MA Recidivism

Carl Feldman
Executive Policy Specialist
Office of Policy Development

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Three Phase Implementation

Phase I	
Shortened/Expedited COMPASS Apps for returning citizens	11/16

Phase II	
Manual MA Suspension	5/20/17

Phase III	
Auto-Suspend & RTE for returning citizens	3/18

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Phase I

- DHS Intends to provide MA benefits to needy individuals released from incarceration with instantaneous enrollment
- The new process will increase the efficiency when applying for benefits for a returning citizen.

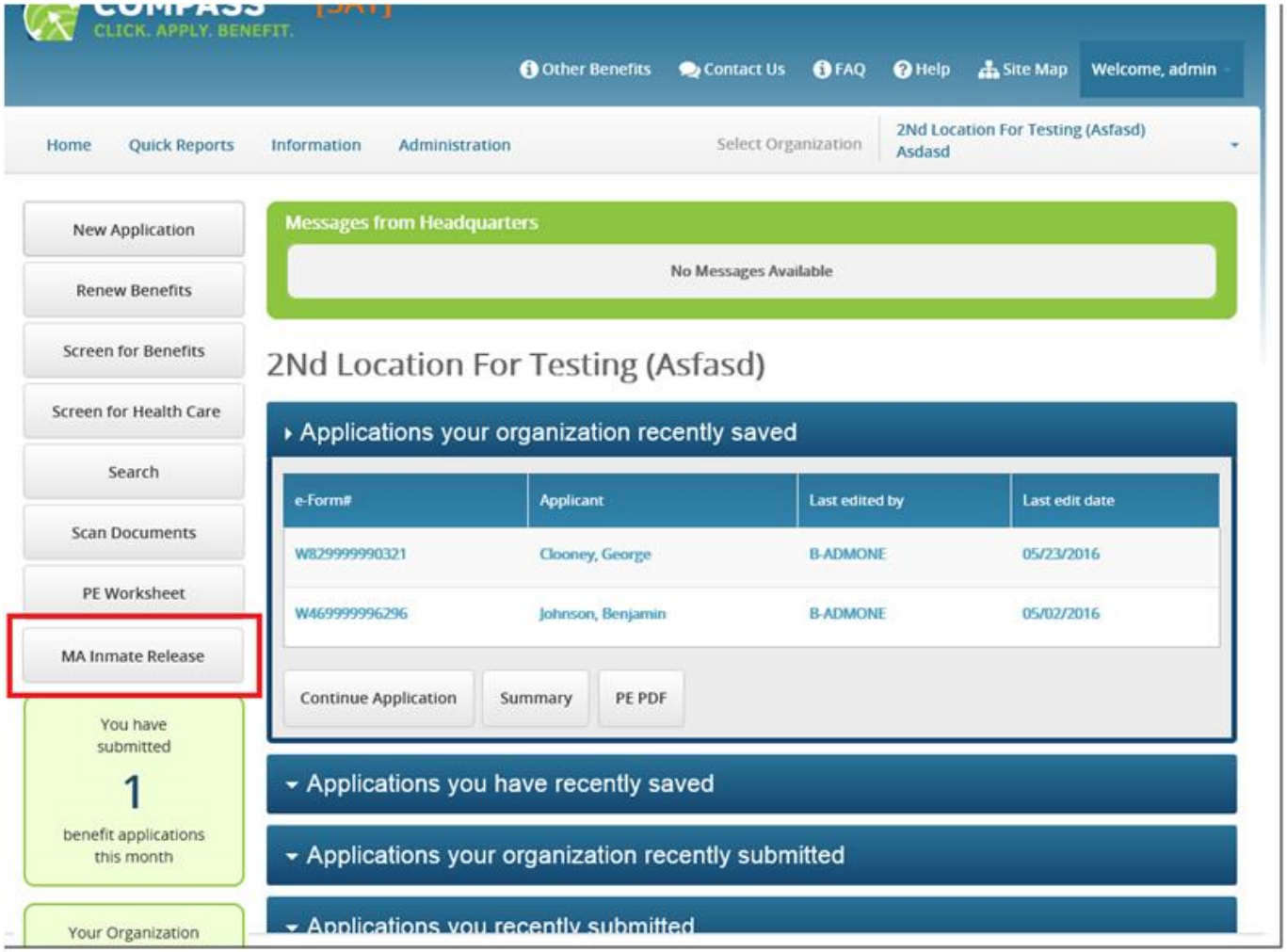
