

Bronx Lebanon-CBC Health Home Health Home Presentation

Health Home and Criminal Justice
Pilot Workgroup Meeting

January 22, 2013

Goals of the Health Home

- Goal 1: Reduce utilization and expenses associated with avoidable (preventable) inpatient stays and emergency room visits
- Goal 2: Create integrated care delivery and information system to link care coordination efforts for Health Home clients among CBOs and medical providers
- Goal 3: Improve care and outcomes for persons with chronic conditions, mental illness and/or substance use disorders
- Goal 4: Improve Preventive Care
- The Health Home will be accountable for reducing avoidable health care costs, specifically:
 - ✓ Preventable hospital admissions/readmissions
 - ✓ Skilled nursing facility admissions
 - ✓ Emergency Room visits
- The Health Home will be responsible for meeting quality measures.

Provider/Partner Network

Partners

- CBC/FEGS
- Bronx Lebanon Hospital Center
- Martin Luther King Jr. Medical Center
- BronxWorks
- Narco Freedom
- All Med Medical & Rehabilitation of New York
- Corinthian Medical IPA
- ESSEN Medical Associates

Network Providers

- Dannelisse Corp.
- Argus
- Aguila
- Project Renewal
- CitiWide Harm Prevention
- Puerto Rican Family Institute
- EAC
- Bronx Psychiatric Center
- Comunilife
- Palliadia
- Dominican Sisters Family Services
- Addiction Research & Treatment Corporation
- Damon House
- NADAP
- Bronx Parents housing Network
- Pathways to Housing

Plans for engaging Criminal Justice Population

- MOU and DEAA signed for Bronx Health Home
- Line of Communication is established
 - Central contact person identified at BLHC to provide information about whether Rikers patients returned to care
 - Exploring possible next steps

HHUNY – Finger Lakes
Huther Doyle Memorial Institute, Inc.
Health Home Presentation

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Goals of the Health Home

1. Patient-Centered: Meeting the patient's needs, providing support, striving to meet the patient preferences of care.
2. Effective: Achieving outcomes related to improvement in the patient's condition or measurable progress toward patient's goals.
3. Efficient: Providing a reasonable and cost effective service delivery model

