



Division of Criminal
Justice Services

MEDICAID HEALTH HOMES AND CRIMINAL JUSTICE

NYS DCJS/OMH Justice & Mental Health Collaboration Program
June 22, 2015

DCJS JMHCP Webinar Agenda

- DCJS Justice Mental Health Collaboration Program
 - Robert Maccarone, Deputy Commissioner DCJS/Director of the Office of Probation and Correctional Alternatives
- Introduction to Presentations,
 - Valerie Chakedis, JMHCP Consultant
- Medicaid Health Homes
 - Deirdre Astin, Program Manager, Health Home Program, Division of Program Development & Management, NYS Department of Health
- Monroe County Medicaid Health Home-Criminal Justice Pilot Program
 - Robert Lebman, President & Chief Executive Officer, Huther Doyle

Webinar Agenda (continued)

- Phase I JMHCP County Schenectady Health Home – Criminal Justice Collaboration
 - Darin Samaha, Director of the Office of Community Services, Schenectady County
- Questions
- Resources

Webinar Audience

- DCJS JMHCP Pilot Counties—Probation Directors, Mental Hygiene Commissioners and Jail Administrators

Invitation is extended to:

- All Probation Departments, County Mental Hygiene Directors, Jail Administrators, ATI Programs and Health Homes
- New York City Department of Health and Mental Hygiene
- 19 DCJS funded County Re-Entry Taskforces

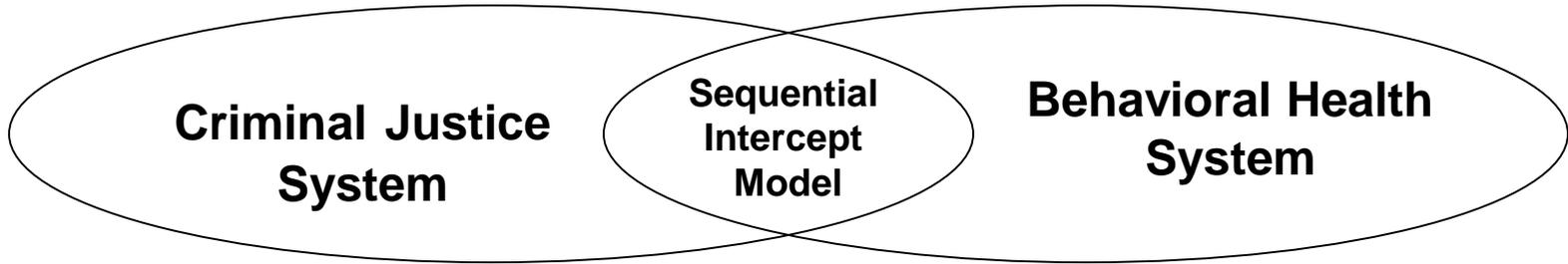
JMHCP--Intersection of Medicaid HH and Criminal Justice Goals

Address physical and behavioral health needs and ensure that justice – involved individuals have access to healthcare to promote pro-social behavior and recovery;