Shortened/Expedited MA Application

Phase I

Shortened/Expedited MA Application

- Inmates can have applications submitted on their behalf by the institution or by third parties on behalf of the inmate and the institution
- Applications must be submitted no sooner than 15 days prior to release date
- Applications should be submitted no later than five days prior to release date to ensure release date open
- Release date is the begin date
- Cards are mailed to location specified by inmate in the application

Phase I



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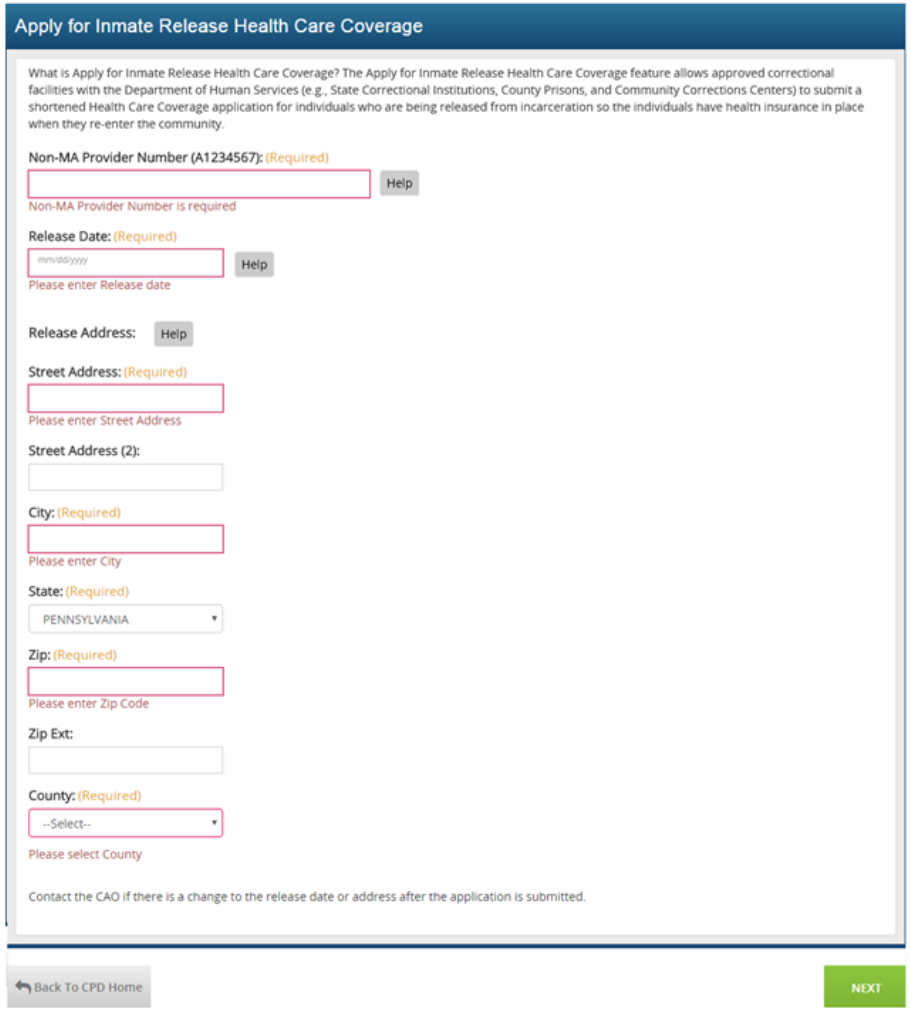
Phase I



