



Behavioral Health Data: How to get, analyze, share and use data

Linette T Scott, MD, MPH, FACPM
Chief Medical Information Officer
Deputy Director, Information Management Division
Department of Health Care Services



Data Sharing – Ins and Outs

- Importance of Integration
- Confusion About Rules
- Foster Care
- DHCS Programs
- Federal Funding Opportunities
- Next Steps



Importance of Integration



Data Symposium & Webinar on High Utilizers of Medi-Cal Services

- Hosted by California Health Care Foundation (CHCF)
- One-day symposium to discuss new research by state officials and university partners on the characteristics, health care usage, and costs associated with Medi-Cal's high-cost populations, as well as research emerging from Washington State
- Webinar on June 9 - "Understanding Medi-Cal High-Cost Populations," by Ken Kizer and Jim Watkins
- <http://www.chcf.org/events/2015/medical-data-symposium>



WHEN CHRONIC ILLNESS & MENTAL/BEHAVIORAL ILLNESS COMBINE, UTILIZATION & COSTS RISE

Of the 5% costliest enrollees, 45% have a serious mental illness.

DIABETES



DIABETES + ALCOHOL/DRUGS + MENTAL ILLNESS



Annual per member

ANNUAL SPENDING PER MEMBER



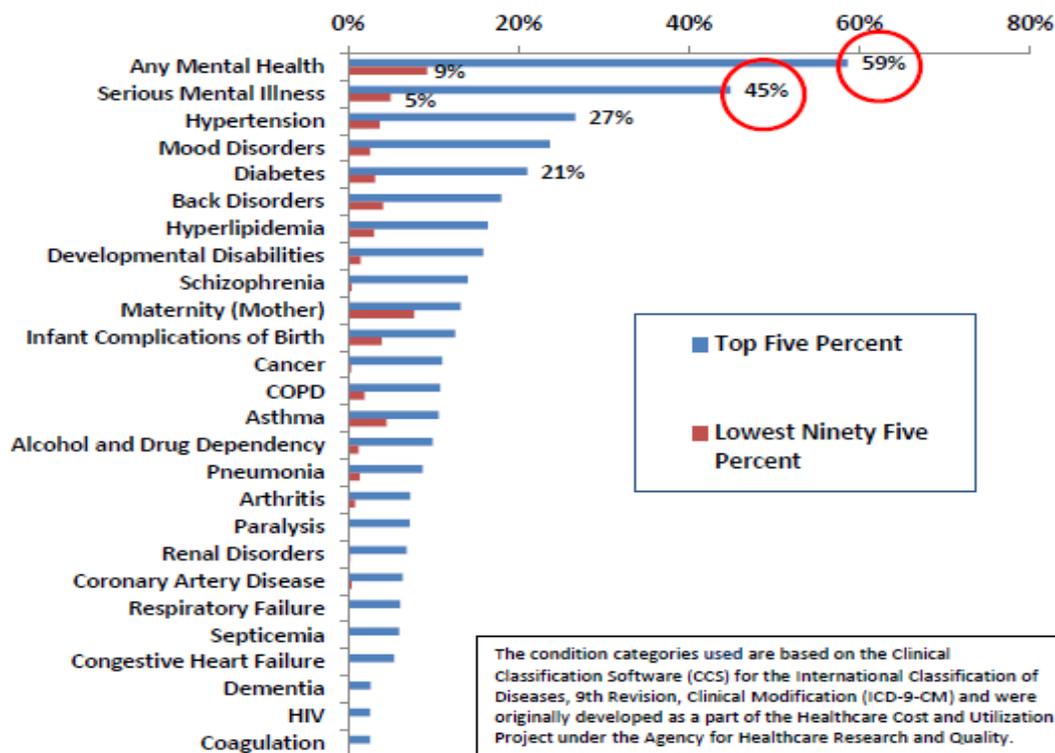
Source: California Department of Health Care Services
www.chcf.org/medi-cal-matters

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Medi-Cal Disease Burden 2011

Prevalence of Major Diseases Treated Among the Most Costly 5% and Least Costly 95% Individuals Eligible For Medi-Cal Only
Participating In FFS, FFS_MC, MC
Eligibles = 7,914,215, Total Spending = \$26 Billion



Mental illness was commonly found among the most costly cohorts.

Among the most costly 5% of the population, mental illness of any kind had a treatment prevalence of 59%.

Serious mental illness (SMI) had a treatment prevalence of 45%.

Other conditions that had a treatment prevalence significantly different from the least costly cohorts included diabetes, hyperlipidemia, schizophrenia, infant complications of birth, COPD, asthma, alcohol and drug dependency, pneumonia, arthritis, paralysis, renal disorders, coronary artery disease, respiratory failure, septicemia, congestive heart failure, and HIV.



