Continuity of Care for Prison Reentry

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Objectives

- An overview of SAMHSA's APIC model and application for prison healthcare continuity of care planning will be provided including the importance of coordination of care from prison-based to community-based programs. Includes patient identification, initial assessment of need, approach to reentry planning, and community supports.

- Participants will learn about WA DOC Health Services reentry programs including Reentry Community Services (RCS) (formerly Offender Reentry Community Safety), State Opioid Response (SOR II) Grant for those with Opioid Use Disorder and a grant funded medical reentry program.

- Efforts to create system-wide continuity of care planning to improve patient community health outcomes will be shared.

Health Services Overview

8 Major Prison Facilities

- Medical
- Dental
- Substance Abuse Recovery Unit (SARU)
- Mental Health
- Sex Offender Treatment and Assessment Program (SOTAP)
- Pharmacy

Specialized Units

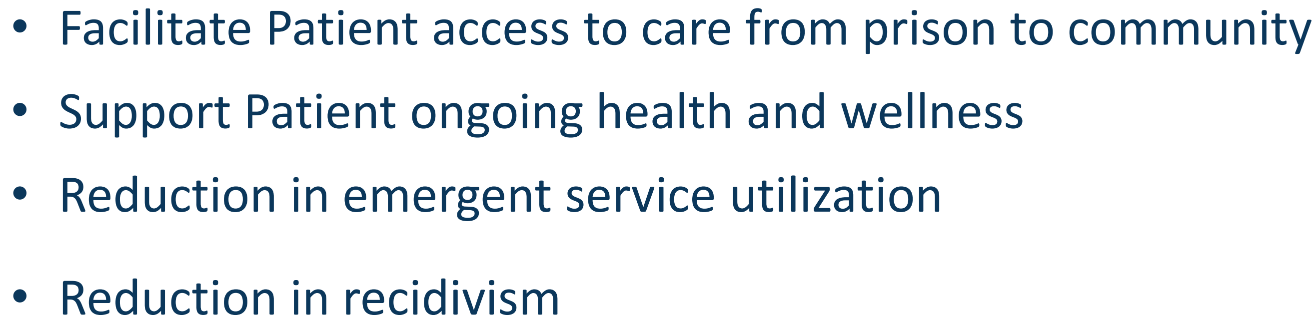
- Unit K at Airway Heights Correctional Complex (AHCC) for age 50+
- SAGE – (Assisted living unit)
- Inpatient hospital beds
- Dialysis Unit
- Therapeutic Communities
- Residential Treatment Unit (RTU): MH & SUD
- Skill Builder Unit (SBU): Developmental Disabilities

Continuity of Care

Roles

- Social Workers
- Nurses (Reentry, Release Medication, MOUD)
- Reentry Care Navigators

Purpose



APIC Overview

ASSESS the individual's clinical and social needs and public safety risk

PLAN for the treatment and services required to address the individual's needs, both in custody and upon reentry.

IDENTIFY required community and correctional programs responsible for post-release services.

COORDINATE the transition plan to ensure implementation and avoid gaps in care with community-based services

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. **PDF**

ASSESS

- Initial Health Screenings at Prison Intake
  - SUD Assessment
  - MH Screening
  - Medical Screening
  - Criminogenic Risk using Washington One (Case Manager)
- Identify high needs individuals within 6-12 months of release with referrals and data reports
  - Chronic and Acute Medical Conditions
  - Release from Specialized Unit
  - Major Mental Disorder
  - Medication for Opioid Use Disorder (MOUD)
  - Dental follow up care

PLAN

- Complete Needs Assessment
  - Physical/Mental Health
  - Substance Use Services
  - SOTAP
  - Public Benefits
  - Housing, Legal
  - Community Supports
  - AI/AN, Veteran, DDA, HCS

- Partner with prison Case Manager who develops Reentry Plan for incarcerated individuals

IDENTIFY

- Referrals for identified needs
- Schedule follow up medical, mental health and other appointments pre-release when possible
- Linkage with Reentry Division and Community Partners to provide warm handoffs
- Care Navigators and RCS clinicians provide services starting pre-release and continuing post-release