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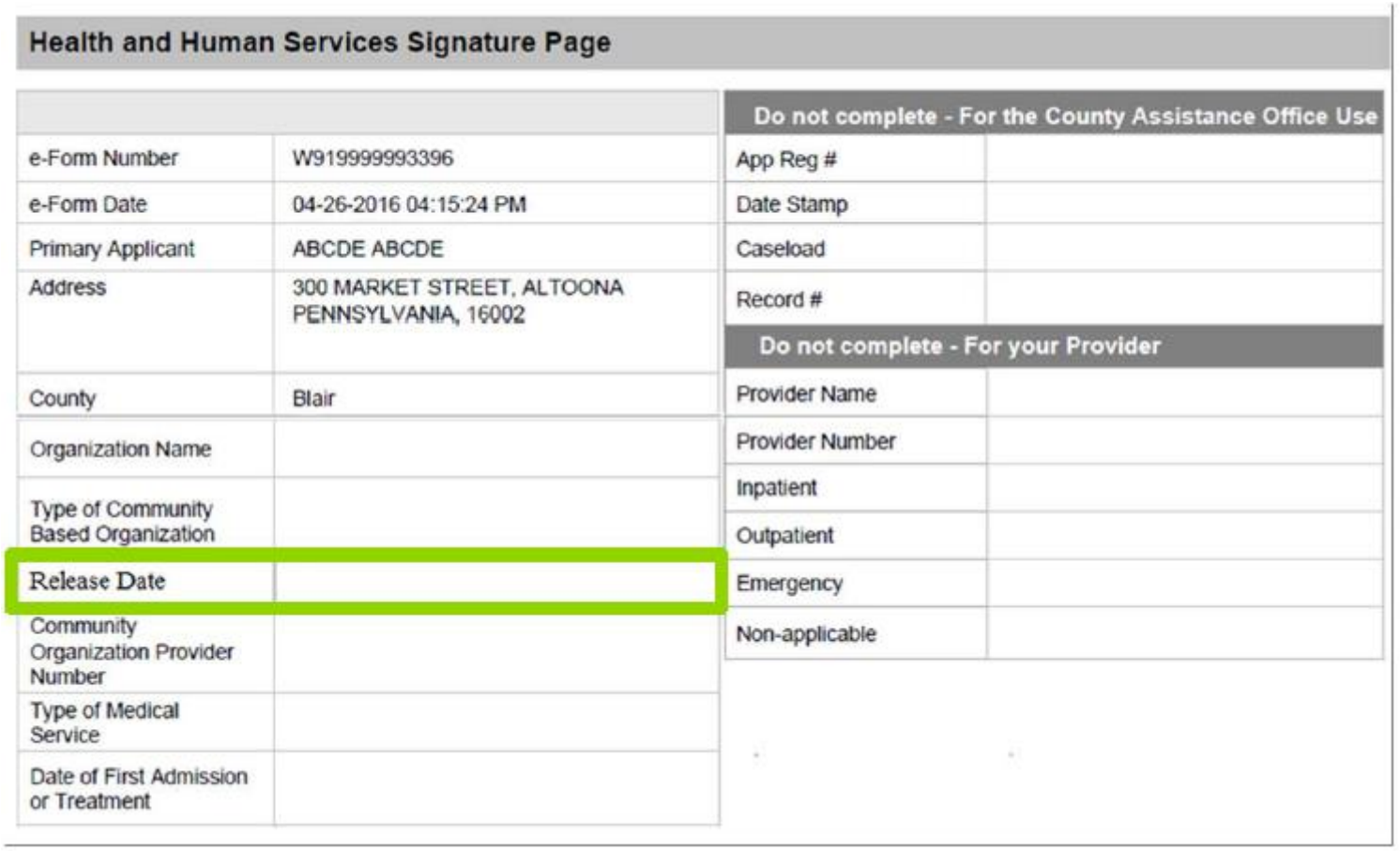
Phase I



Health and Human Services Signature Page

e-Form Number	W919999993396
e-Form Date	04-26-2016 04:15:24 PM
Primary Applicant	ABCDE ABCDE
Address	300 MARKET STREET, ALTOONA PENNSYLVANIA, 16002
County	Blair
Organization Name	
Type of Community Based Organization	
Release Date	
Community Organization Provider Number	
Type of Medical Service	
Date of First Admission or Treatment	

