OneCity Health Innovation Fund Awardee

Connections to Care (C2C) Program

LEAD ORGANIZATION: The Fortune Society, Inc

JOINT APPLICANTS: NYC Health + Hospitals/ Correctional Health Services (CHS)

NEIGHBORHOODS PROJECT INTENDS TO SERVE: All of New York City

BUDGET: $487,000

OVERVIEW

The Fortune Society (Fortune) and NYC Health + Hospitals/Correctional Health Services (CHS) will implement a Connections to Care (C2C) Program, operated in conjunction with multiple community partners, to screen individuals on Rikers Island who will soon be released. This program will specifically target chronically ill adults who are Medicaid-eligible, are at a high risk of substance abuse relapse or avoidable Emergency Room (ER) use and are returning to NYC neighborhoods from jail, with a particular focus on individuals with opioid use disorder.

Through this program, we will provide individuals with transitional care coordination to ensure that their primary health, as well as holistic support service needs, are met. While incarcerated, participants anticipating discharge will receive a physical, behavioral and social health assessment. Upon discharge, participants will be offered transportation and then be directly connected to the NYC Health + Hospitals/Bellevue Hospital Transitions Clinic, NYC Health + Hospitals/Gotham Health sites, and/or other health care providers to receive essential health care, including medication-assisted treatment (MAT), for those with opioid use disorder who received MAT on Rikers Island.

The program will target improvement in the following four areas:

- Linkage with Primary Care
- Initiation of Alcohol/Drug Treatment
- Engagement of Alcohol/Drug Treatment
- Reduction in Preventable Emergency Room Visits

DSRIP METRICS THIS PROJECT WILL ADDRESS

Connecting high-risk, chronically-ill, recently incarcerated individuals directly with primary health care and behavioral health care, particularly MAT for those with opioid use disorder, will significantly reduce ER visits and inpatient hospitalizations due to relapse or untreated chronic health issues for this population. Currently, 75 percent of individuals referred by CHS to the Bellevue Hospital Transitions Clinic for MAT do not show up upon release. By working directly with health care providers, starting during incarceration and continuing post-release, this program will ensure that participants are directly connected to care upon release and that they can successfully navigate care transitions in the community.