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R E P O R T

Behavioral Health in the District of Columbia

Assessing Need and Evaluating the Public System of Care

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Summary

S.1. Background

As a result of the tobacco litigation settlement reached in 1998, more than \$200 million was made available to the District of Columbia to invest in the health of the city's residents. In 2007, the District contracted with the RAND Corporation to study the health of District residents and the health care delivery system in the District and provide an informed assessment of policy options for improvement, including through the investment of the tobacco settlement funds. The findings from this work are summarized in two RAND reports (Lurie et al., 2008a, and Lurie et al., 2008b).

Community and provider focus groups were conducted as part of the RAND evaluation. One of the resounding concerns that surfaced was access to health care services for behavioral health issues, including both mental health and substance abuse problems. Primary care physicians in the District, for example, reported significant challenges in finding specialty care for patients enrolled in Medicaid, including notably limited options for Medicaid patients with mental health problems. District residents perceived substantial gaps in the availability of outpatient specialty care. District parents reported that getting behavioral health care for their children was a daunting problem.

These findings pointed to the need for a more intensive study focused on behavioral health and health care in the District and, in particular, on the public behavioral health care system, given its predominant role in the delivery of the relevant services to District residents. In this study, we build on and extend previous analysis of health and health care in the District by

- providing a richer understanding of the prevalence of mental health disorders and substance use among District residents
- characterizing the organization and financing of public behavioral health services in the District
- tracking utilization of public behavioral health services among District residents
- reporting on key challenges facing the District's public behavioral health care system as identified by stakeholders
- summarizing key issues and developing recommendations for improving the District's behavioral health care system.

Our approach blends qualitative and quantitative methods and utilizes data from a wide range of sources, including survey data, administrative data, claims data, and data from focus groups and stakeholder interviews. To estimate the prevalence of mental health disorders and substance use, we primarily use data from four surveys: the Behavioral Risk Factor Surveillance System (BRFSS); the National Survey of Drug Use and Health (NSDUH); the National Survey of Children's Health (NSCH); and the Youth Risk Behavior Survey (YRBS).

To evaluate the utilization of behavioral health care services among District residents, we use administrative data from three sources: eCura, which is the D.C. Department of Mental Health

(DMH) electronic patient management and billing system; Medicaid managed care claims data from managed care organizations operating in the District; and District of Columbia Hospital Association data. For information about the functioning of the behavioral health care system, we rely on stakeholder interviews and focus groups. For a detailed discussion of our data sources, see Chapter 1.

S.2. Key Findings

Below we summarize key findings from our analyses of the prevalence of mental health disorders, substance use, and substance use disorders among District residents; analyses of utilization of public behavioral health services among District residents; and our stakeholder interviews and focus groups.

Prevalence of Behavioral Health Disorders

For the District to be able to appropriately and strategically plan for its behavioral health system, foundational knowledge about the population's behavioral health care needs and access to services is critical. Toward that end, we described the prevalence of mental health disorders and estimated potential levels of unmet need for specific types of mental health care in the District, using the best data available from a combination of the surveys cited above. We were unable to perform similar analyses to estimate potential unmet need for substance abuse treatment because there are no data on which to base estimates of the reach of the services provided by the Addiction Prevention and Recovery Administration (APRA), the District's agency with responsibility for providing public substance abuse prevention, treatment, and recovery services. We were unable to obtain a data extract from APRA's client management system, owing to its recent implementation. Historical data on levels of service use were also unavailable.

Our analyses suggest the following key findings:

- The prevalence of mental health conditions in the District resembles patterns nationally, among both adults and youth. One exception is that, compared to children nationally, D.C. youth appear to have a higher percentage of parent-reported behavioral problems.
- Suicide attempts among District high school students are more common than among high school students nationally, and prevalence appears to be rising in the District. Among high school students who attempt suicide, District youth are twice as likely to require medical care because of an injury.
- District adults have a higher burden of illness on measures of heavy drinking, binge drinking, alcohol dependence, and inadequacy of treatment. Binge alcohol use and heavy alcohol use increased over the last decade, although the trend has reversed somewhat between 2003 and 2008.
- District youth are less like to use or abuse alcohol across several measures than youth nationally, and alcohol use and binge drinking have decreased over the past decade.
- District adults had a higher prevalence of drug use and drug use disorders than the national average on five of seven measures, including higher percentages of marijuana and cocaine use and illicit drug dependence or abuse.
- District youth had a higher estimated prevalence of lifetime use of heroin, nonprescription steroids, and any injectable illegal drug but have similar or lower levels

of crack, marijuana, methamphetamine, and ecstasy use compared to their peers nationally.

- Among District youth, prevalence of marijuana use has decreased since the late 1990s, but the use of illegal injectable drugs and steroids has increased.