Do not complete - For the County Assistance Office Use	
App Reg #	
Date Stamp	
Caseload	
Record #	
Do not complete - For your Provider	
Provider Name	
Provider Number	
Inpatient	
Outpatient	
Emergency	
Non-applicable	

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Phase II

- Currently an individual's case is closed or the individual is removed from the household upon incarceration. It takes time to have the inmate's MA benefit reestablished causing them to miss out on urgently needed MH/substance use treatment
- This new process is to quickly reestablish the returning citizen's benefit and improve accuracy for DHS

Manual Worker Suspension

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Phase II

- Client's whose case is placed in suspend status will be suspended for a maximum of two years
- The case will be auto-renewed at 12 months and batch closed at 24
- The caseworker must request the reopen of the benefit a minimum of 15 days prior to release to release
- If release date changes open date can be adjusted

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Phase II

Worker gets JNET hit

If children in the household take steps to determine their whereabouts

If app is received or 10 days have passed take steps to authorize MG99 for the incarcerated individual

Phase II

If multiple member household designate incarcerated “Non-Mandatory Member” for SNAP/CASH

Worker updates facility placement information

Run eligibility and open in suspended category

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Phase III

- This established a direct file transfer with DOC to process inmate intake/release information on clients
- Uses this information to automatically suspend incarcerated individuals
- Uses this information to automatically un-suspend the benefit upon release
- Provides ACCESS number to DOC to enable same day benefit use
- Offers Real-Time-Eligibility (RTE) for MA applications from returning citizens who were not previously enrolled

Automated Suspension

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Phase III

MA status determined by DOC Intake; Seek approval to apply and review R&R

Open MA case is a suspended category

On release date case is run in RTE

Progress and Challenges

- Active Phase III process with DOC
- Discussions ongoing with PDP

- Phase II Challenges
  - Information completeness/timeliness
  - Sentenced vs. non-sentenced populations

- Solutions
  - Workers verify all county jail JNET hits
  - Ensure immediate benefit reopening with client contact

Questions

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Forensic Interagency Task Force Meeting Narrative

Department of Corrections Training Complex Elizabethtown, PA

7/24/18

This is the eighteenth meeting of this resumption of the Forensic Interagency Task Force(FITF) convened by FTAC with approximately 35+ attendees. The Attendees included: ????

Facilitator, Dave Dinich of Family Training and Advocacy Center, welcomed the group. He shared the question about how the term Seriously Mentally Ill is defined and accepted. He asked if there is a question about whether there are other definitions that might be shared. There is a plan to have the one established through some recent litigation with the DOC to be shared through this mailing list as well. It is attached, as forwarded, by one of our presenters, Lucas Malishchak He then asked attendees for self-introductions and a relating of new things that are happening in their areas of the Commonwealth from their varied perspectives.

Vivian Spiese, of FTAC and a CIT Presenter, noted that the annual Forensic Rightrs conference has been set for November 28, 29 at the Holiday Inn at Grantville. There is a call for presentations and a website application available to allow potential presenters to apply through that site. She also shared that the founder of CIT Training will be offering a Workshop at that event as well.

The First Agenda Item was a presentation from Carl Feldman, Executive Policy Specialist, Office of Policy Development, DHS with an update for the Compass Expedited Application Process for returning citizens. His presentation is entitled, ” MA Recidivism.” We requested a copy of this presentation and it is expected to be attached to this Narrative. He shared that the beginning of this process started with Act 76 in 2016, which intended to effect the suspension of MA

benefits while incarcerated and the beginning of the enrollment process as the inmate is reaching the end of his/her time before re-entry.

This involved a three phase initiation: A shortened Expedited Compass Application on 11/16, Manual MA Suspension by 5/17, and Auto-Suspend for returning citizens initiated by 3/18. These time frames were all achieved.

