DATA-DRIVEN JUSTICE: DISRUPTING THE CYCLE OF INCARCERATION

June 7, 2017

TODAY'S CALL

- NACo and Arnold Foundation updates
- Update on SAMHSA meeting
- Presentations
  - **Lourdes Benedict**, Director of Human Services, Pinellas County, Fla.
  - **Kamala Mallik-Kane**, Research Associate, Urban Institute Justice Policy Center

NACo UPDATES

Upcoming Webinars
www.naco.org/events

Conducting a Comprehensive Process Analysis and Inventory of Services for People with Mental Illnesses in Jails

- June 29th at 2 pm EDT

Doing Things!

Pinellas County Human Services

Behavioral Health Pilot

6-7-17

Behavioral Health Pilot - Why?

- Stabilize high utilizers
- Streamline the Behavioral Health System
  - Reduce the wait time for Behavioral Health Services
  - Determine gaps in the Continuum of Care
  - Develop solutions to meet the needs of the community
- Reduce high utilizer's visits to the Crisis Stabilization Unit, Emergency Departments & Jail

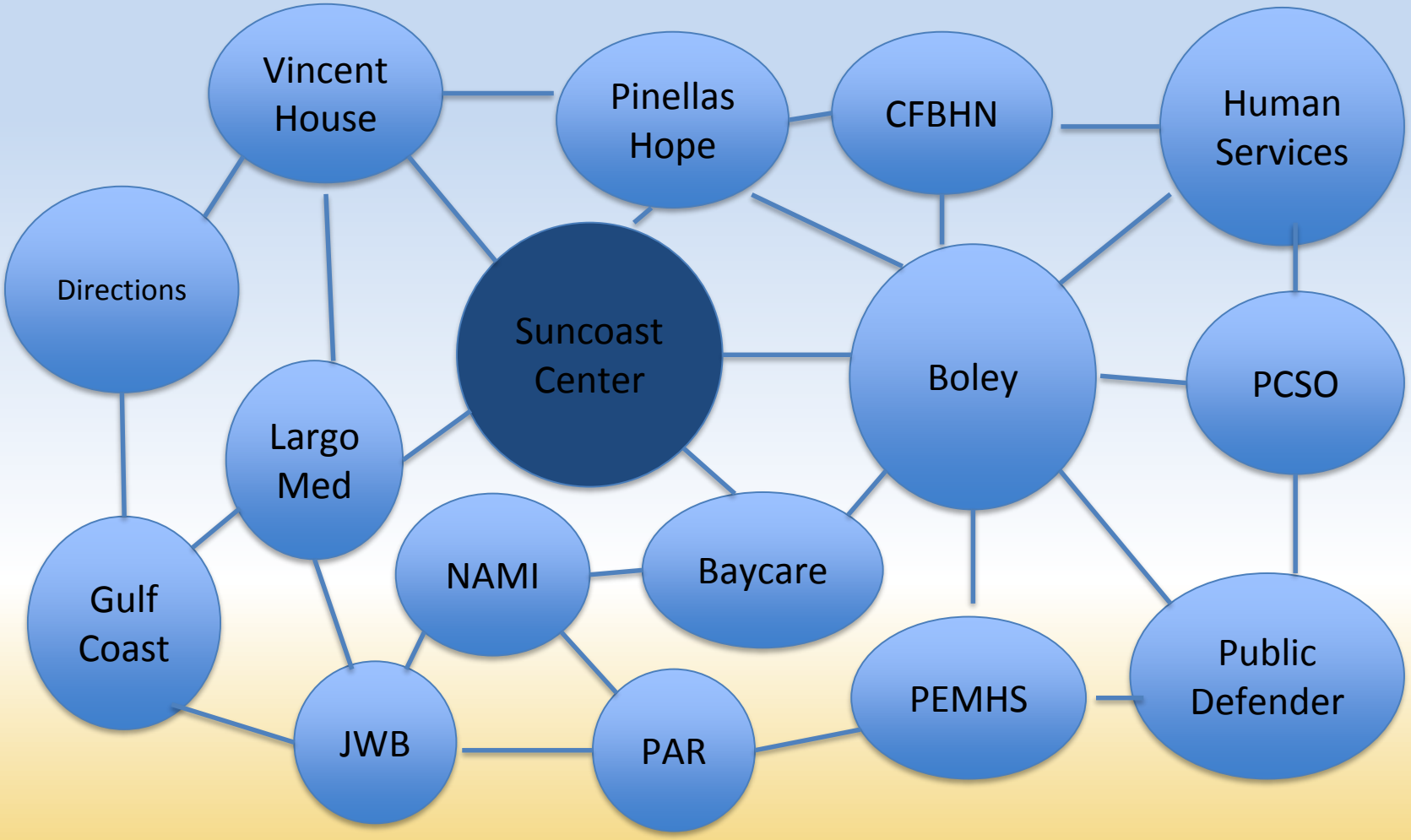
Behavioral Health Pilot – Who?