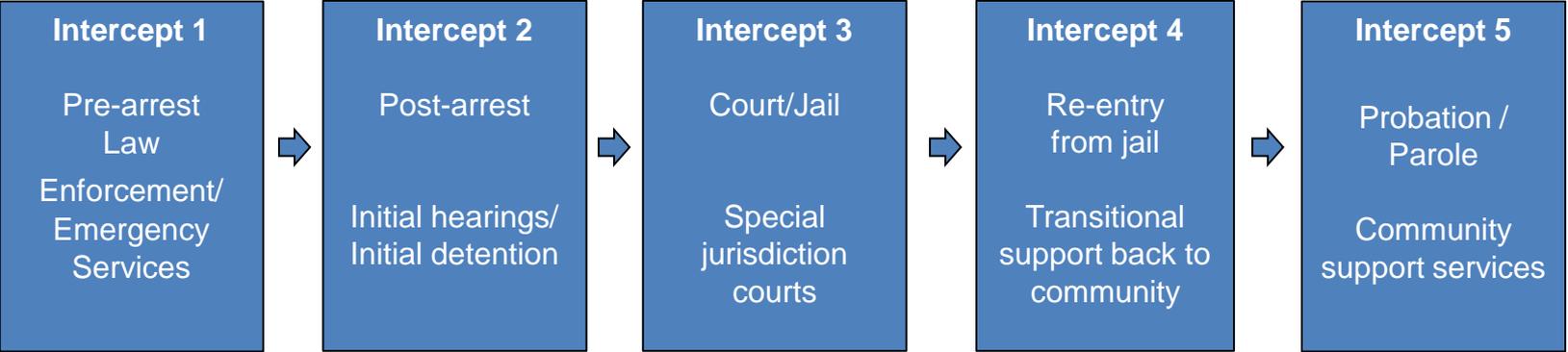
Support the goals of the Medicaid Redesign for better health, lower costs and criminal justice goals for greater public safety and reduced recidivism

JMHCP Pilot Site Selection

IMPACT Counties:	Implementation Phase	2010 Population	Violent Crime 2011 Count	Violent Crime 2011 Rate per 100,000	OMH 2010-11 Medicaid MH Costs: Individuals with High Utilization: \$2 - \$4,000 plus/month	OMH 2010-11 Medicaid MH Costs including OASAS: Individuals with High Utilization: \$2 - \$4,000 plus/month
Albany	2	295,267	1,161	379.9	79	183
Broome		191,892	521	258.6	41	119
Chautauqua		131,411	301	222.1	25	67
Dutchess		291,541	623	208.5	74	178
Erie	2	895,158	4,201	455.1	160	423
Monroe	1	724,942	2,654	355.0	175	446
Nassau	1	1,344,303	2,226	165.4	119	261
Niagara	2	211,650	811	373.0	43	122
Oneida		228,059	548	232.3	61	150
Onondaga	2	449,339	1,656	353.0	77	223
Orange	2	383,475	979	261.4	68	194
Rensselaer	1	154,087	485	302.8	12	42
Rockland		298,092	552	176.3	34	82
Schenectady	1	151,036	687	442.0	19	62
Suffolk		1,511,183	2,213	147.5	214	509
Ulster		179,764	335	182.7	36	96
Westchester	1	948,303	2,451	257.1	250	613
		8,389,502			1,487	3,770



Criminal Justice System



Diversion of appropriate adults throughout CJ system

BH System

Community Services and Supports:
crisis support, residential and vocational support, case management, treatment

Criminal Justice System



Intercept 1
Pre-arrest

Law Enforcement /
Emergency
Services

Intercept 2
Post-arrest

Initial hearings /
Initial detention

Intercept 3
Court/Jail

Special jurisdiction
courts

Intercept 4
Re-entry

Transitional support
back to community

Intercept 5
Probation /
Parole

Community
support services

Dashboard Measures

- Law Enforcement**
- # of EDP incidents responded to by Police
 - EDP incidents-# of Injuries sustained by civilians – police
 - EDP incidents-time required for police response
 - # of First Responder Forums held
 - # of First Responder agencies participating
 - # issues identified-addressed

- Initial Detention**
- # of people screened pre-arraignment for SMI and/or co-occurring disorders
 - # of people referred for mental health assessment

- Jails/Courts**
- # of people screened at jail for SMI and/or co-occurring disorders
 - # of people referred for mental health assessment
 - # of people with SMI and/or co-occurring disorders engaged in treatment in jail
 - # of people with SMI and/or co-occurring disorders released from jail with a discharge plan

- Re-Entry**
- # of jail admissions shared with the county mental health service agencies
 - # of agencies receiving jail admission data

