

Minutes of Criminal Justice and Health Homes Committee

Attendees

DOCCS, DCJS, State Commission of Corrections, OMH, DCJS, Governor's Office, DOB, DOH, OASAS
Monroe County, DOHMH
ASAP, LAC, EAC TASC, Correctional Association, Fortune Society, CASES
CHN, Huther Doyle, Bronx-Lebanon, Brooklyn HH (Maimonides), BAHN

Introductions

After the introductions, both Greg Allen and Paul Samuels spoke about the national attention being paid to the Committee's work, including by CMS and BJA. Greg also mentioned that he would be presenting soon on the Committee's efforts at a national conference. Paul pointed out that, even though there remains so much to be done, New York is further along in the process than almost anywhere else, both in terms of signing individuals up and linking them to care.

Greg then reiterated the committee's emphasis on local collaborations, including with criminal justice agencies and that the Committee has chosen to take a fairly hands off approach to the health homes' efforts to set up their pilots.

Greg also spoke about the various other related issues that will affect this work, including the "carving in" of behavioral health into managed care, which is increasing the pressure for court mandates to be more clinically informed, as well as the various conversations going on around Medicaid and health home eligibility. He also mentioned the various sub-committees working to address specific issues. He talked about broadening the conversation, by looking at courts for example, and raised the possibility of the Committee beginning to expand from the original 6 pilots to look at other jurisdictions. He then called for the Committee to start examine what progress the pilots had made to date and what common elements the pilots had (such as entrance criteria, common interventions). He talked about creating a crisper sense of the process and scope, so that the group could begin concretizing the work and drawing boundaries.

Finally, Deputy Secretary for Public Safety, Thomas Abt, introduced himself and his team. He described the link between criminal justice and health as a "significant priority for public safety" and said that he was looking to increase public safety's engagement in the work. Lastly, he spoke about a broader conversation that would look at alignments around the shared priorities between health and criminal justice.

Survey Results

Alejandra Diaz gave a presentation about the survey of the health homes that she had been conducting. She began by giving a little background, explaining that this was a second round of surveying the pilots. She spoke about the general goals of the project of integrated care, reduced readmissions to incarceration and hospitalization, and cost savings. She also mentioned the lack of rural settings among the six pilots.

Alejandra explained that there had initially been differences among the pilots in terms of their priorities. She said that the upstate sites have much broader targets compared to the city sites. She also said that there were initially nuances between the sites in terms of their focus on education, customer satisfactions and measuring success.

Alejandra then went through some of the results of the most recent survey. She pointed to the breakdown in services, with the pilots identifying that over a quarter of the services they provided involved housing and other social services, the biggest category, closely followed by substance abuse and mental health. (She explained that the questions did not break down whether this referred to the number of providers in the network or the amount of services provided.) Greg responded to this by explaining that the health homes had been selected as pilots with a purposeful eye to behavioral health specialization.

All of the pilots have experience dealing with the criminal justice system. Some sites added providers since the first survey in order to offer more holistic services, something which it was suggested could be an emphasis in broadening the number of pilots.

Alejandra then described some of the outreach that had been done by the pilots, including linking to Rikers, working with Parole, with drug and/or mental health courts, with sheriffs and/or district attorneys, as well as leveraging existing relationships.

The group then started having a broader conversation. There was a discussion about setting up a steering committee and about who to engage in such a conversation and how. Deputy Secretary Abt explained that this would depend on where the committee was focused, whether we just concentrate on reentry or looked at the front end as well. He explained that, with the front end, there were many more parties involved in the conversation (DAs, police, courts, jails).

Rosemary Cabrera then spoke about efforts by CHN to connect their health home with the NYC Department of Homeless Services. She mentioned the fact that such a large share of the population with mental health issues and/or substance use disorder is homeless (and vice versa). Additionally, for many, the criminal record creates additional barriers to housing, including problems caused by the federal

definition of homeless. Therefore, there was a need to address some of the criminal justice barriers to housing.

Bob Macarone suggested connecting the Health Homes to the Article 13A process through the Criminal Justice Advisory Board and the Reentry Taskforces.