- Top 33 utilizers of public Crisis Stabilization Unit (CSU) & County Jail
  - 33 identified in 2015 during planning - used to understand population and needs
  - Current 33 identified in 2016 at implementation
- High utilizer criteria
  - Group 1: Top utilizers of public CSU (PEMHS)
  - Group 2: Most frequently referred from jail to public CSU

Behavioral Health Pilot - What?

- Developed by community stakeholders – subject matter experts
- Current cost to system $2.4m (Jail, Hospital Inpatient, CSU)
- BCC authorized $964,000 (Psychiatrist, Case Manager, Therapist, LPN & Law Enforcement, Services, Operations)
- Repeated engagement
  - Relationship building
  - Consistent and frequent contacts with patients
  - Knowledge that case workers are available when ready to get clean.
  - Warm connections to services (shopping, benefits, medical care, treatment)

Behavioral Health Pilot - Partners



Behavioral Health Pilot – Current Situation

Top 33

- 32 Located (2 need to be engaged/enrolled)
- 1 not located
- 6 Replace with new participants
  - 4 Out of county/state
  - 1 Prison
  - 1 FACT

Behavioral Health Pilot – Current Situation

Top 33

- 1 Jail
- 1 Challenge to engage
- 19 Long acting injectables
- 15 County Health Program
- 9 Medicaid
- 6 Housed at Boley
- 1 Independent Apartment
- 13 Transitional Housing Waiting Permanent
- 31 Have Substance Abuse Issues

Behavioral Health Pilot

- PCSO reported fewer arrest & severity
- 1 Addicted to Cocaine currently clean
- 1 Spice – PAR helping no current detox
- Help with basic life skills
- No one has dropped out
- Vincent House

Behavioral Health Pilot - Performance Management

- Lead Evaluators: University of South Florida, Florida Mental Health Institute
  - Quantitative and qualitative evaluation
  - Reports: Baseline, 6 mo., 12 mo., 24 mo., and Final report March 2022
- Pinellas County Data Collaborative (1999)
  - Identify and access state and local datasets
  - Data use agreements already in place for most datasets; secured others

Behavioral Health Pilot - Performance Management

- Key quantitative measures – frequency and costs
  - CSU utilization
  - Jail utilization
  - ED use and hospitalization
  - Detox
- Qualitative components to pilot success and barriers
  - Staff
  - Patient
  - Coordination of services
  - Others as identified (lessons learned)

Behavioral Health Pilot – Outcomes

Pinellas County HUMAN SERVICES

Define - Measure - Analyze - Improve - Control

Project or Program: Pinellas County Behavioral Health High Need/High Utilizer (HNHU) Pilot Program
Goal: HNHU Pilot clients stabilized in the community