As to Phase one-the Shortened/Expedited MA Application. This was a process developed to be used before the final phase started previously this year. The Jail or another third party can achieve implementation of this process, so long as the organization has a non-MA provider number. The goal is that the inmate, upon the day of release, is given an ACCESS number to coincide with the release date in order to begin the successful enrollment/re-enrollment for benefits. It is based on the corrections facility code as a non-MA provider number. That number can be secured by contacting Carl's Office and requesting it. This involves a two page application—only for MA benefits, not SNAP or other benefits.

As to Phase two, the current practice of closing the MA case by the local Case Manager, can be manually changed to a suspension. This is done in order to rapidly reestablish the returning citizen's benefit and improve accuracy for the DHS. Prior to this, the guidance was to terminate the case, based on compliance with federal requirements that claims cannot be paid by MA for an enrollee while s/he is incarcerated. This allows for the person to remain an eligible MA beneficiary, but not currently receiving benefits. This suspension cannot last longer than 24 months based on federal guidance as well. If there is no information to the contrary during that time frame, the case must be closed after that point in time.

As to how it looks to the County Assistance Case Worker, there is a need to determine if there are children in the household with communication with them and the local CA Office. The facility placement information then is updated. This gives notice to the DHS to suspend claims payment for the individual while incarcerated. The children's benefits remain open during that time, while the DHS seeks to verify the children's caretaker(s) during this time of primary

beneficiary's incarceration. This is done to pull the incarcerated individual out of the process to assure that this benefit validity happens.

As to Phase three, this establishes a direct file transfer with the DOC to process inmate intake/release info on clients. This automatically suspends the benefit for the incarcerated individuals. If the incarceration is less than two years, the benefit can be effectively returned to active status on the day of release. The pharmacy can fill a prescription without an ACCESS card, with just a number. This is more challenging with the larger pharmacy providers. Smaller, local pharmacies seem to be more able to respond positively to this process at this point. The mailing address that is used is the one that is shared with DHS by the DOC facility. That will either be the hometown address or the County Assistance Office in the home community where the former inmate is expected to be living, if no home address has been established. There was a policy change from the DHS to the CAO's to allow for this to be acceptable as the address to be used by the County Assistance Office Caseworkers.

There was a question about what happens if a release date has to be changed. Mr. Feldman noted that it can be updated, so long as it is shared in the file from the DOC to the DHS.

The Real Time Eligibility(RTE) for MA applications is what makes this process work and the expediting of the eligibility to be effective.

Mr. Feldman agreed to share some of these policy statements with the FITF which can coordinate some of these practices.

There was question about the coordination of prescriptions with the applicable BMHCO for the county to which the individual is set to return to assure that there can be consistency in medications that are prescribed in the corrections system are to continue in the community. It was stated that the formulary within the DOC is, currently, confidential, and cannot be shared to help in assuring that continuity of care can be in place. This was questioned from a community BH advocacy standpoint.

The next stages of this process will be to help coordinate the exchange of information for all inmates in all jails in the Commonwealth to assist with these processes of benefits restoration. There are active discussions going on with the

Philadelphia Department of Prisons, specifically on the Active Phase three process.
It is also recognized that this is an additional amount of work being placed on the County Assistance Office Case Workers; but that it is recognized as being important, if not essential, to their successful return to the community and reduced rates of recidivism for those with BH problems.
There was a question about MA coverage for inpatient services received outside of the jail setting, even when the inmate will return to the jail. It was verified that this will be the case. There remains the semi-annual updating process with renewal every year. Of course, the individual's return initially will be in the fee-for-service MA program and then to the BMHCO in the next month.
There was a question about to whom the release, presented for signature to the inmate, should be made in these application situations. Mr. Feldman stated that he will gain clarification on this issue and will share it with the FITF when a response can be secured.

Next was a presentation from Lucas D. Malishchak, DBA |A/Director of the PA Department of Corrections Psychology Office on Update for the DOC Psychology Department regarding: "Changes in services, treatment options and case management relationships with County Forensic Personnel". He noted that he is in this position for about six months and that he replaced Dr. Marsh, who has moved on to become the Superintendent of a DOC facility in State College. He shared that in the past, there was no intention to have Social Workers in every DOC facility. While there were some exceptions, the overall responsibility for inmate transition upon re-entry is the responsibility of all involved with the inmate.

