DATA DRIVEN JUSTICE:

A Playbook for Developing a System of Diversion for Frequent Utilizers

Arnold Ventures

NATIONAL ASSOCIATION of COUNTIES NACo

TABLE OF CONTENTS

INTRODUCTION

Close to 11 million people moved through the country's local jails in 2017, 91 percent of which are operated by county governments. Counties invest more than $93 billion in justice and public safety annually, including $22 billion to operate jails.[1] A quarter of the individuals who enter jail are accused of misdemeanor level crimes.[2]

A large share—44 percent—of people who are sentenced to jail have been diagnosed with a mental illness by a professional, 63 percent have a substance use disorder, and 45 percent suffer from chronic health problems.[3] With three times more people experiencing mental illness incarcerated than in mental health treatment facilities, the criminal justice system is at the front lines for people experiencing mental health crises.[4]

Communities across the country have recognized that a relatively small number of people cycle repeatedly through local jails, hospital emergency rooms, shelters, and other public systems. Often called frequent utilizers, these individuals tend to struggle with a combination of complex health and social issues, including mental illness, substance use disorders, and unstable housing. Their conditions often worsen if arrested and incarcerated, leading to costly recurring interactions with emergency medical services, law enforcement, and other services. Despite the many resources devoted to responding to frequent utilizers, care is often provided in fragmented ways that do not promote recovery or better outcomes for individuals or communities.

To address these challenges and more effectively treat these individuals, counties and other jurisdictions across the country have joined Data-Driven Justice (DDJ) — a project of the National Association of Counties (NACo) and Arnold Ventures (AV) that aims to help local jurisdictions use data to better align resources to respond to people with complex health and social needs, particularly those who are frequent utilizers of justice, health, and human services systems. Through a coordinated multi-system approach, jurisdictions participating in DDJ aim to develop a continuum of data-driven, innovative practices that provide law enforcement and other first responders with appropriate crisis response options to reduce arrest, incarceration, and use of emergency medical services, and increase frequent utilizers' access to treatment and engagement with services in the community.

PURPOSE OF THE PLAYBOOK

The Playbook is designed to help guide the development of a multi-system strategy to successfully divert frequent utilizers, when appropriate, away from the criminal justice and emergency health systems and toward community-based treatment and services. DDJ communities played a key role in developing the Playbook, sharing lessons learned and successful practices so that other communities can build from the work already underway and accelerate progress towards impactful solutions that improve outcomes for vulnerable individuals in their community.

STRUCTURE OF THE PLAYBOOK

A data-driven diversion strategy has five key elements:

Element 1. Build Stakeholder Consensus.

Element 2. Understand the People You Hope to Serve.

Element 3. Establish a Framework for Data Governance.

Element 4. Conduct Resource Scan and Identify Gaps in Services and Treatment.

Element 5. Build Continual Data Use and Information Sharing into Cross-System Organizational Operations and Policy Discussions.

Each of these elements is described by a section in this playbook and includes:

- Key implementation guidance;
- Brief case examples that highlight promising data sharing, integration, and analysis practices that have improved system efficiencies and individual outcomes; and
- Call-out information on insights and tips collected from on-the-ground experiences of DDJ communities.

While this playbook serves as a resource to help communities harness the power of data to divert frequent utilizers from justice and emergency health systems, there are many other resources available that discuss programs and practices that can address the underlying health conditions and needs of these individuals. We have embedded references to these resources throughout the Playbook, but the appropriateness of specific models or interventions will vary from community to community and we encourage you to consider, pilot, and adapt the resources to your community's unique circumstances.

Additionally, the information contained in the Playbook is intended to offer guidance and insight into how your community can implement DDJ. We encourage any community to tailor the information within to suit their particular context, and adapt the sequencing of the various elements to best meet their needs.

If your community would like to learn more about DDJ, please visit www.NACo.org/Data-Driven-Justice for more information on how to get involved.

1. BUILD STAKEHOLDER CONSENSUS.

A successful response builds from coordination, collaboration, and consensus-building among a diverse set of stakeholders. This could include local elected officials, law enforcement, behavioral health service providers, housing and homelessness service providers, faith-based organizations, community-based advocates, people with lived experience, and other resource and service providers.

In many communities, these stakeholders do not have organized working relationships or resources in place to help facilitate cross-sector partnerships. DDJ project leads should focus early efforts on identifying who should be involved and building consensus among those stakeholders, formalizing partnerships, and creating a roadmap to improving outcomes for frequent utilizers. Initiating and maintaining a system of diversion for frequent utilizers requires strong collaboration, and investing time and effort during this relationship-building phase will allow DDJ to have a long-lasting, sustainable impact in your community. The following action items represent key steps that communities can take to build stakeholder consensus.

1.1 Bring together a comprehensive group to mobilize interest and willingness to improve outcomes for frequent utilizers.

A. Identify who should be at the table: It is important to recognize that the issue of frequent utilizers cuts across multiple stakeholders; this provides an opportunity for a more coordinated response. DDJ project leads should start by identifying the potential stakeholders that can play a key role in identifying and defining the problem and building an effective solution. DDJ groups should be inclusive of all potential stakeholders. This should include representatives from the population you want to better serve. People with lived experiences bring unmatched insight and perspective on existing processes and gaps and can inform the development of effective approaches.