Using Medi-Cal Data to Improve Care for Serious Mental Illness

- Webinar hosted by the California Health Care Foundation
 - Tim Bruckner, PhD, associate professor, University of California, Irvine
 - Todd Gilmer, PhD, professor of health economics, University of California, San Diego
 - Christina Mangurian, MD, associate professor of clinical psychiatry, University of California, San Francisco

<http://www.chcf.org/events/2015/webinar-medical-mental>



Health Disparities Fact Sheets

Mental Health & Substance Use Disorder

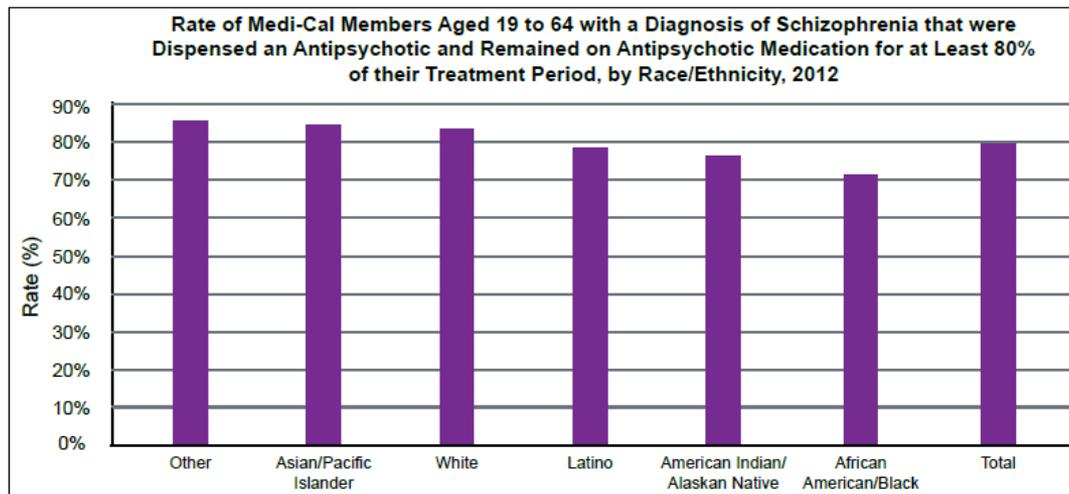
- [Adolescent Depression, 2013](#)
- [Adult Depression, 2013](#)
- [Schizophrenia Medication Adherence, 2015](#)
- [Substance Use Disorder Services, 2015](#)

<http://www.dhcs.ca.gov/dataandstats/reports/Pages/DisparitiesFactSheets.aspx>



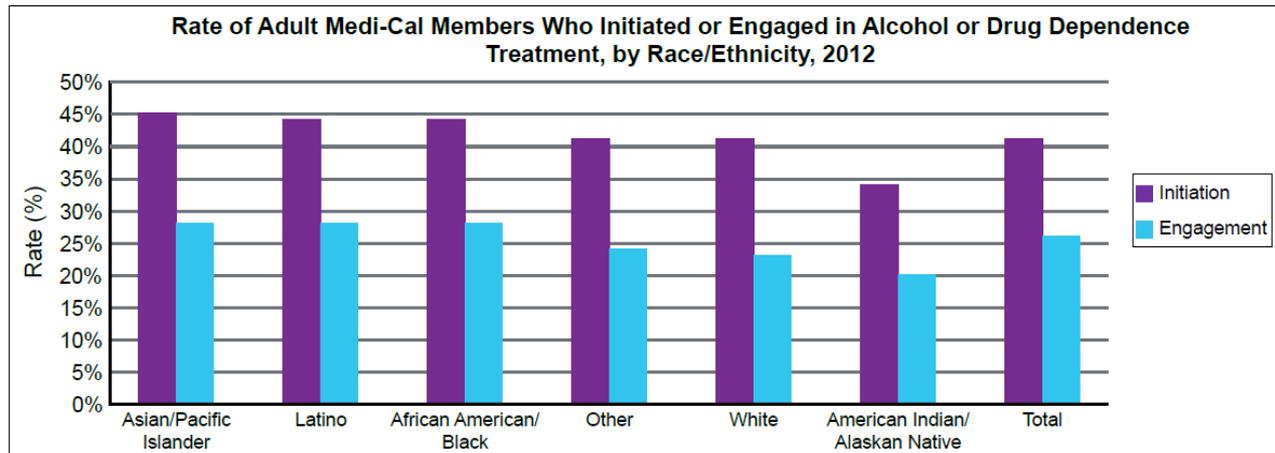
Fact Sheets

Figure



Source: Medi-Cal Management Information System/Decision Support System (MIS/DSS), 2012
 Note: Members eligible for both Medicare and Medicaid were excluded
[Click to link to more detailed graph by race/ethnicity](#)

Figure



Source: Medi-Cal Management Information System/Decision Support System (MIS/DSS), 2012
 Note: Members eligible for both Medicare and Medicaid were excluded
[Click to link to more detailed graph by race/ethnicity](#)



DHCS Programs



Medi-Cal 2020 Waiver

- California's 1115 Waiver Renewal approved by Centers for Medicare and Medicaid Services (CMS) Dec. 30, 2015
- Medi-Cal 2020 will guide us through the next five years as we work to transform the way Medi-Cal provides services to its more than 13 million members, and improve quality of care, access, and efficiency
 - NEW: Public Hospital Redesign and Incentives in Medi-Cal (PRIME), Global Payment Program, Whole Person Care, Dental Transformation
 - CONTINUING: Medi-Cal Managed Care, Community-Based Adult Services, Coordinated Care Initiative, Drug Medi-Cal Organized Delivery System, Uncompensated Care for Indian Health Service and tribal facilities, Low-Income Pregnant Women

