HealthierHere

Clinical Summary
Transitions of Care from Jail

Goal

Immediate: Implement an integrated whole person model of care that ensures safe and successful transitions from jails back into community settings.

Long-term: Reduce avoidable emergency department (ED) visits and hospital readmissions, as well as readmissions to jail. Expand community-based support services for high-risk individuals leaving jails, including those individuals who experience homelessness.

Focus Populations

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

Key Project Elements

The following interventions are recommended for participating provider organizations. Pursuing the recommended strategies as appropriate for specific focus populations is likely to help Practice Partners achieve their goals related to HealthierHere's 2019 pay for progress incentives.

HealthierHere is taking a broad, portfolio approach to inform King County's transformation efforts. The evidence-based models identified by the Health Care Authority (e.g., Bree Collaborative Model, Coleman Model, Collaborative Care Model, APIC, and the Chronic Care Model), have congruent underlying principles that are foundational to system and service delivery transformation.

Based upon the APIC model, implementing organizations are encouraged to utilize the following key strategies. Specific criteria used for assessments and stratification will be determined by HealthierHere and implementing partners through Quality Improvement Learning Collaboratives.

Utilize Population Health Management Tools:

- Use electronic health records and registries to identify individuals and the services that are needed, share integrated care plans and other Continuity of Care Documents as appropriate and allowed by law with primary care providers, social service providers (such as, supportive housing), individuals, and their caregivers.
- Measure and monitor against a defined set of indicators to track progress.
- Conduct routine quality assurance and improvement reviews of panels of high-risk individuals.

Assess Whole Person Care Needs:

- Whole person care needs include the following: physical health, behavioral health, oral health, and the social determinants of health. Partners will determine their standard assessments and/or adopt HealthierHere's recommended assessments which have yet to be determined.
- Offer in reach services before reentry to identify and plan for necessary medical, behavioral health, justice system, social services, and community supports, including assistance with health coverage, ensuring Medicaid eligible individuals are enrolled since coverage is suspended while they are incarcerated.

Implement Team-based Care:

- Form a person-centered, multi-disciplinary, integrated care team. Composition of the team should be based on an individual's needs and risk stratification, and members could include a behavioral health specialist, social worker, or other appropriate provider.
- Develop a plan for the treatment and services required to address the individual's needs, the identification of 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.
- Establish relationships with community-based physical and behavioral health providers and community partners who address the social determinants of health.
- Accommodate in reach services and provide a "warm hand off" for those individuals requiring additional help.
    - The individual will be introduced to a community support specialist (e.g., a care coordinator, community health worker, or peer support specialist with lived experience in the correctional system and/or behavioral health recovery) before reentry to establish trust.
    - Assign individuals at high risk for complications to a care manager.

Develop Integrated Care Planning:

- Create individually tailored, culturally appropriate transition/reentry plans that support patient engagement with the care team. Language needs, including interpretation and translation, must be incorporated in the care planning and delivery.
- Share individuals' transition/reentry plan with their community support specialist and primary care provider (PCP)/community behavioral health provider to facilitate implementation and avoid gaps in care with community-based services.
- Ensure first appointment with PCP and/or community behavioral health provider with prescribing capability is scheduled prior to reentry. This appointment should take place as soon as possible, ideally within one week of release.

Provide Self-Management support:

- All focus population individuals should receive self-management support by a member of the integrated health care team. Establish an individually tailored self-management goal, which should be reviewed at each visit. When applicable, provide individuals with a 7-day supply of needed medications and a prescription for a 30-day supply, along with a medication plan and instructions on medication management upon reentry. As appropriate and allowed, the medication plan should be shared with the individual's community support specialist so that they can provide continuity and make sure the medication plan is shared with the PCP and care team on the receiving end and followed.
- Upon reentry, the assigned community support specialist will meet an individual and accompany them to his/her first appointment to establish a relationship with a partnering medical or behavioral health provider.
- After reentry, the community support specialist conducts in-person meeting(s) such as, home visits and follow-up by phone and/or telehealth options, in service of the following goals:
    a. Increase self-management skills
    b. Ensure personal goals are congruent with individual's self-efficacy
    c. Improve continuity of care with primary care follow-up
    d. Ensure medication management and reconciliation with PCPs or other providers including pharmacists
    e. Practice advocacy by identifying key questions for PCPs/specialists
    f. Educate on health system navigation

g. Ensure individual can "teach back" expectations from physical and behavioral health appointments, including what medications are needed and why.

Link to Community Resources:

- As needed or desired, the care team will refer individuals to community resources.
- To address the social determinants of health, the integrated care team will connect individual with appropriate resources, social services agencies, and community based organizations depending on the individual's needs (e.g., transportation, food, shelter). For applicable individuals, the integrated care team will work with the individual and community support specialists to support selected activities. In such cases, the community support specialist will communicate with PCP and/or specialist(s) regarding the individual's treatment and progress.

Pay for Performance Metrics

Incentive payments for ACHs and partnering provider organizations are dependent on improvement in project-specific Pay for Performance metrics selected by the Health Care Authority. Partnering provider organizations participating in the Jail Transitions project will agree to help HealthierHere improve the following set of metrics.

Metric	Definition
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.
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 years, 18-64 years, and 65 years and older.

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References/Guidelines

A Best Practice Approach to Community Re-entry from Jails for Inmates with Co-occurring Disorders: The APIC Model, http://www.prainc.com/wpcontent/uploads/2015/10/best-practice-approach-community-re-entry-inmates-co-occurring-disorders.pdf