- Community Corrections**
- # probationers screened and identified as having SMI
 - # individuals with SMI on specialized caseloads
 - # and % individuals with SMI successfully completing specialized supervision
 - # and % individuals stepped down from specialized supervision
 - # of peer specialist groups held
 - # and % of probationers with MI completing peer specialist groups
 - # of consumers completing a subjective individual survey tool

JMHCP Technical Assistance

INTERCEPT 1	LAW ENFORCEMENT
<p>EDPRT (<i>Emotionally Disturbed Persons Response Team</i>) – This Critical Incident Training program is designed to develop police officers' effective communication with persons with Serious Mental Illness (SMI), provide information regarding mental illness and offer technical assistance to police departments to develop departmental procedures for responding to incidents involving persons with SMI.</p>	
<p>First Responders Forum – First Responder Meetings focused on developing mutual goals and practices involving the response to persons with SMI. The First Responders Forum includes representatives from police, fire, EMS, hospital emergency, and mental health providers. One of the Primary Goals is to reduce total police time required to safely and effectively respond to incidents.</p>	
INTERCEPT 2	INITIAL DETENTION
<p>Pretrial Screening and Identification of Individuals with SMI – Training to probation and private agency pretrial service programs in the use of standardized screening instruments to identify individuals with mental illness and co-occurring disorders following arrest.</p>	
INTERCEPT 3	JAILS/COURTS
<p>Screening and Identification of Individuals with SMI – Offer training in the use of standardized screening instruments to identify individuals with SMI and/or co-occurring disorders.</p>	
<p>Jail/Mental Health Information Sharing – Provide technical assistance on information sharing models between jail facilities and mental health treatment professionals/agencies.</p>	
INTERCEPT 4	RE-ENTRY
<p>Discharge Planning and Linkage to Community-Based Treatment – Technical assistance and training to improve coordination between the jail and mental health clinicians in preparing inmates for discharge.</p>	
INTERCEPT 5	COMMUNITY CORRECTIONS
<p>Probation Mental Health Specialized Supervision – Cross training of probation and mental health professionals to supervise/manage probationers with SMI and/or co-occurring disorders. Credential probation officers as supervision specialists.</p>	
<p>Probation, Mental Health and Peer Specialist Supervision Groups – Offer technical assistance to implement peer advocacy supervision model leading to better outcomes supporting recovery.</p>	
ADDITIONAL JMHCP TECHNICAL ASSISTANCE	
<p>Community Care Coordination – A program that ensures access to high quality services and promotes recovery using a Care Coordinator who creates and supports implementation of Individualized Service Plans. There have been demonstrated cost savings with this program in Westchester County.</p>	

JMHCP Expansion Grant

- April 2015 submitted proposal to BJA for a JMHCP expansion grant for additional 5 counties
- October earliest possible start date
- If awarded, OPCA will:
 - Add 5 more counties
 - Increase technical assistance
 - Offer new technical assistance in the areas of:
 - Job readiness, employment and retention
 - Risk, need and responsivity training for criminal justice and treatment providers

Introduction to Presentations

- Collaboration goal is to engage and provide services to justice involved individuals as early as possible in the community – ideally before entering and leaving institutions and immediately upon re-entry.
- The following presentations are intended to provide examples and resources for Counties, Health Homes and criminal justice entities to consider for enhancing collaboration



Department
of Health

Medicaid
Redesign Team

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

Deirdre Astin, 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.

New York State Health Home Model

Managed Care Organizations (MCOs)



New York State Designated Lead Health Home
Administrative Services, Network Management, HIT Support/Data Exchange



Health Home Care Management Network Partners (includes former OMH TCM, and HIV/AIDS COBRA Providers)
Comprehensive Care Management
Care Coordination and Health Promotion
Comprehensive Transitional Care
Individual and Family Support
Referral to Community and Social Support Services
Use of Health Information Technology to Link
Services (Electronic Care Management Records)



Access to Required Primary and Specialty Services (Coordinated with MCO)
Physical Health, Behavioral Health, Substance Use Disorder Services, HIV/AIDS, Housing, Social Services and Supports

