Community-Based Care Management and Criminal Justice: Applying a Care Transitions Model Across Sectors

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Medicaid Health Homes

• An initiative through the New York State Department of Health

• Expands on the work of the Medical Home model

• Medicaid dollars fund community-based care management services to promote comprehensive, coordinated care

• Utilizes electronic data exchange and information sharing
2005: BHIX
Consortium of hospitals, nursing homes, home health providers & insurers establish BHIX with HEAL NY funds

2006: Co-location of primary care and behavioral health services at South Beach

Jan. 2010: HEAL 10
MMC receives funding to develop MHH model and HIT infrastructure; 7 stakeholders and South Beach Psychiatric enter into HEAL contracts to improve care for schizophrenics

Jan. 2011: HEAL 17
Consortium of hospitals, nursing homes, home health providers & insurers establish BHIX with HEAL NY funds

July 2012: HCIA
MMC receives CMS Health Care Innovation Aware to enhance HIT functionality, develop care management training program, and migrate from FFS to total cost-of-care payment model

April 2014: DSRIP
Planning for the DSRIP program begins; MMC Steering Committee organizes Community Care of Brooklyn

April 2015: DSRIP DY 1 begins; Community Care of Brooklyn launches first DSRIP projects in October 2015

April 2017: MMC enters into a pilot as a VBP contractor in a HARP pilot with Healthfirst
The Brooklyn Health Home (BHH)

• Provides community-based care management services to:
  • Medicaid Patients
  • High-utilizers with multiple chronic medical diseases, serious mental illness (SMI), and/or HIV/AIDS
  • Community members with functional impairments
  • Community members coping with social determinants of health (e.g., poverty, fragile housing, justice system involvement, food insecurity)

• BHH currently provides services to approximately 11,000 individuals across Brooklyn, NY

• Network comprised of twenty-two care management agencies, including hospitals, community-based organizations, and social service providers
Brooklyn Health Home Model

Key Feature:
Virtual co-location of providers and services enabled by health IT and coordination of services
Goals

- Identify and address the full range of behavioral, medical and social problems affecting chronically ill patients

- Foster collaboration and the timely exchange of patient information among involved providers, particular around critical events and transition points

- Drive measurable improvements in:
  - Clinical outcomes (readmissions, ED visits, preventive care)
  - Social outcomes (stable housing, food security, etc.)
  - Quality of life (functionality, engagement, satisfaction)
Key Standards of Practice

- Each patient has a Care Team
- Each patient has an integrated care plan
- Outreach to patients during hospitalizations
- Follow-up appointment within 7 days of medical discharge, 5 days of psychiatric discharge
- Involved in discharge planning
- Timely post-discharge appointments with PCP, specialist, or psychiatrist, as appropriate
- Case Conferences
BHH creates and maintains a variety of tools available for the network including:

- Case Conference guidelines
- Assessment guidelines
- Resource manuals and guidelines for: Domestic Violence, Housing, Psychiatric providers
- Care Coordination/Diagnostic Confirmation Request
- Rules for Outreach (adopted by NYS)
- Criminal Justice Alerts Response Workflow and other Justice-Specific Resources
- Lost to Contact Guidelines
- Core Services Definitions and Guidelines
- Provider Information Sheets and Referral Forms
- Chart Review Tool
- Network wide committees – Clinical Committee, CM Workflow, Business Ops, etc.
• BHH is partnered with 1199SEIU Training and Upgrading Fund to develop and administer a Care Manager Training Program

• Curriculum topics include:
  - Self-Management and Care Management Interventions
  - Motivational Interviewing and Health Coaching
  - Navigating the Criminal Justice System
  - Chronic Conditions and Co-morbidities
  - Care Planning and Documentation
  - Risk Assessment
  - Advocacy and Diplomacy
  - Transitions in Care
  - Managing a Caseload
  - Care Coordination
  - Interdisciplinary Teamwork and Care Planning
  - Ethics, Cultural Competency and Health Disparities
  - Patient-Centered Communication
  - Supervisor Training
Coordinated Care Plan (CCP)
Case Conferences

