# HEALTH HOME COLLABORATIVE PILOT:

## *CARE MANAGEMENT/COORDINATION FOR CRIMINAL JUSTICE INVOLVED INDIVIDUALS*

CBC
TRANSFORMING COMMUNITY HEALTHCARE

NYC Department of Probation

NYC Health
THE NEW YORK CITY DEPARTMENT OF
HEALTH AND MENTAL HYGIENE

MAY 2014

# AGENDA

- Welcome And Introductions
- Criminal Justice: Health And Behavioral Health Disparities
- Aims: Outcome Measures Public Health/Public Safety
- Health Care Access And Connections Across The Criminal Justice Continuum
- Project Partnerships
- Rollout And Implementation
- Voices From The Field: Care Coordinator, Client And Probation Officer
- Findings: Initial Outcomes: Ground Up Enrollment & Data Match
- Challenges
- Q & A

# CRIMINAL JUSTICE: HEALTH AND BEHAVIORAL HEALTH DISPARITIES

- 53% of women & 35% of men involved in the criminal justice system report a current medical issue (National Health Care For The Homeless 2013)
- Between 60 % and 80% of all individuals under supervision have a substance use related issue (SAMHSA 2013)
- 17% of all individuals under supervision have been diagnosed with a serious mental illness, of this 17%, 75% have a co-occurring disorder (CSG 2013)
- 64% of all those in jail have some form of mental illness (OJP 2013)
- 17% are either HIV+ or living w/AIDS (National Health Care For The Homeless 2013)

# AIMS: OUTCOME MEASURES IN PUBLIC HEALTH/PUBLIC SAFETY

- Enrollment/Access to Care
  - # of clients newly connected to public/commercial insurance
  - # of clients newly connected to health home care coordination thru ground up enrollment
  - # of identified eligible consumers identified by State through data matching
- Public Health
  - Hospitalization rates for Medical, BH and SUD
  - ER usage for same
  - Connectivity to primary care
- Public Safety
  - Recidivism rates
  - Rearrests
  - Violations
  - Compliance with supervision, successful discharge from probation

