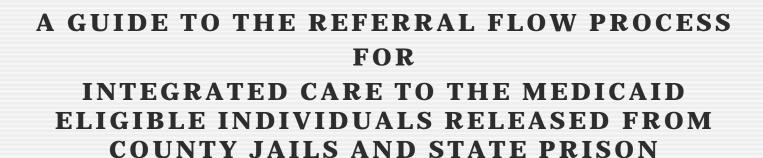
# BEHAVIORAL HEALTH HOMES and THE NEW JERSEY DEPARTMENT OF CORRECTIONS





# **Project Overview**

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- Individuals who are incarcerated have a disproportionate rate of serious mental illness and significant physical health needs. The prevalence of serious mental illness is two to four times higher in the state prisons than in the community
- Upon release, if left untreated, these serious concerns lead to increased recidivism, higher health care costs and unmet social needs
- Integrated care, which addresses both the mental health and physical health needs, available immediately upon release, presents one option for addressing these obstacles to integration into the community for released inmates

## **Project-Goals**



- Develop the most effective means by which NJ Family Care/Medicaid can provide integrated services for individuals leaving state and county correctional facilities who have a serious mental illness
- Establish linkage between BHH, MCO Case Management and the correctional system with ongoing information sharing and regular contact through face to face meetings or conference calls
- The State to pilot, develop procedure and coordinate services utilizing BHH in existing five counties by which the DOC's centralized transition release team can identify eligible individuals and initiate contact with the BHH providers prior to release

#### **DOC Referrals**

- ➤ Rutgers University Correctional Health Care (UCHC) will fax the following documents to NJ Family Care contact for individuals released from county jails and state prisons from five counties (Bergan, Mercer, Atlantic, Cape May, Monmouth)
- ➤ Cover sheet with the client's demographic information, diagnosis and DOC contact information Client's discharge summary including presenting problem, procedures, medications, immunizations, directives, allergies and adverse reactions and services due



#### **Referral Flow Process**



- Medicaid contact person will log information into the referral tracking sheet, reach out to the clients county BHH and if the county has more than one BHH the referral will be based on the proximity of the client's future community residence and client choice
- The BHH administrator will provide the following update to the NJ Family Care contact person about each client:
  - Acceptance status and the BHH enrollment date
  - Engagement activities
  - Discharge date from the program with the reason
- ➤ The DOC referral flow should be included in the BHH provider policy and procedure manual



## **Referral Flow Process**



- ➤ The BHH Care Coordinator reaches out to the DOC social worker/contact person listed on the referral fax cover sheet. Contact should be made within 24 hours in order to:
  - Engage with an individual prior to release and ensure an initial appointment to be scheduled as quickly as possible
  - Develop a care plan for the treatment and transition from the correctional institution to the community



## **Outcomes Reporting**

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- ➤ The BHHs should continue to report outcomes that are required as part of the approval of the existing SPA
- Other data elements may be added for the DOC population.



## **Contact Information for Referrals**



Anjana Multani, MSW

**BHH/DOC Project Coordinator** 

Office of Managed Health Care, Behavioral Health Unit

**Department of Human Services** 

NJ Division of Medical Assistance and Health Services

5 Quakerbridge Plaza

Trenton, NJ 08619

Anjana.Multani@dhs.state.nj.us

Tel. <u>609.588.3828</u>

Cell. 609 789 7602

Fax 609.588.3354



#### **DMHAS Contact**



John J. White LPC, LCADC, ACS

Coordinator of Utilization Management

SAPTI Program Manager

Behavioral Health Home Program Manager

Office of the Medical Director

Division of Mental Health and Addiction Services

Capital Place One

222 South Warren Street

PO Box 700

Trenton, NJ 08625

Tel: (609) 633-8693

E-Mail: john.white@dhs.state.nj.us