INPUTS	ACTIVITIES		OUTCOMES		
What we invest	**What we do**	**Who we reach**	**Short-term results**	**Intermediate results**	**Long-term results**
$ 964,441.50 (proposed budget) **Provider Partners:** Law Enforcement – Liaison, Law Enforcement Representative[1] Behavioral Health – Case Manager[1], Therapist[1] Housing – facilities to temporarily house up to 33 pilot participants in collective locations Hospital/Medical providers – Emergency Rooms Liaison, Department of Health	Client engagement Client Assessment Rapidly house homeless clients Provide indicated treatment and support Arrange supportive services Case Management Rapid team response to system re-entry or other crises	Top 33 High Need/High Utilizers (HNHUs) of CSU and Jails identified using Baker Act (PEMHS[2]), HNHU (CFBHN[3]), and Arrests (PCSO) data.	#/% Clients engaged and enrolled in pilot #/% of Homeless clients housed within 1 week of pilot entry by type of housing (transitional, Permanent Supportive Housing, etc.) #/% of Clients receive LOCUS[4] or other approved assessment within one week of pilot entry #/% of clients receive SPDAT[5] assessment within one week of pilot entry #/% of clients have housing and service plans within one week of pilot entry #/% of clients who receive treatment indicated in service plan #/% Clients receive indicated wrap-around services: Financial Assistance Self-sufficiency Employment training Budgeting	Reduction in #/% of clients arrested 1 & 3 months post pilot entry Reduction in # jail bed-days 1 & 3 months post pilot entry Reduction in #/% of clients with Baker Acts 1 & 3 months post pilot entry Reduction in total # Baker Acts 1 & 3 months post pilot entry Reduction in #/% clients hospitalized 1 & 3 months post pilot entry Reduction in #/% clients with ER visits 1 & 3 months post pilot entry #/% Clients enrolled in training/skills program (eg. Vincent House)	#/% Clients who successfully complete treatment Increase in #/% Clients in permanent/permanently supported housing >6 months Reduction in #/% of clients arrested >6 months months post entry Reduction in # jail bed-days >6 months months post entry Reduction in #/% of clients with Baker Acts >6 months post entry Reduction in #/% of clients with Baker Acts>6 months post entry Reduction #/% Clients admitted to Detox >6 months Reduction in #/% Clients hospitalized >6 months (to be defined) Increase in #/% Clients stable in community/self-sufficient (eg. receiving Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI)) Increase in #/% Employed in paid positions Increase in #/% Engaged in meaningful, productive activity, eg., school, day services, volunteer work

[1] Members of Treatment Team
[2] Personal Enrichment Through Mental Health Services
[3] Central Florida Behavioral Health Network
[4] Level of Care Utilization System Assessment - used to determine the resource intensity needs of individuals who receive adult mental health services
[5] Service Prioritization Decision Assessment Tool - used for intake and service delivery to prioritize clients for housing and wrap-around services

Updated 02/22/16

Behavioral Health Pilot – Interim Findings

- Wait time for behavioral health services
- Access to Substance Abuse services
- Lack of a secure Marchman
- Lack of staff community resource knowledge due to turnover and program changes
- Baker Act & Discharge Plan – revolving door
- Data Sharing
- Jail medical services & Jail release times
- Gaps in the continuum of care – need more secure housing, intensive case management, wrap around services, transportation

Behavioral Health Pilot – Next

- Pilot should evolve as the system evolves and opportunities change.
- Pilot began on May 10, 2016 for a 1 year term and has been renewed for 2 additional 1 year terms.
- Year 1 focus:
  - Ongoing engagement and services for top 33
  - Evaluate success of engagement, progress made, status, etc
  - I.D. System Barriers and Gaps / Develop solutions
  - Assess funding utilization and service needs of target population
  - Review budget and ensure critical needs being met
- Year 2 focus:
  - Develop and implement solutions for identified systems issues (low-hanging fruit)
  - Develop transition plan for those ready to move out of intensive case mgmt.
  - Assess ability to engage next group of high utilizers

Contact Information

Pinellas County Florida Human Services

Lourdes Benedict, Director

lbenedict@pinellascounty.org

Stephanie Reed, Section Manager

Planning & Quality Assurance

sreed2@pinellascounty.org

Connecting Criminal Justice to Health Care (CCJH) – Introduction to Performance Management

NACo Data Driven Justice Webinar

June 7, 2017

Presented by Kamala Mallik-Kane
Urban Institute
kkane@urban.org

URBAN INSTITUTE

manatt

CCJH Initiative Overview

With support from the U.S. Department of Justice's Bureau of Justice Assistance, the Urban Institute and Manatt Health facilitated the CCJH initiative, which brings together state and local corrections and health care officials to develop and implement strategies for connecting justice-involved individuals with health care.

- In early 2016, the State of Maryland and Los Angeles County were selected as participant sites in the CCJH initiative.
- Throughout 2016 both sites participated in Learning Collaboratives (LCs) to identify priorities and solutions in three key areas.
- The insights, policies, and operational strategies that emerged from the LCs will be highlighted in issue briefs and a policy guide that will become publicly available later this year.

