

Advancing policy to integrate behavioral health requires relevant data to understand behavioral health in a state environment, including:

1. Behavioral health utilization and cost patterns;
2. Prevalence patterns of behavioral health conditions;
3. Behavioral health workforce: types of providers, distribution across care settings, and gaps defining unmet needs;
4. Measurable health outcomes and reported health status.

In most cases, all relevant data do not reside with one agency or organization, may not be defined consistently across agencies, and may or may not cover all the data needs for the project at hand.

Relevant data sources for understanding behavioral health needs, utilization, and outcomes may include: public and private payers for utilization and cost data (e.g., Medicaid and/or All-Payers Claims Data), health departments for public health outcomes data, and state agencies overseeing workforce data. Also consider what relevant publicly available data may be available, e.g., CDC Behavioral Risk Factor Surveillance System; SAMSHA mental health facilities data. See endnotes for additional data consideration.

Purpose

To identify and organize available data sources for analysis and provide a standardized method of requesting data from state agencies and payers.

1. Identify what data are needed to understand behavioral health integration in your state; confirm that all partners are working from a shared and relevant definition of that data
2. Indicate which agencies or organizations manage the relevant data; and
3. Begin to organize data as a whole, collecting and synthesizing as needed from separate agencies or databases.

How to use this tool

Identify a partnering data analyst to complete this tool to identify relevant behavioral health data and facilitate data requests. Together,

1. Consider which state agencies, payers, or organizations may have the kinds of behavioral health data you need [use the [Integration Networking Tool](#)]. Identify someone at each organization to complete the data request section or to discuss with you by phone. Either an analyst or content expert may serve as the best contact.
2. Prepare a description of what the analysis is trying to learn or achieve, and describe the benefits you hope it will bring to potential partners. This provides a reason to work together.
3. When making a request to complete the tool, ask your analyst for data that can be shared. Explain how you will use and protect it and adhere to whatever sharing rules they have. This type of behavioral health analysis can be conducted with aggregated data containing no personally identifiable information and generally a Data Use Agreement (DUA) is not required. However, always determine if a DUA or another type of agreement is needed between organizations.
4. Explain that the findings of the behavioral health data analysis may be shared with stakeholders and included in reports, infographics, or maps. Identify any required protocols to be followed to include data in shared reports.
5. Facilitate continued data sharing. Once this tool is complete, and the landscape of available data is known, facilitate the process to obtain the data from other agencies and organizations. Request any data documentation that describes how the data are collected, stored, and managed.

Data Request:

Of the following categories of data, please check all available for the latest fiscal year:

Claims or Encounter Data Related to Behavioral Health Services (Medicaid and other major payers):

- Members
 - Age Group
 - Delivery Model (e.g. Fee-for-Service, Managed Care Organization, etc.)
- Geographic Region (e.g. Regional, County, Zip Code, etc.) – preferably the smallest boundary without causing confidentiality issues

Data Request:

Of the following categories of data, please check all available for the latest fiscal year:

- Diagnostic Categories (based on ICD-9 codes – primary behavioral health diagnoses and medical with secondary behavioral health diagnoses)
- Total Expenditures
- Services
- Provider Type
- Provider Specialty
 - Service Type (e.g. Inpatient, Outpatient, Emergency)
 - Place of Service (e.g. hospital, federal qualified health center, etc.)
 - Delivery Model (e.g. Fee-for-Service, Managed Care Organization, etc.)
- Geographic Region (e.g. Regional, County, Zip Code, etc.) – preferably the smallest boundary without causing confidentiality issues
- Diagnostic Categories (based on ICD-9 codes)
- Total Expenditures
- Pharmacy
 - Drug Category
 - Age of Recipient
 - Service Type (e.g. Inpatient, Outpatient, Emergency)
 - Delivery Model (e.g. Fee-for-service, Managed Care Organization, etc.)
- Geographic Region (e.g. Regional, County, Zip Code, etc.) – preferably the smallest boundary without causing confidentiality issues
- Diagnostic Categories (based on ICD-9 codes)
- Provider Type
- Provider Specialty
- Total Expenditures

How are your claims or encounter data formatted?

(i.e., Excel, Tableau, SAS, etc.):

Do you have a data codebook or dictionary (If yes, please attach with this request)?

