NEW YORK
STATE OF OPPORTUNITY.

Community, Opportunity, Reinvestment (CORe) Initiative

July 16, 2015

Monthly COReSTAT Webinar

Agenda

1:00PM – **Welcome and Introductions**

1:10PM – **Monthly Data Review and Action Step Updates**

- Office of Mental Health (OMH) will provide a brief overview of select behavioral health indicators.

1:25PM – **Discussion: The Intersection of Criminal Justice and Mental Health**

- Department of Health (DOH) will provide a brief overview of the Criminal Justice Health Home development.

1:50PM – **Questions and Next Steps**

2:00PM – **Close**

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I. Welcome and Introductions

COReSTAT Indicators Reminder

- COReSTAT is a tool for measuring indicators of distress at the neighborhood-level (i.e. ZIP or census-tract).
- COReSTAT indicators are TREND data on community conditions and are used to drive discussion and further inquiry.
- COReSTAT indicators are not OUTCOME data suitable for programmatic evaluation.
- COReSTAT indicators should not be used to infer causality between disparate data.

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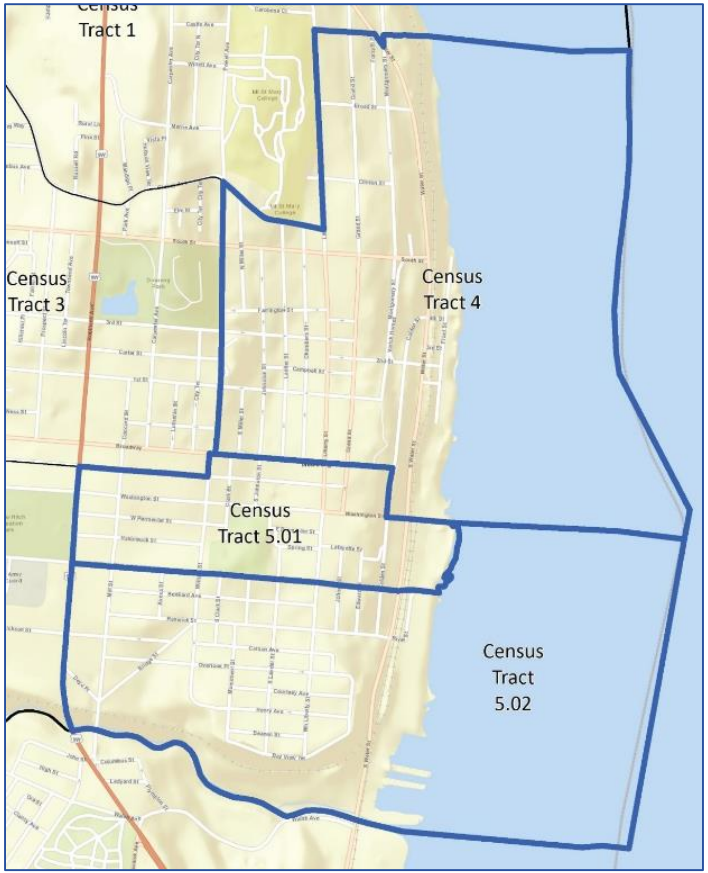
II. Monthly Data Review & Action Step Updates

CORe Neighborhoods

Newburgh

- ZIP
  - 12550

- Census Tracts
  - 5.02
  - 5.01
  - 4



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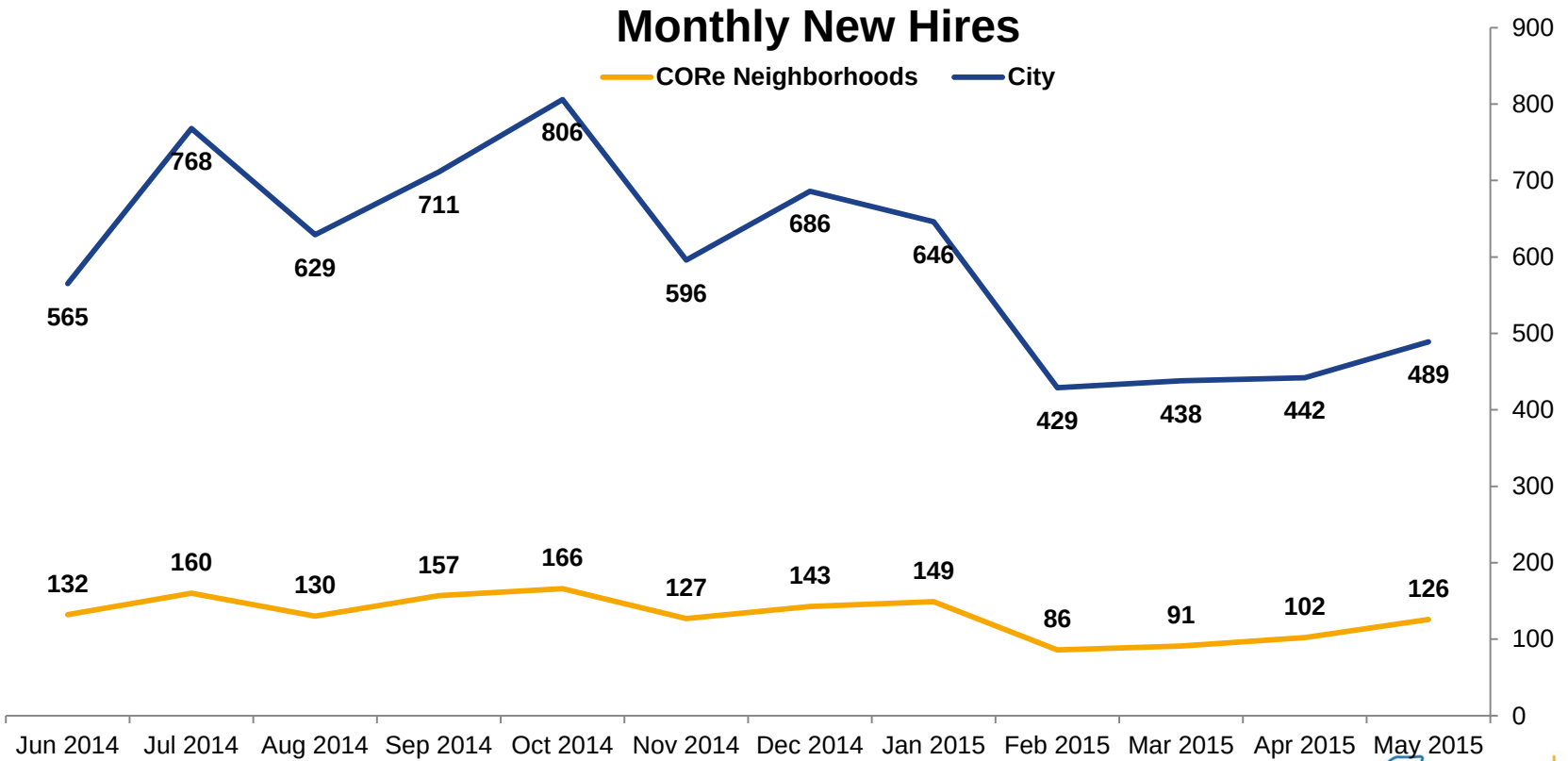