Learning Collaborative Areas of Focus

What is Performance Management?

Goal: Improve Services to Clients

- **Learn if programs have been implemented as intended**
- **Measure and recognize success**
- **Motivate staff**
- **Demonstrate program impact**
- **Identify what's working, what needs improvement**
- **Make adjustments to service delivery**
- **Use resources effectively**

Adapted with permission from Lampkin, Linda M. and Harry P. Hatry. (2003). *Key Steps in Outcome Management*. Washington, DC: The Urban Institute. Also Hatry, Harry P. "Managing for Outcomes" presentation, November 19, 2003.

What is Performance Management (and what isn't it)?

Ongoing performance *management* =
Tracking, interpreting, and responding to performance *measures* over time

	Performance Measurement Data Collection	Program Evaluation Data Collection
Goal	Continuous program improvement	Major program decisions
Frequency	Regular, ongoing	One-time, irregular
Program coverage	Widespread	Selected program sites
Depth of information	Data only "tells the score," not why; Team interprets & responds	Data seeks reasons for program performance
Costs	Spread out	High for each study

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Types of Performance Information

A. Inputs

- Costs, staff time, resources (e.g., budget for road repair)

B. Outputs

- Amount of work completed (e.g., miles of road paved, numbers of potholes filled)

C. Outcomes

- Intermediate outcomes (e.g., driver satisfaction)
- End outcomes (e.g., percent of roads in good, safe, driveable condition)

D. Efficiency

- Amount of inputs per unit of output or outcomes (e.g., dollars per mile of road paved)

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Outputs vs. Outcomes

Outputs = Work done	Outcomes = Aims achieved
Roads repaired	• Roads in good condition
Educational sessions held	• Students' increase in knowledge
Applications filled	• Percent who applied for Medicaid within 30 days of release • Percent who gained coverage within 30 days post-release
Prescriptions written	• Percent of high-need clients who received a prescription at release • Percent who filled prescription within 30 days of release
Referrals made	• Percent who received an outpatient service within 30 days of release

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Sample Performance Report – Keep it Simple & Outcome-Focused!

Mission statement: Enroll people in Medicaid before release

	Number released	Number of applications submitted	Applied for Medicaid (%)	Target	Difference (Percentage points)
All	500	200	40%	50%	-10
Gender					
Male	450	162	36%	50%	-14
Female	50	40	80%	50%	+30
# Chronic Conditions					
0	100	20	20%	25%	-5
1	150	30	20%	50%	-30
2+	250	150	60%	75%	-15

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Analyze and Use Performance Data to Improve Services

Hold regularly scheduled "How are we doing?" meetings

- Keep it simple
- Keep it positive
  - Not an audit or "gotcha"
- Review outcome data
- Identify successes and areas for improvement
- Seek explanations for good and poor outcomes
- Consider service improvements

Adapted with permission from Morley, Elaine and Linda M. Lampkin. (2004). *Using Outcome Information*. Washington, DC: The Urban Institute. Also Hatry, Harry P. "Managing for Outcomes" presentation, November 19, 2003.

Example: Using Performance Data to Seek Explanations

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# Chronic Conditions					
0	100	20	20%	25%	-5
1	150	30	20%	50%	-30
2+	250	150	60%	75%	-15

What worked well? Can we replicate with men?

Is this typical? What can we change?

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Getting Performance Data: Cross Agency Coordination

Can use aggregate data from different sources

- **Outcome measures are usually a percentage of some target population**
  - **Numerator data – about Medicaid or another health care outcome**
  - **Denominator data – about the justice population**
- **Aggregate data OK if numerator & denominator reflect *roughly* the same people**
  - **DOC collects info about Medicaid outcomes**
  - **Medicaid/health agencies flag CJ-involved clients**
- **Privacy, workload & technological considerations to tracking individual-level outcomes**

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Implementing a Performance Management Process

- **Designate Performance Management Team**
  - Form a working group to develop measures and oversee initial implementation
  - Select programs and initiatives to include
- **Decide on Performance Measures**
  - Identify program mission, target population, and outcomes
  - Define indicators to measure outcomes
  - Select data sources and data collection procedures for each indicator
  - Identify key client and service characteristics to link to outcome information
- **Collect and Report Performance Data**
  - Pilot test data collection, revise, and implement
- **Hold Regular "How are we doing?" meetings**
  - Review data, seek explanations for findings, make service improvements