Alejandra then spoke about the different ways in which pilots were dealing with education issues and the different ways in which it was becoming a focus. The different education areas being addressed by the pilots include:

- Educating clients to see the value of Health Homes and engage them in services
- Educating providers within the network
 - Teach patient-centered, recovery-focused
 - Finger Lakes HH providing bi-weekly webinars
- Educating Criminal Justice partners by giving tours of providers
- Including downstream providers in planning

Patricia Amati (?) from the State Commission on Corrections suggested that there be an effort to educate the medical profession about the criminal justice population, through continuing education. Rosemary Cabrera suggested that there also be an effort to educate managed care organizations about this population.

Alejandra also spoke about the essential importance of the link between the criminal justice system and the health homes. This led Rosemary Cabrera to talk about the importance of reaching individuals early because so much recidivism occurs in the first few months after individuals are released.

Alejandra then laid out a number of ongoing challenges that had been identified. The first involved housing. She spoke about health homes' need for more housing partners and about what can be done to support the sites (someone suggested involving the Department of Housing and Community Renewal). There was also discussion of the Medicaid Redesign Team Housing Committee. Greg Allen explained that there was increasing acceptance of housing as a key social determinant of health, that the Committee was looking to marry state and city housing programs to health homes, and that there was talk of reinvesting Medicaid savings into housing, with particular promise on the nursing home side. There was also discussion with CMS about doing this on the behavioral health side, as part of the conversation around the waiver, though CMS remained reluctant. There was also talk about dedicated housing for specific need sets, an idea that CMS seemed more open to. There was discussion about the need for collecting data to show the importance of housing in both criminal justice and health improvement. Lastly, Anita Marton suggested the work to the criminal justice committee looking at barriers to housing for the criminal justice population.

Another major challenge identified was around access to Medicaid. Particular areas of concern included:

- Difficulties around lifting suspensions when people are released;
- Communication of information about reactivation of Medicaid works – while communication seems to occur at the “upper levels,” it does not always get passed down to the individuals themselves or those working with them;
- The current inability to do suspensions for those incarcerated in local jails;
- Difficulty in getting cards after release – while providers are supposed to provide services without cards, they sometimes do not. Alternatively providers need to know that they can serve individuals even if they do not have a card;
- There was also discussion about the role of managed care in enrollment.

DOCCS explained that it had heard that there were particular problems around obtaining pharmacy services without a Medicaid card. This led to discussion about the possibility of obtaining a card prior to release. Greg suggested that maybe the health home could be responsible for this. While it was clear that a number of issues would need to be resolved, the committee could make a list, perhaps using the AIDS Institute’s Criminal Justice Initiative as a model for getting people what they need. There was also agreement about the need to get the relevant agencies involved in the conversation, as well as how to resource the conversation both centrally and regionally. This then led to discussion about the possibility of expanding New York State’s presumptive eligibility options, including specifying local jails as an option (as some other states have begun doing).

Additional areas of challenge identified included accessing the population prior to release. Currently, there is no funding to support such access or providing services. Additionally, individuals must have a Medicaid number before any appointments can be set up. There was some discussion about obtaining resources through the 1115 waiver application.

The last challenge identified was transportation, in particular the ability to coordinate a pick up when individuals are initially returned to the community. This too was an area for which the waiver might be able to provide funding.

The discussion of these challenges led to a discussion about what role the committee could play in helping to solve some of these problems, using the six pilots to troubleshoot problems.

The final area of the survey discussed was around lessons learned. These included:

- The importance of starting the relationship between individuals and health homes prior to release;
- Having a strong relationship between criminal justice and health agencies;
 - While priorities might be different, the relationship must be strong

- Ensuring adequate training of care coordinators in how to deal with this population;
- Holding care coordination meetings;
- Importance of access to transportation.

Acuity Tiger Team

Rosemary Cabrera and Bob Lebman presented the results of the most recent discussions of the Acuity Tiger Team, which is looking into how to provide acuity scores for the jail and prison populations, who mostly do not have the relevant Medicaid history.

Rosemary explained that the Committee had decided that it needed to restart the process. She explained that the Team was held back by the lack of information and felt that there was a need for additional research around the criminal justice population's risks and needs. She then presented some basic statistics about the criminal justice system, its health expenditures, and the population passing through it.

She talked about the need to prioritize the high risk population, which had resulted in a decision to move away from trying to determine acuity and instead focus on risk and need, broken into high, medium and low. She explained that the Team had decided to move from the original proposal of 2 acuity buckets to 1, which would focus on those being transitioned into the community and those released in the preceding 180 days. She explained that the Team was now looking at a rate structure that would be based on case load size, number of touches per month, and the average statewide per member per month rate.