B. Identify who can bring people together: Equally important is the identification of a community leader, or leaders, who can bring people to the table. Community leaders with credibility across stakeholder groups such as a county commissioner or judge have convening power that can bring people together and can help lead the development of a shared vision for the community. Additionally, consider leveraging existing groups of stakeholders that meet regularly on related issues, such as Criminal Justice Coordinating Committees or justice or health commissions.

Who should be at the table? Your community's DDJ group could include:

Elected Officials:

- County commissioners or supervisors
- City leaders, including mayors and city council members
- Judges
- District attorneys and prosecutors
- Sheriffs

Criminal Justice Professionals:

- Police executive leaders
- Police officers
- Public defenders
- Jail administrators
- Probation and/or pretrial services
- Reentry organizations

Healthcare Professionals:

- EMTs
- Paramedics
- Firefighters
- Hospital and emergency room directors
- Behavioral health treatment providers
- Local federally qualified health centers and clinics

Community Service Providers and Representatives:

- Homeless shelter and service organizations
- Housing authorities
- Faith-based organizations
- Individuals with lived experience in the criminal justice/ behavioral health systems

Academia/Business Partners:

- Data scientists
- Local tech innovators
- Local universities

Start by sharing experiences. This will foster a bond among members of the stakeholder group and help members learn each other's language. It is very likely that the people and entities around the table have not traditionally worked together to serve a single population. Each likely has its own mission, approaches, and budgets to work with the target population. Part of building support and trust involves listening, learning about each other's practices and processes, and identifying opportunities for collaboration that take into consideration these factors. Developing a common language and observing the way each other's organizations and services work on the ground can improve understanding and collaboration.

1.2 Use the data you have to define the problem and demonstrate the need for action.

A. Begin looking at data from available sources — ER and hospital visits, arrests and jail bookings, homeless shelters, behavioral health services, and others — ahead of the first stakeholder meeting: Use the data to identify the individuals who make up the frequent utilizer population and understand their characteristics and patterns of service use.

B. Create compelling stories on the challenges that frequent utilizers face: Case examples are a great supplement to quantitative data, bringing alive the human impact behind the numbers. Ask potential partner organizations to do the same with data available to them.

Start with data to understand the problem. At this stage, the objective is to describe and understand the problem using data that is available to you, gathered in any way possible, whether it be through a one-time data extraction or a download to an excel spreadsheet. Tell each partner to bring to the table their understanding of how frequent utilizers flow through their system, the associated resource burden, and where they see gaps in care. Think about cost, number of contacts with the system, and meaningful outcomes that speak to the unique challenges that frequent utilizers face.

1.3 Establish an agreement that improving outcomes for the frequent utilizer population is a priority that requires cross-sector collaboration and information sharing.

A. Develop a purpose statement or guiding framework: A purpose statement, mission statement, or similar framework can build trust, foster collaboration, and focus the group on goals, objectives, and activities. Develop this statement collaboratively so that everyone clearly understands and agrees on the reason for their collaboration and the desired results.

1.4 Start developing an action plan with stakeholders.

A. Agree on what success looks like: In developing an action plan, set realistic milestones and goals. Recognize that change takes time and adjusting to new ways of doing business does not happen overnight. Similarly, new processes that aim to provide effective support to an individual after years of fragmented, cross-system interactions may not have an immediate, measurable impact. A plan or process may need to be modified after a few months to improve efficiency or effectiveness. Acknowledge and manage expectations at the onset and celebrate small successes along the way.

B. Identify a Project Coordinator: Once initial meetings have been held, it may become evident that there are champions of change who are willing and able to lead the DDJ efforts in your community. Identifying a champion of change who can oversee management of DDJ by coordinating stakeholders and pushing DDJ efforts forward will help build accountability into your strategy. Think about ways that this lead entity's and partners' commitment can be formalized and documented, further ensuring a long-term focus on improving outcomes for frequent utilizers.

C. Plan to communicate regularly: As conversations and joint activities progress, clarify roles and key processes, develop working groups, and consider a charter to formalize policies and procedures. Clearly define roles and responsibilities and foster a team dynamic where colleagues are comfortable calling or emailing to ask questions or flagging issues for each other between formal, in-person meetings.

Sample charges, bylaws, missions, policies, and procedures that may help inform the development of your group's official agreement can be found in Appendices D and E of the U.S. Department of Justice's Guidelines for Developing a Criminal Justice Coordinating Committee.

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2. UNDERSTAND THE PEOPLE YOU HOPE TO SERVE.

To improve outcomes for frequent utilizers, it is important that communities start to understand the service utilization patterns and service gaps experienced by this population. Despite the fact that frequent utilizers, by definition, have repeat contacts across multiple systems, information and individual-level data are often siloed, creating barriers to effectively understanding and serving the needs of this population.

Developing and implementing plans to combine data across criminal justice, human services, and healthcare entities and agencies is an essential part of the process to identify frequent utilizers of multiple systems, coordinate service delivery, and track and monitor the impact of programs and interventions. Efforts to optimize the role of data in your DDJ strategy will require navigating legal, privacy, and security concerns identified by different systems, and should be built from a foundation of legal compliance and responsible data sharing, driven by a common goal established by the participating parties and strong justification of the need for information. The following action items represent key steps that communities can take to understand frequent utilizers.