MAPP



RHIO



Health Home Vision

TODAY'S CARE	HEALTH HOME CARE
My patients are those who make appointments to see me	Our patients are those who are registered in our health home
Patients' chief complaints or reasons for visit determines care	We systematically assess all our patients' health needs to plan care
Care is determined by today's problem and time available today	Care is determined by a proactive plan to meet patient needs without visits
Care varies by scheduled time and memory or skill of the doctor	Care is standardized according to evidence-based guidelines
Patients are responsible for coordinating their own care	A prepared team of professionals coordinates all patients' care
I know I deliver high quality care because I'm well trained	We measure our quality and make rapid changes to improve it
Acute care is delivered in the next available appointment and walk-ins	Acute care is delivered by open access and non-visit contacts
It's up to the patient to tell us what happened to them	We track tests & consultations, and follow-up after ED & hospital
Clinic operations center on meeting the doctor's needs	A multidisciplinary team works at the top of our licenses to serve patients

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.

New York State Health Home Population

- More than five million Medicaid members in New York State.
- 1.2 million individuals meet the Federal criteria for Health Homes.
- Target enrollment for NYS is 829,000 (prioritizing for highest risk). Over 140,000 individuals engaged to date
- There are 31 Health Homes serving all counties of the State (some Health Homes serve more than one county).



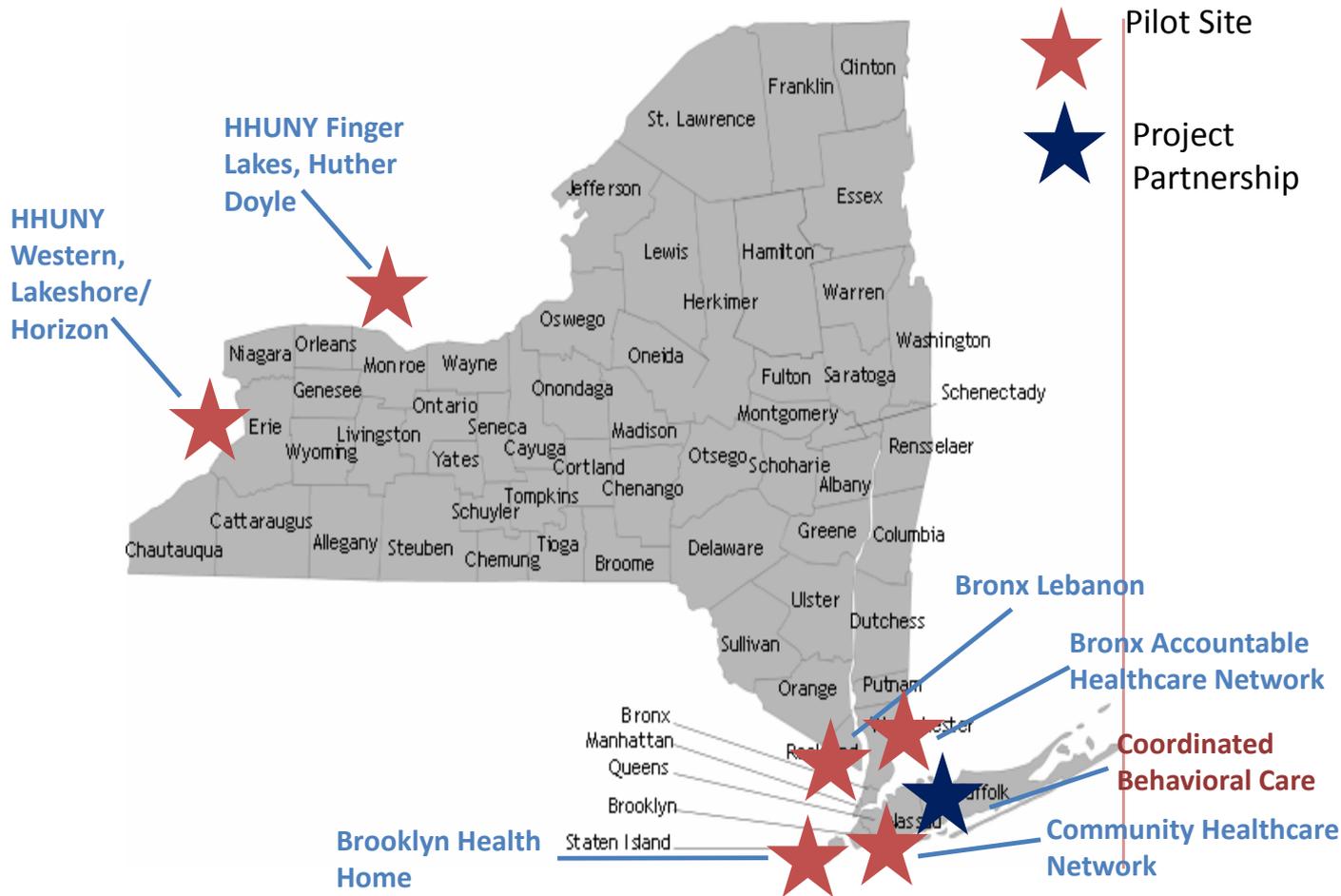
Who is Eligible to be Enrolled in a Health Home?