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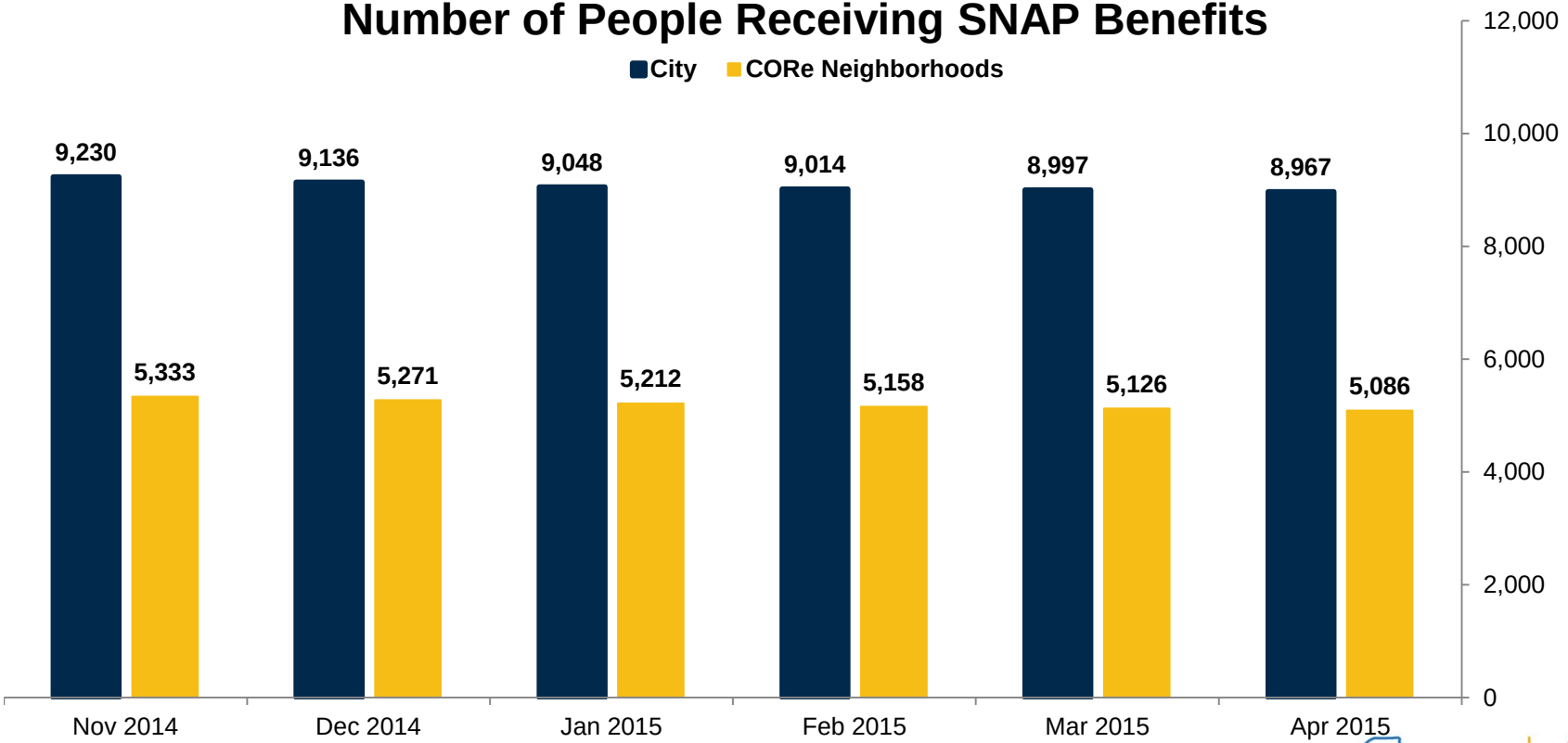
Number of People Receiving SNAP Benefits



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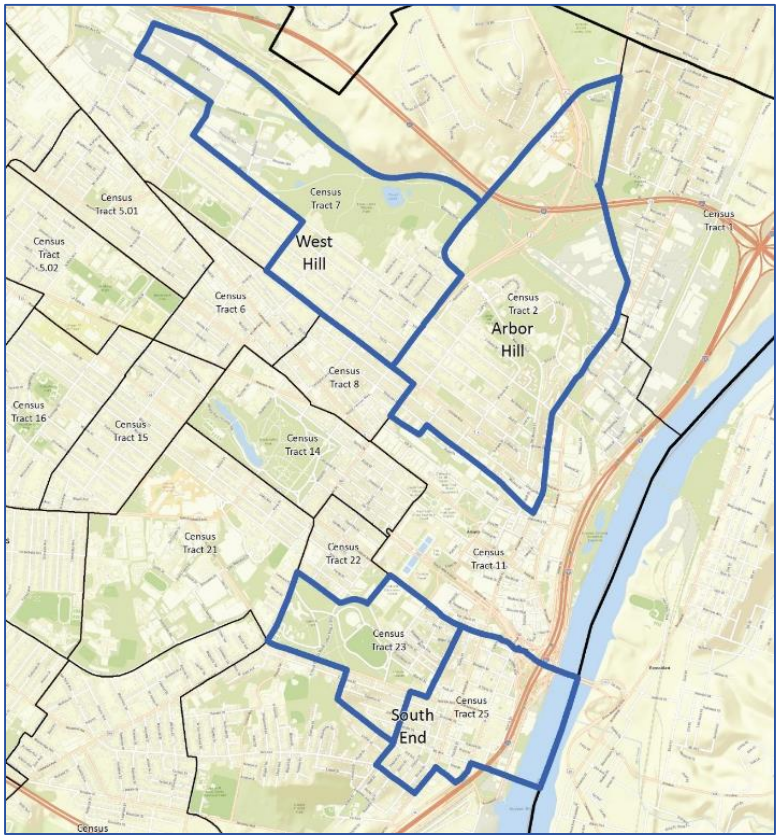
CORe Neighborhoods

