

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

Project 1: Develop an integrated health care setting within select county probation offices or Department of Corrections (DOC) parole offices to address beneficiary health care needs upon release and throughout the term of probation/parole for individuals transitioning out of incarceration.

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	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 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 within probation and/or DOC parole offices.	N/A
2	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.	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.
3	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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4	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
5	The practice should conduct a screening and assessment for both physical and behavioral health needs (including substance use disorder needs) during the individual's first visit to probation/parole unless the beneficiary declines a request from the practice.	Demonstrate that the practice has a protocol for performing and assessment and screening during the first visit.	N/A
6	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
7	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, and information on other support resources.	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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CC #	Core Component	DY 1	DY 2
		Practice Reporting Requirement for DSRIP Payment	Practice Reporting Requirement for DSRIP Payment
8	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. <hr/> Document protocols used for engaging these resources on behalf of patients and for referring patients to these resources.	N/A
9	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.
10	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.

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11	Participate in RBHA training and education.	Demonstrate that the practice participated in RHBA-provided training during the DY.	Demonstrate that the practice participated in each RHBA-provided training during the DY.



Strategic Focus Area: Justice System Coordination for Individuals Involved in the Juvenile System – DRAFT

Project 2: To be defined

Objective: To be defined

		DY 1	DY 2
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The DSRIP entity and individual practices participating in this strategic focus area will be held accountable for reporting their performance on a specified number of measures, to be defined by AHCCCS, beginning in DY2, and for improving their performance beginning in DY3. The measure list below includes measures under consideration for use at the DSRIP entity and/or practice level.

NQF #	Measures
0710	Depression Remission at 12 months
1884	Depression Response at 6 months
2605	Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other
0105	Antidepressant Medication Management
CMS	Screening for Depression and Follow-up Plan
0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
0576	Follow-up after Hospitalization for Mental Illness (7-day)
0018	Controlling High Blood Pressure
0061	Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mmHg)
0055	Comprehensive Diabetes Care: Eye Exam
0059	Comprehensive Diabetes Care: Hemoglobin A1c Poor Control (>9.0%)
0575	Comprehensive Diabetes Care: Hemoglobin A1c Control (<8.0%)
0062	Comprehensive Diabetes Care: Medical Attention for Nephropathy
1799	Medication Management for People with Asthma
0068	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic
NCQA/ 0421	Adult BMI Assessment <i>or</i> Adult Weight (BMI) Screening and Follow-up
0028	Tobacco Use: Screening and Cessation Intervention
0032	Cervical Cancer Screening
0034	Colorectal Cancer Screening
2372	Breast Cancer Screening