• Bi-weekly case conference for the entire network

• CMAs present complex and challenging cases

• Led by a BHH psychiatrist and PCP, with support from MSWs, to provide input, feedback, and guidance

• Staff from throughout the network offer recommendations and suggest referrals for community-based services
Applying the Model to the Criminal Justice Population

• BHH’s care management model for high-risk individuals with SMI—including a particular focus on hospital to community transitions—has demonstrated:
  • Reduction in ED utilization
  • Reduction in inpatient admissions
  • Average Medicaid savings of $944 PMPM¹

• BHH initiated a program² utilizing this model to apply a community-based care management intervention upon release from jail, recognizing:
  • Substantial overlap between BHH population and Rikers population
  • High prevalence of SMI and substance use disorders among incarcerated individuals
  • Release from incarceration is a “critical time” to intervene, secure short-term stability and safety, and develop a set of intermediate and long-term goals to achieve optimal well-being, functioning, and integration in the community

² Program partially supported with funding from the New York Community Trust and the New York State Department of Health
Individuals with criminal justice history/involvement are more likely to have:

- Significant history of trauma
- Higher rates of chronic medical and mental health issues
- Barriers to services and housing due to criminal history
  - Insurance (Medicaid suspended while member is incarcerated)
  - Court imposed restrictions (e.g., parole mandates)
  - Providers’ willingness and/or ability to work with justice-involved individuals
  - Housing
- Increased mortality rate post jail/prison discharge
Since 2014, BHH has engaged in a formal partnership with the Correctional Health Services (CHS) bureau of New York City Health + Hospitals to incorporate Health Home service provision into existing discharge planning services at NYC jails.

BHH has established and expanded partnerships with the New York City Mayor’s Office of Criminal Justice, the Center for Court Innovation, the Fortune Society, and others.

BHH has invested in relationships between the Health Home and the jail system, the prison system, and alternatives to incarceration (ATI) programs to:

- Identify HH eligible individuals in the justice system
- Retain members and their connections to care post-incarceration
- Promote stability in the community
- Reduce recidivism
Key Program Elements

Overall Goals
- Improve member engagement and retention
- Improve member outcomes (quality of life and cost/utilization)
- Enhance network capacity to provide high quality community-based care management
- Expand cohort of care management teams trained in Critical Time Intervention

Justice-Informed Workflow Committee
- Educate network on community-based resources
- Provide justice-informed and trauma-informed care training
- Identify justice “specialists” within the network

Case Conference
- Provide clinical guidance on complex cases with bi-weekly and ad-hoc conferences

Quality Monitoring
- Conduct regular, standardized chart reviews to evaluate the quality of care plans, the strength of interventions, and the procedures around critical events including incarceration and discharge from incarceration
BHH-CHS Workflow

1. Receive weekly CHS match list (BHH members and NYC jail census)
2. Scrub list for BHH members assigned to a CMA
3. Send alerts through EMR to CM
4. CMs contact jail discharge planners
5. Discharge planner (D/C planner) obtains consent from member
6. BHH coordinates and facilitates case conference with D/C planners and CM
7. CM reengages member and facilitates connection to all necessary providers
Data Collection Methodology

- Quarterly Justice Assessment completed by the Health Home Care Manager
  - Data reported to NYS Department of Health
  - Chronic conditions, provider engagement (MH, PCP, HIV, specialist), housing and employment status

- Monthly data sharing with a coalition of Health Homes in the DOH Justice pilot
  - Number of active members (outreach or enrolled) currently in NYC jail
  - Number of inactive potential members (with previous BHH connection – enrollment or outreach)
Engagement and Retention

Member Retention

Q1 20%
Q2 65%
Lessons Learned and Next Steps

• Further analysis on member disengagement from behavioral health, substance use disorder, and specialty care in order to develop tailored improvement plans

• Identification of additional justice-specific community resources (e.g. housing, employment)

• Enhance infusion of trauma-informed care principles into all care management training

• Continue to expand criminal justice programming
  • Prison re-entry
  • Alternatives to Incarceration (ATI)

• Implement formal Critical Time Intervention program for justice-involved members, beginning in an ATI setting

• Ongoing mitigation of communication and collaboration barriers across siloed settings (i.e., jail, healthcare, social services)
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