# PROJECT PARTNERSHIPS

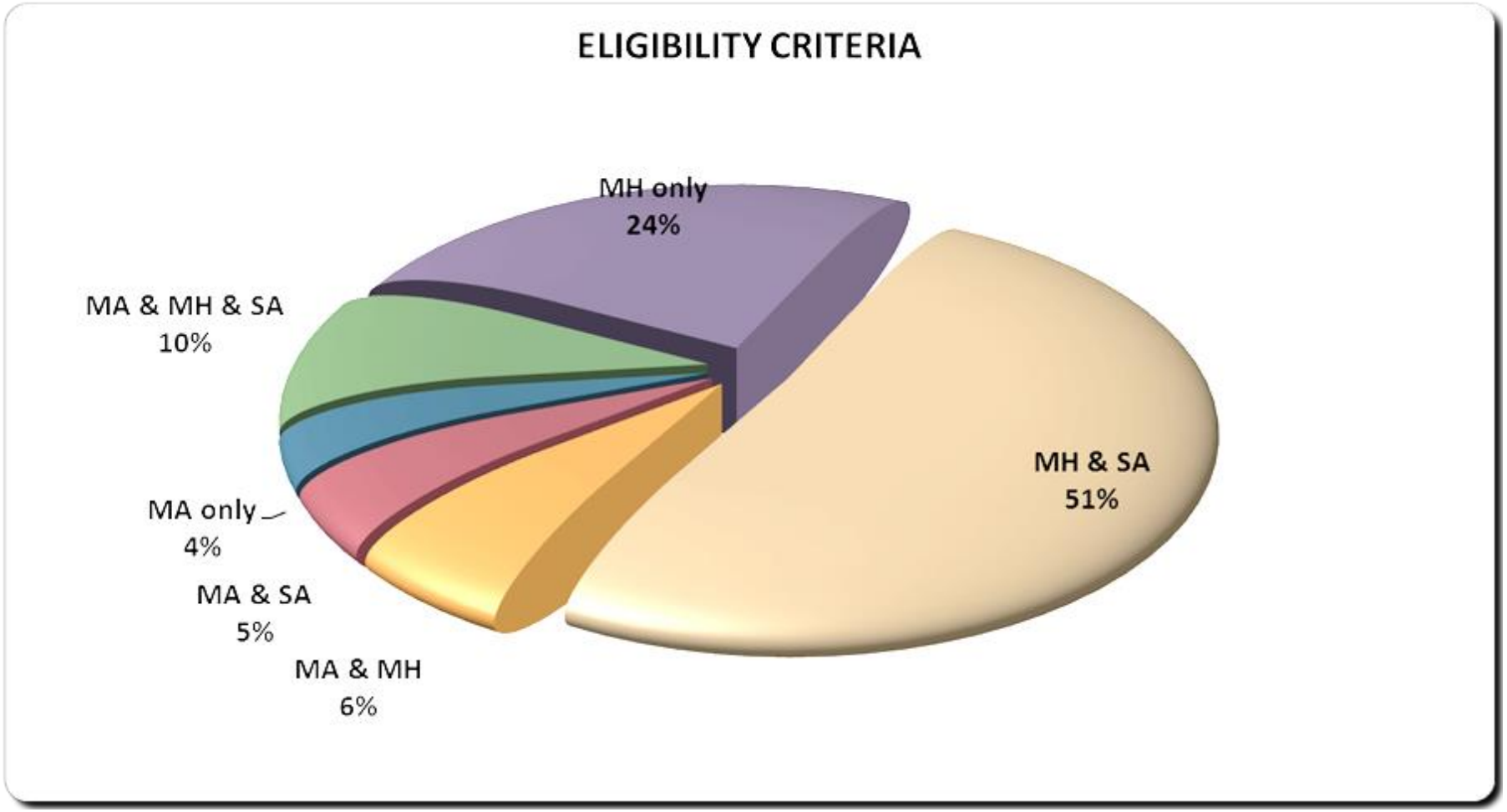
- NYC Dept. of Probation and NYC Dept. of Health and Mental Hygiene partnership
  - Dept. of Probation submitted application to NYSDOH Health Home Portal
  - DOP and DOHMH executed data sharing agreement to analyze client outcomes
- CBC Health Home | NYC DOP
  - Executed DEAA and MOU to allow for data sharing of client level information
  - CBC identifies six care management agencies in their network to join pilot: JBFCS, ICL, SUS, NADAP, Catholic Charities Neighborhood Services and FEGS Dual Method engagement/enrollment process
  - Ground up enrollment thru co-location of care managers at DOP branch offices
  - Front end data matching with targeted outreach thru probation office/officers
- Downtown Brooklyn: Pilot site
  - Highest concentration of direct report clients city wide (6,100 clients, 2100 direct reports)
  - Highest number of referrals to behavioral health treatment programs 2012

