HEALTH HOME COLLABORATIVE PILOT:
CARE MANAGEMENT/COORDINATION FOR CRIMINAL JUSTICE INVOLVED INDIVIDUALS

MAY 2014
AGENDA

- Welcome And Introductions
- Criminal Justice: Health And Behavioral Health Disparities
- Aims: Outcome Measures Public Health/Public Safety
- Health Care Access And Connections Across The Criminal Justice Continuum
- Project Partnerships
- Rollout And Implementation
- Voices From The Field: Care Coordinator, Client And Probation Officer
- Findings: Initial Outcomes: Ground Up Enrollment & Data Match
- Challenges
- Q & A
53% of women & 35% of men involved in the criminal justice system report a current medical issue (National Health Care For The Homeless 2013)

Between 60% and 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)
AIMS: OUTCOME MEASURES IN PUBLIC HEALTH/PUBLIC SAFETY

- **Enrollment/Access to Care**
  - # of clients newly connected to public/commercial insurance
  - # of clients newly connected to health home care coordination thru ground up enrollment
  - # of identified eligible consumers identified by State through data matching

- **Public Health**
  - Hospitalization rates for Medical, BH and SUD
  - ER usage for same
  - Connectivity to primary care

- **Public Safety**
  - Recidivism rates
  - Rearrests
  - Violations
  - Compliance with supervision, successful discharge from probation
PROJECT PARTNERSHIPS

- NYC Dept. of Probation and NYC Dept. of Health and Mental Hygiene partnership
  - Dept. of Probation submitted application to NYSDOH Health Home Portal
  - DOP and DOHMH executed data sharing agreement to analyze client outcomes

- CBC Health Home | NYC DOP
  - Executed DEAA and MOU to allow for data sharing of client level information
  - CBC identifies six care management agencies in their network to join pilot: JBFCS, ICL, SUS, NADAP, Catholic Charities Neighborhood Services and FEGS Dual Method engagement/enrollment process
  - Ground up enrollment thru co-location of care managers at DOP branch offices
  - Front end data matching with targeted outreach thru probation office/officers

- Downtown Brooklyn: Pilot site
  - Highest concentration of direct report clients city wide (6,100 clients, 2,100 direct reports)
  - Highest number of referrals to behavioral health treatment programs 2012
PHASED ROLLOUT IMPLEMENTATION 2013-2014
“NUTS AND BOLTS”

- Develop guidelines, training principles, forms, protocol and work flow
- Cross Training for Care Management Staff (50 CC and Supervisors) and DOP (100 PO's/SPO's & BC's)
- Co-location of collaborative services start January, 13th, 2014 for a period of six months, with ongoing evaluation of progress
  - Care Coordination staff assigned across 2 DOP reporting sites, 3.5 days per week
  - 2 NeOn locations receive dedicated health home enrollment staff person (Brownsville, East NY)
- Individual Case Reviews of all caseload bearing officers
- Biweekly Stakeholder Meetings implemented to monitor, review and problem-solve
- Ground up engagement and enrollment and data-match to occur simultaneously.
- Outcomes Metrics: Public Safety and Public Health
DEPT. OF PROBATION CLIENT HEALTH HOME ELIGIBILITY

MH - mental health
MA - medical issues
SA - substance abuse

ELIGIBILITY CRITERIA

- MH only: 24%
- MH & SA: 51%
- MA & MH & SA: 10%
- MA only: 4%
- MA & SA: 5%
- MA & MH: 6%
DEPT. OF PROBATION REFERRAL SOURCES

- **SOU** - sex offender unit, 25:1 caseload
- **IEU** - Intensive engagement unit, 25:1 caseload
- **NeOn** - neighborhood units (mixed risk levels)
- **CILD** - client development (high risk)
PRELIMINARY FINDINGS AND OUTCOMES

- **DOP referral numbers**
  - 200 ground up referral forms completed by Officers (thru case review process)

- **CBC Pathways to Wellness ground up outreach and enrollment numbers**
  - Care Coordinators received a total of 130 referrals (face to face)
    - As of May 7th, 2014: 69 clients are in active outreach or enrolled status
    - 29 clients were prevented from enrolling due to lack of insurance and Medicaid enrollment lag time.
    - 5 clients were prevented from enrolling due to out of network partners supporting only “family planning” services

- **CBC/DOP data match numbers**
  - 1st round front end data match (source: 6 pilot CMA’s, Brooklyn only, all active status choices)
    - 4600 unique names, 40 matches
  - 2nd round front end data match [source: all CMA’s in CBC network, city-wide, registration, outreach or formerly in outreach status (exclusions: currently enrolled)]
    - 17,000 unique names, 91 matches
CHALLENGES

- Medicaid enrollment obstacles:
  - Delays in Medicaid enrollment verification
  - High percentage of clients without insurance
- Data Sharing hurdles
- Culture shift for two systems: behavioral health providers & criminal justice agency
- On-going cross training (aligning treatment goals & foundations of collaboration)
- Co-location of services can lead to association of care coordination services with law enforcement conditions
- Need for HIT connectivity across systems
- Lack of DOP resources to identify and coordinate referrals
THANK YOU