He started by asking if all are using the same definition of SMI. It was shared that there was a definition established through a Disability Rights Network through litigation a few years ago to address vulnerable individuals. He referred to the creation of a priority group within the Prison setting and that it might differ from that in the community. The Prison definition includes those with Personality Disorders. The prison definition was framed in the context of the disciplinary process with the DOC system. This involves the identification of individuals who

might meet the diagnostic definitions of mental illness, but who also have behavioral manifestations that get them into trouble, functional impairment, in that system. Thus, this includes all personality disorders which fall under that type of guidance. The goal is the safety of the other inmates and that of the staff. Functional impairment is one of four processes involved.
The next is Guilty But Mentally Ill(GBMI) as identified by the court, even before the person enters into the DOC facility or system. At times this designation can be spot on, and in others, it may not be. The decision was made to include all those designated as GBMI to be included on the D-Roster within the DOC system with safeguards that have been established.
The next is the designation of Intellectual Disability(ID). There are about 230 folks in the DOC system thus designated and who are treated with the same safeguards in place as for those with SMI. The assessment of ID within the DOC system creates a challenge in this context as well.
There seem to be about 55 diagnostics that can be seen as SMI both in the community as well as the DOC system.

Emerging Best Practices within the DOC, based on the DRN Lawsuit requirements, was his next set of topics. In the past the psychology department, would basically come by the prisoner in her/his cell and ask questions and get answers in the more or less non-confidential setting of the prison, with other prisoners in the area and able to listen in on them. There has been a new set of circumstances adopted since the lawsuit and the settlement agreement. There was a significant increase of staff in the DOC's, both in the areas of clinical support as well as the Corrections Officers. In addition, these services needed to be moved to a confidential setting which did not involve bars separating the inmate and the clinician.
There was also an intention to assess individuals who are in need of services beyond that of the typical Outpatient program. There are now Intensive Outpatient services, called the "Residential Treatment Units" in 14 of the 25 DOC sites which can serve individuals. This involves the delivery of mediations to those units as well as the offering of counseling/therapeutic services to that setting as well. There is also an effort to make these units "feel" like a treatment setting.

There are murals painted on the walls, versus the bare blocks of a standard Corrections facility.

In addition, there has been an intense training regimen of training the CO's in CIT to work with these folks who are in these Residential Treatment Units. That is forty hours in duration and held here at the Training Academy. This is augmented to include a focus on de-escalation.

There was a question about the offering of Mental Health First Aide to all 16,500 employees. This was completed, but the advanced training of CIT was especially important for the workers in the prison settings.

In response to a question about whether a stroke could place an inmate on the D-Roster. Mr. Malishcak shared that the diagnosis of having experienced a stroke does not place a person on the D-Roster. Rather the behavioral manifestations, such as wandering, might. He did note that Dementia is included as one of those criteria.

Thus, the importance of the D-Roster is not to get services from the community once the inmate is released. Rather it is intended to provide for better, comprehensive services within the DOC while s/he is there.

There was question about the assignment of Social Workers to every institution. It was shared that there were decisions reached within each of those institutions as to how the staffing would be arranged and what other staff would be hired to effect the changes required through the DRN Lawsuit compliance. Thus, there is no common definition of the responsibilities of the Social Workers that were assigned to all of the institutions. Rather, there is the intention to have them all work with Psychology and other aspects of the DOC setting to the best benefit of the inmate population, as a whole, and the D-Roster inmate specifically. It was also clarified that there are new hires who are still very new and still learning to become adept in that setting and others who are very seasoned and prepared to provide effective service support in their respective settings.

It was shared that there remain some challenges to recruiting these Social Work staff at certain locations—Forest SCI is one of those which has not, yet, been able to achieve that hire. Community Corrections now have social workers with three mental health representatives in each region as well.