# PHASED ROLLOUT IMPLEMENTATION 2013-2014

## *"NUTS AND BOLTS"*

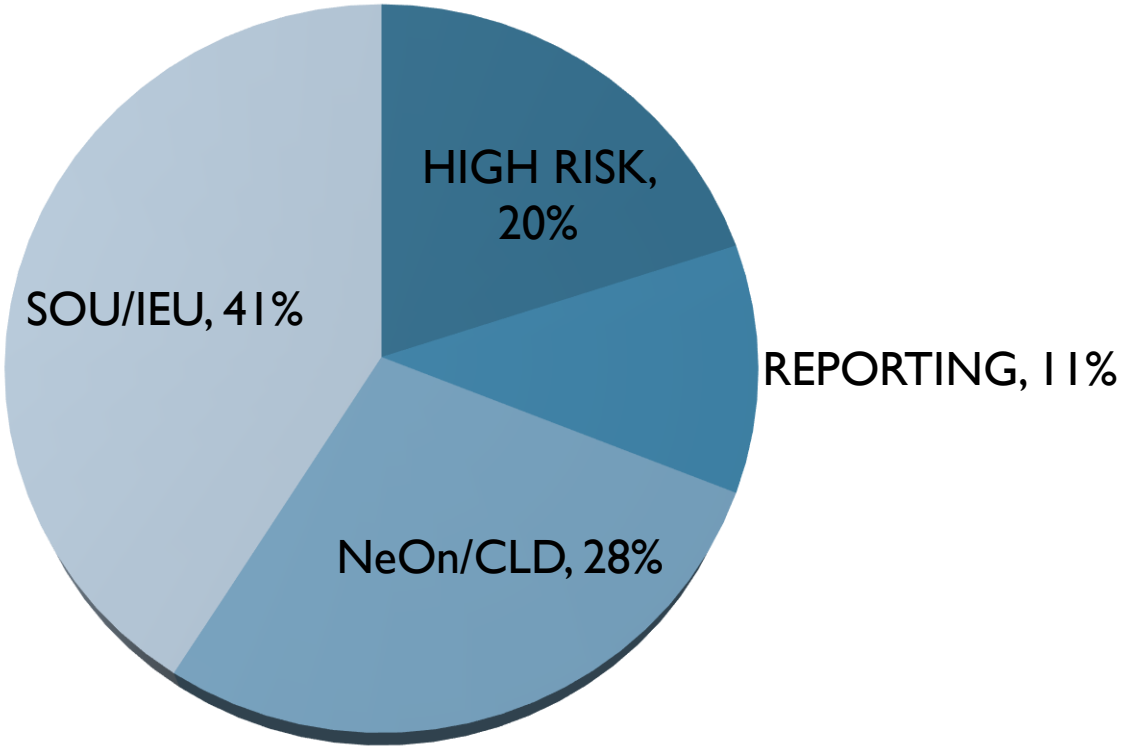
- Develop guidelines, training principles, forms, protocol and work flow
- Cross Training for Care Management Staff (50 CC and Supervisors) and DOP (100 PO's/SPO's & BC's)
- Co-location of collaborative services start January, 13th, 2014 for a period of six months, with ongoing evaluation of progress
  - Care Coordination staff assigned across 2 DOP reporting sites, 3.5 days per week
  - 2 NeOn locations receive dedicated health home enrollment staff person (Brownsville, East NY)
- Individual Case Reviews of all caseload bearing officers
- Biweekly Stakeholder Meetings implemented to monitor, review and problem-solve
- Ground up engagement and enrollment and data-match to occur simultaneously.
- Outcomes Metrics: Public Safety and Public Health

# DEPT. OF PROBATION CLIENT HEALTH HOME ELIGIBILITY




**MH**-mental health
**MA**-medical issues
**SA**-substance abuse

# DEPT. OF PROBATION REFERRAL SOURCES




**SOU**-sex offender unit, 25:1 caseload

**IEU**-Intensive engagement unit 25:1 caseload

**NeOn**-neighborhood units (mixed risk levels)

**CLD**-client development (high risk)

# PRELIMINARY FINDINGS AND OUTCOMES

- DOP referral numbers
  - 200 ground up referral forms completed by Officers (thru case review process)
- CBC Pathways to Wellness ground up outreach and enrollment numbers
  - Care Coordinators received a total of 130 referrals (face to face)
    - As of May 7th, 2014: 69 clients are in active outreach or enrolled status
    - 29 clients were prevented from enrolling due to lack of insurance and Medicaid enrollment lag time.
    - 5 clients were prevented from enrolling due to out of network partners supporting only "family planning" services
- CBC/DOP data match numbers
  - 1st round front end data match (source: 6 pilot CMA's, Brooklyn only, all active status choices)
    - 4600 unique names, 40 matches
  - 2nd round front end data match [source: all CMA's in CBC network, city-wide, registration, outreach or formerly in outreach status (exclusions: currently enrolled)]
    - 17,000 unique names, 91 matches

# CHALLENGES

- Medicaid enrollment obstacles:
  - Delays in Medicaid enrollment verification
  - High percentage of clients without insurance
- Data Sharing hurdles
- Culture shift for two systems: behavioral health providers & criminal justice agency
- On-going cross training (aligning treatment goals & foundations of collaboration)
- Co-location of services can lead to association of care coordination services with law enforcement conditions
- Need for HIT connectivity across systems
- Lack of DOP resources to identify and coordinate referrals


# THANK YOU