Albany

- Arbor Hill
  - Census Tract: 2
  - Zip: 12210
- West Hill
  - Census Tract: 7
  - Zip: 12206
- South End
  - Census Tracts: 23, 25
  - Zip: 12202



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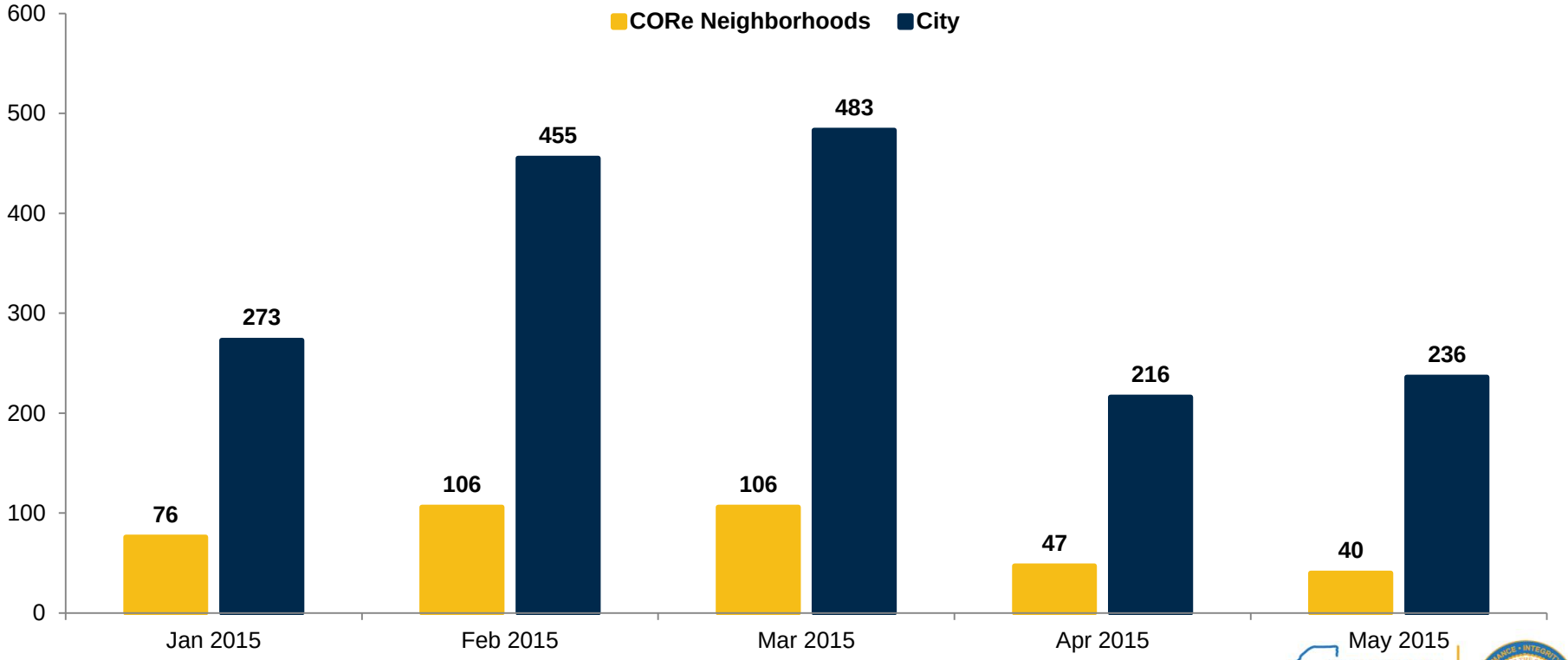
Number of Code Violations



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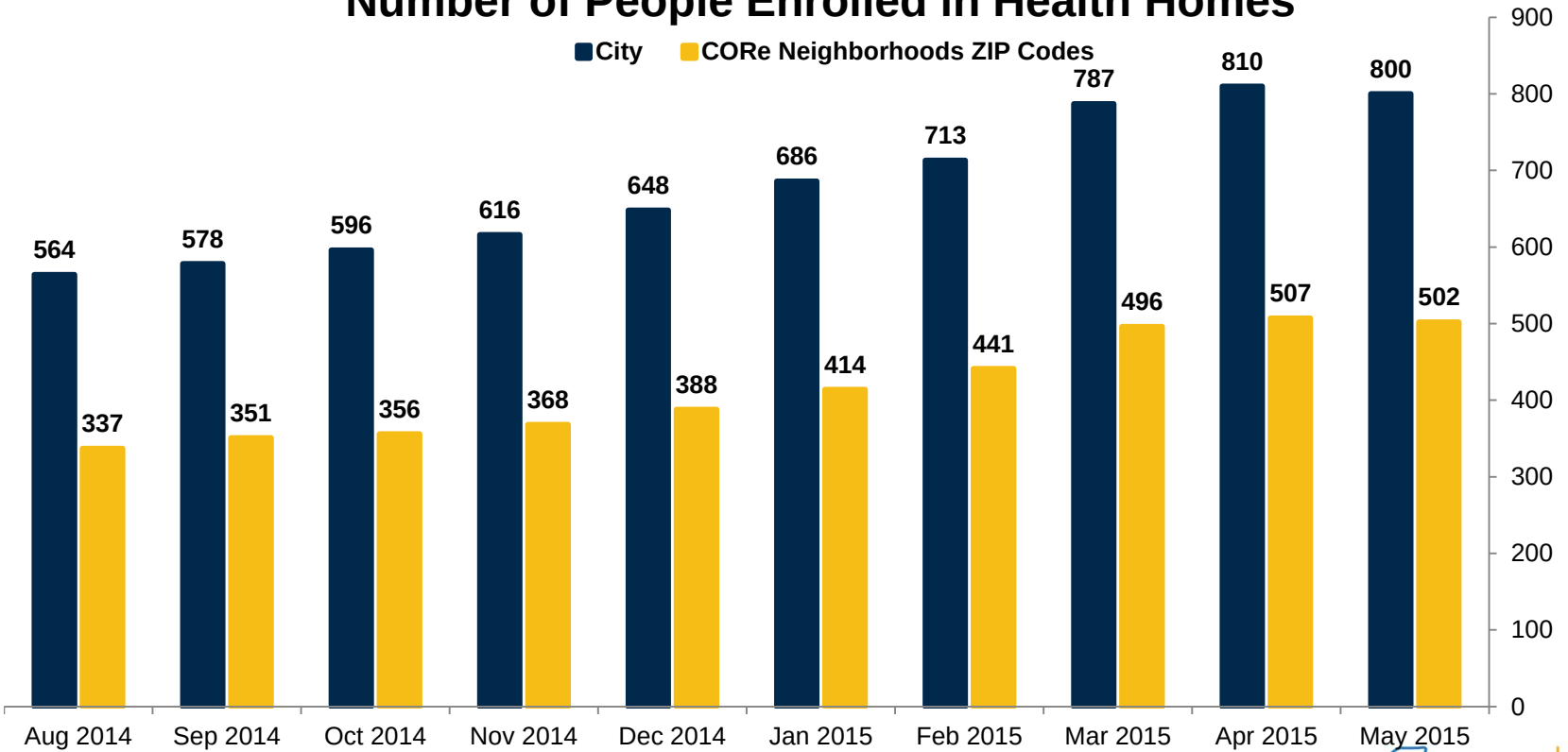
Number of People Enrolled in Health Homes



