



District of Columbia

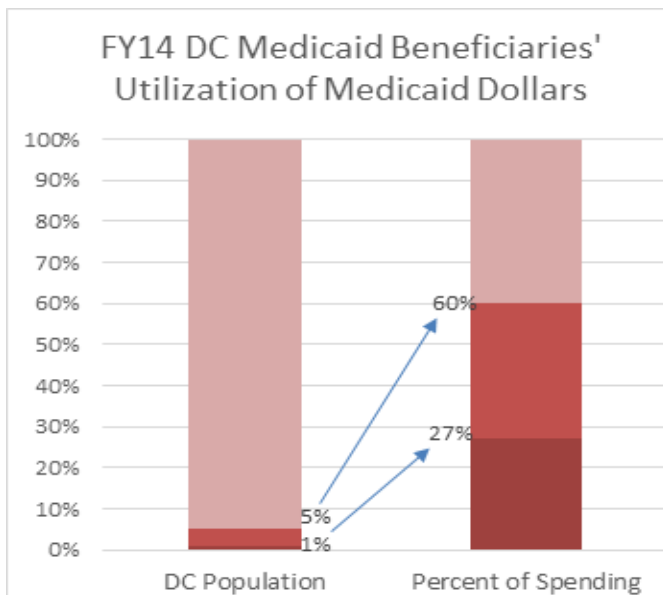
Statistical Analysis Center

FALL 2016

BRIEF: SUPER-UTILIZERS IN THE DISTRICT OF COLUMBIA

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DEFINITION



Source: DC Department of Health Care Finance

According to the Robert Wood Johnson Foundation, a “super-utilizer” is a person whose “complex physical, behavioral, and social needs are not well met through the current fragmented health care system.”¹ Super-utilizers typically suffer from mental health issues, chronic health issues, and often face unstable or non-existent housing conditions. Individuals who frequently use public systems, such as jails, hospital emergency rooms, and behavioral health services have substantial negative public safety and public health consequences for the communities in which they reside. Super-utilizers often touch multiple systems at a disproportionately greater rate than the general population, and account for a large proportion of spending. National data on Medicaid indicate that five percent of Medicaid clients account for over 50 percent of expenditures.² In FY2014, the top one percentile of Medicaid beneficiaries in the District (2,339 beneficiaries)

made up 27 percent of total Medicaid spending; the top five percentile (13,855 beneficiaries) accounted for 60 percent of total Medicaid spending. While the average per person fee-for-service Medicaid spending in the District was \$27,738, the top one percentile had an average per person spending of \$495,861.³

1 <http://www.rwjf.org/en/library/collections/super-utilizers.html>; retrieved 9/12/2016

2 S. Cohen and W. Yu: The Concentration and Persistence in the Level of Health Expenditures over Time: Estimates for the U.S. Population, 2008-2009. Agency for Healthcare Research and Quality. January 2012.

3 DC Department of Health Care Finance (DHCF) data submission “Key Data Takeaways (FY14)”

VOLUME 1 ISSUE 3

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PREVALENCE OF MENTAL ILLNESS IN JAILS

Each year, more than 11 million people move through America's local jails.⁴ Many of the individuals in local jails suffer from mental illness or substance use disorders, and many have chronic health problems. A Treatment Advocacy Center national survey revealed that state prisons and county jails hold as many as ten times more people with serious mental illness as state psychiatric hospitals.⁵ Jurisdictions around the country are taking steps to increase patient identification and systemic collaboration between health, mental health, and criminal justice agencies to address the needs of super-utilizers by providing targeted services and interventions. Specific to justice populations, many hope to effect overall reductions in the prevalence of persons with mental illnesses in jail,⁶ in addition to other health and safety goals.

NATIONAL CONTEXT – ADDRESSING THE NEEDS OF SUPER-UTILIZERS

King County, Washington, worked to identify super utilizers over the years through information sharing across health and mental health systems, as well as information systems that track homeless populations. Their model is one that strives for immediate identification when a person visits an emergency room, utilizes EMS, or accesses psychiatric emergency services. Interventions for core issues are recorded in statewide systems that capture and share the information.