It was also shared that Nurses and other team members who now receive CIT training within the DOC.

This presenter concluded, noting that there remains a need for Social Workers and Licensed Psychologists within the DOC. He has personally tried to establish an effective management structure for these additional staff members. Recently, he also has established a contracting out for psychologists. There was a recent time when there was a significant lack of Psychologists within the system and the need for Psychologist mangers. That happened in the process of the expansion of the D-Roster from 800 individuals to over 4500. They were sent to and one of the fourteen prisons across the Commonwealth. There were "Recruitment Corridors" created to help drive the efforts toward addressing these needs.
He also noted that Jeannine Christ, Lynne Patrone, LaCoste Mussoline, Kim Drum were the folks who might be best tapped for future presentations to the FITF as well, given their orientation to this population within the DOC.

Dave asked for suggestions for future topic and received several: The potential of having a housing update. The PRA implementation might be another topic with updates on addressing the lawsuit and the settlement timelines, etc. This might be met by a presenter form OMHSAS, such as Phil Mader. There is also a possibility that a representative from the C-CAP might be a good idea as well. Brinda Penyak of that organization agreed to seek a group of counties that might be ready to present at that time as well.

The next meeting of the FITF is scheduled for September 25, 2018 at 10:00AM on the DOC Training Academy campus.

Respectfully submitted,

Lloyd G. Wertz, FSS/FTAC

Definition of a Serious Mental Illness (SMI) Outline

A. Definition of Serious Mental Illness will include:

1. Inmates determined by the Psychiatric Review Team (PRT) to have a current diagnosis or a recent significant history of any of the ***DSM5 diagnoses (using ICD10 codes and letter tags):***

   a. Substance-Induced Psychotic Disorder (excluding intoxication and withdrawal)
   F10.159, Alcohol-Induced Psychotic Disorder, with mild use disorder,
   F10.259, Alcohol-Induced Psychotic Disorder, with moderate-severe use disorder,
   F10.959, Alcohol-Induced Psychotic Disorder, without use disorder

   Substance-Induced Psychotic Disorders employ the same specifiers (.159; .259; .959)
   With cannabis F12; sedative, hypnotic, anxiolytic F13; cocaine F14; amphetamine F15;
   other hallucinogen/ phencyclidine F16; inhalant F18;
   and other substance/unknown substance F19

   b. Schizophreniform Disorder ***F20.81***

   c. Schizophrenia ***F20.9***

   d. Delusional Disorder ***F22a, Erotomanic type***
   F22b, Grandiose type
   F22c, Jealous type
   F22d, Persecutory type
   F22e, Somatic type
   F22f, Mixed type
   F22g, Unspecified type

   e. Brief Psychotic Disorder ***F23***

   f. Schizoaffective Disorder ***F25.0, BIP type***
   F25.1, DEP type

   g. Other Psychotic Disorders
   F06.0, Psychosis due med condition w/ delusions
   F06.2 Psychosis due med condition w/ hallucinations
   F28 Other specified schizophrenia spectrum and other Psychotic Disorder
   F29 Unspecified schizophrenia spectrum and other Psychotic Disorder

   h. Bipolar I and II
   F31.0, BIP I, current or most recent episode hypomanic
   F31.11, BIP I, current or most recent episode manic, mild
   F31.12, BIP I, current or most recent episode manic, moderate
   F31.13, BIP I, current or most recent episode manic, severe
   F31.2, BIP I, current or most recent episode manic, w/psychotic features
   F31.31, BIP I, current or most recent episode depressed, mild
   F31.32, BIP I, current or most recent episode depressed, moderate
   F31.4 BIP I, current or most recent episode depressed, severe