COORDINATE

- Collaborate with Prisons, Reentry, CCD, community partners
- Data Sharing
- Continuity of Care Plans to MCOs
- Medicaid Applications
- Transitional Offender Assistance Program (TOAP)
- Release Medications
- Narcan
- Medications for Opioid Use Disorder (MOUD)

Transition Programs

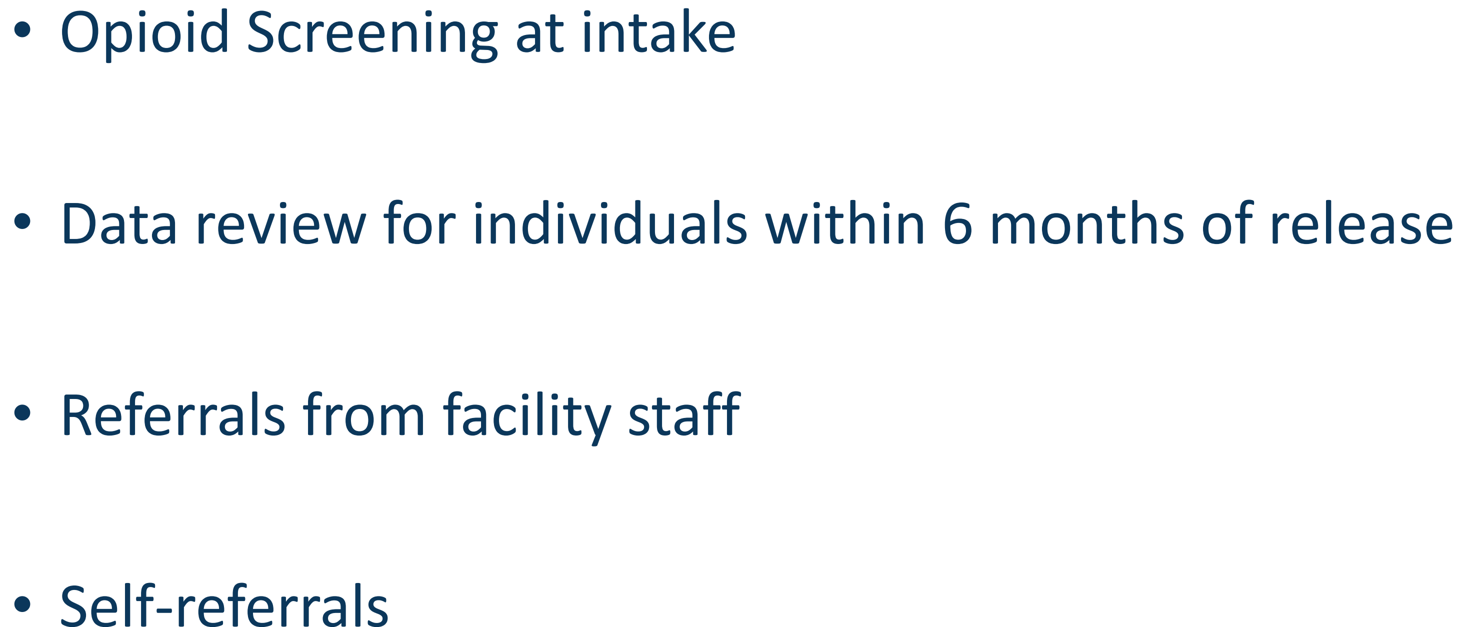
- SOR II COORP
- Community Linkage & Care Coordination
- Reentry Community Services
  - formerly Offender Reentry Community Safety Program (ORCS)

SOR II COORP

Elements of services provided:

- Medication for Opioid use disorder (MOUD)
- Referrals to community providers to continue medication or to start medication after release
- Naloxone Kit when released along with education on how to administer