Combining data across multiple systems is fundamental to the success of your community's efforts to improve outcomes for frequent utilizers. In order to ensure that integrated data is produced and used to the benefit of all, especially those who are and have been historically marginalized, your data strategy must center racial equity and proactively work to dismantle legacies of racist policies that have disadvantaged Black, Indigenous, and people of color (BIPOC), and/or people living in poverty.

For strategies and best practices on how to center racial equity in data integration efforts, see Actionable Intelligence for Social Policy's (AISP) report, A Toolkit for Centering Racial Equity Throughout Data Integration. Please also refer to NACo's county resources on diversity, equity and inclusion for additional information.

Data sharing does not mean all parties get access to personally identifiable data. A robust, ethical, and responsible data system will allow for differential access among stakeholders, all in accordance with HIPAA, 42 CFR Part II, and other data privacy related policies and regulations. As you begin this process, consult the various resources provided at the end of the Playbook to ensure that you build ethical and responsible data sharing infrastructure.

A note from DDJ community member, Johnson County, Iowa. "A very important part of data sharing is providing access to relevant data for service providers to do their job. It is equally important to guarantee an individual's data is only accessed by those with permission and for legitimate reason. These security controls are a very important part of the conversation when talking with citizens. They need to know that even though law enforcement participates in data sharing, it does not mean they have access to data provided by others. That is a common assumption that causes great concern to many individuals. While it can be exciting to hear law enforcement is working to divert individuals away from the criminal justice system, they want assurance that law enforcement does not have access to protected health information and will not use their access to data to target individuals."

2.1 Understand the current utilization patterns of the people you hope to serve.

A. Understand each other's definitions of frequent utilizers: Start your data-sharing efforts by working through respective definitions of frequent utilizers. Ask each agency or organization involved in the DDJ project to pull their records on individuals who come into frequent contact with their system, recognizing that each agency will define frequent utilizers differently. Discuss the datasets used to determine this, the individual's cost to the system, how the classification is used (e.g., prioritize someone for service), etc.

B. Combine data to understand how individuals touch multiple systems: By combining datasets from multiple systems, stakeholders can gain a better understanding of how individuals move through them and where the gaps in service exist. Start with institutional insights that can lead you in the right direction towards what data to share and how to do so. For example, law enforcement and emergency services representatives in most cases have several names that come to mind when asked who they encounter most frequently. Request each agency pull records for these individuals and start to build a comprehensive view of their service utilization patterns. Some communities do this by asking agencies to identify individuals with the most frequent contacts (e.g., the police department compiles a list of most frequent arrestees), then cross check those individuals' involvement with other systems (e.g., ER transports, homeless services, and behavioral health services). At this stage, the purpose of data analysis is to describe and understand the problem, not to enroll individuals into a program. Once data sets have been linked, the resulting matched data can be de-identified before analysis and exploration begins.

Sonoma County, California: In 2017 Sonoma County began an effort to identify the county's most vulnerable residents and improve services through better coordination across agencies. The project is called "ACCESS Sonoma County," which stands for Accessing Coordinated Care & Empowering Self Sufficiency and aims to coordinate care across the social safety net system for clients with complex needs.

To help shed light on this population, the county and California Policy Lab (CPL) integrated anonymized utilization records from health, mental health, substance abuse, housing, criminal justice, and human services systems on approximately 425,000 individuals for fiscal years 2014 through 2018. Defining "high utilizers" as any person whose combined utilization across systems is in the top 1% in a given year, Sonoma County found that high utilizers of multiple systems are usually not the highest users of specific domains. This allowed the county and researchers to reach key insights that will guide service type and delivery. According to the report, "Most high utilizers of the housing and behavioral health systems are also multi-system high utilizers... In contrast, only a third of criminal justice high utilizers are multi-system high utilizers, and only 16% of health high utilizers are multi-system high utilizers. This suggests that at least part of the health high utilizer population is comprised of individuals who were extremely physically ill, but with relatively few multi-dimensional needs. In contrast, the majority of housing and behavioral health high utilizers accessed services in at least one other domain, suggesting these individuals had a broader set of needs."

To learn more about this work, read CPL's full report High Utilizers of Multiple Systems in Sonoma County.

One way that your community might begin its data analysis to better understand its frequent utilizer population is by working with one criminal justice dataset, establishing a threshold definition of frequent utilizers (e.g., x number of jail bookings over a set amount of time), and asking the following questions of it.

