

HealthierHere

The Accountable Community for Health of King County

Project Workgroup: Transitional Care - Jails

May 7, 2018



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Transitions of Care from Jails / Expansion of Reentry Case Management Services

Project Goal

Immediate: Implement the APIC Model, demonstrated by assessment of an inmate's clinical and social needs, and public safety risks; a plan for the treatment and services required to address the inmate's needs, the identification of required community and correctional programs for post-release services, and coordination of the transition plan to ensure implementation and avoidance of gaps in care with community-based services.

Long-term: Expand re-entry case management services to high-risk individuals including those individuals who experience homelessness. Reduce potentially avoidable emergency room visits and potentially avoidable readmissions.

Focus Populations

Medicaid beneficiaries returning to the community from jail who have complex health and behavioral health conditions that necessitate care coordination and disease management.

Based upon King County's Familiar Faces Initiative, the high-risk population were identified as individuals who had been booked four or more times in a twelve-month period and who have a behavioral health condition.

Interventions

The APIC Model is a framework of best-practice guidelines for post-release discharge of people with mental health and substance use disorder needs. The model was developed to support community re-entry of inmates of the correctional system. It focuses on elements of successful re-entry to plan their transition to the community and help them engage with supportive services after their release.

While in custody, jail health services (either provided or contracted for) are responsible for addressing the individual's needs, including:

- Screen newly detained individuals at the entry point, including a healthcare practitioner to detect substance use disorders, mental disorders, co-occurring substance use and mental disorders, and criminogenic risk.
    - For individuals with positive screens, jail health staff will complete comprehensive assessments to inform the development of treatment plans.

For re-entry, correctional systems and/or jail release planners will:

- Establish relationships with community-based physical and behavioral health providers forming a "care team" to assure that appropriate health, behavioral health, and social services are included in discharge planning and transitional services.
    - For instance, access to medications in the first hours and days post-release is critical in maintaining people in the community. Inmates should have a minimum of a week's

supply of medication upon release, with provisions for additional supplies to bridge any gaps before scheduled appointments.

- Work with individuals to identify and plan for necessary physical health care, behavioral health care, justice system, and community supports, including assistance with health coverage/ Medicaid in advance of their scheduled release dates.
- Provide a "warm hand off" for those individuals requiring additional help. The individual will be introduced to a community health worker or peer support specialist.
    - Upon discharge, a community health worker or peer support specialist (with lived experience in the correctional system and/or behavioral health recovery) will meet an individual at release and accompany the individual to his/her first appointment to establish a relationship with a partnering medical or behavioral health provider.
- Assign a "health home" if the individual does not have one (assigned by a member of the care team prior to discharge).

Innovations

- Measurement based care with validated tools
- Coordinated, team-based care
- Stronger linkages to community-based organizations addressing social determinants

Metrics

- All-Cause Readmission Rate (30 Days)
    - Among Medicaid beneficiaries age 18-64 years old, the percent of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission within 30 days.
- Inpatient Hospital Utilization
    - For members 18 years and older, the risk-adjusted ratio of observed to expected acute inpatient discharges during the measurement year.
- Follow-up After Emergency Department Visit for Alcohol or Other Drug Dependence
    - The percent of discharges for members 18 years and older who had a visit to the ED with a primary diagnosis of alcohol or other drug dependence during the measurement year AND who had a follow-up visit with any provider with a corresponding primary diagnosis of alcohol or other drug dependence, reported separately for follow-up within 7 and 30 days after discharge.
- Follow-up After Emergency Department Visit for Mental Health
    - The percent of discharges for members 18 years and older who had a visit to the ED with a primary diagnosis of mental health during the measurement year AND who had a follow-up visit with any provider with a corresponding primary diagnosis of mental health, reported separately for follow-up within 7 and 30 days after discharge.
- Follow-up after hospitalization for Mental Illness
    - The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a

mental health practitioner, reported separately for follow-up within 7 and 30 days of discharge.