In 2014, the National Governors' Association (NGA) sponsored a multi-state policy academy to help improve the care and reduce the cost of persons with various behavioral health needs that are often complex. The states included Alaska, Colorado, Connecticut, Kentucky, Maryland, Michigan, Rhode Island, West Virginia, Wisconsin, and Wyoming.⁷ The goal of this academy was to bring together state executives to coordinate data systems, and better provide targeted services. Data collection and information sharing are central to these discussions nationally, and will aid in the cross-system serving of residents, rather than often duplicative and disjointed care that mark the

4 U.S. Department of Justice, Bureau of Justice Statistics, Jail Inmates at Midyear 2014 Bulletin, June 2015, p.8 <https://www.bjs.gov/content/pub/pdf/jim14.pdf>

5 Torrey EF, Zdanowicz MT, Kennard AD, et al. The Treatment of Persons With Mental Illness in Prisons and Jails: A State Survey. Arlington, VA: Treatment Advocacy Center; 2014.

6 J. Perla: Colorado Super-Utilizer Activities: A Primer: 2013. <http://docplayer.net/9627087-Colorado-super-utilizer-activities-a-primer-prepared-by-julie-perla.html>. Retrieved May 2, 2016.

7 <http://www.nga.org/cms/home/news-room/news-releases/2015--news-releases/col2-content/states-improve-care-reduce-cost.html>

touch points of super utilizers.⁸ Even when a provider is providing excellent services, if they are not able to share information there is room for duplication, error, and resultant waste.

In Harris County, TX, a super-utilizer program, in place since 2014, is geared towards health care and envelopes other systems such as justice and mental health. The Primary Care Innovation Center (PCIC) is housed within the Houston health care system, first worked to identify the most vulnerable patients who visit the ER 10 or more times each year, and have "chronic medical and behavioral conditions." Just 1% of the patients seen in 2009 were utilizing 21% of the medical services consumed. Like many models in the country, there is no single prerequisite system that a person must be utilizing in Harris County, such as mental health or justice, but rather a combination of various systems that deal with their chronic conditions, mental illness, substance abuse, and/or social factors that include justice, homelessness, and the like. In Texas, the focus begins with information and data sharing, and extends into case management, working to collaborate across the multiple systems involved.⁹ This approach aims to achieve two goals: first to individualize care, and second to improve the overall functioning and policies of the systems with which these clients interact.

In Camden, NJ, the Camden Coalition of Healthcare Providers came together initially through hospital and health care access points to understand those that were frequent system utilizers. Theirs has become a national model built on information sharing and collaboration across many sectors, and reaching specifically into criminal justice in recent years to further their impact on service provision and coordination. The Camden Administrative Records Integration for Service Excellent (ARISE) takes public data systems and matches information to health service records to more wisely allocate resources.

DISTRICT OF COLUMBIA RESPONSES TO MENTAL HEALTH IN THE CRIMINAL JUSTICE SYSTEM

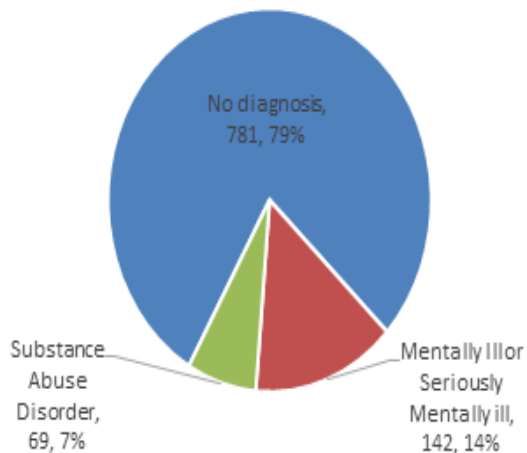
In the District of Columbia, criminal justice, health, and behavioral health agencies and organizations have a number of initiatives in place to address the needs of persons with mental illness and co-occurring substance use disorders who come into contact with the criminal justice system.