F31.5 BIP I, current or most recent episode depressed, w/psychotic features
F31.71, BIP I, current or most recent episode hypomanic, in partial remission
F31.72, BIP I, current or most recent episode hypomanic, in full remission
F31.73, BIP I, current or most recent episode manic, in partial remission
F31.74, BIP I, current or most recent episode manic, in full remission
F31.75, BIP I, current or most recent episode depressed, in partial remission
F31.76, BIP I, current or most recent episode depressed, in full remission
F31.81, BIP II disorder
F31.9a, BIP I, current or most recent depressed, unspecified
F31.9b, BIP I, current or most recent episode hypomanic, unspecified
F31.9c, BIP I, current or most recent episode manic, unspecified
F31.9d, BIP I, current most recent episode unspecified

i. Major Depressive Disorders

F32.0, MDD, single episode, mild
F32.1, MDD, single episode, moderate
F32.2, MDD, single episode, severe
F32.3, MDD, single episode, w/psychotic features
F32.4, MDD, single episode, in partial remission
F32.5, MDD, single episode, in full remission
F32.9a, MDD, single episode, unspecified
F33.0, MDD, recurrent, mild
F33.1, MDD, recurrent, moderate
F33.2, MDD, recurrent, severe
F33.3, MDD, recurrent, w/psychotic features
F33.41, MDD, recurrent, in partial remission
F33.42, MDD, recurrent, in full remission
F33.9, MDD, recurrent, unspecified

NOTE: For the purpose of this definition, the term “recent significant history” shall be defined as “currently in existence or within the preceding three months.”

2. Inmates diagnosed by PRT with ***DSM5*** disorders that are commonly characterized by breaks with reality, or perceptions of reality, that lead the individual to experience significant functional impairment involving acts of self-harm or other behaviors that have a seriously adverse effect on life or on mental or physical health.

3. Inmates diagnosed by PRT with Intellectual Disability, a dementia, or other cognitive disorders that result in a significant impairment involving acts of self-harm or other behaviors that have seriously adverse effect on life or on mental or physical health.

4. ***Any inmate sentenced GBMI.***

B. Clinical Guidelines for Functional Impairment

Factors for consideration when assessing significant functional impairment shall include the following:

1. Whether the inmate has engaged in self-harm which shall be defined as a "deliberate, intentional, direct injury of body tissue with or without suicidal intent. Such acts include but are not limited to the following behaviors: hanging, self-strangulation, asphyxiation, cutting, self-mutilation, and ingestion of a foreign body, insertion of a foreign body, head banging, and drug overdose, jumping and biting themselves.

2. The inmate has demonstrated significant difficulty in his or her ability to engage in activities of daily living, including eating, grooming and personal hygiene, maintenance of housing area, participation in recreation, and ambulation.

3. The inmate has demonstrated a pervasive pattern of dysfunctional or disruptive social interactions including withdrawal, bizarre or disruptive behavior.

C. Intellectual Disability

Inmates scoring 70 or below on the ***BETA-III*** will be administered an individual IQ test (***WASI-II*** or WAIS-IV) at the parent facility. ***If their WASI-II IQ is 70 or below then a full WAIS-IV will be administered. If this WAIS-IV comes out to*** 70 or below, a measurement of adaptive behavior including the following will be assessed:

1. Conceptual skills – language and literacy; money, time and number concepts; and self-direction.

2. Social Skills – interpersonal skills, social responsibility, self-esteem, gullibility, naiveté, social problem solving, and the ability to follow rules/obey laws and to avoid being victimized.

3. Practical Skills – activities of daily living (personal care), occupational skills, healthcare, travel/transportation, schedules/routines, safety, use of money, use of telephone.

NOTE: An assessment to determine if the disability originated during the developmental period should be conducted to establish if the intellectual and adaptive deficits were present during childhood or adolescence. This assessment should include corroborative information obtained from complementary reliable and valid sources, which reflect functioning outside of the prison setting. Additional factors to take into account include the community environment typical of the individual's peers and culture, linguistic diversity, cultural differences in the way people communicate, move and behave. Assessments must also assume that limitations often coexist with strengths, and that a person's level of life functioning will improve if appropriate personalized supports are provided over a sustained period.

F70, Intellectual Disability (Intellectual Developmental Disorder) mild = 50/55-70
F71, IDD, moderate =35/40-50/55
F72, IDD, severe =20/25-35/40
F73, IDD, profound =<20/25
F74, IDD, severity unspecified