- All Cause Emergency Department Visits per 1000 Member Months
  - The rate of Medicaid beneficiary visits to emergency department per 1000 member months, including visits related to mental health and substance use disorder, reported for three age groups: 10-17 years, 18-64 years, and 65 years and older.
- Percent Homeless (Narrow Definition)
  - The percentage of Medicaid enrollees who were homeless in at least one month in the measurement year. Excludes "homeless with housing" living arrangement code within the DSHS database ACES, reported for three age groups: 0-17, 18-64, and 65 and older.
- *30-day Psychiatric Inpatient Readmissions
  - For members 18 years of age and older, the number of acute inpatient psychiatric stays that were followed by an acute readmission for a psychiatric diagnosis within 30 days.
- *Substance Use Disorder Treatment Penetration
  - The percentage of members with a substance use disorder treatment need who received substance use disorder treatment in the measurement year. Separate reporting for three age groups: 12-17 years, 18-64 years, and 65 years and older.
- *Mental Health Treatment Penetration (Broad Version)
  - The percentage of members with a mental health service need who received mental health services in the measurement year. Separate reporting for three age groups: 6-17 years, 18-64 years, and 65 years and older.

*Metrics in addition to Healthier Washington pay for performance metrics for this project

References/Guidelines

1. Osher, F. (2007). Short term strategies to improve re-entry of jail populations: expanding and implementing the APIC Model. *American Jails, 20*, 9-18. http://gainscenter.samhsa.gov/pdfs/reentry/apic_model.pdf
2. Osher, F., Steadman, H. J., & Barr, H. (2002). *A best practice approach to community re-entry from jails for inmates with co-occurring disorders: The APIC model.* Delmar, NY: The National GAINS Center. http://gainscenter.samhsa.gov/pdfs/reentry/apic.pdf
3. Mellow, J., Mukamal, D., LoBuglio, S., Solomon, A., & Osborne, J. (2008). The jail administrator's toolkit for reentry. Washington, DC: Urban Institute Justice Policy Centre. http://www.jjay.cuny.edu/Jail_Admin_Toolkit.pdf
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5. Grisso, T., & Underwood, L. (2004). *Screening and Assessing Mental Health and Substance Use Disorders Among Youth in the Juvenile Justice System: A Resource Guide for Practitioners*. Office of Juvenile Justice and Delinquency Prevention. https://www.ncjrs.gov/pdffiles1/ojjdp/204956.pdf
6. National GAINS Center (n.d.). *Instructions for Completing GAINS Jail Re-Entry Checklist.* http://gainscenter.samhsa.gov/pdfs/reentry/Reentry_Checklist.pdf
7. Warwick, K., Dodd, H., & Neusteter, R. S. (2012). *Transition from Jail to Community Initiative practice brief: Case management strategies for successful jail reentry.* Washington, D.C.: National Institute of Corrections and Urban Institute. http://static.nicic.gov/Library/026912.pdf
8. Substance Abuse and Mental Health Services Administration. Guidelines for Successful Transition of People with Mental or Substance Use Disorders from Jail and Prison: Implementation Guide. (SMA)-16-

4998. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2017. https://store.samhsa.gov/shin/content/SMA16-4998/SMA16-4998.pdf

Evidence-Based Approaches: Transitional Care

Evidence Based Approach	Model Target Population	Model Description
The APIC Model: A Best Practice Approach to Community Re-entry from Jails for Persons with Co-occurring Disorders	Target Population #: 1 Medicaid members returning to the community from **prison or jail.**	Set of critical elements (Assess, Plan, Identify, Coordinate) that are likely to improve outcomes for person with co-occurring disorders who are released from jail.
Peer Bridger Program	Target Population #2: Medicaid members with **serious mental illness or substance use disorder** discharged from inpatient care, including psychiatric inpatient facilities and psychiatric units in hospitals.	Peer Bridger is a community/home-based outreach service designed to be short term community support. Peers are state-certified Peer Support Specialists who have lived with mental illness or substance use and are in recovery.
Care Transitions Intervention/Coleman Model	Target Population #3: Adults and people with disabilities **transitioning from inpatient care and long-term care facilities** who could benefit from the Care Transitions Intervention, also known as the Coleman Model.	The Care Transitions Intervention® is also known as the Coleman Model® and is a 4-week program where patients, with complex care needs, and family caregivers receive specific tools and work with a Transition Coach to learn self-management skills that will ensure their needs are met during the transition from hospital to home.