8 <http://www.nga.org/files/live/sites/NGA/files/pdf/2015/1509UsingDataBetter-ServeComplexPatients.pdf>

9 https://www.hhsc.state.tx.us/hhsc_projects/ECI/docs/PCIC-Houston-super-utilizer-program-012516.pdf AND <http://www.pcictx.org/>

The high prevalence of individuals with mental illness in jail represents a serious issue in the District of Columbia, and across the nation. District of Columbia Department of Corrections (DOC) intake data shows that, from a cohort of 992 intake transactions during March 2014, 142 persons were diagnosed as mentally ill or severely mentally ill; 69 additional individuals were diagnosed as having a substance abuse disorder.¹⁰

DOC: March 2014 Intakes



Source: DC Department of Corrections Data Submission

Additionally, many individuals with mental health needs are not identified. A Vera Institute of Justice Report found that about 33 percent of adult DC residents arrested during June 2008 had some indication of mental health need in partner agency records between 2006 and 2011.¹¹ The report found that many of those arrested with mental health needs were not known to community mental health care providers; most of the individuals studied with mental illness were known to at least one criminal justice agency (83 percent), yet the Department of Mental Health (now, Department of Behavioral Health – DBH) was only aware of 59 percent of these individuals during the same period. At the same time, 33 percent of cohort members known to DBH as having a psychotic spectrum disorder or bipolar disorder were not identified by any of the criminal justice agencies.¹² Moreover, individuals with severe mental illnesses are at greater risk for arrest and incarceration than the general population.¹³

¹⁰ DC-Department of Corrections (DOC) Data Submission

¹¹ J. Parsons, T. Sandwick, Closing the Gap: Using Criminal Justice and Public Health Data to Improve Identification of Mental Illness (2012): 2.

¹² Id. at page 3.

¹³ McFarland BH, Faulkner LR, Bloom JD, et al: Chronic mental illness and the criminal justice system. *Hospital and Community Psychiatry* 40 (1989): 718-723.

Many persons in the District suffering from mental health crises have encounters with police officers, and are taken to the District's Comprehensive Psychiatric Emergency Program (CPEP), a 24-hour facility that provides emergency psychiatric services. During FY2015, the Metropolitan Police Department (MPD) involuntarily detained 2,132 persons they later brought to CPEP for treatment. By mid-year FY2016, 982 individuals have been taken to CPEP.¹⁴

The Department of Behavioral Health

The Department of Behavioral Health (DBH) is the State Mental Health Authority for the District of Columbia. It oversees a network of community based providers that serve more than 22,000 District residents. DBH also operates Saint Elizabeth's Hospital, the District's public psychiatric hospital, the Comprehensive Psychiatric Emergency Program (CPEP), the District's 24-hour psychiatric emergency facility, a Detoxification and Assessment Center for individuals with substance use disorders, and two urgent care clinics for adults and children providing a safety net mental health and substance use disorder services.

DBH has deployed staff and resources throughout each point of intercept in the criminal justice system (where defendants and offenders with mental illness are likely to be identified as needing mental health or co-occurring services) per the Sequential Intercept Model. These points of intercept are: Pre-Booking (Phase 1), Post-Booking (Phase 2), Jail/Incarceration (Phase 3), and Reentry (Phase 4).

DBH works to ensure District residents have access to quality services, including the use of Evidence Based Practices (EBPs) and other critical services. These programs are for both those who are justice involved and other residents, and include Assertive Community Treatment, Trauma Informed Care, the Access Helpline, and the Juvenile Behavioral Diversion Program.

The Pretrial Services Agency

The Pretrial Services Agency (PSA) houses Specialized Supervision Units (SSU), which provide specialized services and supervision to defendants with mental illness, mental disabilities, and/or co-occurring substance use and mental health disorders. In administering these services, the SSU works collaboratively with DBH, the Department of Disability Services, and designated mental health service

¹⁴ FY2016 CPEP data covers the period from October 1, 2015 through April 30, 2016.

providers. Due to the high numbers of persons needing these specialized services, PSA created an additional SSU team in 2016.

DC Superior Court

The DC Superior Court Mental Health Community Court (MHCC) seeks to integrate community resources to meet the unique needs of persons with mental illness in the court system. Participation in MHCC is completely voluntary. Participants must be both legally and clinically eligible for MHCC. MHCC legal eligibility precludes pending domestic violence, violent felonies or gun convictions. Clinical eligibility is defined as having a severe mental health diagnosis such as schizophrenia or bi-polar, and requires that the defendant be approved for supervision under PSA's Specialized Supervision Unit. Persons with a co-occurring substance abuse disorder may be allowed into MHCC but must be willing to cooperate with drug testing and substance abuse treatment recommendations. If compliance with treatment services is maintained, as well as the other conditions set by the court, participants are allowed to enter into a diversion agreement for a period of four months. Upon successful completion of the agreement, the participant graduates from MHCC and the prosecution then requests that criminal charges be dismissed or reduced.