Identification of Individuals with Opioid Use Disorder

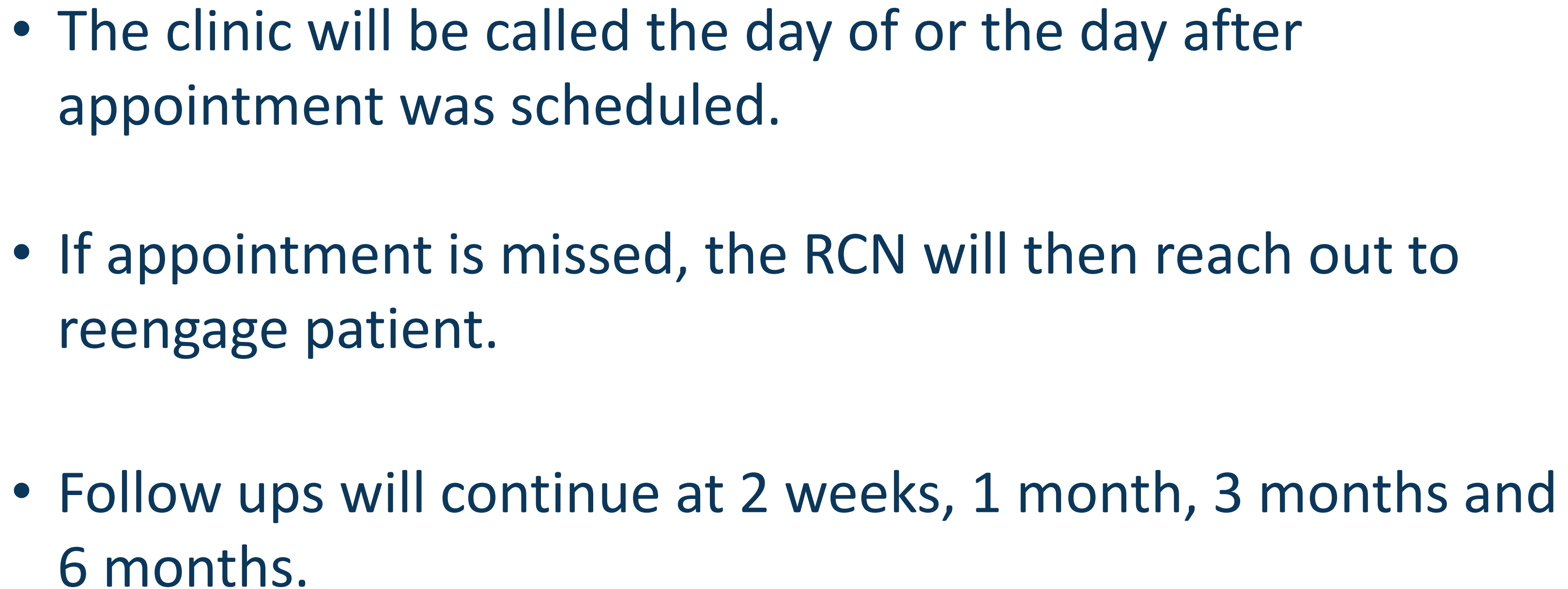


Role of the Reentry Care Navigators

Reentry Care Navigators (RCN)

- Meet with potential participant to determine interest in program
- Identify community resource needs including Substance Use Treatment (opioid, methamphetamine) services and establish referrals.
- Maintain communication with program participants, DOC staff, and service providers to ensure continuity of care
- Follow up with providers and participant after release

Follow up after release



Summary over the last two years (May 2019- May 2021):

Individuals started on MOUD:

- Prisons: 724
- Work Release: 143
- GRE/CPA (reentry programs): 10
- Total: 877

Community appointments:

- There have been 1,764 (recorded) community appointments scheduled out of a total of 2,116 client enrollments in the last 2 years.

Narcan Distribution:

- Prisons: 1,202
- Work Release: 113
- Total: 1,315 (recorded) kits distributed in the last 2 years

Community Linkage & Care Coordination

Provide reentry services, case management and housing to individuals living with HIV

- Comprehensive Assessment completed during incarceration
  - Education
  - Employment
  - Financial Information/History
  - Substance Use
  - Family/Community Support
  - Mental Health
  - Trauma History
  - Community Services Needs
  - Activities and Interests
  - Criminal History
  - Housing History and Goals