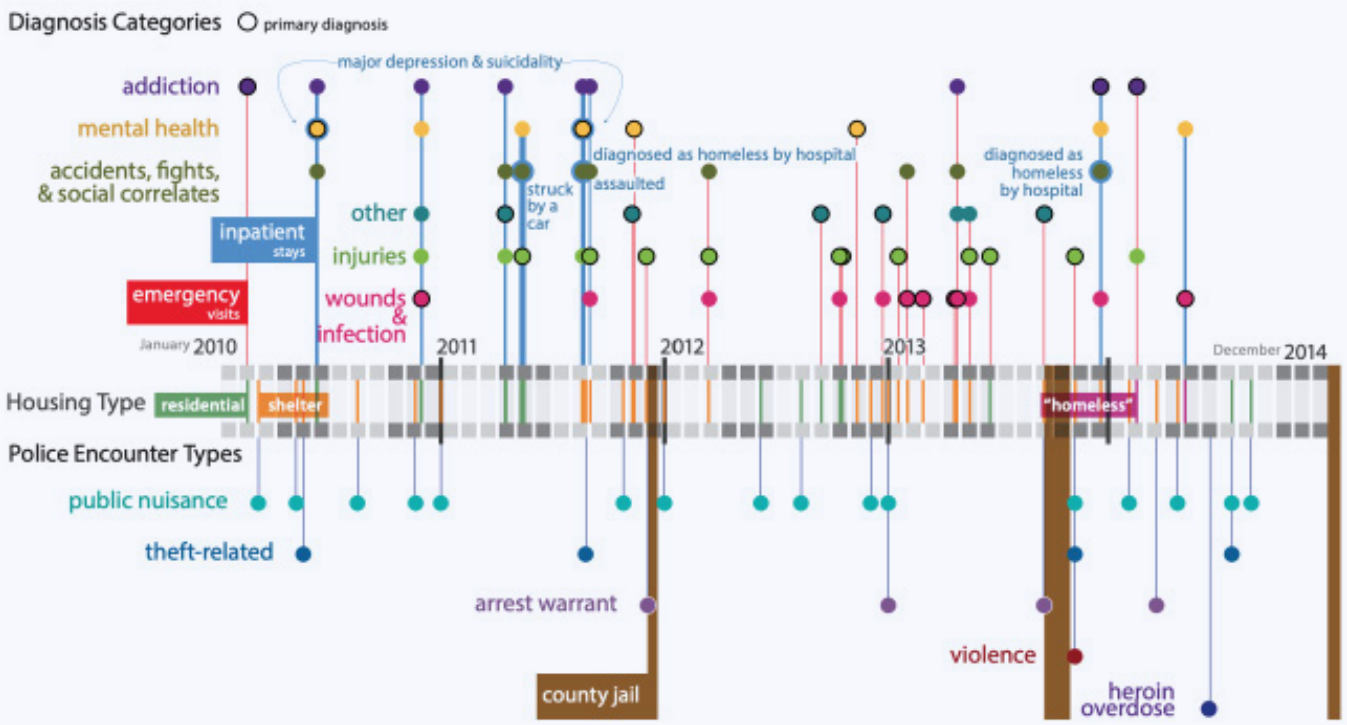
1. Describe the full file (dispatch, arrest, booking):
   - ***a.*** Who? - Gender, race, ethnicity, age, residence
   - ***b.*** What? - Charge seriousness, type, arresting agency, reason for dispatch
   - ***c.*** How long? - length of stay, release type
2. Describe the frequent utilizers in the file (dispatch, arrest, booking):
   - ***a.*** Who? - Gender, race, ethnicity, age, residence
   - ***b.*** What? - Charge seriousness, type, arresting agency, reason for dispatch
   - ***c.*** How long? - length of stay, release type
3. Compare the two groups, look for demographic shifts, offense shifts, etc.
4. Test the implication of frequent utilizer thresholds

Continue this process with other data sets from other systems and/or agencies, including but not limited to hospital or EMS data.

C. Use data to show that change is needed: Bring together the leading service providers — governmental and non-governmental — to analyze the data and identify the pressure points within the system and areas that need immediate attention. Begin discussions to develop a robust plan for working together to address these problems.

Combined data often reveal the intertwined systems providing services and the significant costs associated with fragmented care. Often the overlap of clients is so significant and the associated service costs are so high that it creates an "ah-ha" moment among community leaders about the need to better serve frequent utilizers. Initial analysis of de-identified data can move understanding of population and utilization patterns. For more information, read the report Early Lessons from Data-Driven Justice Pilot Sites for lessons on data integration from the Data-Driven Justice Pilot Initiative – a project supported by Arnold Ventures to test new methods of coordination between police, hospitals, and social services to better improve responses to frequent utilizers in three jurisdictions: Middlesex County, MA, the City of Long Beach, CA, and Johnson County, IA.

Camden, NJ: Researchers from the Camden Coalition of Healthcare Providers created the case study and graphic below to illustrate an individual's cycles through hospital and criminaljustice systems.



"Contacts with the health care system are reflected above the gray bar in figure 4, with blue lines denoting the times that Abe's ED visits resulted in a hospital admission. Housing issues are noted in the center of the gray bar. Interactions with the criminal justice system are shown below the gray bar, with each thin line marking contact with law enforcement and each thicker line representing a period of incarceration."

For more information, read Integrated Health Care and Criminal Justice Data — Viewing the Intersection of Public Safety, Public Health, and Public Policy Through a New Lens: Lessons from Camden, New Jersey from the Executive Session at Harvard Kennedy School on Community Corrections.

