BROOKLYN HH
HEALTH HOME PRESENTATION

Health Home and Criminal Justice Pilot Workgroup Meeting

January 22, 2013

GOALS OF THE HEALTH HOME

1. Outreach and engagement of assigned patients
2. Linkage to care
3. Follow up care and additional linkage to community resources
4. Ensure all professionals involved in a member's care communicate with one another
5. Develop a single integrated care plan
6. Share all information via one HIE Platform
7. Meet overall health home requirements inclusive of 6 core services, quality matrix, meaningful use, PCMH, QUARR, HEDIS, and C-Mart requirements

- Improve health and behavioral outcomes= reduction in ER utilization and Hospitalization

PROVIDER/PARTNER NETWORK

- Care Manager leads an interdisciplinary team including:
- Primary Care Provider
- Mental health provider
- Substance Abuse Counselor
- Medical Specialist
- Nurse
- Home Based Providers (home attendant etc)
- Housing Specialist
- Hospitals
- MCOs
- Others

CHN'S TEAM STRUCTURE

- Deputy Director (LCSW). Responsible for the regional reports and the behavioral and social quality matrix
- HH Quality Supervisor (RN) responsible for the care plan approval and clinical quality indicators
- Coordinator/Supervisor (Licensed Nurse or Social Worker with supervisory experience and experience working with populations with complex medical, mental health and psycho-social needs). Responsible for the daily supervision and daily reporting tracking
- Care Manager- TEAM LEAD (Bachelors Degree and experience working with populations with complex medical, mental health and psycho-social needs) Responsible for the overall care coordination, linkage to services and care planning of the patient
- Patient Navigator (H.S Diploma, community experience working with populations with complex medical, mental health and psycho-social needs). Responsible for outreach activities, engagement, patient consent, screening, and assist with follow up and escort services

PLANS FOR ENGAGING CJ POPULATION

- Pre arrangement made prior to release date
- Patients drop offs at our clinics
- Patients seen at the clinic the day of release
- Informed engagement
- In-person screening
- In person assessment
- Goal setting
- Coaching
- Self-management (disease specific knowledge and skills)
- System access and navigation
- Modeling (joint visits to PCPs and specialists)
- Ongoing support with court mandate
- Coordination and communication with Parole officers
- Primary, Specialty and Mental Health Care
- Referring and connecting with community resources
- Housing, transportation, social support, etc