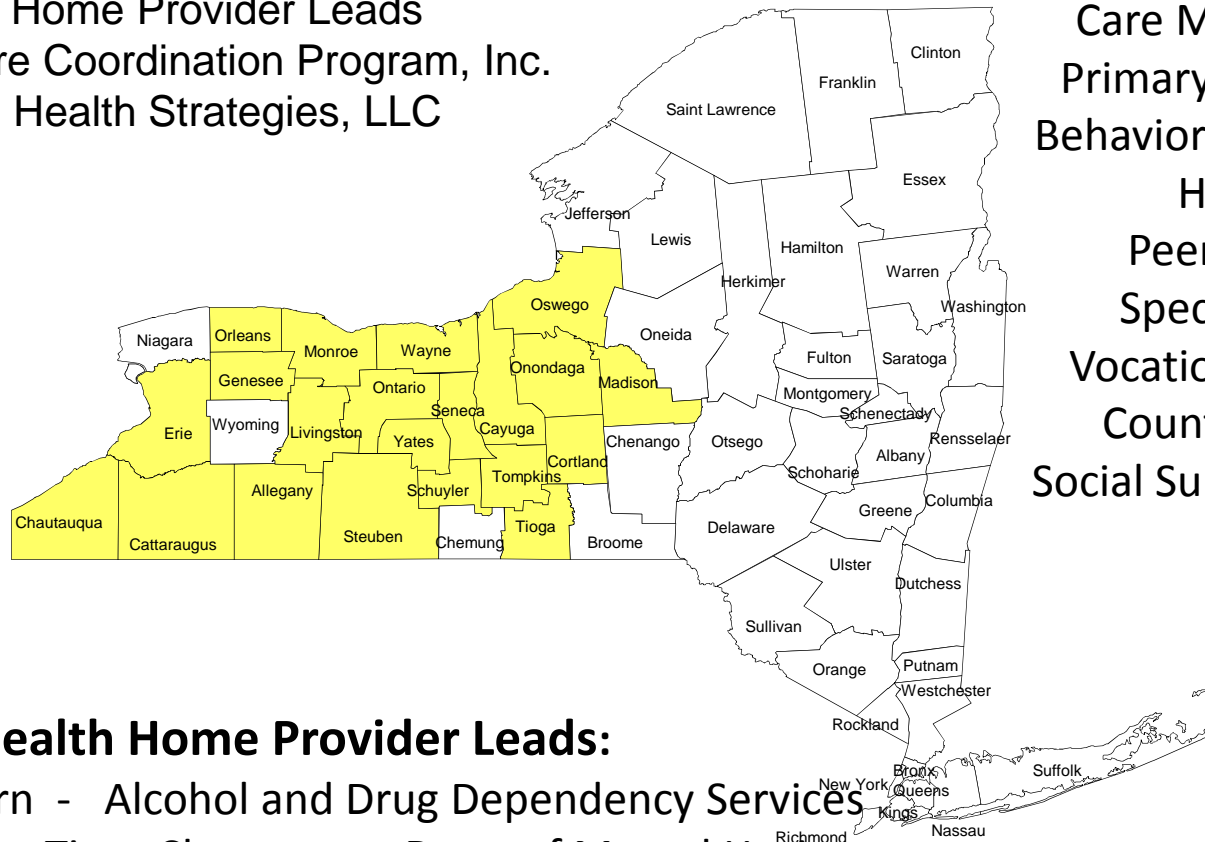
Health Homes of Upstate New York

Governing Partners

Health Home Provider Leads
New York Care Coordination Program, Inc.
Beacon Health Strategies, LLC

Service Provider Networks:

Care Management
Primary Health Care
Behavioral Health Care
Housing
Peer Services
Specialty Care
Vocational Services
County Services
Social Support Services



Health Home Provider Leads:

HHUNY Western - Alcohol and Drug Dependency Services
HHUNY Southern Tier - Chautauqua Dept. of Mental Hygiene
HHUNY Finger Lakes - Huther Doyle Memorial Institute
HHUNY Central - Onondaga Case Management Services, Inc.

Plans for engaging CJ population – Finger Lakes

- The Health Home Provider Network currently includes a broad representation of treatment and community-based agencies that already have working relationships with the criminal justice system and serve large numbers of individuals in that system
- All of the Re-entry (federal and state) lead organizations are in the network
- Agencies providing Drug Court Case Management are included in the Network
- Preliminary conversations have been held with the Monroe County District Attorney and Sheriff
- A care manager with extensive re-entry experience is on staff at the Lead Agency
- The Lead Agency is represented on the County Re-entry Task Force (and Executive Committee) and Board of the community-based Re-entry focused group

**HHUNY-Western
Alcohol & Drug Dependency Services, Inc.
Health Home Presentation**

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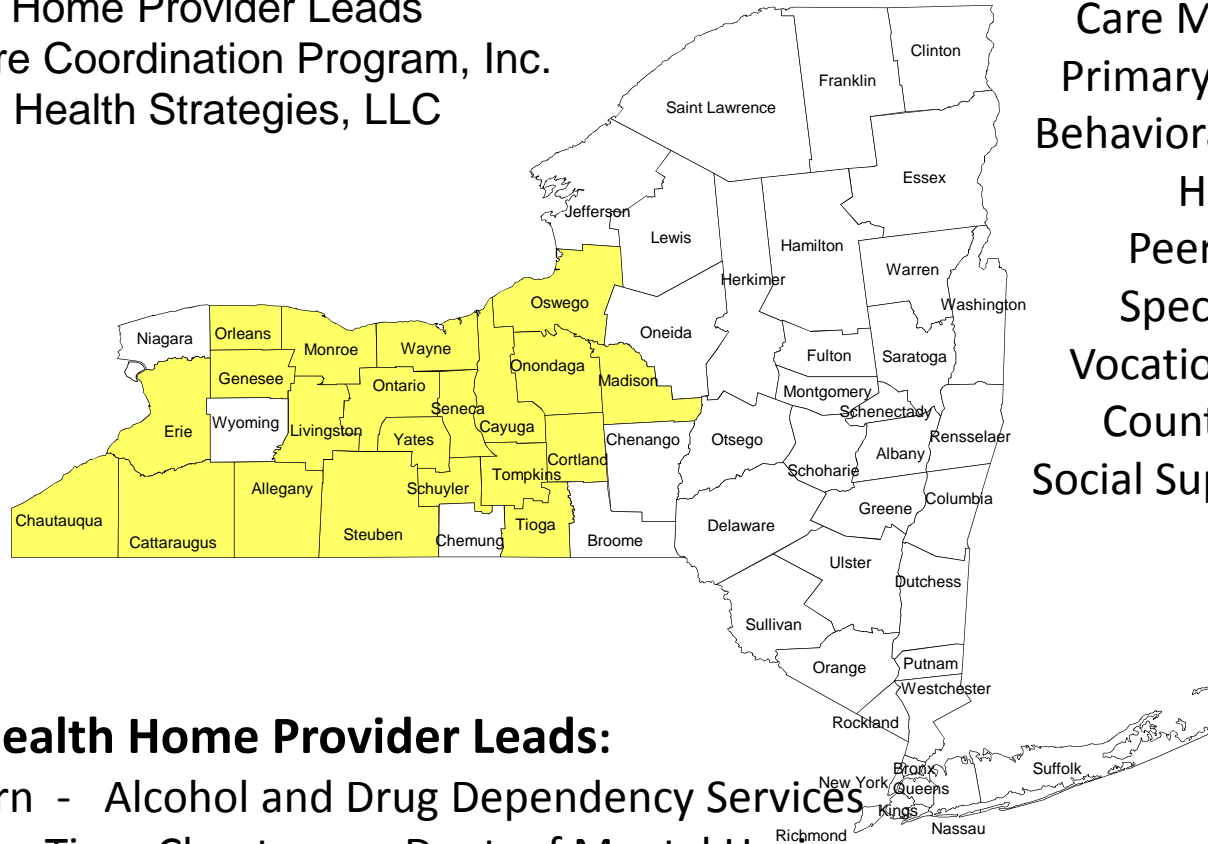
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Plans for engaging CJ population