Community Linkage & Care Coordination

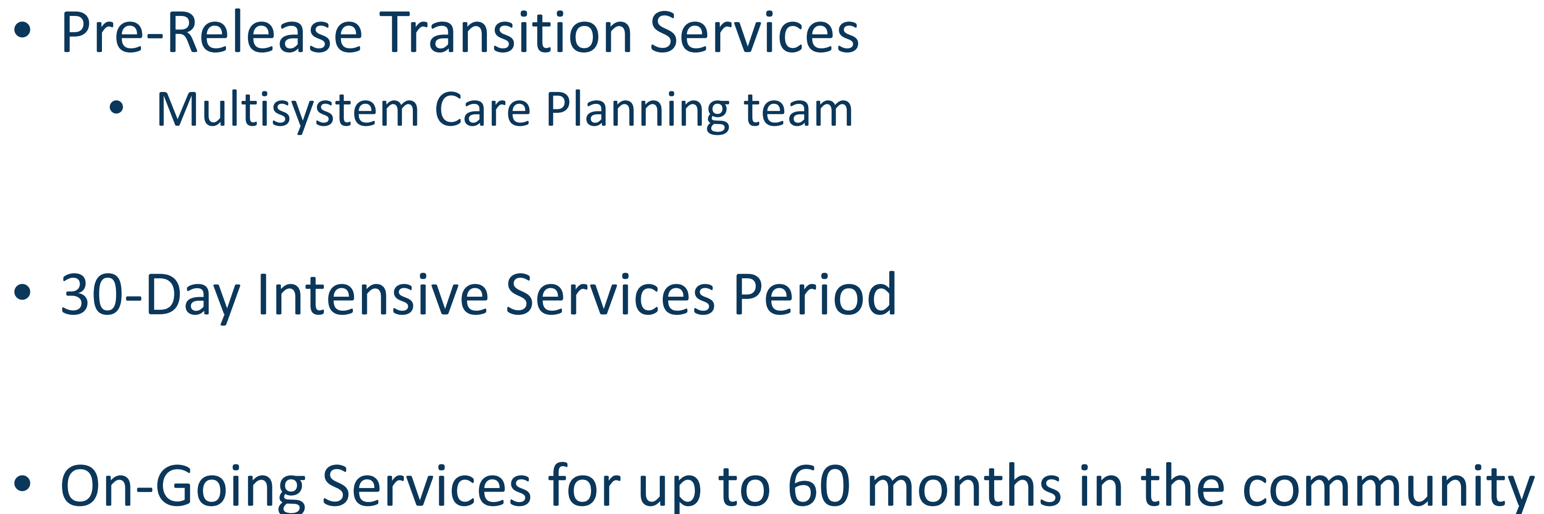
- Release planning includes as needed
  - Access to resources for essentials and other needs identified through the comprehensive assessment
  - Housing
  - Medical appointment scheduled and transportation to first community appointment
  - Healthcare set up and DSHS applications

- Support and assist patients with housing funding, up to 24 months with focus on access to long-term housing.

- Provide on-going support in the community:
  - Peer Navigators
  - Housing needs
  - Medical appointments
  - Other community resource needs
  - Connecting with Community Case Management Agency

Reentry Community Services

formerly Offender Reentry Community Safety (ORCS)



Pre-Release Transition Services

- Multi-System Care Planning Team (MSCPT)
  - Transitional Corrections Mental Health Counselor
  - Classification Counselor
  - Psychiatric Social Worker
  - Primary Mental Health Therapist
  - Psychiatric and Medical Provider (as needed)
  - Community Corrections Officer
  - Community Mental Health Provider
  - Other Community Partners as identified (Home & Community Services, Developmental Disabilities Administration, etc.)
  - Family, sponsor or other identified community supports

Transition Plan Components

Part I (Designee)

- Contacts and emergency numbers
- Housing information
- Transportation Plan
- Community Resources
- Treatment Plan Goals
- Hobbies/Activities
- 7-day Release Calendar
- Medication Information

Part II (Multisystem Care Planning Team)

