Strategic Focus Area: Adults Transitioning from the Justice System – DRAFT

Project 1: Develop an integrated health care setting with select county probation offices or Department of Corrections (DOC) parole offices, or near select offices through the use of mobile units, to address beneficiary health care needs upon release and throughout the term of probation/parole for individuals transitioning out of incarceration. County probation offices and Department of Corrections parole offices could also potentially be relocated to primary care practice sites under this project.

Objective: Develop an integrated health care setting within selected probation and parole offices to (i) coordinate eligibility and enrollment activities to maximize access to services, (ii) assist with health care system navigation, (iii) perform health care screenings, (iv) provide physical and behavioral health care services, (v) provide care coordination services to assist the individual in scheduling initial and follow-up appointments with necessary providers within or outside of the integrated setting, and (vi) assist individuals with arranging and coordinating continuing care once the individual is no longer required to participate in probation/parole activities.

CC #	Core Component	DY 1 Practice Reporting Requirement for DSRIP Payment	DY 2 Practice Reporting Requirement for DSRIP Payment
1	Establish contracts with acute plans and T/RBHAs to be reimbursed for integrated services, ideally within select county probation offices or Department of Corrections (DOC) parole offices.	Document executed contracts with acute plans and T/RBHAs	N/A
2	Upon the request of the RBHA, participate in the RBHA-convened process designed to identify opportunities consistent with the objectives of this project for integrated care, ideally in select county probation office or DOC settings, and develop a strategy for addressing identified opportunities.	Document collaborative participation with the RBHA and work in good faith to identify opportunities for developing an integrated health care setting, ideally within probation and/or DOC parole offices.	N/A
3	Establish an integrated health care setting(s) co-located within select county probation offices and/or DOC parole offices, the number to be determined by the RBHA and AHCCCS. If the RBHA and provider agree, a provider using a mobile unit in near proximity to the offices, or a permanent location in close proximity to the probation office and/or DOC parole offices will be acceptable; however, those practices will receive fewer dollars for meeting the Core Components in this project.	N/A	Document that a) the integrated practice is operational and fully staffed, and b) the integrated practice is operating consistent with parameters set forth by AHCCCS, including in its facility and clinical operations.

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		DY 1	DY 2
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4	Develop a marketing plan in cooperation with the probation and parole offices to encourage individuals pre-release to utilize the integrated health care setting post-release.	Document a marketing plan developed in cooperation with probation and parole offices.	N/A

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5	For individuals who have suspended Medicaid eligibility while incarcerated with a known release date within 30 days for those in jail and within 90 days for those in prison, develop protocols with probation and parole offices to coordinate health care assessments and care management meetings with probation/parole pre-release visits and schedule appointments in the integrated co-located health care setting upon release.	Document protocols with agreement from the probation and/or parole office(s) for coordinating health care assessments and care management meetings at the integrated site pre-release and scheduling appointments upon release.	N/A
6	The practice should conduct a screening and assessment for physical and behavioral health needs (including substance use disorder needs) using standard protocols of the practice's choosing, and one for criminogenic risks using a tool agreed upon between practices and RBHAs during the individual's first visit to probation/parole, all unless the beneficiary declines a request from the practice.	Demonstrate that the practice has a protocol for performing screenings and assessments for physical and behavioral health needs and criminogenic risks during the first visit.	N/A
7	Develop protocols to ensure that prior to the conclusion of a visit, (i) a follow-up appointment has been made at a mutually convenient time, (ii) that the individual has a plan to access transportation to the follow-up appointment, and if not, that the care manager or a peer support assists the beneficiary in developing a plan to access transportation and (iii) that the practice has obtained contact information to reach the individual.	Demonstrate that the practice has developed protocols consistent with all three elements of this Core Component.	N/A

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8	Practices must have reliable and consistent access, within the practice or via telemedicine-enabled consultation, to medication-assisted treatment (MAT), and must develop or adopt protocols to provide MAT of opioids based on DSRIP entity guidelines; and must develop protocols to provide MAT of opioids using evidence-based guildelines. Such guidelines can be found here: http://store.samhsa.gov/product/Medication-Assisted-Treatment-of-Opioid-Use-Disorder-Pocket-Guide/SMA16-4892PG	Demonstrate that the practice has at least one physician who can prescribe buprenorphine. Demonstrate that the practice has developed protocols consistent with the evidence-based guidelines issued by SAMHSA.	N/A
9	For homeless enrollees who need a short-term connection to assist effective community re-entry and connection to health services (as defined by AHCCCS and RBHA), provide post-incarceration health appointments, navigation, transportation and referral to appropriate social services within ___ days of release.	Document a process for identifying enrollees who are homeless within ___ days from release and protocols for providing expedited assessment, health services and linkage to needed social service supports.	Report upon the numbers of enrollees who were homeless upon release and were seen by the practice within ___ days of release and provided expedited services.
10	Peer support staff are part of the co-located staff to assist formerly incarcerated individuals with, including but not limited to, eligibility and enrollment applications, health care education / system navigation, information on other support resources, health literacy and financial literacy training.	Demonstrate that peer support staff have been hired and have participated in training provided by the RBHA; Provide evidence of job descriptions.	N/A

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11	Enhance relationships with community-based social service resources, including self-help referral connections, community group resources, specialty mental health and substance use services, peer professionals, housing and employment support services by (a) identifying the resources in the community, and (b) creating protocols of when to engage or refer patients to these community-based resources.	Document the resources in the community, including contact information, and describe a schedule for periodically updating the resource listing with up-to-date information. Document protocols used for engaging these resources on behalf of patients and for referring patients to these resources.	N/A
12	Assess patient satisfaction with integrated practice services and identify what the practice might do to attain higher utilization of practice services among those on probation and parole and traveling to the probation or parole office per the terms of their release. Develop and implement changes in response to patient satisfaction assessment findings.	N/A	Assess patient satisfaction and identify what the practice might do to attain higher utilization of practice services among those on probation or parole. Develop and implement changes in response to patient satisfaction assessment findings.

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13	Enter into an arrangement with AzHeC to participate in bidirectional exchange of data with the HIE (both sending and receiving data).	Document that an agreement with AzHeC has been executed.	Demonstrate that the participating provider is actively participating in AzHeC, by supplying it with data on a routine basis, and incorporating its data into care management activities conducted by the provider.
14	Participate in RBHA training and education.	Demonstrate that the practice participated in RBHA-provided training during the DY.	Demonstrate that the practice participated in each RBHA-provided training during the DY.