<http://www.dhcs.ca.gov/provgovpart/Pages/medi-cal-2020-waiver.aspx>



Medi-Cal 2020 Standard Terms and Conditions, STC #78, State Supporting Infrastructure

a. Information and Data Sharing. Achieving care integration across Medi-Cal delivery systems is a priority for the state. In particular, since managed care has become the predominant delivery mode serving 90 percent of all full-scope Medi-Cal members, data linkages and care coordination among MCPs and other partners such as participating PRIME entities is critical. As such, DPHs will be required to strengthen data and information sharing with MCPs under the PRIME. To support this requirement, **DHCS will establish data and information sharing guidelines and/or mechanisms, consistent with applicable state and federal data privacy and security law, to provide for timely sharing of beneficiary data, assessment, and treatment information, for purposes of identifying and treating the beneficiary for PRIME and WPC.**

http://www.dhcs.ca.gov/provgovpart/Documents/MC2020_FINAL_STC_12-30-15.pdf



Drug Medi-Cal Organized Delivery System Waiver Goals

- Improve service for Substance Use Disorder beneficiary
- Least restrictive level of care
- Authority to select quality providers
- Consumer-focused; use evidence based practices to improve program quality outcomes
- Support coordination and integration
- Reduce emergency rooms and hospital inpatient visits



Diverse Services, Information Sharing & Analysis

- Amendment to 1115 Waiver – Five year Pilot – Counties choose to Opt-in
- American Society of Addiction Medicine Criteria to support range of services
- Case Management – coordinate across multiple providers and services
- Quality improvement across system
- Evaluation of program



Monitoring Specialty Mental Health Services

One of the first goals of the Performance Outcomes System was to create reports using existing data to evaluate specific population demographics and system performance metrics.

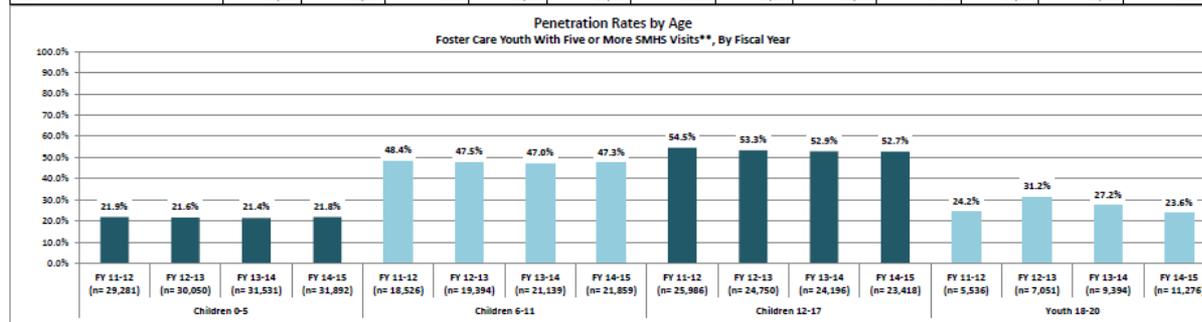
Foster Care and Open Child Welfare Cases Reports (matched with CDSS data)

September 2016 Foster Care Reports

- [Statewide Report.pdf](#)
- [Small Population Counties.pdf](#)
- [Medium Population Counties.pdf](#)
- [Large Population Counties.pdf](#)
- [Rural Population Counties.pdf](#)
- [Statewide Report - ADA.pdf](#)
- [Small Population Counties - ADA.pdf](#)
- [Medium Population Counties - ADA.pdf](#)
- [Large Population Counties - ADA.pdf](#)
- [Rural Population Counties - ADA.pdf](#)

Penetration Rates* Report: Children and Youth in Foster Care With Five or More Visits** Statewide as of August 3, 2016

	FY 11-12			FY 12-13			FY 13-14			FY 14-15		
	Foster Care Youth with 5 or more SMHS Visits	Certified Eligible Foster Care Youth	Penetration Rate	Foster Care Youth with 5 or more SMHS Visits	Certified Eligible Foster Care Youth	Penetration Rate	Foster Care Youth with 5 or more SMHS Visits	Certified Eligible Foster Care Youth	Penetration Rate	Foster Care Youth with 5 or more SMHS Visits	Certified Eligible Foster Care Youth	Penetration Rate
All	30,879	79,329	38.9%	31,113	81,245	38.3%	32,048	86,260	37.2%	32,301	88,445	36.5%
Children 0-5	6,404	29,281	21.9%	6,499	30,050	21.6%	6,746	31,531	21.4%	6,961	31,892	21.8%
Children 6-11	8,965	18,526	48.4%	9,214	19,394	47.5%	9,945	21,139	47.0%	10,329	21,859	47.3%
Children 12-17	14,170	25,986	54.5%	13,203	24,750	53.3%	12,798	24,196	52.9%	12,350	23,418	52.7%
Youth 18-20	1,340	5,536	24.2%	2,197	7,051	31.2%	2,559	9,394	27.2%	2,661	11,276	23.6%
Black	4,736	13,040	36.3%	4,826	12,534	38.5%	4,838	12,809	37.8%	4,840	12,690	38.1%
Hispanic	8,828	28,836	30.6%	9,170	29,430	31.2%	9,636	30,790	31.3%	9,185	30,013	30.6%
White	15,496	28,519	54.3%	15,063	30,208	49.9%	15,269	33,164	46.0%	15,663	36,298	43.2%
Other	1,817	8,934	20.3%	2,049	9,073	22.6%	2,305	9,497	24.3%	2,613	9,444	27.7%
Female	14,779	37,832	39.1%	14,824	38,847	38.2%	15,402	41,339	37.3%	15,485	42,459	36.5%
Male	16,100	41,497	38.8%	16,289	42,398	38.4%	16,646	44,921	37.1%	16,816	45,986	36.6%