Rosemary then explained that, following discussions with health home leads around the state, the Team had determined that the average case manager around the state had a caseload of 50-65 and spent about 3 hours per member per month on each case. The Team had determined that the current estimated an average caseload of 20-25, with an estimated average of 12 hours per member per month, which resulted in more hours than there were in the work week. She explained that the Team had come up revised recommendations for case load and hours required, based on the risk level of the population (e.g. for the high risk population, it was determined that a more appropriate caseload would be closer to 15, with 9 hours average spent on each member – though there were concerns that this might be too low). Rosemary explained that the Team was still working on calculating an appropriate rate. The Team had also identified COMPAS as their proposed common assessment tool, although some people continued to feel that there was a need for more detail on the link between criminal justice risk and health needs.

Among some of the challenges identified by the Team that need to be addressed was the need to overcome the distrust felt by much of this population and the resulting

unwillingness to share information or enter programs. As a result, the Team felt it was essential to have 1 contact working with the individual, starting early – the recommendation is to start building the relationship at least 30 days prior to release. This would require grant funding to pay for starting working with the individuals during their transition before Medicaid was in place after their release. The Team also identified the need for transportation when a person is first released as a key need. Lastly, the Team proposed the creation of a referral form with an estimate of what risk/need category the client falls into.

Operations Subcommittee

Bob Lebman presented on the most recent discussions of the Operations Subcommittee. After mentioning the significant overlap with the other reports, Bob described the grid that the Subcommittee was developing. He explained that the grid was separated according to which part of the criminal justice system the individual was in. Among the key issues addressed in the grid are:

- Sharing of information (and any possible barriers caused by state/federal confidentiality regulations)
- Co-location of services in facilities
 - Possible barriers at state level because of prison possibilities
 - Developing of relationships at local level with jails/sheriffs
- Medicaid enrollment

John Volpe of DOHMH described some of DOHMH's work with the City Department of Probation. Bob MacCarone suggested that DCJS could provide trainings to other probation departments around the state. He also suggested the possibility of getting a federal grant and getting training from the American Probation and Parole Association.

There was also discussion about next steps and how to move forward. Among the key suggestions were the need to catalogue existing practices and barriers to implementation from the pilots. Other steps identified included moving ahead with training and look for replicable models. The Committee was encouraged to send their feedback on the grid to Sebastian Solomon and Tracie Gardner. Greg also suggested the need to identify what the core competencies are that are required for serving this population (as opposed to elements that are "nice to have"). It was suggested that part of doing this would involve the sharing of successful models.

Mandate Subcommittee

Paul Samuels presented on behalf of the Mandate Subcommittee. He explained that the group had subdivided the issues that need to be addressed in terms of court mandates to care between clinical issues and other issues.

In term of clinical issues, the subcommittee drafted a set of common principles for when care could be mandated by a court. These principles focused on who should be making decisions about levels and types of care; what type of tool should be used for making this assessment (one that was scientifically validated); what types of care should be available (the full range of services); and what managed care should be expected to pay for.

The other issues the subcommittee felt needed to be addressed included: public safety (the subcommittee suggested using COMPAS); people being mandated to addiction services who do not have addiction needs; mental health care; and intensive residential services.

Others suggested the need to include an acuity assessment to determine where this population fell in risk assessment – this led to the suggestion that the mandate subcommittee and the acuity tiger team should begin having conversations. It was felt that the discussion of acuity was also related to the issue of how to assess people for eligibility for the state’s proposed “Health and Recovery Plans” (HARP). This led to conversations about the lack of assessment tools to determine mental health needs and about the need for the state to have standardized assessment tools throughout the Medicaid system. (At the same time, the group felt that level of care determinations in the mental health arena were less problematic an issue for managed care than in the substance abuse arena.) Tom Smith felt that the relevant people at the Office of Mental Health needed to be part of the conversation and offered to bring them a table.

There was also discussion about who else should be at the table and when they should be invited to participate – the feeling was that the group needed to begin talking to the health plans.

Next Steps

The next steps identified by the group included:

- Filling the Operations Subcommittee grid with more detail
- Starting conversations between the Mandate Subcommittee and the Acuity Tiger Team
- Exploring the possibility of expanding the State’s presumptive eligibility opportunities
- Developing a tool to begin gathering information about problems that need to be resolved from the pilots
- Setting up the next round of meetings