The APIC Model

A set of critical elements creating bridges between mental health and continual health care and the criminal just system to improve outcomes for persons with co-occurring disorders who are released from jail:

Assess

- Assess the person's clinical and social needs, public safety risks, motivation for treatment and capacity for change, and financial ability to pay for services scaled to the length of stay, so even short-stay (72 hours) inmates may benefit.

Plan

- Plan for the treatment and services required to address the person's needs; addressing the critical period immediately following release (the first hour, day, and week after leaving jail) as well as the long term needs: housing, integrated treatment for co-occurring disorders, medication, other behavioral care, medical care, income support/entitlements, food, clothing, transportation, and child care.

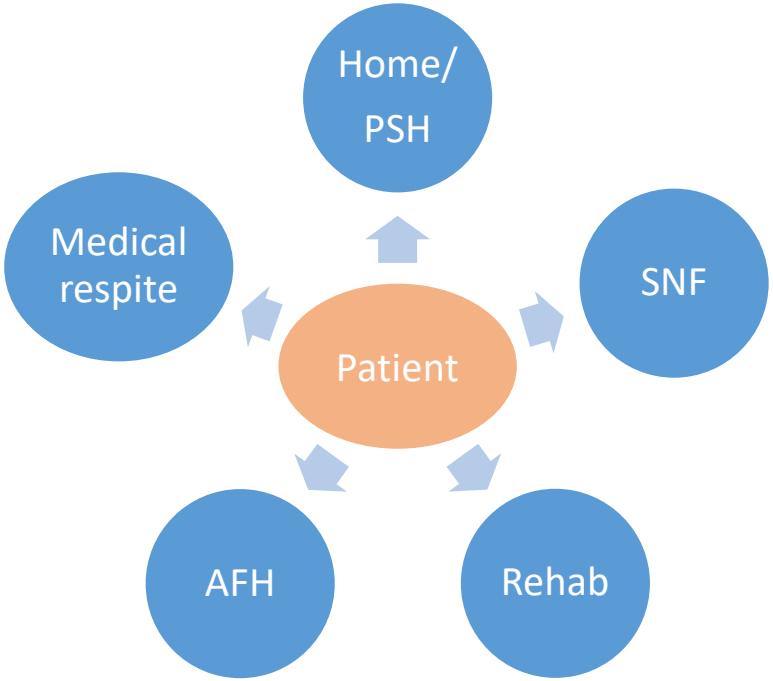
Identify

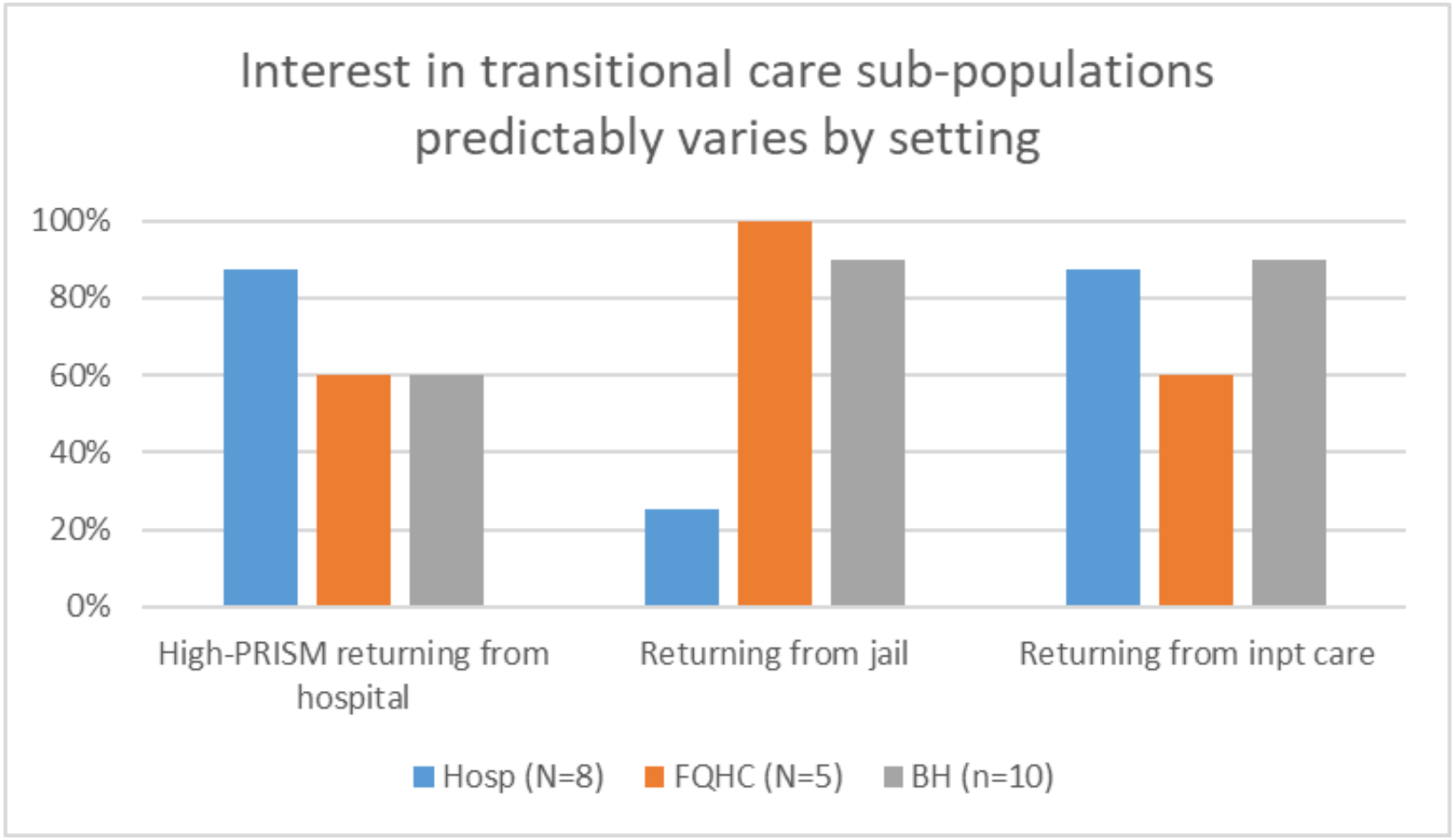
- Identify required community and correctional programs responsible for post release services and creation of a transitional plan based on the underlying clinical diagnosis, cultural and demographic factors, financial arrangements, geographic location, and the inmates legal circumstances.