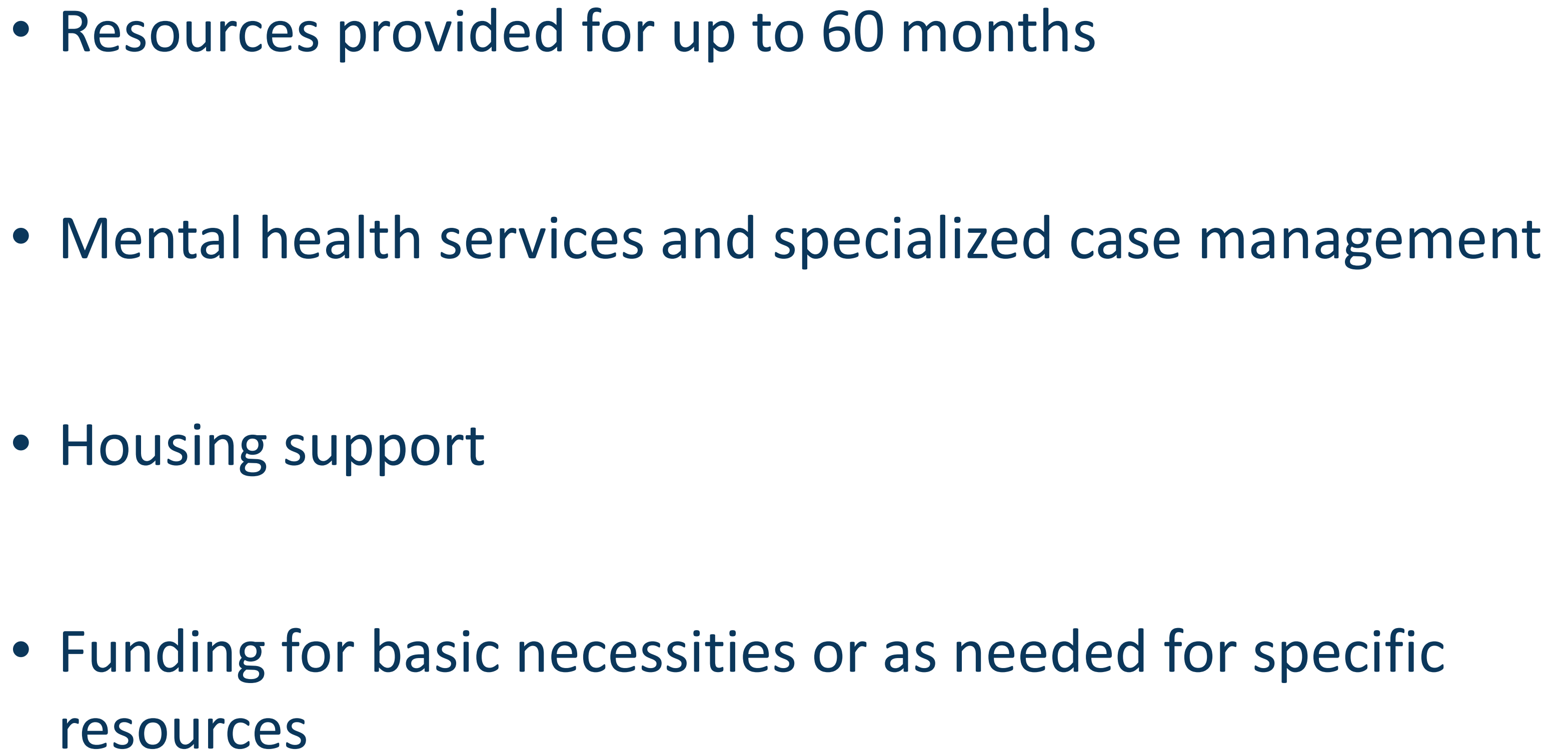
- Multisystem Care Planning Team Members
- Housing
- State/Federal Benefit information
- Release day transportation
- Signs of decompensation (symptoms)
- Adaptive equipment needs
- Substance use disorder information

