

Minutes of December 20th Meeting of the Health Home and Criminal Justice Committee

Greg Allen and Paul Samuels welcomed meeting attendees.

Greg Allen provided an overview of the goals of the health home initiative and noted that New York wanted to be aggressive in creating innovative approaches to the development of health homes and did not simply want to have this model of care management be “bolted onto existing structures”.

Paul Samuels provided an overview of issues that must be addressed to implement the pilots successfully. These issues were identified by participating health homes as well as different stakeholders in the criminal justice and health arena. They included:

- Operational issues
- Information sharing and coordination
- Housing and supportive services
- Behavioral services
 - Medicaid caps on services
- Reimbursement/payment

Each of the six health homes in attendance introduced themselves and spoke briefly about the ways in which they had plans to engage or were engaging the criminal justice population:

- Montefiore: Doing 90 day holds before dis-enrolling anyone.
- CHN: Integrating what they know from their work on HIV care coordination
- Huther Doyle: already working with DAs, judges and others in the criminal justice system in Monroe County who are interested in finding ways to divert people; also planning to open a primary care clinic to focus on individuals with substance use disorders and mental health issues.
- ADDS: focusing on “on the ground” collaborations with reentry services
- Maimondes: actively working with NYC DOHMH, have experience from conducting TB screens for people arrested in NYC
- Bronx Lebanon: has been working with Rikers to develop systems for sharing information between the health home and the jail.

Greg presented a PowerPoint “NYS Care Management for High Need Patients” that included an overview of the health home initiative and series of charts on physical and behavioral health issues for the health home population. The data very dramatically demonstrated that the health home population with the highest risk and need for integrated care were largely those with behavioral health diagnoses. The presentation also included a preliminary data match of individuals in Rikers who are health home eligible and who were already engaged with a health home. The match showed that a significant number of the more than 1100 individuals in the Rikers data and who had a mental health and/or substance use disorder diagnosis were already engaged with a health home (NYC HHC).

Following Greg’s presentation, there was a discussion about the need to develop a set of metrics for the work of the pilots. The goal would be to collect 2-3 measures. These measures should utilize data that could be easily collectible, meaningful and would help to accurately measure the effectiveness of any intervention. This discussion raised questions about the need to find ways to capture the health status of the incarcerated population. The group agreed to establish a workgroup that would focus on metrics.

Greg asked Dr. Lynda Hohmann to coordinate the workgroup on behalf of State DOH. Several participants volunteered to participate in the metrics workgroup.

Joel Copperman of CASES gave an overview of the criminal justice system, describing how individuals pass through the system, using the “sequential intercept model” developed by CASES and others. Among the data that he highlighted was:

- There are approximately 500,000 arrests/year in NYS
- There are significant issues related to where people are released within the criminal justice process, which will impact whether and how health interventions can be made. For example, in NYC, 50% released at arraignment.

The meeting concluded with a discussion of issues that will need to be addressed as the group moves forward:

- At Greg’s suggestion, the group decided that there should be a multi-phase process:
 - Phase I would focus on the jail release process (where the most significant infrastructure already exists)
 - Phase II would expand to ATI, court-based, and other populations.
- The group agreed that conversations about expanding to Phase II could happen as soon as the health homes began putting Phase I in place. Phase II could then begin as soon as each health home was ready and that this did not need to occur on a uniform basis for each health home.
- There was also discussion about some of the challenges posed by some of the other sub-populations; possible areas of focus within the other populations; as well as what work was already being done through the larger health home workgroup process.
- The group also discussed the need to determine which issues were already being addressed by the larger health home workgroup, so as not to do unnecessary work or contradict decisions being made in other forums.
- There was also a discussion about funding and the waiver was mentioned as a possible source of support. It was felt that phasing the work would give the group more time to think about financial support sources.

Next Steps:

- Metrics Group to meet before next meeting.
- DOH and LAC would work on prioritizing issues for the committee to work on at future meetings, including thinking about topics for other workgroups.
- The 6 Health Homes should prepare a more in depth presentations at next meeting
- Finalize meeting schedule: the group agreed to convene about every two months.