2.2 Establish a consensus frequent utilizer definition.

A. Identify key characteristics of your community's frequent utilizers and how they interact with existing systems: Using this information, develop a common definition for frequent utilizers in your community. Note that this is an art and not a science and should be informed by your community's goals and use of data. For example, you may consider how many individuals can be served by frequent utilizer interventions identified through systems gap analysis; the number of individuals needed to support a rigorous evaluation of newly developed frequent utilizer programs; decisions about whether the resulting list of individuals actually aligns with the definition of frequent utilizers, as defined by the data, etc.

Examples of Frequent Utilizers Definitions

- Sonoma County, CA: A "high utilizer" is any person whose combined utilization across systems [physical health, behavioral health (mental health and substance use), criminal justice, housing and homelessness, and human services] is in the top 1% in a given year.
- City of Long Beach, CA: (1) Individuals with 3 or more arrests in prior 18 months, and (2) Individuals with 2 arrests in prior 18 months who also meet at least one of the following criteria: (a) nonviolent crime arrest in the past 18 months, (b) identified by police department record as transient, or (c) at least one substance abuse charge in the past 18 months.

- Johnson County, IA: Six or more bookings during a two-year period.
- Eau Claire County, WI: "Booked into the jail 9 or more times in the past 5 years."
- Franklin County, OH: "Must have SPMI [Serious and Persistent Mental Illness] and have 5 or more jail/law enforcement/EMS contacts in past 12 months."
- Hood River County, OR: "Three incarcerations within one year and one access to mental health, emergency room, primary care."
- Dane County, WI: "The Dane County Criminal Justice Council identified those booked into jail ten or more times within a one year period."

Frequent utilizers are a diverse group of individuals with different needs: The Camden Coalition of Healtchare Providers, a multidisciplinary nonprofit working to improve care for people with complex health and social needs in Camden, NJ, and across the country, linked all-payer claims data from four regional hospital systems with Camden County Police arrest records. Analysts focused on the top five percent of individuals based on numbers of emergency department visits and arrests. Four subgroups were found in the data (1) nonviolent, medically complex individuals primarily arrested for drug offenses; (2) nonviolent individuals with behavioral health complexity who are arrested predominantly for petty crimes; (3) assault victims with mental health challenges and addictions arrested for crimes against other persons; (4) young men arrested for a wide array of offenses, including drug trafficking, property crime, and violent crime, who have few hospitalizations and a comparatively low prevalence of mental illness and addiction. This analysis helped the Camden Coalition customize their intervention strategies. Integrated Health Care and Criminal Justice Data — Viewing the Intersection of Public Safety, Public Health, and Public Policy Through a New Lens: Lessons from Camden, New Jersey

2.3 Determine outcome measures.

A. Establish benchmarks for your community: Benchmarking is a way to understand what has happened in the past and a benchmark report serves as a point-in-time reference. It allows communities to compare key metrics of your efforts across different points in time (internal comparison) or to other similar efforts (external comparison). Benchmarking can provide valuable data and help communities develop a baseline to assess progress. This may not always be possible if data are unavailable. Noting a lack of specific data is equally valuable information to communities and can provide a starting point for creating benchmarks/baseline data.

B. Identify current measurable outcomes for frequent utilizers: It is important to measure what matters. The value, progress or impact of an effort is difficult to assess without having identified the appropriate outcome measures. The identified outcome measures should be dependent on the identified problem and the goals that the community is trying to accomplish. Outcome measures should be objective and measurable to accurately determine if goals are being met.

Possible outcome measures:

- Connections to treatment and services
- Collaboration across stakeholder agencies
- Encounters with law enforcement
- Encounters with Fire/EMT/EMS
- Arrests and jail bookings
- Emergency room admissions
- Jail costs
- Health care costs

3. ESTABLISH A FRAMEWORK FOR DATA GOVERNANCE.

At this point in DDJ, communities may have already discussed data governance in the context of establishing roles and responsibilities or sharing data to better understand the populations they hope to serve. If not yet addressed, establishing a data governance framework should be a priority for your community. Key components of this framework should aim to set clear parameters for how data will be protected and used; what people, policies, and procedures will govern that data; and the process for obtaining stakeholder buy-in and productive participation in these conversations.

3.1 Identify your community's data integration goals then explore existing tools needed to meet those goals.

A. Depending on your community's goal, the system may enable (a) individual client "lookup" for direct care coordination; (b) identifying high-risk groups to select for programming; (c) extracting datasets, based on flexible criteria, for analysis of population health, program evaluation and costs; and (d) supporting first responders and hospital and jail in-reach programs to support crisis response, crisis stabilization, diversion programs, and connection to treatment.

3.2 Sign data-sharing agreements in order to formalize your data governance model.

Data-sharing agreements formalize the roles and responsibilities, decision-making mechanisms, and accountability processes that support the actions of the group. For more details on what to include in data-sharing agreements and what questions they should answer, see The Beeck Center's Sharing Data for Social Impact: Guidebook to Establishing Responsible Governance Practices and the Council of State Governments Justice Center's Establishing an Information-Sharing Approach

For examples and templates of Memoranda Of Understanding and other agreements, visit the Data-Driven Justice website at www.NACo.org/Data-Driven-Justice

3.3 Build privacy, security, and civil liberty protections into the design of the data-sharing systems from the start.

A. Invite city attorneys, county counsel representatives, and privacy and civil liberty stakeholders into early stage design meetings to help craft protections and protocols. Set up ongoing check-in meetings to review implementation and obtain feedback

B. Conduct a privacy impact assessment: Privacy impact assessment is an analysis of how information will be stored and shared to ensure handling conforms to applicable legal, regulatory, and policy requirements regarding privacy; to determine the risks and effects of the proposed data sharing; and to examine and evaluate protections and alternate processes to mitigate potential privacy concerns.