*Penetration Rate is defined as the percentage of SMHS eligible beneficiaries that have received a SMHS that was claimed via the Short-Day/Mei-Cal claiming system. This does not include non-specialty mental health services provided in the Medi-Cal Managed Care system.
**Children and Youth in Foster Care that have received at least five SMHS in the Fiscal Year.



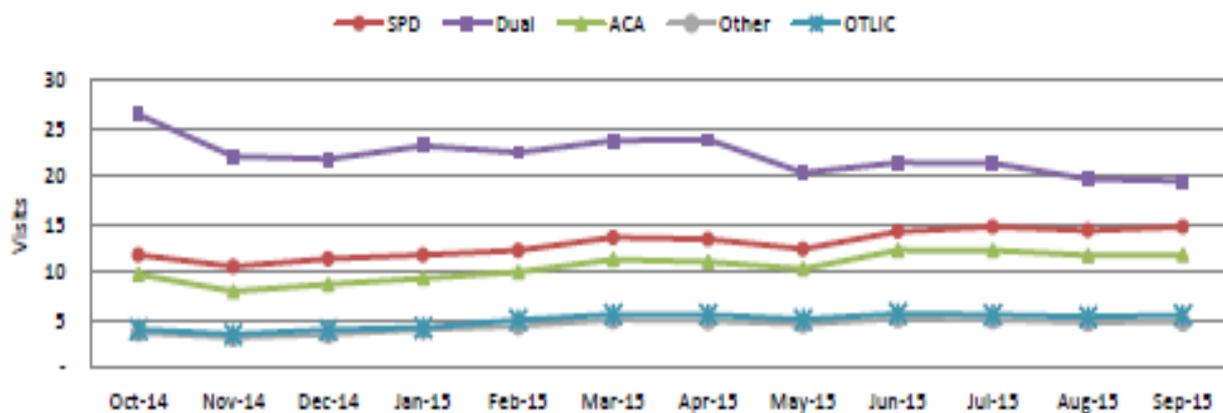
Mild to Moderate Mental Health Services



Medi-Cal Managed Care Performance Dashboard
Released September 15, 2016

UTILIZATION: Statewide October 2014 to September 2015. (Data Warehouse pull August 2016)

Fig 5-3 Mild to Moderate Mental Health Visits per 1,000 Member Months



As of September 2015	
SPD	15
Dual	20
ACA	12
Other	5
OTLIC	6

Note: Data in this dashboard is preliminary and subject to change

Page 5 of 10

<http://www.dhcs.ca.gov/services/Pages/MngdCarePerformDashboard.aspx>



Changing Populations

- Figure 2 – <http://www.dhcs.ca.gov/dataandstats/statistics/Documents/Medi-Cal Penetration Brief ADA.PDF>
- Figure 19 and 11 – http://www.dhcs.ca.gov/dataandstats/statistics/Documents/New_24_Month_Examination.pdf

Figure 2 - Percent of California Population Enrolled in Medi-Cal by Age Group; September 2015

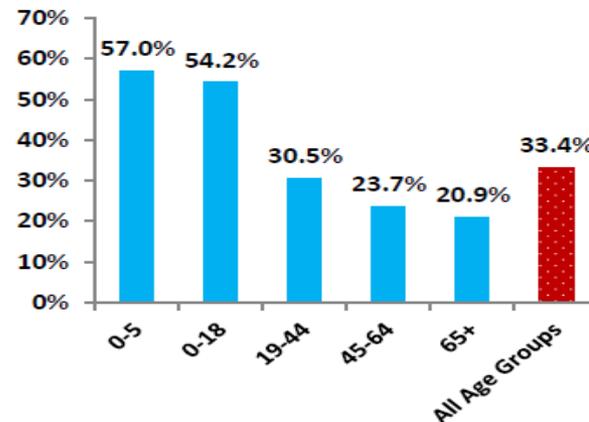
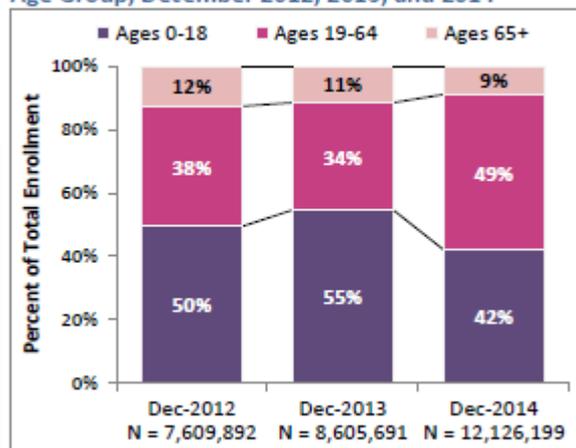
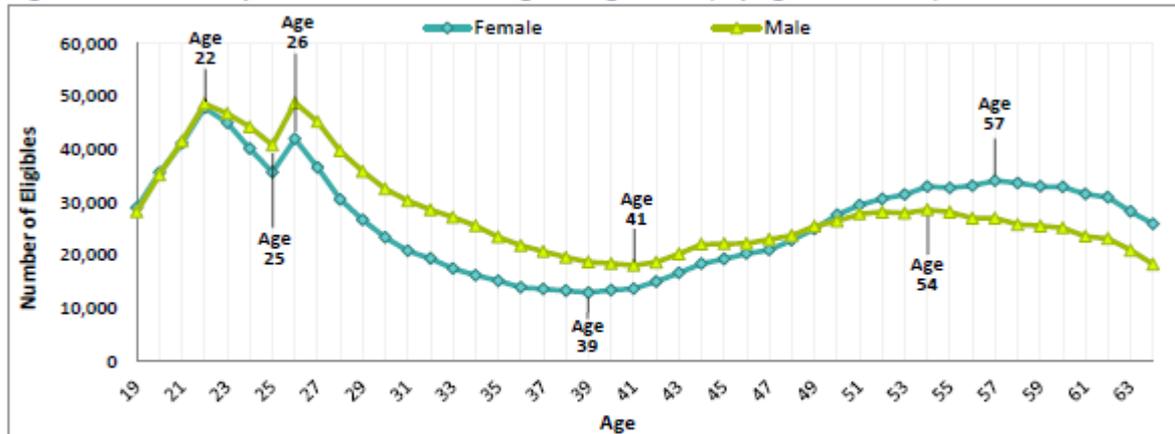