- Build relationships with criminal justice agencies in WNY (NYSDOCCS, County Probation, County Jail, Drug Courts).
- Participate in community-based criminal justice collaborations (diversion, ATI, Reentry Taskforce)
- Implement evidence-based CJ practices in Health Home Model (Peer Mentoring, Vocational Services)

Brooklyn Health Home Presentation

Health Home and Criminal Justice
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Goals of the Brooklyn Health Home

- Identify and address the full range of behavioral, medical and social problems affecting chronically ill patients
- Foster collaboration and the timely exchange of patient information among involved providers
- Drive measurable improvements in patient outcomes, including reduced patient readmissions, and patient/ family engagement and satisfaction with care delivery

Provider/Partner Network

- Maimonides Medical Center
- Lutheran Medical Center
- VNSNY
- CAMBA
- Village Care
- iHealth:
 - AIDS Service Center NYC
 - HELP/PSI Services Corp
 - Gay Men's Health Crisis, Inc.
 - Harlem United
 - Bailey House
 - Richmond Home Need Services Inc.
 - APICHA
 - Housing Works
 - Diaspora Community Services
 - Heartshare Human Services of NY
 - Argus
 - Narco Freedom
- Health Care Choices
- FECS
- PSCH
- JBFCS
- Ohel Children's Home and Family Services
- Brooklyn Community Services
- Catholic Charities Neighborhood Services
- NADAP
- Services for the Underserved (SUS)
- The Puerto Rican Family Institute, Inc.
- Interborough Developmental & Consultation
- Family Services Network of New York, Inc.
- South Beach Psychiatric Center
- CUCS
- First to Care Home Care
- Institute for Community Living
- Brooklyn Plaza Medical Center
- Phoenix House
- National Alliance on Mental Illness (NAMI)
- Liberty Behavioral Management
- St. John's Riverside Hospital
- Medisys Health Network Providers
- Brookdale Hospital
- Beth Israel Medical Center
- SUNY Downstate Medical Center
- Brooklyn AIDS Task Force
- Realization Center
- Bridge Back to Life
- Seafield Center
- White Glove Community Care, Inc.
- Public Health Solutions
- Baltic Street AEH
- Black Veterans for Social Justice
- Center for Behavioral Health Services

Plans for engaging CJ population

- Creating linkages between the Brooklyn Health Home and the criminal justice population
- Identifying transition points to engage this population in the Health Home
- Expanding the provider network to meet the specific needs of these members



Bronx Accountable Healthcare Network Health Home Presentation

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Goals of the Health Home

1. To deliver expert comprehensive and evidence-informed care coordination to facilitate access to high quality, cost effective and culturally relevant person and family centered services
2. To lead and advocate with key stakeholders for the development of community-based linkages to clinical and non-clinical services and supports
3. To promote integration and shared use of health information technology by providers and consumers

Provider/Partner Network

Partners (Governance)

- **Acacia Network**^{1,2,3,4,5,7,9,11}
- **Albert Einstein College of Medicine**^{1,2,3,4,5,7,9}
- **Montefiore Medical Center (Lead)**^{1,2,3,4,5,7,8,9}
- **Morris Heights Health Center**^{1,3,4,5,7,9,11}
- **St. Barnabas Hospital**^{1,2,3,4,9}
- **Union Community Health Center**^{1,2,3,4,9}

Treatment Providers (Non-Governance)