Use the Health Insurance Portability And Accountability Act (HIPAA) as a tool. HIPAA is frequently mischaracterized as a barrier to sharing information to inform data-driven approaches. The U.S. Department of Health and Human Services (HHS) provides answers to many of the most common questions and misperceptions regarding what HIPAA restricts and more importantly how HIPAA can be used as a tool to better serve vulnerable community members. For more information, read Frequently Asked Questions: Data-Driven Justice and the Health Insurance Portability and Accountability Act (HIPAA).

Be aware of state laws that govern data-sharing protocols. Involve your legal and IT teams early and often and strive to work together to find ways to say 'yes'. For more information on sharing information between criminal justice and behavioral health partners, see NACo's blog post Point-of-Service Information Sharing Between Criminal Justice and Behavioral Health Partners: Addressing Common Misconceptions.

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4. CONDUCT A RESOURCE SCAN AND IDENTIFY GAPS IN SERVICES AND TREATMENT.

Once your community identifies its frequent utilizers, it is important to understand your community's capacity for initiating diversion and connection to proper treatment and services.

An effective diversion strategy for the frequent utilizer population increases linkages to health, behavioral health, housing, and other services and support systems and reduces unnecessary arrest and incarceration and emergency health system involvement. Opportunities to divert individuals can be identified at each point in the system, and identifying where these opportunities do or do not exist in your community can facilitate a more coordinated, comprehensive system of care. The following action items represent key steps that communities can take to survey community resources and identify gaps in services and treatment.

4.1 Create a list of the resources available in your community to address the needs of frequent utilizers.

A. One well-documented and successful method that has been employed by a growing number of communities is the tracking of resources along the criminal justice intercept points using the Sequential Intercept Model. The SIM was developed as a conceptual model to inform community-based responses for people with mental illness and substance use disorders in the criminal justice system, and has been a valuable tool for many communities as a way to assess the availability of resources and as a strategic planning tool to determine the gaps in services and plan for community change. Additional methods used to document resources include Program Assessment and Systems Flow Analysis (see below).

An overview of the Sequential Intercept Model is available here.

One other method used to document the resources available in your community is system-flow analysis. Through its involvement in the Stepping Up initiative, Dauphin County, Pennsylvania worked with the Council of State Governments Justice Center to conduct a system-flow analysis to understand how the criminal justice system responds to people who have serious mental illness and identity areas for improvement. For more information on their methodology and results, read Dauphin County, Pennsylvania: A County Justice and Mental Health Systems Improvement Project.

4.2 Develop a plan for how shared data can be used to increase coordination across systems of care:

Communities may find it difficult to acquire more resources to support new programs or policies. However, communities may be able to make use of existing, previously inaccessible resources through increased collaboration and coordination. Community partners should work together to:

A. Understand and improve how systems share information in moments of crisis: Who are the primary responders to crises involving mental illness, substance abuse, or homelessness? Identify useful information that can facilitate de-escalation and linkage to treatment in these situations. Plan to use shared data that may exist in other systems into practice, particularly in moments of crisis.

B. Understand and improve how data facilitates coordination and hand-offs between services: After a crisis situation has been de-escalated, where is the individual taken? These moments are critical to ensuring linkage to treatment in the community. Use shared data to identify resources and direct individuals to the most effective, least restrictive avenues of care.

C. Identify the gaps in communication and service: Where and how do frequent utilizers fall through the cracks in service? How can agencies adopt tactics and policies to facilitate warm handoffs and connections to treatment? Consult or complete SIM or other mapping exercises to understand this.

Pinellas County, FL, used what they learned from an analysis of their frequent utilizer population to leverage existing resources and create the Pinellas County Empowerment Team (PCET).

The PCET assists people who have mental illnesses and substance use disorders to access and receive coordinated care that will reduce recidivism and support frequent utilizers' well-being. For more information, read a NACo case study of their progress — A Cost-Efficient Approach to Serving High-Need Frequent Utilizers.

4.3 Put it all together:

At this point, your DDJ team has a better understanding of services available, how data can be used to increase coordination across those services, and where the gaps in service exist. Use this information to create a roadmap that shows how frequent utilizers should flow through the community's system of care matching against agreed upon outcome measures for frequent utilizers.

A. Continue to update and expand your community's strategic plan of action by charting a path forward that accounts for what your community wants and needs to achieve its objectives.