- Persons enrolled in Medicaid with:
 - At least two chronic conditions
 - One qualifying chronic condition: (HIV/AIDS) or one serious mental illness
- Chronic Conditions Include (but are not limited to):
 - Mental Health condition
 - Substance Use Disorder
 - Asthma
 - Diabetes
 - Heart Disease
 - BMI>25 (overweight or obese)
- Eligibility criteria to be expanded for children, to include trauma with risk for another condition

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



Common Themes to Date

Each site is working with criminal justice partners to identify and engage formerly incarcerated individuals:

- Established partnerships with Correctional Facilities and Court Systems (Personnel) for early identification of potential candidates or current members incarcerated.
 - E.g. – One site has partnered with NYC DOHMH/Correctional Health Services, and another with the County DA and Court.
- Established data systems to track and monitor potential and current enrollees that are discharged from a facility, are admitted to a hospital, and/or have used the ER.
- One way Care Managers establish a trusting relationship with the individual is through engagement prior to release.
 - E.g. – One site has a Care Manager embedded within the jail
 - Care Plans are developed with the enrollee that are centered on individuals' needs and goals.
 - Individual is motivated to take control of his/her care and wellness.

Challenges

- Medicaid enrollment and eligibility
 - Delays in Medicaid enrollment verification
 - High percentage of clients without insurance
- Data sharing and HIT connectivity
 - Medicaid data is subject to strict federal and State protections
 - Criminal justice agencies have not been allowed access for incarcerated Medicaid recipients
- Lack of sufficient resources
- Working with the State Prison System
 - Mobility of incarcerated population
 - Variability in release sites

Solutions: Data Sharing and Connectivity

- Confidentiality Agreement (OCFS + DOH)
 - For connecting NYSID numbers with Medicaid data systems to facilitate outreach and enrollment of CJ involved individuals
- Medicaid Analytics Performance Portal (MAPP) development (OHIP)
 - A web-based portal for greater data sharing and wide scale communication between DOCCS, DCJS, DOH/OHIP + Health Homes, MCO, CMAs, and CJ agencies
- Interagency MOU crafting for sharing of Medicaid Confidential Data (MCD)
- Working with the State Prison System for identification of linkages
 - DOCCS has shared a de-identified cohort of 22,000 releases with OHIP to test and refine member-level data matching