Figure 19: Distribution of All Certified Eligibles, by Age Group; December 2012, 2013, and 2014



Source: Created by RASD using data from the MIS/DSS data warehouse.

Figure 11: Count of Optional Adult Certified Eligibles Ages 19-64, by Age and Gender; December 2014



Source: Created by RASD using data from the MIS/DSS data warehouse.



Foster Care



Data Sharing to Support Outcomes

- Global Interagency Agreement
 - California Department of Social Services
 - California Department of Health Care Services
 - County Government (potentially 58 counties)
- Authorizes data sharing for the care of children in child welfare
- Provides process to identify data to share and document data sharing activities



Global Data Sharing

- Agreement signed between DHCS and CDSS in Spring 2015
- Counties have been signing on to the agreement since then
- Matched data is used to accurately identify children in foster care under the care and supervision of the child welfare system
- Counties have received client-specific reports



Counties participating in Global Data Sharing

- Alameda
- Butte
- Contra Costa
- El Dorado
- Humboldt
- Kern
- Lake
- Madera
- Mendocino
- Modoc
- Placer
- Sacramento
- San Diego
- San Francisco
- San Luis Obispo
- San Mateo
- Santa Clara
- Santa Cruz
- Sonoma
- Ventura
- Yolo
- Yuba



Monitoring Behavioral Health

- ADD: Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication includes an initiation phase and a continuation phase
[Reported to CMS2016] [SB 484, Ch. 540, Statutes of 2015, SB 1291, Ch. 844, Statutes of 2016]
- FUH: Follow-Up After Hospitalization for Mental Illness includes a 7 day and a 30 day follow up
[Reported to CMS2016]
- APP: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics *[SB 484, SB 1291]*
- APC: Use of Multiple Concurrent Antipsychotics in Children and Adolescents *[SB 484, SB 1291]*
- APM: Metabolic Monitoring for Children and Adolescents on Antipsychotics *[SB 484, SB 1291]*



Sharing Data - Addressing Confusion About the Rules



CalOHII - Patient Authorization Guidance Tool

- Required elements of a valid authorization:
 - Code of Federal Regulations Title 45 section §164.508(c)(3)
 - California Civil Code sections §§56.11-56.14, §56.21
- Designed to help healthcare providers determine when they need to obtain a patient's authorization to send that patient's information to another provider
- Applies only to healthcare providers as defined by both HIPAA and the Confidentiality of Medical Information Act (CMIA)

<http://www.chhs.ca.gov/OHII/Pages/Resources.aspx#PatientAuthorizationTool>



KEY QUESTIONS TO POSE BEFORE YOU DISCLOSE

SUBSTANCE ABUSE TREATMENT RECORDS

When is a patient authorization NOT required?