In addition, with regard to potential unmet need for behavioral health care services:

- Our analyses suggest that potentially several thousand District residents have unmet need for mental health care services for severe mental illness, and potentially 60 percent of adults and 72 percent of adolescents enrolled in Medicaid managed care who have depression have unmet need for depression services.
- Gaps in surveillance surveys made it impossible to estimate levels of potential unmet need among children with severe mental health conditions.
- Enrollees in the DC Healthcare Alliance (Alliance, a public program that provides access to health care to eligible District residents) and uninsured residents have significant mental health needs, with at least 12,000 adults and adolescents potentially having depression alone. Utilization among these individuals is not captured systematically, and, therefore, the level of unmet need cannot be readily estimated.

Utilization of Public Behavioral Health Care Services

To the extent possible with available data, we analyzed the levels and types of service use among District residents served by the public behavioral health care system. We summarize key findings related to use of services by enrollees in the District's Mental Health Rehabilitation Services (MHRS) programs; by adults and children enrolled in Medicaid managed care; by children with disabling mental health conditions enrolled in the Health Services for Children with Special Needs (HSCSN) program, a specialized managed care plan; and to use of emergency department services for mental health conditions among all District residents.

Based on claims data describing utilization by MHRS enrollees, we find that:

- 60 percent of children and 54 percent of adults enrolled in MHRS have over 10 visits per year to a Core Services Agency (CSA) treatment facility. CSA is a provider that contracts with DMH to provide mental health rehabilitation services.
- Approximately 16 percent of children and 15 percent of adults enrolled in MHRS have contact with the MHRS system only one or two times per year. For individuals undergoing active treatment for severe mental illness, such utilization rates are likely to be inadequate.
- Only 10 percent of children and 5 percent of adults enrolled in MHRS receive intensive community-based treatment for mental health issues in the forms of community-based intervention (CBI) and assertive community treatment (ACT), respectively.
- 45 percent of children and 41 percent of adults enrolled in MHRS have gaps in care that exceed six months during a 12-month period, and 19 percent of children and 18 percent of adults have gaps of ten months or longer.

Based on Medicaid managed care organization (MCO) claims data on utilization by adults and children enrolled in Medicaid managed care, we found that:

- 11 percent of children and 17 percent of adult enrollees with mental health disorders who had at least some mental health services use had no outpatient visits over the course of one year but had one or more inpatient admissions or visits to an emergency department (ED) during the same period.
- Among youth Medicaid managed care enrollees with psychotic or bipolar disorders who used some mental health services, 25 percent had at least one inpatient admission over a 12-month period and 29 percent had one or more ED visits. Among adult enrollees with these same disorders who used some mental health services, 20 percent had inpatient stays and 18 percent had ED visits.
- 4 percent of children and 6 percent of adult Medicaid MCO enrollees who received some mental health services during the course of a year received them exclusively through EDs.
- Thirty-day readmission rates after a mental health hospitalization were 20 percent for children and 16 percent for adults.
- A minority of adult Medicaid MCOs enrollees had office visits in the 30 days following a mental health–related inpatient stay (18 percent) or following discharge from the ED (18 percent).

Our analyses of claims data from the District’s HSCSN program show the following:

- A substantial fraction of children with disabling mental health disorders had no mental health specialty visits, including nearly three-fourths of children with an emotional disturbance, two-thirds of children with adjustment disorders, more than half of children with a depressive disorder, and one-third of children with an episodic mood disorder.
- Approximately 10 percent of children with episodic mood disorders and 9 percent of children with emotional disturbance received care exclusively through the ED. Children with episodic mood disorders were far more likely to have multiple inpatient stays and repeated ED use compared to other HSCSN enrollees.

Our analyses of hospital discharge data indicate that:

- Between 2004 and 2008, rates of ED utilization for bipolar disorder more than doubled for residents ages 18–39 and increased fourfold for residents ages 40–64.
- The rate of ED use associated with schizophrenia is considerably higher in Wards 7 and 8 compared with all other parts of the District; rates are as much as twice the District-wide rate for most age groups.
- The rate of ED use associated with all mental health conditions among residents of Wards 7 and 8 is much higher than the District average.
- The rate of ED use for substance abuse disorders increased by 50 percent among 40–64 year olds and doubled among 18–39 year olds over the last several years, fueled by increases in Wards 4–8.

Focus Groups and Stakeholder Interviews

We conducted interviews with a wide range of individuals and organizations to provide insight into the behavioral health safety net system in the District of Columbia. Interviewees included government employees from behavioral health agencies, providers of mental health and substance abuse services, primary care providers, insurance company executives, representatives

of hospitals, local nonprofit organizations, and researchers and experts on the delivery of behavioral health care.