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Action Step Update

Identifying Behavioral Health Indicators

- In April, the NYS Office of Mental Health (OMH) discussed their Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) which is a web-based portfolio of tools designed to support quality improvement and clinical decision-making.
    - PSYCKES uses administrative data from the NYS Medicaid claims database to generate quality indicators including high utilization and care coordination for the behavioral health (BH) population.
    - As a follow-up, OMH shared county-level behavioral health indicators on high utilization/care coordination and generated “hot-spot” analysis at the ZIP code-level on high utilization within the CORe geographies.

Action Step Update

NYS Office of Mental Health (OMH)

Molly Finnerty
Director, Bureau of Evidence Based Services & Implementation Science

Erica Van De Wal
Medical Informatics Project Director

M. April Ellis
Research Scientist
Senior Manager, Specialized Data Management Systems

Action Step Update

Identifying Behavioral Health Indicators

- The BH population includes:
  - Medicaid individuals who received either a mental health or substance use disorder service, diagnosis, or psychotropic medication in the 9 months and
  - Medicaid individuals who ever received a BH diagnosis and were admitted to the hospital in the past 9 months.

Medicaid Enrolled Behavioral Health Population by Geography

Source: NYS DOH and OMH

Geography	Number of People Enrolled in Medicaid	Number of BH Medicaid Recipients	Percent of BH Medicaid Recipients
Albany - South End (ZIP 12202)	5,825	1,993	34.21%
Albany - West Hill (ZIP 12206)	9,436	3,349	35.49%
Albany - Arbor Hill (ZIP 12210)	4,209	1,501	35.66%
Newburgh - East End (ZIP 12550)	18,732	4,633	24.73%

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Action Step Update

Identifying Behavioral Health Indicators

- While OMH's PSYCKES data tool currently provides county-level indicators by default, the PSYCKES team has recently piloted ZIP code-level "hot-spot" analyses to provide greater population health information.
    - OMH provided "hot-spot" maps for the CORe geographies based on high-utilization in the BH population of inpatient admissions or emergency room visits.
    - High-utilization is defined as four (4) or more inpatient admissions or emergency room visits – for medical or behavioral health cause – within the past year.

Action Step

Medicaid BH Population:
High Utilization in Albany CORe ZIP Codes

Number of BH Medicaid Recipients with 4+ Inpatient Admissions or ER Visits in the past year

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Total Number of BH Medicaid Recipients

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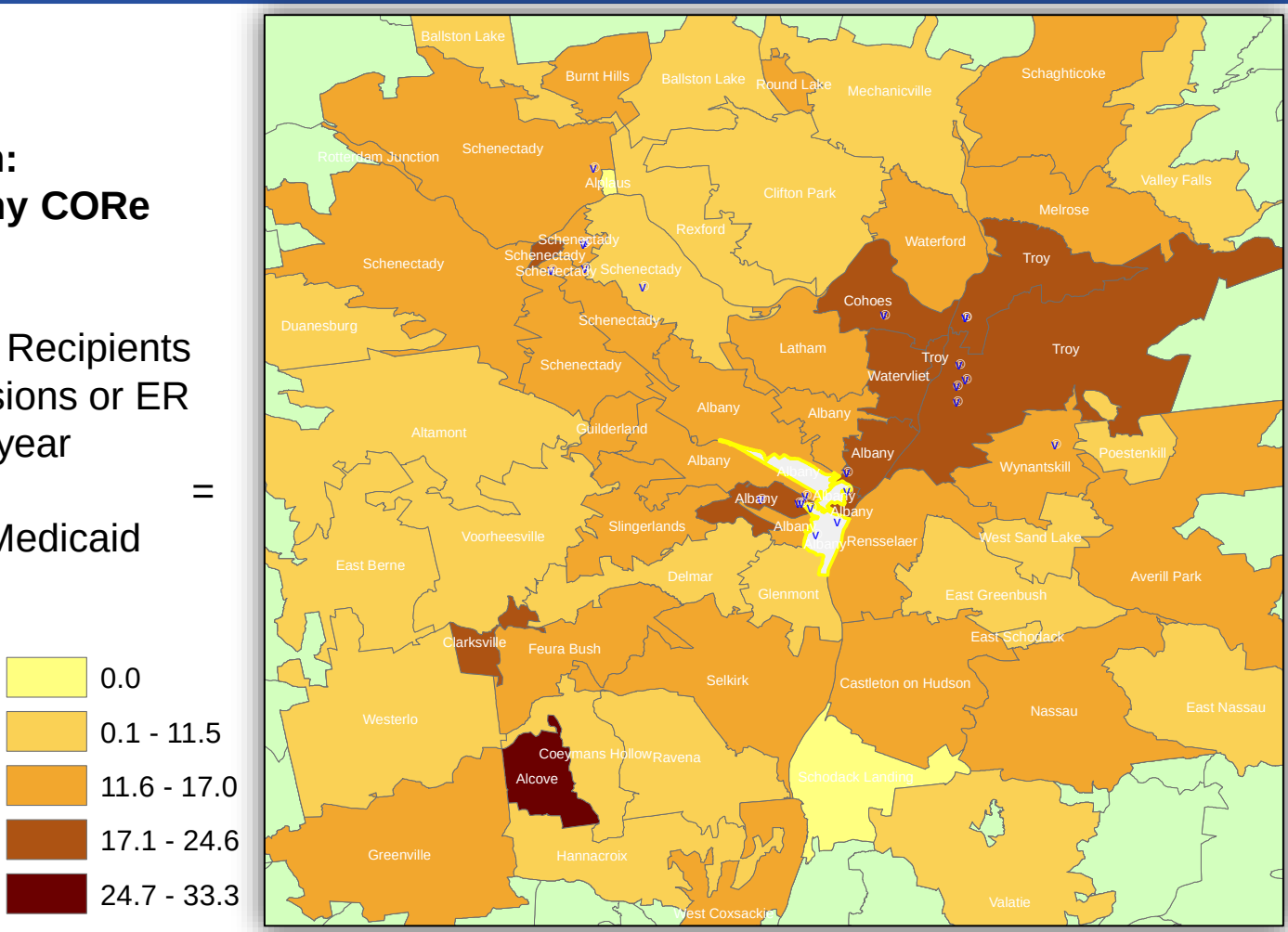