DRAFT

Who Must Comply?	 Program	<div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p>Emergency</p> <p>Research</p> <p>Court Order</p> </div> <div style="width: 35%; text-align: center;"> <p>Internal Communications by professionals for TX, service, or prevention</p> </div> <div style="width: 30%;"> <p>Qualified Service Organization Communication</p> <p>Required by Law</p> <p>Crime on Premises</p> </div> </div>
	 Community Mental Health Provider	<div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p>Court Order</p> <p>Required by Law</p> </div> <div style="width: 35%; text-align: center;"> <p>Emergency</p> <p>Child Abuse</p> <p>Elder Abuse</p> </div> <div style="width: 30%; text-align: center;"> <p>Internal Communications by professionals for TX, service, or prevention</p> </div> </div>
	 General Medical Facility	<div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p>Court Order</p> <p>Required by Law</p> </div> <div style="width: 35%; text-align: center;"> <p>Emergency</p> <p>Child Abuse</p> <p>Elder Abuse</p> </div> <div style="width: 30%; text-align: center;"> <p>Internal Communications by professionals for TX, service, or prevention</p> </div> </div>
Disclose What?	<p>Substance abuse treatment records: Alcohol and drug abuse records, patient records, or discrete portions thereof, specifically relating to evaluation and treatment of alcoholism or drug abuse; any information, whether in writing, orally, electronically, or by other means. Disclosure: A communication of records containing "patient identifying information" (PII). PII: Includes name, address, social security number, fingerprints, photographs or other information by which patient's identity can be determined with reasonable accuracy/speed identifying someone as having a past/current drug/alcohol problem and/or being a past or current patient in an alcohol/drug program.</p>	
		<p>The Information Practices Act (Civil Code § 1798-1798.78) applies to state agencies. Staff should check with their legal office regarding permissive uses and disclosures under the IPA.</p>

"Please note that there may be other permitted or required disclosures under the law. Contact your attorney for advice."

Published 6/6/2014

KEY QUESTIONS TO POSE BEFORE YOU DISCLOSE

MENTAL / BEHAVIORAL HEALTH TREATMENT RECORDS



DRAFT

When is a patient authorization NOT required?

Who Must Comply?

Providers
of
Health Care

Mental
Health
Services:

Private acute care
hospitals with no
psychiatric unit
(voluntary
patients)

Private
Psychotherapists

The following uses and disclosures are permitted:

- Board, commission, or administrative agency for adjudication
- Required by Law
- Health Oversight Agencies
- Limited uses for internal training programs
- Probate Court Investigator
- Provider Competency Review
- Third party for encoding, encrypting, anonymizing data
- Coroner Investigation
- Court Order
- Elder & Child Abuse
- Emergency Medical Personnel
- Inmates: TX, health, safety, good order facility
- Funeral Directors
- Payment
- Payor Billing
- Treatment
- Disability Rights California
- Nat'l Defense – Protect President
- Organ Procurement Agency
- Patient Representative
- Public Health Reporting
- Quality Assurance
- Search Warrant
- Secretary of US DHHS
- State or Federal Disaster Relief Agency

Note: If you are an acute psychiatric hospital, inpatient psychiatric unit, government-operated hospital or clinic, or a health care provider serving involuntarily detained mental health patients, refer to [the Lanterman-Petris Short Act Patient Authorization Tool](#).

In All
Cases:

- ✓ Validate the identity and authority of the individual requesting the information
- ✓ Develop internal written procedures and train employees on the requirements
- ✓ Limit the disclosure to what is described in the authorization
- ✓ Account for the disclosure within the patients record as required by the HIPAA Privacy Rule
- ✓ Designate individual(s) to process disclosure requests

"Please note that there may be other permitted or required disclosures under the law. Contact your attorney for advice."

Published 6/6/2014.



KEY QUESTIONS TO POSE BEFORE YOU DISCLOSE

ALL INFORMATION FOR PROVIDERS SUBJECT TO THE LANTERMAN PETRIS SHORT (LPS) ACT

DRAFT

When is a patient authorization NOT required?

What are some scenarios?	Disclose to whom?	Who Must Comply?
<ul style="list-style-type: none"> ▪ As needed for the protection of federal and state elective constitutional officers and their families ▪ As needed to protect reasonably foreseeable victims from serious danger of violence ▪ Conservatorship proceedings ▪ Court order for administration of justice ▪ Crime on the premises ▪ For aid, insurance, medical assistance – minimum necessary ▪ For conducting health care services and/or mental health treatment, developmentally disabled services for ward, dependent of juvenile court or those taken into temporary custody or petition to remove ▪ In facility communications between professionals providing services or referrals ▪ Protection and advocacy > Disability rights of California ▪ Upon patient death 	<ul style="list-style-type: none"> Appointed developmental decision maker for a minor, dependent or ward Coroner Correctional Agencies Court County Social Worker Custodial Guardian Probation Officer QA Committee Secretary of US DHHS 	<p>Service providers of patients who are involuntarily treated or evaluated and of patients who are voluntarily treated in a:</p> <ul style="list-style-type: none"> ▪ Community program (refer to your legal counsel) ▪ Community program specified in the W.I.C.S. 4000-4390 and 6000-6008 ▪ County psychiatric ward, facility or hospital ▪ Federal hospital, psychiatric hospital or unit ▪ Mental health rehabilitation center (Welfare and Institutions Code § 5675) ▪ Private institution, hospital, clinic or sanitarium which is conducted for the care and treatment of persons who are mentally disordered ▪ Psychiatric health facility (Health and Safety Code § 1250.2) ▪ Skilled nursing facility with a special treatment program service unit for patients with chronic psychiatric impairments ▪ State developmental center ▪ State mental hospital

"Please note that there may be other permitted or required disclosure under the law. Contact your attorney for advice."