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Form a Performance Management Working Group

Factors for Success

- **Membership**
  - **Representation from DOCs and Medicaid**
- **Leadership support**
- **Stable organizational structure**
- **Commitment of staff time and resources**
- **Access to data for simple analytics**
  - **IT involvement may help**

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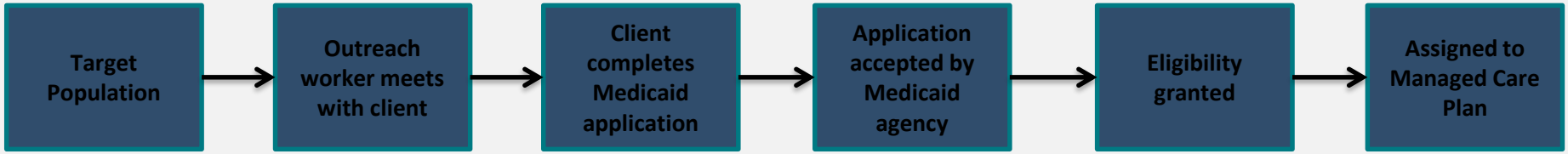
Select Outputs and Outcomes to Measure

Develop a logic model of the service provided & list desired measures
Outcome sequence chart



Target Population	Outreach worker meets with client	Client completes Medicaid application	Application accepted by Medicaid agency	Eligibility granted	Assigned to Managed Care Plan
Number of clients in target population	Number of clients who met with worker Number of days before release	Number of clients who completed application Number of days before release Client satisfaction with application assistance	Number of applications accepted by Medicaid agency Time between application submission and agency acceptance	Number of clients granted eligibility Reasons for denied applications Time from application to eligibility determination (alt. time from release)	Number assigned to managed care plan Time from eligibility determination to MCO selection (alt. time from release)

Deciding on Performance Measures

- Map program activities to potential data sources
  - Can be aspirational
  - Process may prompt data improvements (e.g., add Qs to intake screening)
- Define target population(s)
  - All
  - Level of health needs (e.g., chronic physical, mental or addiction problems)
  - Risk factors (e.g., homelessness)
- Plan to answer key questions
  - Compare data to benchmarks/performance targets
  - Compare across key subgroups (e.g., gender, race, program locations)

Potential Data Sources

- **Agency Records**
  - Jail or Prison Management Information System
  - Correctional Health Records
  - Tracking Forms Used by Agency Staff
  - Medicaid Application and Eligibility Determination System
  - Medicaid Claims Database
  - Community-based Electronic Health Records
- **Clients**
  - Client Surveys (measure: client characteristics, service quality)
  - Focus Groups (get suggestions for improving service)
- **Trained Observer Rating Procedures**
  - Structured Observation of Services Provided

Focus measurement on outcomes & the right population

Activity	Outcome Indicator	Potential Data Sources: *Numerator*	Target Pop "Universe": *Denominator*
Clients approached	*Number & percent* of inmates who met with an enroller and received targeted enrollment assistance	• Enroller reporting • DOC agency data (e.g., health services, case management, or discharge planning records)	• All inmates in facility • All releases • Releases of a certain legal status • Releases with certain needs or risk factors
Applications filled	*Number & percent* of inmates who submitted a Medicaid application (within X days of release)	• Enroller reporting • DOC agency data • Medicaid agency data	• All inmates in facility • All releases • Releases of a certain legal status • Releases with certain needs or risk factors
Prescriptions written	*Number & percent* of inmates who received a prescription at release	• DOC agency data • Medicaid agency data	• All releases • Releases of a certain legal status • Releases with certain needs or risk factors

Resources

- **Webinar on Performance Management**
- **Forthcoming: National Policy Guide and Issue Briefs**

Please visit:

www.urban.org/policy-centers/justice-policy-center/projects/connecting-criminal-justice-health-care

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QUESTIONS?

THANK YOU FOR ATTENDING AND PARTICIPATING!

Our next call is Wednesday, July 12th at 3 pm EDT

We will send a follow-up email and
post notes from today's webinar