Solutions: Resources

- Delivery System Incentive Program (DSRIP)
 - \$8 billion in federal MRT savings to achieve comprehensive reform of the healthcare safety net system
 - Safety net providers will be required to form Performing Provider Systems (PPS), conduct Community Health Assessments to identify needs in CJ population, and select projects based on those needs; incentive payments contingent on meeting goals.
- Health Homes are an opportunity to address disparities in the care of the criminal justice involved population. Executive Budget includes \$5 million in 2015-16 and 2016-17 to establish linkages between Health Homes and Criminal Justice system

Resources

Visit the Health Home Website:

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/

Monroe County: Initiatives and CJ-HH Pilot

Robert Lebman, MA
President & CEO Huther Doyle

Rodney Corry, MA, LMHC
Monroe County, Chief, Priority and Socio-Legal Services

Craig Johnson, LMHC, CASAC-G
Supervisor, Behavioral Health Programs, Monroe County
Monroe County Correctional Facility

CJ –HH Pilot lessons Monroe County

Purpose

- Brief overview of MH/CJ collaborative activities in Monroe County (pop. 750,000)
- Organized into regular activities and special projects
- Highlight opportunities for connections between various community initiatives



CJ –HH Pilot lessons Monroe County

Regular activities

- Criminal Justice/Mental Health Committee
 - MCSO; Jail; RPD; Courts; Probation; Parole; District Attorney; Public Defender; RFU; NAMI; Veterans Outreach; MCOMH
- Emergency Services Committee
 - CPEP & ED; Mobile Crisis; Detox; MCSO; Jail; RPD; 911;EMS; OPWDD; START; MCOMH
- Multi-Jurisdictional Crisis Intervention Task Force
 - All police jurisdictions and two area colleges
- Forensic Committee at Rochester Psychiatric Center
 - RFU, RPD, MCSO

CJ –HH Pilot lessons Monroe County

Regular activities (continued)

- EDPRT Trainings for new police officers
 - Week long annual training for new classes
 - Info about mental health, mental hygiene law, other behavioral health topics
- MCOMH on call process for clinical consultation to sheriff/police
 - Real time advisement as incidents occur – Evening and weekends
- Transition Management in MH Court

CJ –HH Pilot lessons Monroe County

Special Projects

- DCJS grant
 - Sequential mapping exercise
 - Technical assistance re: probation peer groups
- MH/Jail Data matching project
 - automated process to match new jail admissions with mental health service utilization data to inform jail staff and current providers (implemented March 2015)
- Trauma Informed Practices consultation and training for all jail staff
 - Scheduled for Fall 2015

CJ –HH Pilot lessons Monroe County

Health Home Pilot to date

- Care Manager assigned part-time to County Jail
- Works with facility staff to identify eligible inmates 3 months pre-release
- Does assessment and ascertains interest
- Identifies re-entry needs: housing, insurance, primary care, mental health/substance abuse, vocational/educational
- Develops interim plan with inmate

CJ –HH Pilot lessons Monroe County

Pilot continued

- Post release: assists in opening/reactivating Medicaid
- Enrolls released inmate in Health Home
- Implements Care Plan and provides necessary support

CJ –HH Pilot lessons Monroe County

Pilot evolving

- Discussions underway to implement Vivitrol induction pre-release for appropriate inmates
- Presentations have been made to Assistant DAs: Health Home services; Vivitrol
- Individuals who may be eligible for Health Home and who have a drug use history will be identified at arraignment
- Health Home Care Manager will be assigned to Drug Court, DWI Court and Mental Health Court

CJ –HH Pilot lessons Monroe County

Pilot Evolving (continued)

- Comprehensive Assessment will be completed and Care Plan developed
- Care Manager will make regular reports to the Court and/or Probation
- District Attorney will arrange presentations to Bar Association and Judges to expand model across criminal justice system
- Re-entry Task Force will place Care Manager in area state facility and replicate Monroe County Jail model

CJ –HH Pilot lessons Monroe County

Future Work

- Health Home lead agency, Correctional staff and Monroe County Socio-Legal will begin meeting to identify areas where information should/can be shared and services coordinated
- The potential for collaborating to track and measure outcomes will be explored