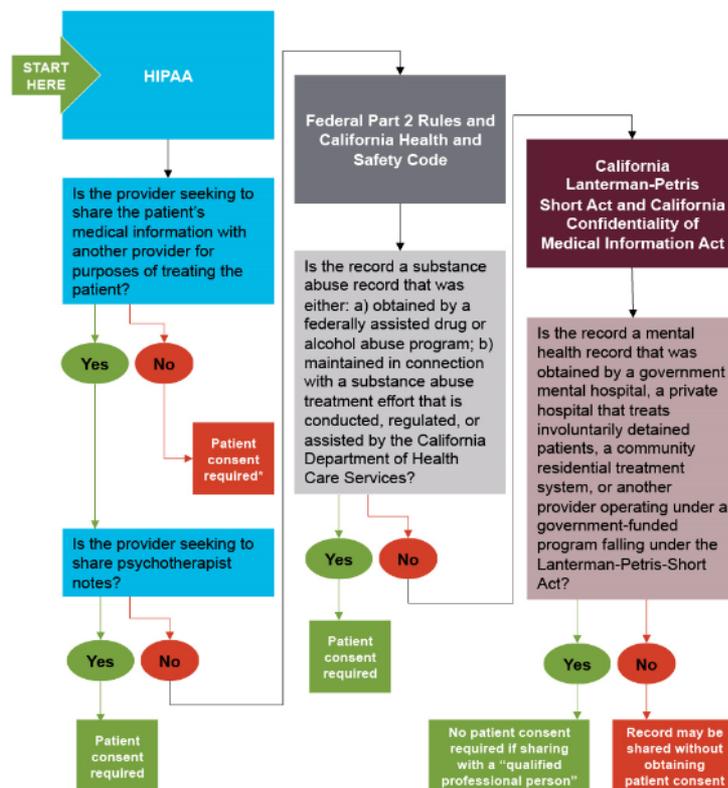
Published 6/6/2014



Fine Print: Rules for Exchanging Behavioral Health Information in California

- Funded by California Health Care Foundation
- Produced by Manatt, Phelps & Phillips
- <http://www.chcf.org/publications/2015/07/fine-print-exchanging-behavioral>

Sharing Behavioral Health Information Under Federal and California Law



*Patient consent would not be required if the information was being shared for another purpose allowed under HIPAA, such as for payment or health care operations.

Sources: 45 C.F.R. Parts 160 and 164, 42 C.F.R. Part 2, California Civil Code Section 56, California Welfare and Institutions Code Section 5328, California Health and Safety Code Section 11845.5.



State Health Information Guidance (SHIG)

- California Health & Human Services Agency Office of Health Information Integrity (CalOHII) is developing an official SHIG on sensitive patient health information with support from the California Health Care Foundation
- Will provide non-mandatory guidance to state and local governments, providers, health information exchange entities, and other stakeholders on the use, disclosure, and protection of sensitive health data related to behavioral health, substance abuse, HIV/AIDS, and genetics.
- Will be published in June 2017



State Health Information Guidance Goals

- Standardizing non-state entities' understanding of state and federal health information privacy, security, and patients' rights laws around sensitive health information (including mental health, substance use, and HIV) and increasing compliance with these laws
- Encouraging appropriate information-sharing to improve care coordination and health outcomes and decrease cost of compliance and care while protecting patients' privacy rights



Federal HHS Priority No Information Blocking

- Help providers share individuals' health information for care with other providers and their patients whenever permitted by law, and not block electronic health information (defined as knowingly and unreasonably interfering with information sharing)
- Examples of Blocking:
 - Contract terms, policies, or other business or organizational practices
 - Charging prices or fees making HIE cost prohibitive
 - Developing or implementing HIT in non-standard ways



Information Blocking

Interference.

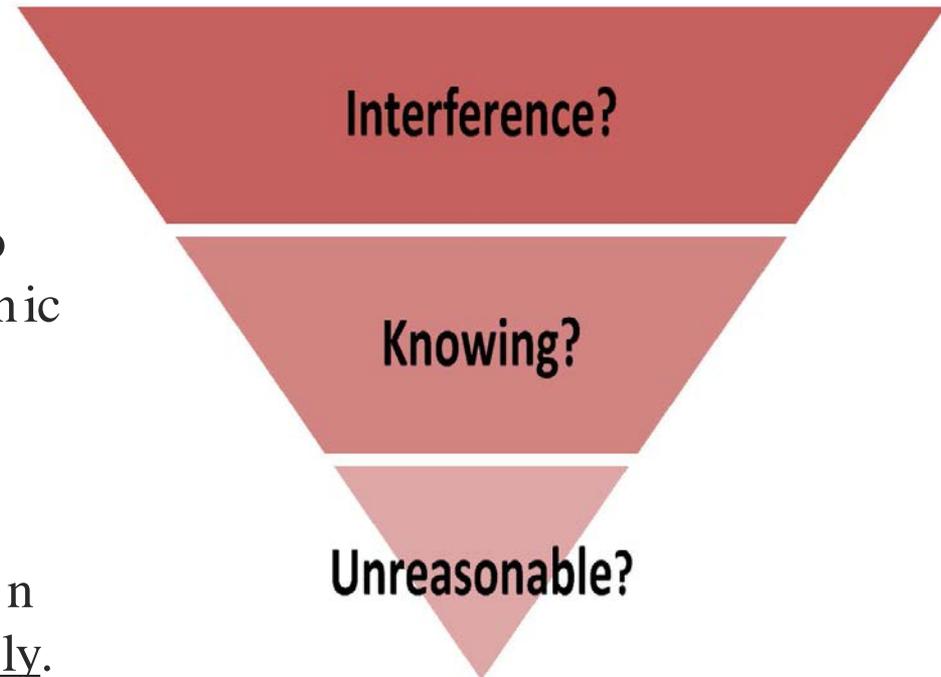
Some act or course of conduct that interferes with the ability of authorized persons or entities to access, exchange, or use electronic health information. (policies, business practices, etc.)