FUSE: The DC Frequent Users Service Enhancement Pilot Program

The District of Columbia Frequent Users Service Enhancement (FUSE) pilot program was launched in 2010, administered by the Corporation for Supportive Housing (CSH) in partnership with University Legal Services (ULS), with the goal of coordinating and improving services for frequent users in DC.¹⁵ The FUSE program identified frequent users of jails and emergency shelters with a qualifying mental health diagnosis through data sharing agreements between the DC Department of Corrections (DCDOC) and The Community Partnership for the Prevention of Homelessness (TCP). The FUSE service delivery model was based on a housing-first approach, with the premise that individuals with mental illnesses and chronic histories of housing instability or homelessness can reduce their use of public systems upon receipt of permanent supportive housing. Those identified in the FUSE pilot in DC experienced some combination of shelter use and incarceration, as well as having been identified for clinical mental health disorders. Many also experienced

¹⁵ <http://www.urban.org/research/publication/frequent-users-jail-and-shelter-systems-district-columbia-overview-potential-supportive-housing>

substance use. The DC FUSE pilot program is no longer in operation.

MOVING FORWARD – ADDRESSING THE NEEDS OF SUPER UTILIZERS IN THE DISTRICT OF COLUMBIA

White House Data Driven Justice Initiative

To break the cycle of incarceration, the White House launched the Data-Driven Justice Initiative (DDJ) in June 2016 with a bipartisan coalition of 67 city, county, and state governments committed to using data-driven strategies to divert low-level offenders with mental illness out of the criminal justice system.¹⁶ The District of Columbia has signed on to be a part of the DDJ coalition. The District will work to bring data together from across criminal justice and health systems to identify the individuals with the highest number of contacts with police, ambulance, emergency departments, and other services, and link them to health, behavioral health, and social services in the community, with a goal of reducing overreliance on emergency healthcare and encounters with the criminal justice system.

As part of the DDJ Initiative, District partners are in discussions to participate in a DDJ Tech Consortium Pilot Project in collaboration with the University of Chicago Data Science for Social Good Fellowship program (UChicago). Noting that disconnection to mental health treatment is a key indicator of an increased likelihood of arrest, UChicago would provide analysis for a set of anonymized District of Columbia partner data, and identify high-risk individuals at the highest risk of further system involvement. District partners would then work to connect the identified individuals to mental health and wraparound services.

BJA Justice and Mental Health Collaboration Program (JMHCPC) Grant

DBH and MPD, with the support of a broad spectrum of District agencies, has been awarded Bureau of Justice Assistance JMHCPC Grant funding to support District efforts to identify and provide enhanced support to justice and mental health services super-utilizers. Though this two-year JMHCPC grant, District partners will leverage existing data systems to track the progress of coordinated system delivery improvement efforts and inform long-term diversion policies that reduce the number of persons with mental illness in jail.

¹⁶ Fact Sheet: Launching the Data-Driven Justice Initiative: Disrupting the Cycle of Incarceration, <https://www.whitehouse.gov/the-press-office/2016/06/30/fact-sheet-launching-data-driven-justice-initiative-disrupting-cycle>

The DC SAC

The Statistical Analysis Center for the District of Columbia (DC SAC), the research arm of the CJCC, was established in 2001 by a Mayoral Executive Order to provide a division dedicated to the collection, analysis, and dissemination of criminal justice system information. The work of the DC SAC is guided by the Interagency Research Advisory Committee (IRAC), which consists of researchers and program representatives from justice system agencies. The IRAC serves as the advisory body for the DC SAC and supports its efforts to collect, analyze, and disseminate relevant research and analysis that can impact the District's adult and juvenile justice systems. The DC SAC strives to provide decision-makers and the public at large with easily accessible and fact-based information about crime and the administration of justice across the District of Columbia.

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