Franklin County, PA, conducts an annual Sequential Intercept Model (SIM) session led by the Behavioral Health subcommittee of the Franklin County Criminal Justice Advisory Board (CJAB).Since 2009, the SIM has been used as a resource for referencing available behavioral health services. In 2017, Franklin County incorporated the latest research on SIM development by adding "Intercept Zero" to its model, which captures the shift towards connecting individuals in need with treatment and services in the community and before a person comes into contact with law enforcement or other first responders. Results of this mapping process have provided Franklin County leadership with a thorough assessment and graphic presentation of their resources, gaps, and opportunities at each contact point. For more information, see the NACo report on Franklin County — Building Data-Driven Justice.

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5. BUILD CONTINUAL DATA USE AND INFORMATION SHARING INTO CROSS-SYSTEM ORGANIZATIONAL OPERATIONS AND POLICY DISCUSSIONS.

DDJ is an ongoing process that requires intentional upkeep and focus from stakeholders. The steps outlined so far in the Playbook — engaging in initial discussions around frequent utilizers, building inter-agency relationships, sharing data, analyzing resource landscapes, and identifying ways to fill the gaps to create better outcomes for frequent utilizers – are integral to setting the foundation for DDJ.

It is important that these efforts are sustained and that communities continue to unlock the power of integrated data. Once established, integrated data should be used to inform and direct policy development, service delivery, and program analysis and evaluation. The following action items represent key steps that communities can take to incorporate cross-system data sharing into ongoing operations and policy discussions.

5.1 Use data to inform policy development:

Having a data-driven understanding of where gaps in services exist and what other types of services are needed in your community is a powerful asset when designing policy or making funding requests of municipal, county, or state policymakers to meet community needs. Insights developed through DDJ into how frequent utilizers move through systems and the costs they impose can help make the case for continual or new investment in innovative programs and policies that can help create better outcomes for vulnerable populations.

What if the experiences of people cycling through the criminal justice system and other emergency systems said more about our policies or system responses to vulnerable populations than it said about the people themselves? It's worth looking at the most frequent crimes of the whole population you are examining as well as the crimes of frequent utilizers. Maybe these are the types of incidents that could be rethought or decriminalized altogether, allowing policy and system levers to impact a significant number of arrests and jail bookings without any individual level interventions. For more lessons on what the data mean, read Early Lessons from Data-Driven Justice Pilot Sites.

In Johnson County, Iowa, public intoxication was the most common charge for frequent utilizers and the second most common charge for all people booked in the jail. This finding led leaders to open a sobering center as a key DDJ intervention. If the county diverts to the sobering center over jail, they estimate they could conservatively save 200 bookings per year.

5.2 Use data to inform service delivery:

Use data to modify existing programs and design and deploy new strategies. Having a data-informed strategy for those most at risk and in need of services in your community can help determine eligibility for resources that are more limited.

In 2017, Boone County, MO, received support from the Corporation for Supportive Housing (CSH) to reduce repeated imprisonment or jail time among the county's homeless residents. CSH, in collaboration with the University of Chicago, developed a web-based data integration tool that matches lists from county jail administrative data to local homelessness data. Merging these data sets allowed service providers to more accurately focus resources on the highest utilizers of those systems.

As detailed in CSH's overview of the project, Data Integration Across Jail & Homeless Services Blueprint for Success, "This focused approach was coupled with extensive work with community stakeholders to design a supportive housing intervention with a targeted number of units over a one to five-year period." These targets were based not only on need but also on available resources and service provider capacity in each community. Communities also discussed how to define success for their identified target population and connect funding to the achievement of that success. In Boone County, this resulted in a procurement for a performance-based contract that will incentivize providers to support tenants in achieving housing stability.

City of Long Beach Multi-Disciplinary Team: In Long Beach, CA, the most common charges among frequent utilizers were possession of unlawful paraphernalia, parks/beach loitering, and public consumption of alcohol. Further, several individuals were arrested for the same charge repeatedly — five individuals had all their four — arrests in the 18 month-period for possession of unlawful paraphernalia and two individuals had all their five — arrests for parks/beach loitering. This highlights the need to potentially consider a different response to such activities. As a result, Long Beach piloted a new intervention, The Multidisciplinary Team (MDT), which convenes city and county departments monthly to better coordinate services such as mental health, substance abuse treatment, and homeless services. The MDT framework encompasses a variety of touchpoints from the street, jail, and pre-trial intercepts. Critical elements of the MDT enabled by DDJ include:

- Information and Data Sharing
- Team-Based Coordination
- Continuous Communication and Follow-Up

To support the program, Long Beach officials also developed a web-based application that will enhance information sharing and communication among service providers who are part of the MDT. The application allows a MDT member to enter a person's name or other identifiers to help locate a client's profile. Once the client is identified, they will have access to their consent form status, recent interactions, and field notes inputted by MDT colleagues.

A. Using data to design tools to promote communication and information sharing: A priority for many DDJ communities is to ensure that front-line case managers, outreach workers, and first responders have the information they need, when they need it. With this goal in mind, communities are working with both government and private technology partners to pilot and test new tools to support information sharing to better serve frequent utilizers.