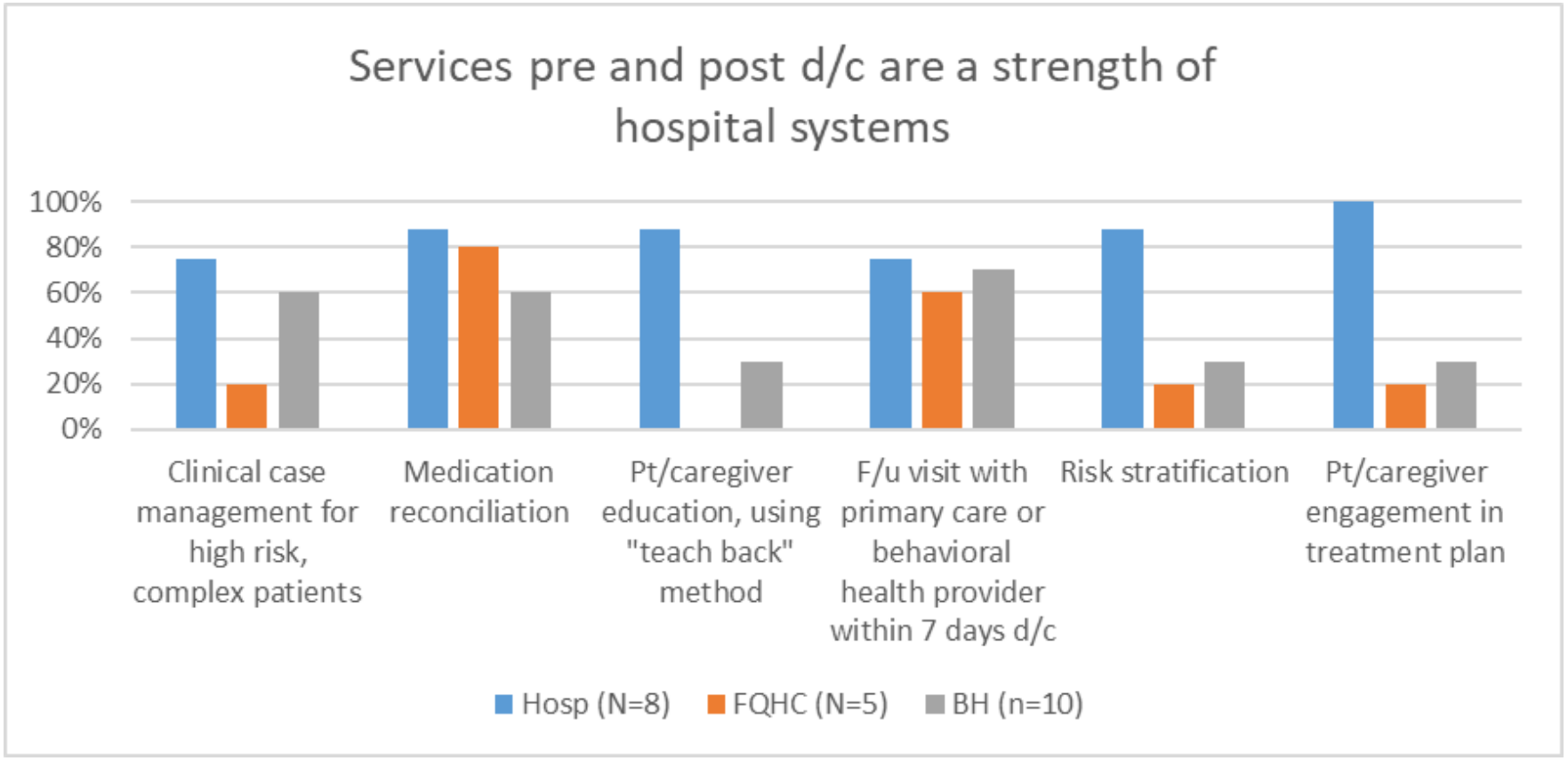
Coordinate

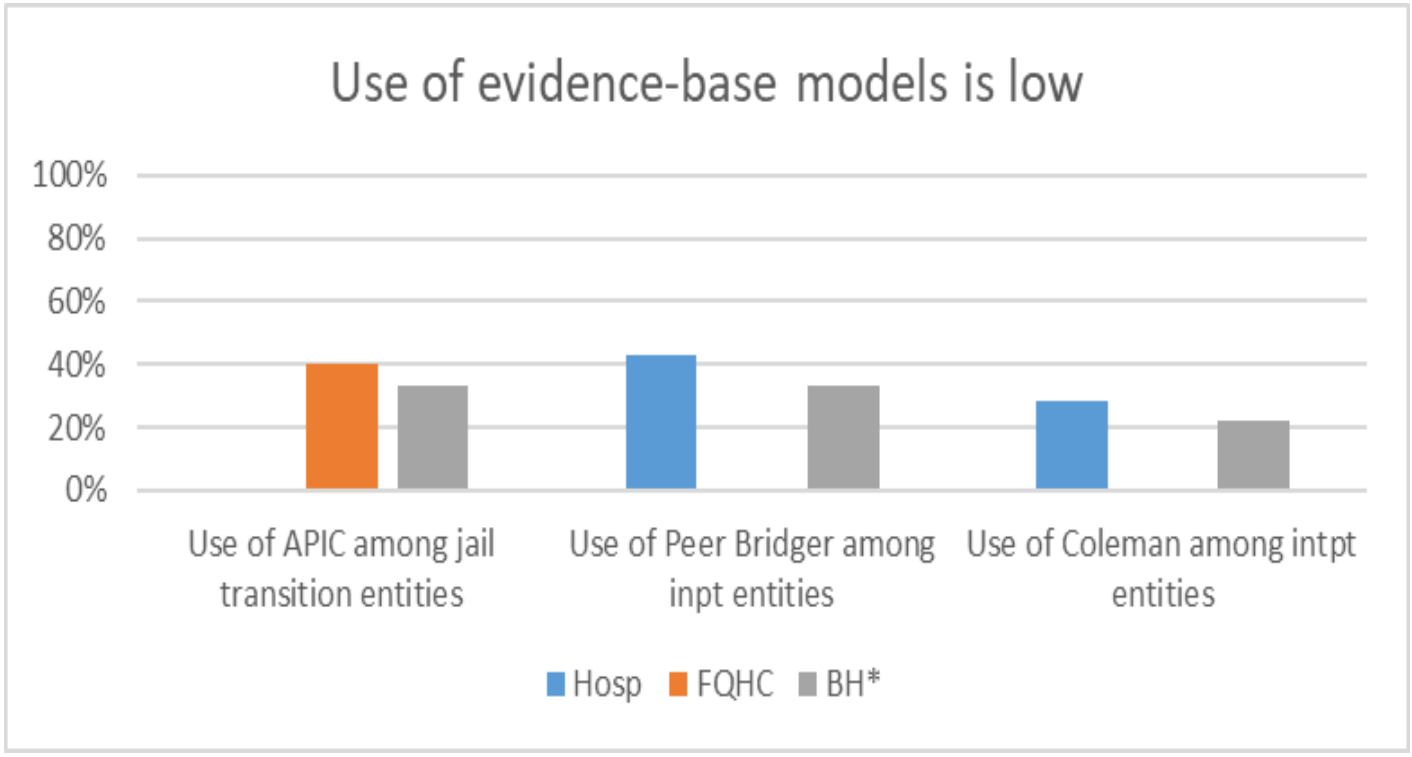
- Coordinate the transition plan to ensure implementation and avoid gaps in care with community-based services ideally leveraging a case manager with cooperation from the inmate and the person's family.

Transitional Care: Project-specific Current State Assessment Results




Interest in transitional care sub-populations predictably varies by setting
100%
80%
60%
40%
20%
0%
High-PRISM returning from hospital
Returning from jail
Returning from inpt care
Hosp (N=8)
FQHC (N=5)
BH (n=10)


Services pre and post d/c are a strength of hospital systems
100%
80%
60%
40%
20%
0%
Clinical case management for high risk, complex patients
Medication reconciliation
Pt/caregiver education, using "teach back" method
F/u visit with primary care or behavioral health provider within 7 days d/c
Risk stratification
Pt/caregiver engagement in treatment plan
Hosp (N=8)
FQHC (N=5)
BH (n=10)