- | | | |
|--|---|---|
| • Americare CSS ^{1,3} | • Institute Home Care ¹ | • St. John's Riverside Hospital ^{1,2,3,4} |
| • Assistance by Improv | • JASA ^{1,5} | • St. Christopher's Inn ^{1,2,3,4,5} |
| • Bronx Independent Living Services | • Institute for the Puerto Rican/Hispanic Elderly ^{3,4,5} | • Urban Health Plan ^{1,2,3,4} |
| • Bronx Psychiatric Center ^{2,3,4,5,6,,10} | • Liberty Behavioral Management ^{2,3} | • Unique People ^{3,4,5} |
| • BronxWorks ^{4,5,7,9} | • Narco Freedom ^{1,2,3,4,5,9} | • VIP Healthcare Services ¹ |
| • Bronxwood Home for the Aged ^{1,5} | • New Alternatives for Children ^{1,3,4} | • VIP Services ^{1,2,3,4,5} |
| • Community Health Care Network ^{1,3,4,7} | • Odyssey House ^{1,2,2,4,5} | • Visiting Nurse Services of NY ^{1,4} |
| • Gay Men's Health Crisis ^{1,2,3,4,7} | • Phoenix House ^{1,2,3,4,5} | • The Children's Village ^{3,4} |
| • FEGS ^{1,2,3,4,5} | • Project Renewal ^{1,2,3,4,5} | • The Salvation Army ^{2,3,4,5,10} |
| • Health People ^{1,4} | • Puerto Rican Family Institute ^{3,4,5,6,9} | • Village Center for Care ^{1,2,3,4,5,7} |
| • Innovative Health Care Systems ¹ | • Riverdale Mental Health Assoc. ^{2,3,4,5} | • Women In Need |

Providers of the following services:

- | | | |
|------------------------|--------------------------|-----------------------------------|
| 1. Physical/Medical | 4. Social/Family Support | 8. MATS |
| 2. Chemical Dependency | 5. Housing | 9. Care Coordination |
| 3. Mental Health | 6. TCM – OMH | 10. Care Coordination Tentatively |
| | 7. TCM – COBRA | 11. FQHC |

Plans for engaging CJ population

- We have not focused on this population to date
- Currently if we find out a Member is incarcerated, they remain in the HH for up to 90 days thereafter in order to ascertain legal disposition; if they are still incarcerated on the 90th day, they are disenrolled



BROOKLYN HH HEALTH HOME PRESENTATION

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GOALS OF THE HEALTH HOME

1. Outreach and engagement of assigned patients
 2. Linkage to care
 3. Follow up care and additional linkage to community resources
 4. Ensure all professionals involved in a member's care communicate with one another
 5. Develop a single integrated care plan
 6. Share all information via one HIE Platform
 7. Meet overall health home requirements inclusive of 6 core services, quality matrix, meaningful use, PCMH, QUARR, HEDIS, and C-Mart requirements
- Improve health and behavioral outcomes= reduction in ER utilization and Hospitalization

PROVIDER/PARTNER NETWORK

- Care Manager leads an interdisciplinary team including:
- Primary Care Provider
- Mental health provider
- Substance Abuse Counselor
- Medical Specialist
- Nurse
- Home Based Providers (home attendant etc)
- Housing Specialist
- Hospitals
- MCOs
- Others

CHN'S TEAM STRUCTURE

- Deputy Director (LCSW). Responsible for the regional reports and the behavioral and social quality matrix
- HH Quality Supervisor (RN) responsible for the care plan approval and clinical quality indicators
- Coordinator/Supervisor (Licensed Nurse or Social Worker with supervisory experience and experience working with populations with complex medical, mental health and psycho-social needs). Responsible for the daily supervision and daily reporting tracking
- Care Manager- TEAM LEAD (Bachelors Degree and experience working with populations with complex medical, mental health and psycho-social needs) Responsible for the overall care coordination, linkage to services and care planning of the patient
- Patient Navigator (H.S Diploma, community experience working with populations with complex medical, mental health and psycho-social needs). Responsible for outreach activities, engagement, patient consent, screening, and assist with follow up and escort services

PLANS FOR ENGAGING CJ POPULATION

- ❖ Pre arrangement made prior to release date
- ❖ Patients drop offs at our clinics
- ❖ Patients seen at the clinic the day of release
- ❖ Informed engagement
- ❖ In-person screening
- ❖ In person assessment
- ❖ Goal setting
- ❖ Coaching
- ❖ Self-management (disease specific knowledge and skills)
- ❖ System access and navigation
- ❖ Modeling (joint visits to PCPs and specialists)
- ❖ Ongoing support with court mandate
- ❖ Coordination and communication with Parole officers
- ❖ Primary, Specialty and Mental Health Care
- ❖ Referring and connecting with community resources
- ❖ Housing, transportation, social support, etc