Knowledge.

Decision to engage in information blocking must be made knowingly.

No Reasonable Justification.

Conduct that is objectively unreasonable in light of public policy.



INFORMATION BLOCKING

<http://www.healthit.gov/buzz-blog/from-the-onc-desk/health-information-blocking-undermines-interopability-delivery-reform/>



Federal Funding Opportunities



New Guidance From CMS

- State Medicaid Director Letter (SMDL) #16-003, February 29, 2016
- Supports “*Connecting Health and Care for the Nation: A Shared Nationwide Interoperability Roadmap Version 1.0*”
- Potential for federal funding at 90% matching rate for state expenditures on activities promoting health information exchange (HIE) that supports Eligible Providers in the EHR Incentive Program meeting Meaningful Use



Changes with SMDL #16-003

- Meaningful Use (MU) modified Stage 2 and Stage 3 require Eligible Professionals (EPs) and Eligible Hospitals (EHs) to demonstrate ability to coordinate with other providers across settings
- **Before** 90% Federal match funding was previously available only if HIE promotion was **directly** correlated to the Medicaid EHR incentive program
- **Now** States may now claim enhanced Federal funding for connecting EPs and EHs to **other** Medicaid providers
- Expanded opportunities due to increased emphasis on coordination of care and transitions of care



MU Modified Stage 2 and Stage 3 Requirement Examples

- An EP might be a physician needing to meet the MU objective for HIE when transitioning patients to another Medicaid provider such as a nursing facility or home health care provider
- An EH might need to meet the objective for Medication Reconciliation and compare records with other providers to confirm the information on patients' medications is accurate when admitting patients



“Other” Medicaid Providers as described in SMDL #16-003

- Behavioral Health Providers
- Substance Abuse Treatment Providers
- Long-Term Care Providers (including Nursing Facilities)
- Home Health Providers
- Pharmacies
- Laboratories
- Correctional Health Providers
- Emergency Medical Services Providers
- Public Health Providers
- Other Medicaid Providers
(including community-based Medicaid Providers)



Uses & Expectations for the SMDL #16-003

- Potential Uses
 - Interoperability and HIE Architecture
 - On-Boarding Medicaid Providers to HIEs or Interoperable Systems
- Expectations of Efforts
 - Promote MITA principles on scalability, reusability, modularity and interoperability
 - Medicaid Enterprise infrastructure will be designed to support these efforts and the MITA principles
 - States to leverage available federal funding for tools and guidance to help EPs demonstrate MU, including strengthening data exchange between EPs and other Medicaid providers



Medicare Goals: Changing the Payment Models

- Fee-for-service payments shift to quality or value payments through alternative payment models such as Accountable Care Organizations or bundled payment arrangements
 - 30 % by the end of 2016
 - 50 % by the end of 2018
- Tying traditional Medicare payments to quality or value through programs such as the Hospital Value Based Purchasing and the Hospital Readmissions Reduction Programs
 - 85% by 2016
 - 90 % by 2018



Next Steps



Data Sharing and Integration

- Common goals to support outcomes
- Identify result to be achieved from data sharing
- Create environments to support data sharing
 - Legal and Policy
 - Technical
- Monitor processes and outcomes



Public Health Role

- Convening – Collaboration
- Data interpretation, analysis, epidemiology
- Framing the issues with interventions and outcomes in mind





References

- **SMD# 16-003** *Availability of HITECH Administrative Matching Funds to Help Professionals and Hospitals Eligible for Medicaid EHR Incentive Payments Connect to Other Medicaid Providers*
<https://www.medicaid.gov/federal-policy-guidance/downloads/smd16003.pdf>
- **SMD# 10-016** *Federal Funding for Medicaid HIT Activities*
<https://downloads.cms.gov/cm sgov/archived-downloads/SMDL/downloads/SMD10016.pdf>
- **SMDL# 11-004** *Use of administrative funds to support health information exchange as part of the Medicaid EHR Incentive Program*
<https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD11004.pdf>
- *Connecting Health and Care for the Nation: A Shared Nationwide Interoperability Roadmap*
<https://www.healthit.gov/sites/default/files/hie-interoperability/nationwide-interoperability-roadmap-final-version-1.0.pdf>



CHHS Data Playbook

<https://chhsdata.github.io/dataplaybook/>

Data De-Identification Guidelines

- As departments classify data tables and catalog their publishable state data, they should be mindful of legal and policy restrictions on publication of certain kinds of data. The CHHS Data Subcommittee commissioned the development of Agency-wide data de-identification guidelines to assist departments in assessing data for public release.
- The [CHHS Data De-Identification Guidelines](#) support CHHS governance goals to reduce inconsistency of practices across departments, align standards used across departments, facilitate the release of useful data to the public, promote transparency of state government, and support other CHHS initiatives, such as the [CHHS Open Data Portal](#).