	0.0
	0.1 - 11.5
	11.6 - 17.0
	17.1 - 24.6
	24.7 - 33.3

Action Step

Medicaid BH Population: High Utilization in Albany CORe ZIP Codes

Number of BH Medicaid Recipients with 4+ Inpatient Admissions or ER Visits in the past year

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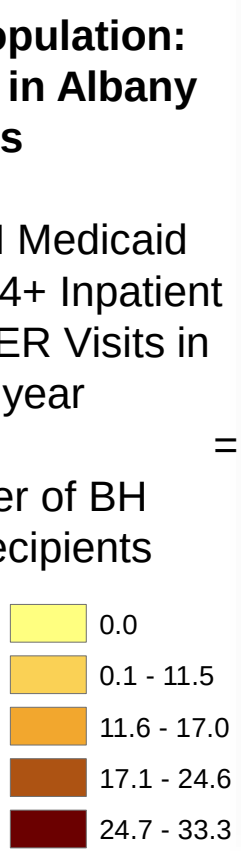
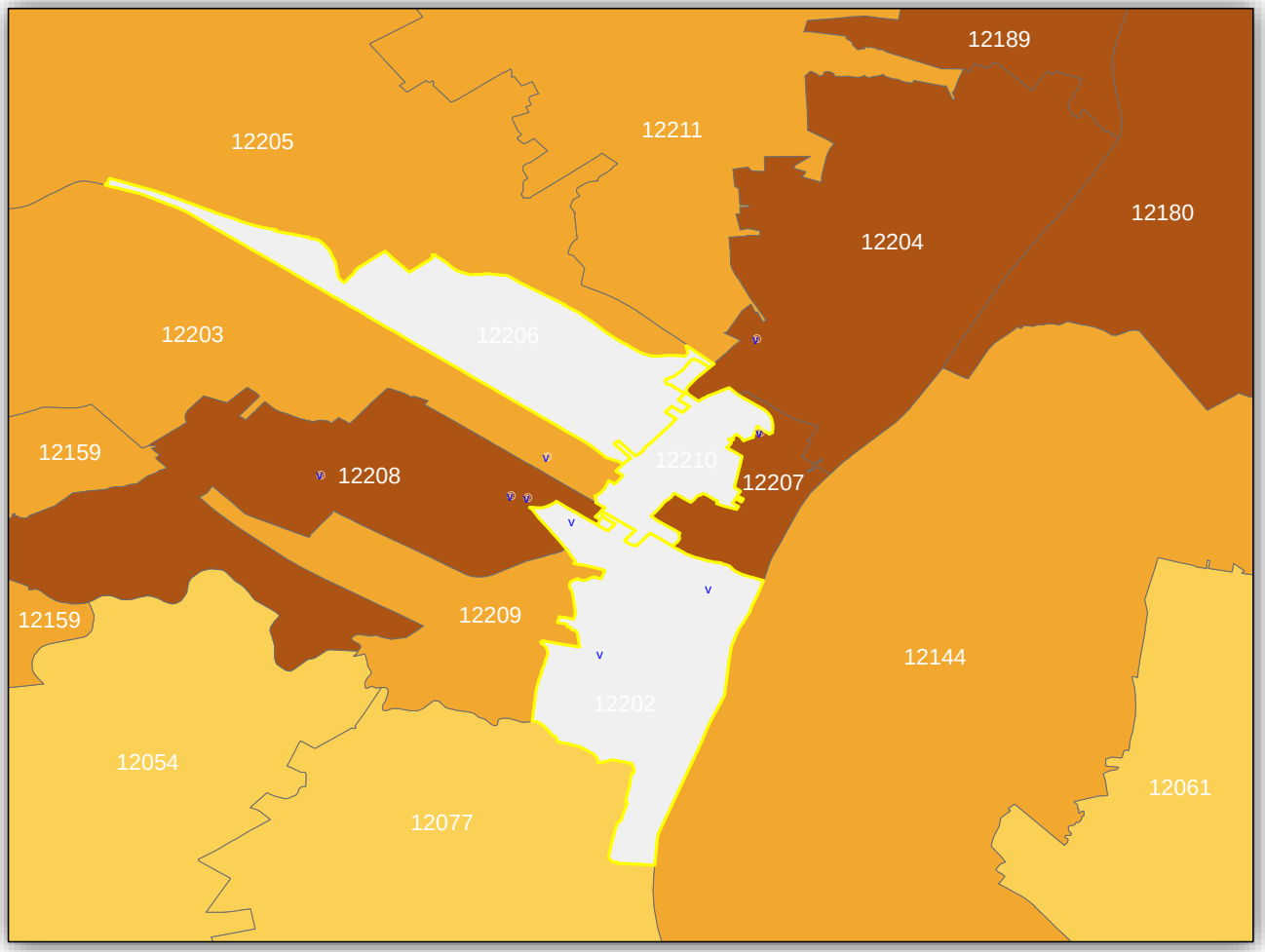
Total Number of BH Medicaid Recipients