30-day Intensive Service Period

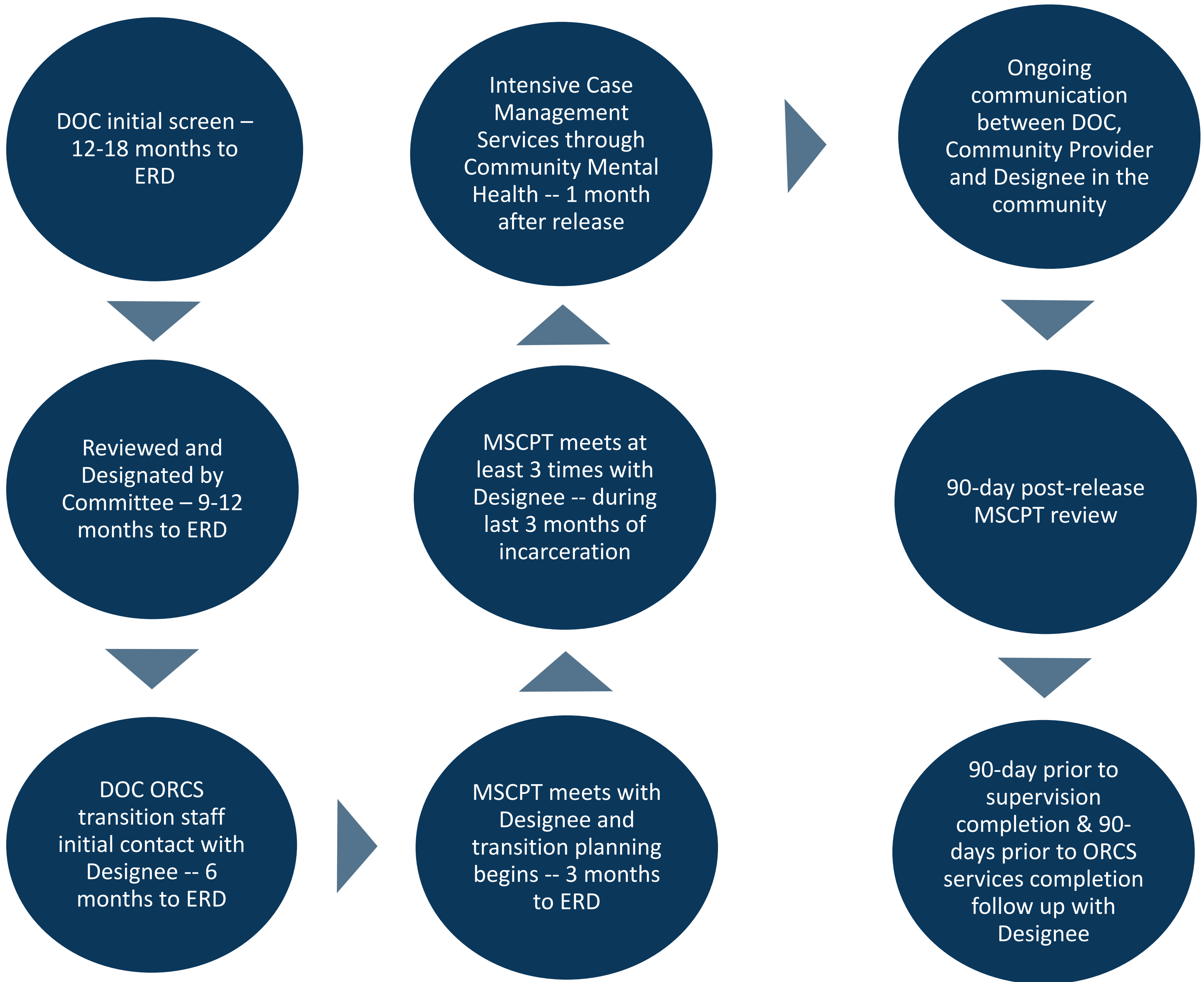
30-days following release to the community

- Follow the Transition Plan
- Establishment of housing and home environment
- Meet with mental health provider on day of release
- Release funds for: basic necessities (clothing, toiletries, food, bedding, phone, bus pass, etc.)
- Linkages to state and federal resources (DSHS, SSI)
- Intake to Mental Health Agency
- Development of Mental Health Treatment Plan (schedule, groups, activities)
- Medication evaluation
- Connection with all family/social/agency supports
- Frequent check-ins with community mental health, DOC and other supports