Participants highlighted several major challenges to the optimal provision of behavioral health services in the District. Two recurring themes were gaps in care and difficulties in coordination of care for particular populations and particular services. Other themes revolved around challenges related to housing, financing, information technology, and quality measurement. We describe some of the key concerns in what follows.

- A number of stakeholders voiced concern that individuals who do not qualify for MHRS may have difficulty accessing mental health services. In particular, those covered under Alliance are vulnerable due to the lack of coverage for mental health service. This concern over lack of access was echoed in the previous report's community stakeholder focus group (Lurie, et al, 2008b). Further, interviewees expressed concerns over a lack of targeted services for specific populations with mental illness, including geriatric consumers; transitional-age youth (under 21 years old) who are not under the care of the Child and Family Services Agency (CFSA, the District agency responsible for protecting at-risk children and child victims); foreign-language speakers in the School Mental Health Program (SMHP); and gay, lesbian, bisexual, and transgender clients.
- Interviewees also described gaps in care for individuals with substance use disorders. Providers described patients frequently arriving in a state of crisis, requiring immediate services that are not currently provided by the substance abuse treatment system.
- People with mental health and substance abuse disorders interact with a host of different agencies and programs. A major challenge facing these individuals is a lack of coordination among the organizations that provide mental health and/or substance abuse services. Barriers to care coordination include mental health providers' inability to bill for time spent in coordination activities, as well as general concerns over patient privacy and lack of an information technology infrastructure.
- Interviewees noted several concerns about substance abuse treatment specific to the youth population, including a dearth of programs and a need for better assessment tools for the intake process. With regard to mental health, stakeholders discussed a lack of several programs and services, including residential programs for youth, youth-focused community-based services, child psychiatrists, and services for children with mental retardation.
- Stakeholders noted that individuals with developmental disabilities may face particular challenges. In particular, stakeholders felt that not enough attention was paid to diagnosing and treating individuals with developmental disabilities, that the Department of Disability Services (DDS) lacks resources and capacity, and that misperceptions of mental illness result in individuals with disabilities being referred to a comprehensive psychiatric emergency program when they may more appropriately be treated by other providers.

- Interviewees described a lack of housing for individuals and families in the District with mental health and/or substance abuse problems. Providers in the focus groups described consumers being placed into unneeded treatment categories and settings solely for the sake of obtaining housing.
- For homeless individuals, interviewees described a need for greater coordination of services with surrounding jurisdictions. Interviewees expressed concern that there were few programs for homeless persons with substance abuse problems and that APRA was not sufficiently involved in the District’s homeless services system.
- Stakeholders expressed concerns that the proliferation of separate behavioral health data systems prevents coordinating care across providers and across systems. The lack of connection, stakeholders stated, not only impeded direct patient care but also led to a system that was unable to adequately plan for the community’s needs. More generally, stakeholders described a lack of connection between DMH’s and APRA’s data systems.
- Many stakeholders felt that there was still a need for better quality assessment as a means for continued improvement of quality of care. However, they noted that difficulty in obtaining accurate data impeded their ability to understand what aspects of the system were working well.

S.3. Summary of Priority Areas and Recommendations

Our assessment suggests five high-level priorities for the District. We summarize these and describe recommendations related to each in what follows.

Priority Area 1: Work to reduce unmet need for public mental health care.

A key concern is whether the existing patchwork system of care for individuals with mild to moderate mental health disorders who are uninsured or in the Alliance is sufficient for meeting their behavioral health needs. Closing the gap in care could be achieved through investment in expanded mental health benefits for Alliance enrollees and/or investment in free or discounted mental health treatment capacity, including through local clinics or freestanding mental health centers (FSMHCs).

In addition, our analyses suggest the existence of a sizeable pool of individuals (of unknown insurance status) who have severe mental illness but are not connected to MHRS. Outreach is crucial to ensure that eligible individuals with severe mental illness are enrolled in MHRS. The District could establish formal systems for partnering with local hospital EDs and other organizations to identify individuals with severe mental illness who are not connected to the system, enabling follow-up by MHRS staff.

Priority Area 2: Track and coordinate care for individuals in the public system with mental health diagnoses.

A notable opportunity exists for DMH to develop systems to

- identify individuals with significant behavioral health problems who are already enrolled in the system via Medicaid, MHRS, or HSCSN
- set standards for minimally indicated care based on diagnoses
- track progress toward ensuring that enrollees receive minimally indicated services.

Improvements in this area are likely to require significant care coordination and outreach to enrolled individuals.

Priority Area 3: Improve the availability and accessibility of substance abuse treatment services

The best available data suggest that adult District residents have unmet need for substance abuse treatment services. While insufficient capacity may be one explanation for unmet need, another explanation is the difficulty patients report with APRA's central intake system. Another issue is outreach. Service providers indicated that many clients are unaware that the voucher system exists and do not know how to access substance abuse treatment services. Although APRA has recently revised its website to be more user-friendly for residents, limited community outreach by APRA about how to access services might have contributed to the community's lack of awareness.

