

NYS DCJS JMHCP Technical Assistance Bulletin

Additional: *Care Coordination*

Introduction:

In 2008, Westchester County implemented a Care Coordination Program to improve outcomes for persons with serious mental illness. The program was directed at those individuals who had not been effectively engaged by traditional services. The Westchester program was based on the Western Care Coordination Program, a six-county consortium dedicated to transforming services for adults with severe behavioral health conditions. To this model Westchester added a focus on those individuals with frequent police or other criminal justice contact. The goal of the program is to improve outcomes utilizing a person-driven approach. Significant among the outcomes were a reduction in criminal justice contacts and related costs from more effective utilization of treatment and other medical resources.

Program Details:

Among the criteria for participation in the Westchester program were the following:

- adults who have a serious mental illness
- frequent use of emergency rooms, acute psychiatric inpatient units, psychiatric centers and other acute or crisis services with no link to community-based services or
- discharge from jail or prison with no active link to services
- frequent arrests and incarceration
- homelessness

Staff are called Care Coordinators and work with a 1 to 12 ratio with enrollees. Care Coordinators

- Assist the enrollee with the development of an Individualized Services Plan to identify services, supports and providers that will help in recovery, wellness and satisfaction.
- Provide or arrange for desired services and supports.
- Ensure that services are being provided as identified the Individualized Services Plan.
- Assist enrollees establish and maintain Medicaid, housing and other public assistance benefits and promote rehabilitation recovery and wellness into all program activities.

In addition, individuals with similar histories to the enrollees, who are in recovery may be supported by the program. These peers are called Recovery Mentors and are available if enrollees request their assistance.

Care Coordination mental health services have been paid primarily by Medicaid. Medicaid does not cover costs for other necessary services such as housing and job training. Local “self-determination funds” have been used to assist with access to these other and important services related to goals as established in the Individualized Services Plan.

Program Benefits:

The Bazelon Center Performance Improvement Project for Westchester County Department of Community Services conducted a study that included information about 14 enrollees from pre-enrollment to 24 months later. Among the outcomes were the following:

1. Ancillary Services: The use of Self Determination funds and Recovery Mentors seems to increase significantly at the 6-month mark. After that, involvement is more inconsistent over time. This pattern likely indicates that participants understand the services that are available and utilize the services as necessary.
2. Types and Amounts of Self-Directed Funds Used: Housing related (rent, household items, furniture): \$5,105; Transportation/car related expenses: \$474; Health/wellness/symptom mgmt: \$1,325; Communications: \$900; and Other (food, clothing): \$1,505. The total spent on Self-Directed Funds for the 14 enrollees was \$9,306.
3. Days of Homelessness: Individuals enrolled in the Care Coordination Program experienced a drastic decline in the average number of homeless days. During the 6 months prior to enrollment, the average number of homeless days for the clients included in this report was 75. This number dropped significantly to 9 days for those individuals enrolled in the program for 24 months, representing a savings of \$71,837 in shelter costs.
4. Incarceration Data: Clients enrolled in Care Coordination demonstrated a 96% decrease in their number of days incarcerated over a 24-month period, representing a cost savings of \$236,750.

NYS Medicaid Health Homes:

The JMHCP expects to offer an in-depth presentation on the opportunities for addressing high utilization of both health and behavioral health services. The health and behavioral health landscape across the state is changing rapidly. Health Homes are being created in NYS to manage health and behavioral health services through improved care coordination and service integration. These changes will affect local health, mental health and behavioral health providers, and it is expected that the services utilized by criminal justice will evolve.

A Health Home is a care management service model. Services will be coordinated by a "care manager" who will oversee and provide access to the services an individual needs to assure that participants receive necessary services to stay healthy. It is expected that this coordination will help reduce out of the emergency room visits and hospital stays.

Resources:

1. Mitchell, G. "Coordinating care program improves outcome, reduces costs." *Mental Health Weekly*, August 17, 2009.
2. Westchester County Department of Community Services. *Care Coordination: A New person-centered Recovery Oriented Program*. N.p.: Westchester County Department of Community Services, n.d. Print.
3. Mitchell, Grant MD, Westchester County Department of Mental Health Community Services: Care Coordination Project Overview: 2007 – 2011 PowerPoint Presentation, undated
4. Giuliano, Mark and the Bazelon Center for Performance Improvement: Westchester County DMHC, PowerPoint, March 2012.
5. New York State Department of Health. "Medicaid Health Homes." Accessed January 5, 2014.
6. Home | New York Care Coordination Program. "Home | New York Care Coordination Program." Accessed January 5, 2014. <http://www.carecoordination.org/default.aspx>.