"Other" models

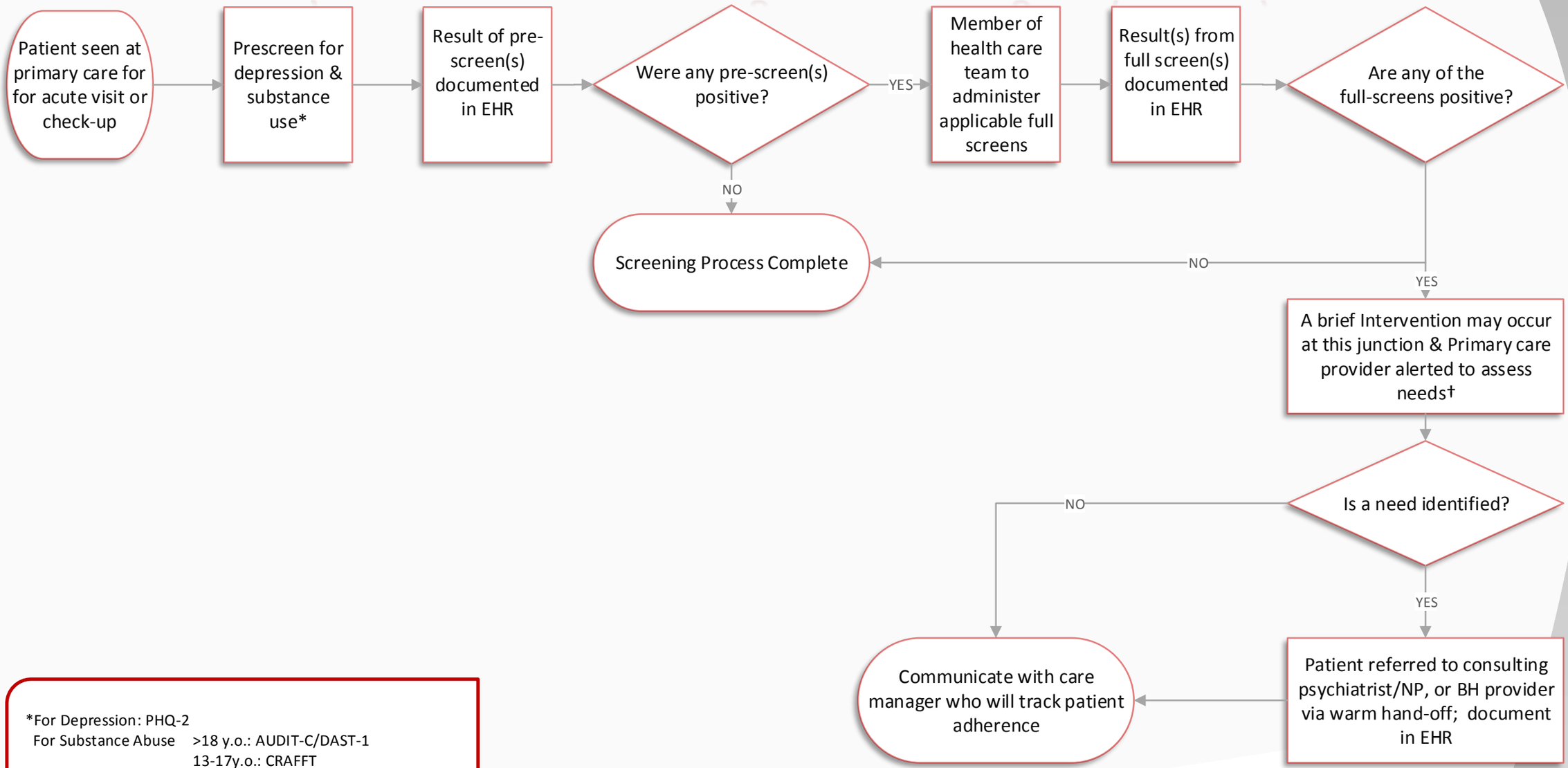
Jail transition: forensic steering committee, intensive case management with LEAD; components of APIC

Hospital transition: care coordination; assertive outreach; Coleman; peers; PACT; REACH; language-specific CM

Barriers for Transitional Care

- Housing
- Communication/collaboration; d/c info sharing
- Timely access to MH/SUD treatment, specialty care, clinics
- Funding – for outreach, CHWs, longer PCP appts.
- Staffing
- SNF and AFH funding models, beds, willingness to accept pts.

Primary & Behavioral Health Integrated Care Program (Model 3) Flow Chart



*For Depression: PHQ-2
For Substance Abuse >18 y.o.: AUDIT-C/DAST-1
13-17y.o.: CRAFFT

†Brief Interventions if performed following a substance use screening may be billable if required criteria met

Suffolk Care Collaborative