Finally, opportunities may exist to further leverage federal Medicaid dollars for substance abuse treatment. Substance abuse services in the District are financed mainly with local dollars, although an estimated 19 percent of APRA's clients are eligible for Medicaid (District of Columbia Official Code, 2008). More than half of all states provide substance abuse services under Medicaid, such as inpatient detoxification, pharmacy services, outpatient and inpatient services beyond detoxification, and methadone maintenance. A few states are also pursuing other services, such as residential treatment and clinical case management.

Thus, the District should consider strategies to address this priority area, including

- expanding the referral and intake process for substance abuse treatment to additional locations
- increasing marketing and outreach efforts
- increasing capacity for providing buprenorphine as a treatment option
- leveraging Medicaid funding.

Priority Area 4: Increase the coordination of care for individuals with comorbid mental health and substance abuse conditions.

Care for individuals with co-occurring mental health and substance abuse disorders is not well coordinated. In the District, APRA and DMH operate in separate silos. There is little communication between substance abuse and mental health providers caring for the same patient. In addition, systems for tracking individuals who use services through each agency are

not linked; neither are the systems that providers use to become credentialed or to bill for their services.

Strategies to improve coordination in the District might include

- establishing a unified credentialing system to allow providers with capabilities to serve mental health and substance abuse services to be dually credentialed by APRA and DMH in a streamlined process
- cross-training providers in both substance abuse and mental health assessment and treatment to increase the number of providers who can treat individuals with co-occurring disorders so that persons with dual diagnoses can obtain quality care in one locale
- developing a unified billing system in which providers can be reimbursed for mental health and substance abuse services through a central mechanism, a step which may also encourage providers to become dually certified
- developing a uniform consent form that consumers would sign at the time of initial presentation for behavioral services in order to allow information to be shared between substance abuse and mental health providers and help overcome the ambiguities associated with the privacy provisions of the Health Insurance Portability and Accountability Act (HIPAA).

Priority Area 5: Fundamentally upgrade the data infrastructure of the public behavioral health care system to allow for improved monitoring of service utilization, quality of care, and patient outcomes.

The District's data infrastructure is not sufficient for tracking services, monitoring quality, and following health outcomes. Data are vital to the District's ability to promote provider efficiency, improve care coordination within and across agencies, and ensure high-quality service. Key issues include the following:

- Databases maintained by DMH and APRA are not interoperable; there is no common identifier that allows for tracking individuals who use both systems.
- Until recently, APRA has had virtually no ability to consistently track individuals who use APRA services or to track service utilization more generally. New data systems hold the potential for vastly improved monitoring and tracking but need attention and investment to achieve their promise.
- Interoperability across databases within DMH is also limited. For example, it would be useful to track use of outpatient and inpatient services for given individuals over time, but the systems that track outpatient use (eCura) and inpatient services (Avatar) at St. Elizabeth's are not readily linkable. DMH has made progress in its ability to obtain and analyze claims data related to mental health for fee-for-service and MCO Medicaid enrollees, but a key next step is the ability to track service use for a specific Medicaid enrollee who receives care both through DMH and directly through Medicaid. Satellite DMH databases track various other services (e.g., housing, school mental health

services); integration of data across these various systems would allow DMH to track service provision and outcomes for specific patients in a comprehensive way.

- Many of the databases do not collect robust-enough information for strategic planning or performance measurement. For example, the school-based program contains students' names but little else in terms of the type of care delivered. Existing claims databases are not sufficient for tracking changes in the mental health or physical well-being of MHRS enrollees.
- As suggested in Priority Area 2, an opportunity exists for DMH to develop ways of identifying and tracking individuals with significant mental health disorders in Medicaid. Regular and systematic downloads of Medicaid claims from the Department of Health Care Finance (DHCF—the District's Medicaid agency) to DMH and consistent and timely analysis of those data are important first steps.
- Finally, regular tracking of the prevalence and incidence of behavioral health conditions through continued analysis of population-level surveys—NSDUH, NSCH, and BRFSS—is needed. The permanent addition of mental health screening questions to BRFSS should be considered.

In sum, our assessment points to these high-level priorities for the District:

- Work to reduce unmet need for public mental health care.
- Track and coordinate care for individuals in the public system with mental health diagnoses.
- Improve the availability and accessibility of substance abuse treatment services.
- Increase the coordination of care for individuals with comorbid mental health and substance abuse conditions.
- Fundamentally upgrade the data infrastructure of the public behavioral health care system to allow for improved monitoring of service utilization, quality of care, and patient outcomes.