. Intensive process. Does CTDC or Open Data have a standardized approach to suppression? Would like to get there. A minimum standard possibly?* *Need the executive order to move this forward, but has't gotten to the point where usability is the goal. Need data in the form where it has real utility. Legitimate issue for the SEOW to be discussing. More eyes on the data have unearthed issues, allowed for correction.* CERC data limited but searchable. *JU: use them all the time.* *DG: County level health outcomes (County Health Rankings). Is it possible to link to external databases?* Don't do external linkages but would be willing to bring that data in. Data resources tab has external links. Could add the link to website. SEOW and other groups can suggest resources. *JU: not useful DG: rankings are powerful. KB: DPH looking to make local health districts county based (some are towns, some are groups, etc.). Any data w town can aggregate to county. Then the county health rankings would be very useful. Legislation in process. Stay tuned.* *What is the difference between ctdata vs. open data portal? (CM)* The two are not mutually exclusive. Maybe use both..MRN likened it to going to the library and finding books on the floor. Open Data mission to make data publicly available, ctdata mission is to promote access and use of data for community efforts.	
V.	Discussion:	***How can these databases and initiatives interface with CT's other efforts/initiatives?***	

		DPH: What we're doing w the SEOW is educating others about what's available. Have created a database compendium as a starting point. All PHI, so need to go through the HIC. Start with the indicator list. ***What are the issues of sustainability and validity for these databases?*** ***What are the issues within your organizations in interfacing with these data?*** ***On what occasions have you used these data?*** ***What questions have these data helped answer?*** ***How do you make these data real for your constituents and stakeholders?*** ***What barriers do you see to public use of your organization's data?*** ***How can these barriers be alleviated?***	
VI.	SEOW Next Steps	• Update on the Prevention Data Repository and State Opioid Epidemiological Profile • Explore a tutorial in accessing DPH data: UCHC and DPH could focus DPH's scope of presentation (set up meeting). Injury, YRBS, BRFSS, Family Health, newborn/vital statistics.	• CPES will report on progress at next SEOW meeting • Contact Diane Aye, DPH, set up meeting with UCONN Health/CPES

Meeting Accomplishments:

- A rich and fruitful discussion occurred of indicators and risk factors related to NMUPD and opioid deaths;
- Indicators and data sources were identified relevant to this problem;
- The CPES indicator list was expanded;
- Co-existing initiatives were identified, with discussion of how they can work together;
- Data access linkages were made between members;
- Meaningful next steps were identified with regard to data linkage.

Proposed Next Meetings:

July 26, 2017, 10 am-12 noon, CT Data Collaborative Offices
October 18, 2017, 10 am – 12 noon, CT Data Collaborative Offices