IT'S A MATCH:

Bronx Health Home and NYC Jail Pilot

Alison O. Jordan, NYC DOHMH
Virgelina Gonzalez, Bronx Lebanon HC

Presentation to the Health Home / Criminal Justice Workgroup
October 30, 2014
PILOT TIMELINE

8/13 Agreement executed
10/13 Tracking system initiated
9/13 Pilot starts
11/13 BHH/CJ Summit

2/14 Operating protocols with CMOs
3/14 BHH/Jail Patient Match
4/14 Tracking/Reporting Systems sharing
5/14 Integration with MHDP
6/14 Fortune Society Agreement with BHH
7/14 Share Protocols to inform State DOCCS pilot

8/14 Fortun Society Agreement with BHH
9/14 Southwest BK and CHN HH Match
10/14 Montefiore HH Match
PROGRAM COORDINATION

Communication
• Designated liaisons at DOHMH & BHH
• Weekly check-in with Senior Managers

Sharing Tracking Systems
• BHH can access DOHMH Tracking system
• DOHMH records outcomes in BHH Care Director
DOHMH PROJECT ANALYST TASKS

The BHH-funded Project Analyst:

• Reviews match reports to Identify Health Home clients
• Contacts and coordinates with jail-based team to obtain HIPAA consent
• Informs Health Home and its Care Management Organizations (CMO) of client engagement and justice status including jail-based team contact information, projected release and upcoming court dates
• Provides BHH assigned CMO with the key information (i.e. client’s community contact, primary care appointment, projected jail release date)
• Maintains client tracking database and communicates with BHH Coordinator
• Produces regular progress reports and presentations
SYSTEM MATCH

BHH assigned patient roster matched to jail admissions:

• Review Bronx Lebanon Outreach roster against Jail EHR
• 28% on BHH rosters since 3/14 were known to the Jail EHR.
• BHH patients had an average of 3.6 incarcerations (latest roster)
• 123 were incarcerated on 10-23-14.
COORDINATION OF CARE

Service Planning

• Last known community provider shared with NYC Jail team
• Jail release / court dates shared with BHH
• Discharge / Plan medical summary shared with BHH/CMO
• Pre-release telephone conference
## PROGRAM OUTCOMES

<table>
<thead>
<tr>
<th>Clients</th>
<th>Prior to List Match (9/13 to 2/14)</th>
<th>Since List Match (3/14 to present)</th>
<th>Pilot to Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identified</td>
<td>42</td>
<td>449</td>
<td>491</td>
</tr>
<tr>
<td>Unable to Contact / Released</td>
<td>n/a</td>
<td>186</td>
<td>186</td>
</tr>
<tr>
<td>Received Health Education / Health Home Awareness</td>
<td>42</td>
<td>263</td>
<td>305</td>
</tr>
<tr>
<td>Received Transitional Care Plan</td>
<td>42</td>
<td>232</td>
<td>274</td>
</tr>
<tr>
<td>Released with TCP</td>
<td>25</td>
<td>134</td>
<td>159</td>
</tr>
<tr>
<td>Community Connection (Clinical Provider / Care Manager)</td>
<td>23</td>
<td>tbd</td>
<td>tbd</td>
</tr>
</tbody>
</table>
NEXT STEPS

- DSRIP Application Integration
- Evaluating ED Use and Hospital Admission rates
- Match Agreements with other Health Homes
- Replication & Dissemination