Open Lattice CARE App: Middlesex County, MA, and Iowa City, IA,

In an effort to improve law enforcement response to and follow up care for individuals who have experienced a mental health crisis, Iowa City and Middlesex County partnered with OpenLattice to implement a new tool. The CARE application was designed to help law enforcement and co-responding clinicians gather, track, analyze information about police encounters, specifically those involving individuals who are unstably housed, who are experiencing a mental health crisis, or have exhibited need for additional treatment, that would otherwise be undocumented (e.g. successful de-escalation techniques or common behaviors of the individual). In Iowa City, a pilot version of the tool helps responding officers access information such as known triggers and de-escalation techniques to improve their approach to individuals in crisis. The information collected is observational data from law enforcement officers and does not include health records. In Middlesex County co-responding clinicians use the tool to share information across department clinicians, manage caseloads and referrals, and identify individuals who may be in need of additional support and services. In both jurisdictions, the design of the tool was informed by engagement with law enforcement, mental health treatment providers, and families of individuals suffering from mental illness.

5.3 Use data for ongoing trend tracking and program and policy analysis and evaluation.

As your community designs new programs and policies to better serve the needs of frequent utilizers, it is important to have a plan and partnerships in place to leverage data to evaluate process improvement, outputs, and outcomes of these interventions. Not only can this inform further refinement of program implementation, but can help your community better understand what is actually working to improve outcomes for frequent utilizers, and where additional resources or program modifications are needed to improve efforts that may be falling short.

Bexar County, Texas: In March of 2018, a local private hospital foundation released a report detailing an analysis of high utilizers of healthcare in Bexar County for a one-year period. Super-Utilizers were defined as safety net patients who had: 3+ inpatient discharges or had both a serious mental illness diagnosis and 2+ inpatient discharges; ED utilization of 9+ visits. For the analysis, the county "safety net" population was unfunded and underfunded patients as defined by insurance plans and generally included Medicaid (traditional, managed Medicaid, CHIP) and Self Pay/ Charity, CareLink, and other indigent care programs. Encounters across all sites and settings totaled almost $1.2 million with the safety net patients generating on average 3.5 encounters per patient. Two percent of the overall safety net population had 24 or more encounters in the 12-month period studied. The analysis also showed there was significant patient crossover among the major systems in Bexar County for total safety net patients representing a challenge for any provider to put together a coordinated care plan for any patient. The total costs of providing healthcare for the safety net population as a whole exceeded $1.1 billion annually. For more information on Bexar County's efforts to better serve frequent utilizers, see Health Management Associates report — Behavioral Health Crisis and Diversion from the Criminal Justice System: A Model for Effective Community Response.

5.4 Continual assessment and improvement.

DDJ is a process that requires continual engagement with stakeholders. Any mission statement, goals, or objectives will need to be evaluated and updated continually to reflect the needs of your community. While enthusiasm for DDJ at the project's outset may have been strong, involvement may wane over time without demonstrable results. Ensure that your DDJ team continues to meet on a regular basis, and that process improvement remains a priority. Additionally, use every opportunity to celebrate successes and provide support, including attending conferences with your DDJ team, convening stakeholders in an innovative way, and finding ways to present your work to a state or national level audience.

Louisville-Jefferson County Metro Government, KY: The Louisville Mayor convened the Dual Diagnosis Cross-Functional Team (DDCFT) in 2013 to improve system responses to individuals with co-occurring mental illness, alcohol use and substance use disorders who frequently cycle in and out of community treatment, hospitals and jail. The DDCFT comprises government agencies such as law enforcement and the courts, as well as health and behavioral health professionals and advocacy groups. The DDCFT went through an extensive planning process, including reviewing data and participating in a Sequential Intercept Mapping workshop, to identify opportunities for diverting the target population from the justice system. From these processes, the DDCFT initiated a new community-wide and cross-agency network for providing coordinated services to frequent system users. In 2018, the DDCFT launched a Law Enforcement Assisted Diversion (LEAD) Pilot in which they incorporated a new pre-arrest diversion option for 50 individuals suffering from substance abuse disorders involving opioids. Read more about these efforts in NACo's report Louisville-Jefferson County Metro Government, Ky. Supporting People with Mental Illnesses in the Community.

CONCLUSION

Data-Driven Justice seeks to improve outcomes for individuals with complex health and social needs who far too often do not receive appropriate access and connection to the care they need. As this Playbook has outlined, local communities, including counties and other jurisdictions, are at the forefront of this project. By leading with insights gleaned from an integrated data strategy, communities can take direct action to better align and more effectively deliver resources to frequent utilizers of multiple service systems.

The DDJ process — (1) building stakeholder consensus; (2) understanding the people you hope to serve; (3) establishing a framework for data governance; (4) conducting a resource scan and identifying gaps in services and treatment; and (5) building continual data use and information sharing into cross-system organizational operations and policy discussions — is intended to capture the most important elements of creating, sustaining, and continually improving an integrated data system. While the preceding pages contain suggested practices, communities should feel empowered to draw from the overall DDJ process and shape it to match their local needs. Additionally, DDJ should be considered an ongoing project by which the steps contained in the Playbook are revisited, revised and adapted to match changing circumstances on the ground.

By harnessing the guidance, insights, recommendations, and supporting examples contained in this Playbook, your community should be well on its way to creating and sustaining its own integrated data strategy to improve outcomes for frequent utilizers.

For more information, please refer to NACo's Data-Driven Justice project page: www.NACo.org/Data-Driven-Justice.

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