=





Action Step

Medicaid BH Population: High Utilization in Newburgh CORe ZIP Code

Number of BH Medicaid Recipients with 4+ Inpatient Admissions or ER Visits in the past year

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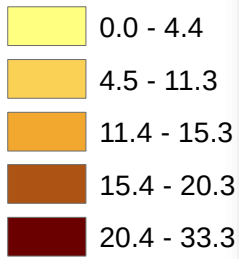
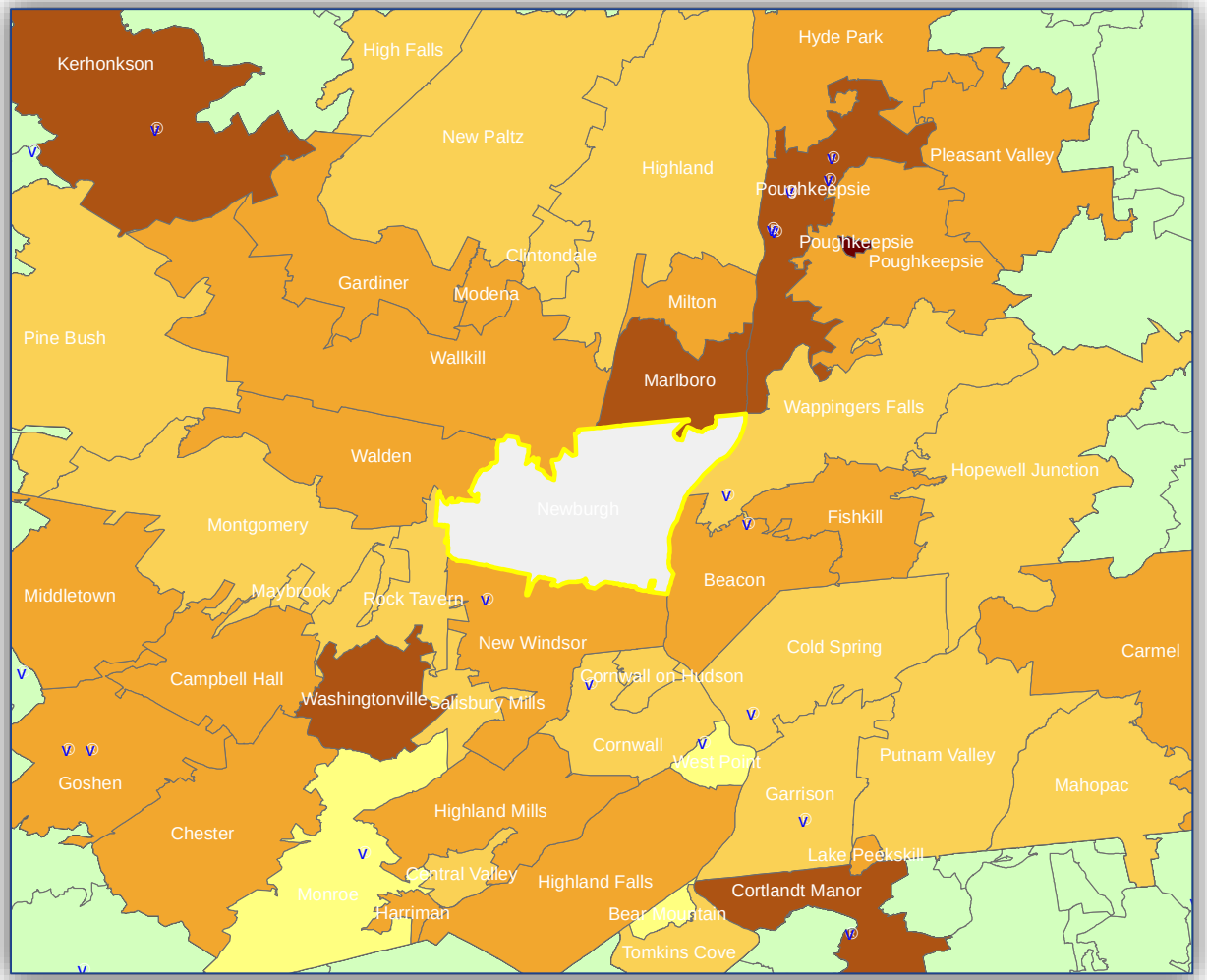
Total Number of BH Medicaid Recipients