- Yes No

Public Health Outcomes Data

- Demographics Age Group
- Gender
 - Race/Ethnicity
 - Education
- Employment Status Insurance Coverage Income
- Morbidity – by age, gender and race/ethnicity for county or region
 - Reported Substance Use
 - Reported Poor Mental Health Status/Days of Poor Mental Health
 - Reported Depression
 - Reported Self-Harm/Self-Injury
 - Reported Suicide Ideation/Planning
- Mortality – by age, gender and race/ethnicity for county or region
- Overall Suicide Rate
- Substance Use Overdose
 - Opioid
 - Alcohol
 - Other Narcotic

How are your public health outcomes data formatted?

(i.e., Excel, Tableau, SAS, etc.):

How are your behavioral health workforce data formatted?

(i.e., Excel, Tableau, SAS, etc.):

Do you have a data codebook or dictionary (If yes, please attach with this request)?

- Yes No

Behavioral Health Workforce

Data on Licensed Providers

Type, examples:

- Psychiatrists
- Psychologists
- Social Workers
- Licensed Counselors and Therapists
- Nurse Practitioners/Registered Nurses
- Physician Assistants

Work Address

Work City

Work Zip Code

County

Region

Work Setting (e.g. Office/Clinic, Hospital, etc.)

Age Group

Race/Ethnicity

Employment Status (Full or Part-time; Hours of Patient Care Per Week; or Equivalent)

Do you have a data codebook or dictionary (If yes, please attach with this request)?

- Yes No

Additional comments:

Please return this form with data and supplementary documents to:

[Insert contact info of behavioral health data analysis lead]

by _____ . _____

[Insert date]

[Data analyst]

is available to answer any questions. Thank you!

ENDNOTES

Additional data considerations:

Other relevant behavioral health data

You may want to confirm the data definitions in use for “behavioral health.” Behavioral health utilization, cost, or workforce data may not be defined in the same way for different agencies and organization.

Payer base: This generally involves all Medicaid claims where the state is a “payer.” Some states may include or have access to behavioral health data from commercial payers or Medicare.

Utilization: In general, the customary definition of “behavioral health utilization” is for mental health diagnoses and conditions, whether they are treated in a mental health center or medical facility. Treatment of behavioral health factors as part of medical care components is likely not included in this customary definition.

Workforce: In general, “behavioral health workforce” includes clinicians licensed in psychiatry, psychology, clinical social work, and advanced practice mental health nurses. Sometimes others are included such as unlicensed behavioral health providers (e.g., peer support specialists; behavioral health trainees and students working towards licensure) .

It may be worth confirming what the local definitions really are, so that you understand the data that is supplied by the various agencies and organizations—and that what they are supplying is comparable.

What constitutes data?

There is a range of data sources, in addition to databases, that may provide useful information when you know where to look. Think broadly and creatively when seeking existing data. For example:

For a project is concerned with utilization, cost, outcomes, or workforce for behavioral health defined more broadly than the familiar mental illnesses and conditions, the data sought might be wider than customary or not available from

traditional sources.. For example, stress, stress-linked physical symptoms, marital and family distress, or mental well-being or loneliness may be the subject of the work, not only familiar diagnoses, such as depression and anxiety. In that case, many federal agencies conduct health-related surveillance systems that ask broad questions about behavioral health such as SAMHSA’s National Survey for Drug Use and Health and CDC’s Behavioral Risk Factor Surveillance System. Consider these resources.

For a project interested in behavioral health of the state’s population, consider commercial payers and private providers and groups who may not take Medicaid to expand the range of data to include all payers within the state.

For a project focused narrowly on a particular behavioral health subpopulation, such as children or opioid addiction, identify what data is needed to describe this specific subpopulation. Who has it, and in what form? How could these populations be distinguished from Medicaid claims for anything related to behavioral health?

For a project with different purposes than the customary claims databases, articulate the modified, expanded, or narrowed data you are seeking, who might have it, or how it might be gathered. Even data that would be helpful, but are not currently available, may be worth keeping in view.

Data that is “good enough” can inform action

Seldom is all the data you want or need easy to find or just what you are looking for. Keep in mind that the purpose of collecting the behavioral health data is to enable the overall project to move forward, NOT to create a perfect behavioral health database. Ask to what extent you have enough data of enough scope and quality to act now, not whether the data is perfect.

The tool helps you and your state partners identify and organize data sources that will be helpful—and is probably just a start. As new or updated data sources emerge, you can take a start, begin, and refine it over time.