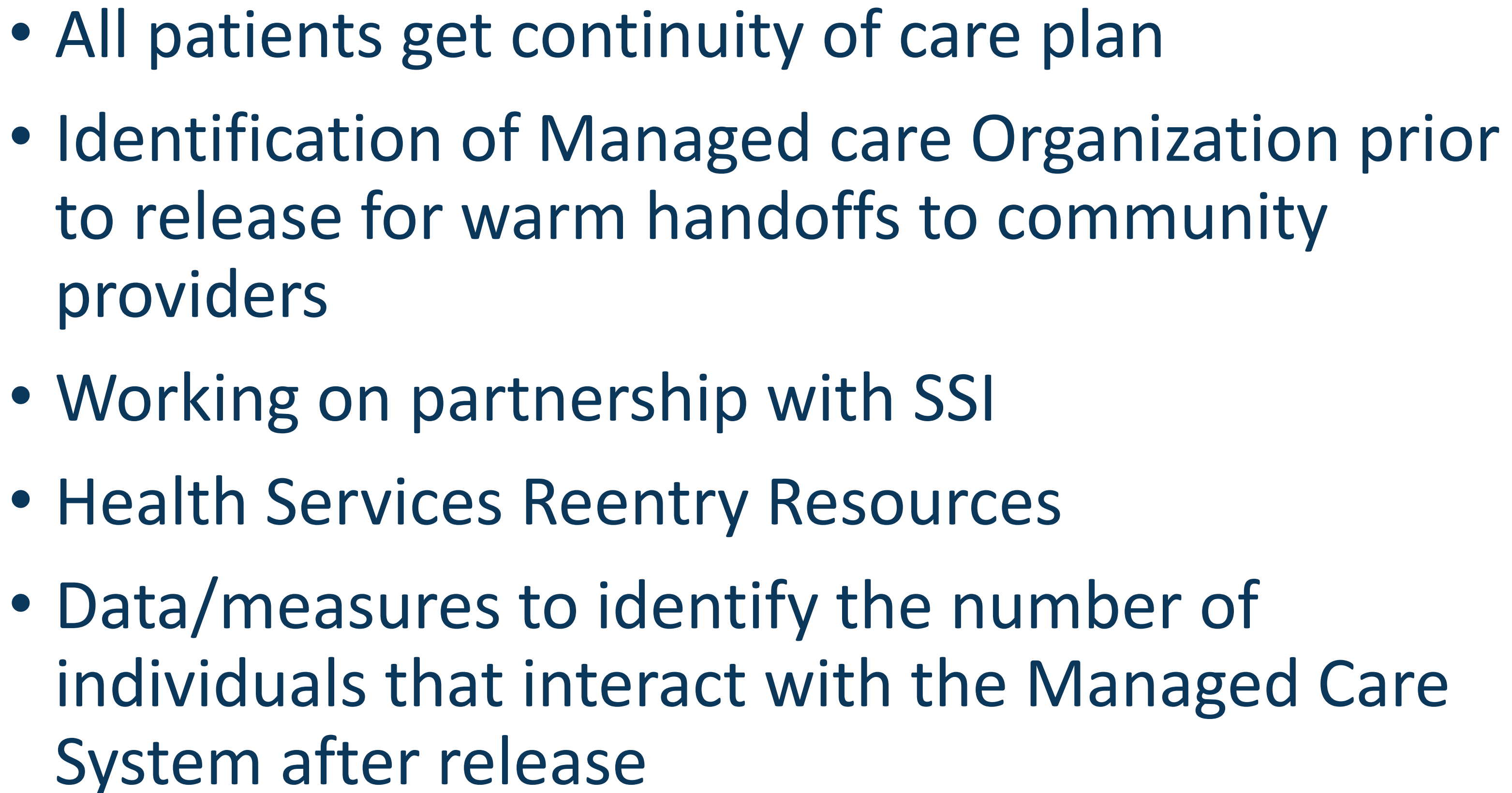
On-going Services



RCS Determination & Transition Timeline



Future State



- All patients get continuity of care plan
- Identification of Managed care Organization prior to release for warm handoffs to community providers
- Working on partnership with SSI
- Health Services Reentry Resources
- Data/measures to identify the number of individuals that interact with the Managed Care System after release