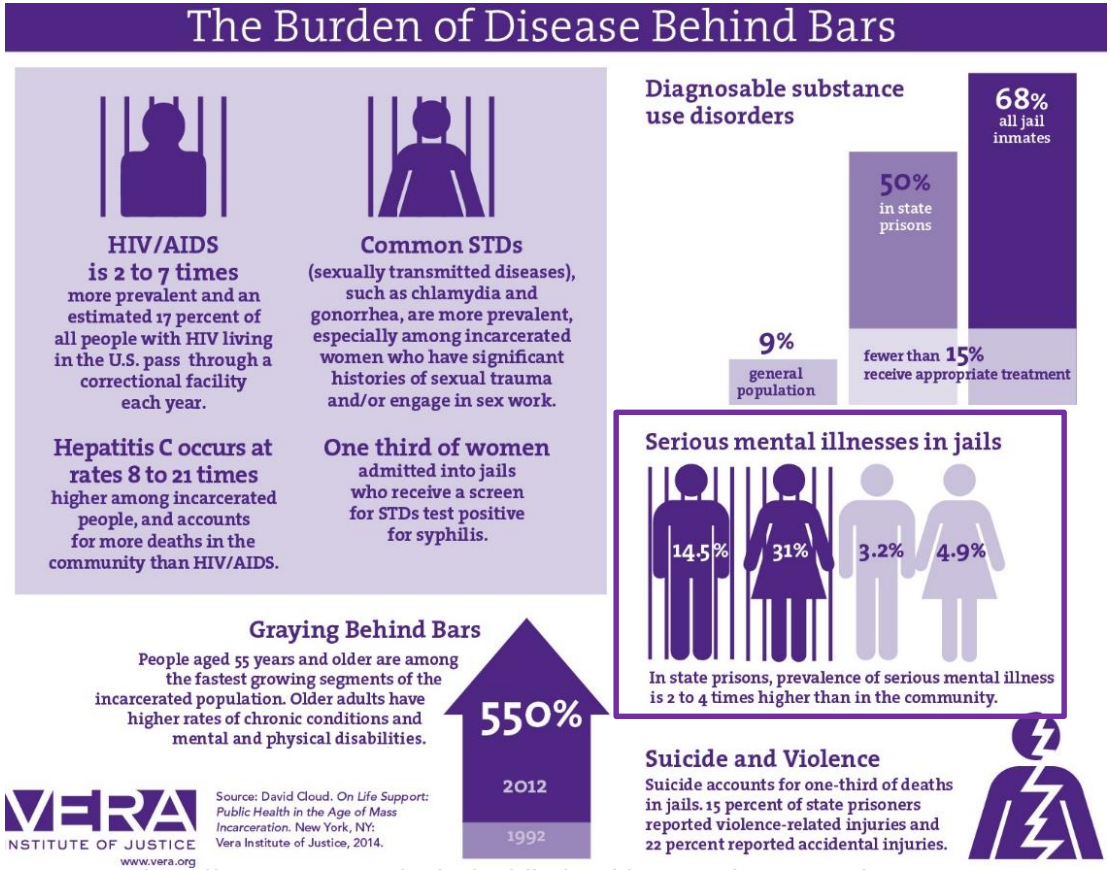
Action Step Update

Identifying Behavioral Health Indicators

- Among the OMH PSYCKES county-level indicators regarding high-utilization, there are several disparities in Albany and Orange County that are notable.
  - In Albany County:
    - The high-utilization rate is **22.01**% among the BH population compared to 10.25% statewide. This increased rate of utilization is witnessed across all providers – including mental health clinics, inpatient providers, and health homes/care management agencies.
  - In Orange County:
    - While the high-utilization rate is 9.4% among the BH population compared to 10.25% statewide, St. Luke's Cornwall Hospital's BH patients have a **15.46**% high-utilization rate.
      - This provider-level detail is derived from a custom PSYCKES report.

III. The Intersection of Criminal Justice and Mental Health

Criminal Justice and Mental Health



Vera Institute of Justice Report

On Life Support: Public Health in the Age of Mass Incarceration

November 2014

http://www.vera.org/pubs/public-health-mass-incarceration

Criminal Justice and Mental Health

NYS Department of Health (DOH)

Joann Susser
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Stephanie Fuertes
Student Assistant, Office of Insurance Programs

NEW YORK STATE | Department of Health | Medicaid Redesign Team

NEW YORK STATE HEALTH HOMES: CARE MANAGEMENT FOR THE CRIMINAL JUSTICE INVOLVED POPULATION

New York State Department of Health
Office of Health Insurance Programs

What is a Health Home?

- Section 2703 of the Affordable Care Act (ACA) authorized an optional Medicaid State Plan benefit to establish Health Homes to coordinate care for people with Medicaid who have chronic conditions.

- Health Homes provide comprehensive, integrated, person-centered care management and coordination to Medicaid enrollees with complex needs through a network of medical, behavioral health, and social service providers.

New York State Health Home Model

Health Homes must have connected under a single point of accountability all of the following:

- One or more hospital systems
- Multiple ambulatory care sites (physical and behavioral health)
- Community based organizations, including existing care management and housing providers

Single Point of Accountability (Designated Lead HH) is responsible for governance and operations, development of standardized policies and procedures for care management across its network of providers.

Health Home Care Management Services

Health homes provide the following Health Home services in accordance with federal and State requirements:

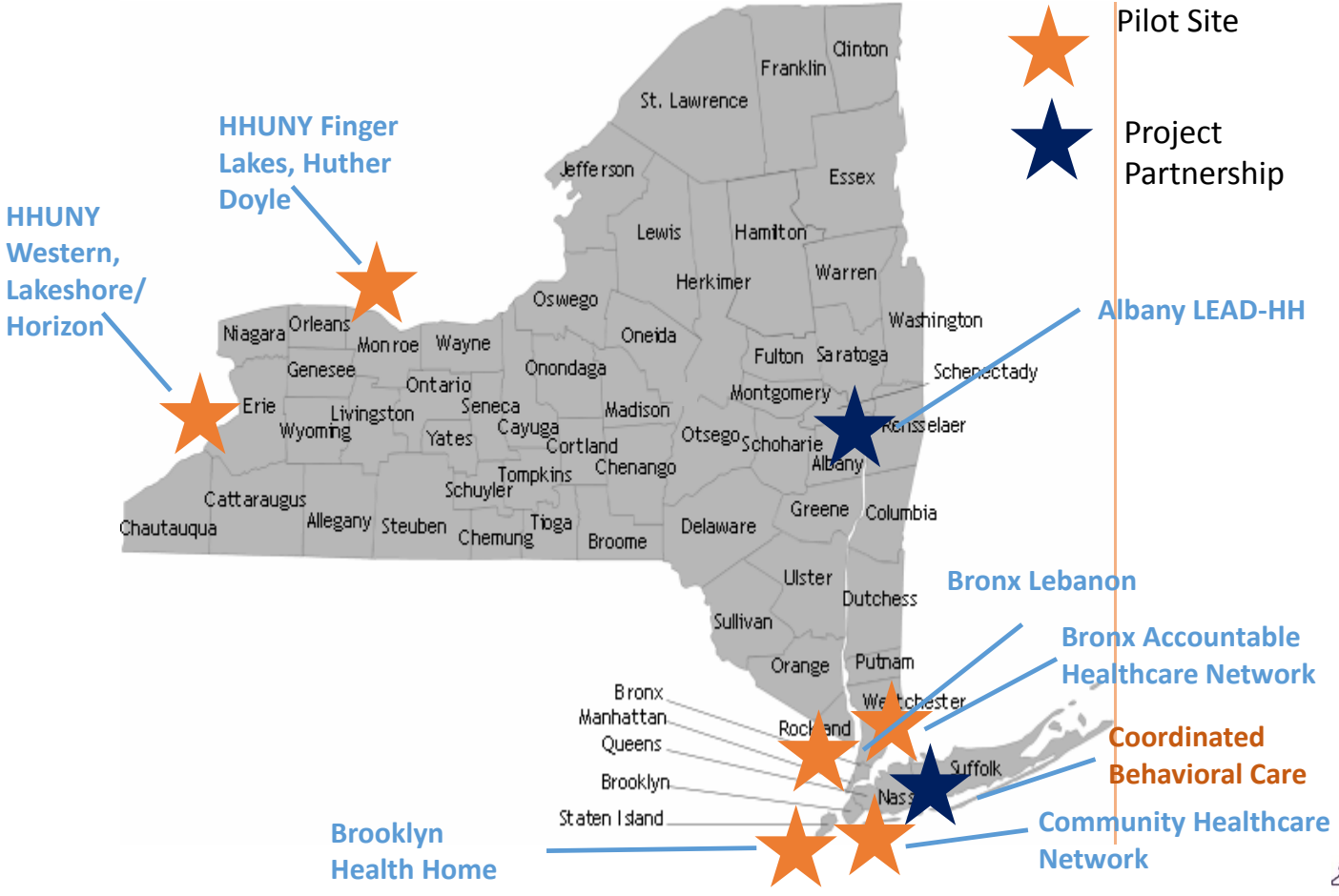
- Comprehensive care management
- Care coordination and health promotion
- Comprehensive transitional care
- Patient and family supports
- Referral to Community and Social Support Services
- Use of Health Information Technology (HIT) to Link Services