Schenectady County Collaboration: Mental Health, Criminal Justice and Health Home

Darin Samaha, LCSW-R
Director of Community Services
Schenectady County

Schenectady County

Overview of MH/CJ collaborations in Schenectady County (pop. 155,000)

Schenectady County JMHCP Phase 1 (January 2014)

Changing Environment - Changing strategies (building the plane as it's flying)

Schenectady County

Collaboration pre JMHCP

- Mental Health Courts (City and County)
- Trauma Trainings
- SPOA
- County Re-Entry Taskforce
- Probation, Mental Health and Peer Specialist Supervision Groups
 - “Tweaking” the model
- Specialized Mental Health Probation Officers
- Executive Leadership Committee

Post JMHCP and Jail MH Grant

- Sequential intercept mapping (SIM)
- Veterans-Track
- Mental Health & Substance Abuse training for Public Defenders and District Attorney's Office
- Mental Health Jail Grant
- Emotionally Disturbed Persons Response Team (EDPRT)

Continued

- SAMHSA GAINS Center – Trauma Informed Law Enforcement Training
 - “11th County”
- Starting Regional Adult Mobile Crisis Team
 - Target Population – Jail/Prison Discharge

Jail Mental Health Grant

- Inmate Services Coordinator
- Peer Mentors Pre/Post Release
- Probation/Peer Transition Group
- Health Home / Forensics Linkage

History of Strong Cross Systems Collaborations

Eventful 2014

Crises and Community Response

- Suicide contagion
- Hurricane Irene and Tropical Storm Lee
- Fires - 50 people homeless
- Nationally Reported Suicide

Schenectady

Care Coordination and Health Home Linkages

Leadership Changes

Addressing System Gaps

Schenectady Problem Solving Model Based on SIM

Schenectady

Forensic Workgroup - June 16, 2015

- All stakeholders involved with jail releases
- Meeting to address gaps and overlaps in the system
- Establish protocols to better coordinate resources and services
- E.g. - Define problems such as: reactivation of Medicaid as soon as possible; provide for adequate medication until intake assessment in the community; create a release checklist; develop list of other issues or problems to resolve and subgroups as needed

Next steps - formalize group into Behavioral Health- Criminal Justice workgroup

JMHCP

Questions?

Handouts

Mapping the Criminal Justice System to Connect Justice-Involved Individuals with Treatment and Health Care under the Affordable Care Act, Bureau of Justice, National Institute of Corrections, Lore Joplin, June 2014

The Affordable Care Act and Criminal Justice: Intersections and Implications, Andrea A. Bainbridge, Bureau of Justice Assistance, U.S. Department of Justice, July 2012

The Stepping Up Initiative: A National Initiative to Reduce the number of People with Mental Illnesses in Jails, Council of State Governments (CSG) and the National Association of Counties (NaCO)

The Affordable Care Act and County Jails: A Practical Guide to Strategies and Steps for Implementation, Denver Sheriff's Department, Sheriff Gary Wilson, December 2013

Health Coverage and County Jails: Suspension vs Termination, National Association of Counties (NaCO), December, 2014

Ten Ways Corrections Systems Can Help Link Returning Offenders to Health Insurance, HealthCare.gov

Health Homes Survey of the County Re-Entry Taskforces, DCJS/OPCA June 2015

Resources

New York State Department of Health Health Home website

- http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/

Federal ACA Website

- <https://www.healthcare.gov/incarcerated-people/>

Pennsylvania response to ACA - website

- <http://www.pacenterofexcellence.pitt.edu/ACA.html>

Website for state information on criminal justice and health care

<https://www.statereforum.org/node/9737>

Study of health care and public safety

- <http://www.arnoldfoundation.org/researchers-study-affordable-care-act's-impact-public-safety>

Stepping Up: A National Initiative to Reduce the Number of People with Mental Illnesses in Jails

- <https://stepuptogether.org>