Health Home care management is an opportunity to link CJ involved individuals to systems of health, behavioral health and community care and supports to reduce disparities and recidivism rates.

Criminal Justice:
Health and Behavioral Health Disparities

- 53% Women & 35% Men involved in the criminal justice system report a current medical issue. (National Health Care For The Homeless 2013)
- 60-80% 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)

Health Homes and Criminal Justice Pilots



Survey Common Themes to Date

- Sites are working with local jails, as well as have established agreement(s) – (E.g. DEAAs and Business Partnership Agreements)
- Sites have developed various methods of communicating with the CJ System for diversion including Care Managers present in the courts and Agency Boards comprised of local county justice professionals and representatives (i.e. – County DA, Sheriff, city police, etc.)
- Current population engagement plans include:
  - Identification of eligible individuals
  - Establishment of connections/partnerships between justice professionals and Care Managers
  - Attempting to have Care Managers enter the jails for early interventions and prevention of rearrests
- Current methods towards population improvement of preventive care includes:
  - Disease management
  - Promotion of health literacy / Health Home Program promotion
  - Monthly meetings / conferences within the network

Key Results: Criminal Justice Linkages

- All five sites stated they currently work with local jails, though there are no established collaborations with state prisons as of yet.
  - Two sites (40%) are working with parole and/or probation.
  - One site (20%) is currently working with community re-entry task forces.
  - All five sites reported established agreement(s) – E.g. DEAA and Business Partnership Agreements
- A few of the sites described their process for communicating with the Criminal Justice System for diversion. In particular:
  - Huther Doyle has an Agency Board that consists of the County DA, Sheriff, founding Drug Court Judge, and a representative of the Rochester City Police. The Board discusses linkages and coordination of programming.
  - Lake Shore has Care Managers present in the courts, allowing them access to the jail/holding center. They also have working relationships with Erie County's Forensic Mental Health Team.

Key Results: Population Engagement

- Four sites (80%) reported engagement of the criminal justice population prior to the pilot.
  - E.g. – Community Healthcare Network had always served individuals released from incarceration. Their interdisciplinary team approach (model of care) has been maintained.
- Some current population engagement plans:
  - Identification of eligible individuals
  - Establishment of connections/partnerships between justice professionals and Care Managers
  - Attempting to have Care Managers enter the jails for early interventions and prevention of rearrests

Key Results: Improvement of Preventive Care & High Patient Satisfaction

- Steps sites are pursuing towards preventive care:
  - Identification of members/candidates and linkage to needed services
  - Disease management for chronic conditions
  - Promotion of health literacy/ Health Home Initiative promotion
- Steps sites have taken towards high patient satisfaction:
  - Systems implemented such as monthly meetings, conferences and system partnerships
  - Utilize a person-centered approach
  - Specifically some sites have stated:
    - Brooklyn Health Home – "Open Door Policy" for guidance and support.
    - Huther Doyle – Has routine patient surveys that demonstrate high patient satisfaction
    - Lake Shore – Requires that Care Managers attend mandatory trainings for Cultural Competency and Trauma Informed Care, as well as has access to interpreters.

Questions?

For more information, please visit:

DOH Medicaid Health Homes
www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/

- This page contains detailed information on the current health home providers.

DCJS Justice and Mental Health Collaboration Program
www.criminaljustice.ny.gov/opca/justice-mental-health.htm

- This page contains information from a June 22, 2015 Medicaid Health Homes and Criminal Justice Webinar.

Pathways to Neighborhood Success

- In Albany, CORe is implementing Pathways to Neighborhood Success – a unified framework to coordinate and align targeted interventions (already in place or under development). This alignment occurs through data-sharing and partnerships that ensure maximum impact with minimal duplication.
  - Early Intervention Youth Case Management System
  - Work for Success / Ready, Set, Work! Collaborative
  - Law Enforcement Assisted Diversion (LEAD) / Medicaid Health Homes

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Pathways to Neighborhood Success: LEAD

- Law Enforcement Assisted Diversion (LEAD)
  - LEAD is a pre-booking diversion program that directs low-level nonviolent offenders away from the criminal justice system and into community services such as health care and coordination, treatment services, and housing.
  - In 2011, LEAD was developed in Seattle (WA). In 2013, Santa Fe (NM) became the second jurisdiction to enact LEAD.
  - Last month, Albany (NY) became the third jurisdiction – *and first on the East Coast* – to develop LEAD.

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Pathways to Neighborhood Success: LEAD

- LEAD Key Partners
  - Albany Police Department
  - Albany County District Attorney
  - City of Albany Mayor's Office
  - Albany County Executive and Departments
  - Albany County Sheriff
  - Central District Management Association
  - Center for Law and Justice
  - Drug Policy Alliance
- Next Steps
  - Creation of Officer Work Group
  - Development of Operational Team and Protocol
  - Analysis of LEAD Participant Data

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IV. CORe Online – Social Media

CORe Online: Social Media

- Follow CORe on Twitter **@NYS_CORe** for the latest updates on neighborhood revitalization efforts in New York State.
  - URL: twitter.com/NYS_CORe

V. Questions and Next Steps

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Next COReSTAT Webinar

- Thursday, August 20th 2015 at 1:00PM

July 16, 2015

Questions? Contact Nora Yates at Nora.Yates@exec.ny.gov