

REPORT TO THE LEGISLATURE
Pursuant to P.A.124 of 2007
Section 406(2)
Minimum Standards for the Michigan Prisoner ReEntry Initiative (MPRI):

Introduction

The following is a status report on the development of minimum standards for the Michigan Prisoner ReEntry Initiative (MPRI) as required by the Fiscal Year 2008 appropriations law. These requirements from the Legislature pertaining to standards are found in Section 406.1 and 406.2 and state as follows:

Sec. 406 (1) By December 1, 2007, the department shall develop uniform minimum standards for MPRI sites and the expenditure of MPRI funds, including funds appropriated for prisoner reintegration programs. At a minimum, the standards shall address all of the following:

- (a) The acceptable range or ranges for administrative costs*
- (b) How local program results are to be reported and quantified*
- (c) The acceptable range or ranges for per-participant expenditures*
- (d) Procedures for referral and follow up by the department on the status of referrals to substance abuse treatment, health care, and mental health treatment*
- (e) Any other standards determined by the department to be consistent with good management practices and optimum program results*

(2) By March 1, 2008, the department shall report to the senate and house subcommittees on corrections, the senate and house fiscal agencies, and the state budget director on the standards required by subsection (1). The report shall include information explaining how each standard was determined and how it is being implemented. The department shall implement these standards after review by the senate and house appropriations subcommittees on corrections.

The Michigan Department of Corrections and our local partners are moving MPRI from its current statewide status to “scale” in Fiscal Year 2010 so that no later than October 1, 2009 every prisoner who enters the system will have the benefit of the MPRI Model. Our goal is that by January 1, 2011 the Initiative will cease to exist as a project and will simply be the way we do business. In order for the Model to be fully implemented, MDOC has engaged in a process to interpret the Model for all of our policies, procedures, programs and funding streams and have a clear and productive line of communication from the top of our agency to the field where much of the work of prisoner re-entry takes place. Additionally, MDOC is currently dedicating significant resources with our partner departments (Department of Labor and Economic Growth, Department of Education, Department of Community Health, Department of Human Services) so that they too can become clear on how to use their resources, policies, and practices to take MPRI up-to-scale within their departments.

Our challenge is to simultaneously change the way we do business to achieve the mission of MPRI, while assuring that every new process is accountable and effective as required in the FY2008 appropriations law. As the Office of Offender ReEntry (OOR) and our partners work to take MPRI up-to-scale, we have engaged in a continual, stringent process of quality assurance. Because of our commitment to continual quality improvement, OOR regularly improves the policies, procedures, and standards of MPRI and makes modifications as necessary to increase its accountability and effectiveness.

As part of MDOC’s commitment to quality and meaningful collaboration with local partners, OOR convened local MPRI stakeholders to ask for their input into minimum standards as well as additional methodology that will help us move from minimum standards to continuous quality improvement. This statewide workgroup has been charged with synthesizing input from stakeholder surveys, focus groups, and other local partners to make recommendations for improving MPRI’s Comprehensive Planning and Community Development System. Their recommendations are due in April 2008 and will be used to redesign the Comprehensive Planning System for FY2009.

MPRI Minimum Standards

Minimum standard for the acceptable range of administrative costs: 10-20% of the total cost of the contract.

Rationale

The administrative fees associated with MPRI align with standard practice for government-funded contracts. Working with MDOC's Bureau of Fiscal Management, OOR assessed the current administrative fees in re-entry related contracts. During this assessment, OOR found that most administrative fees were approximately 10% of the total cost of the contract.

Through MPRI's local Comprehensive Community ReEntry Plans, MDOC has established an expectation that the funds available through MDOC to support the successful transition of offenders back home must be used to leverage existing community-based resources and other sources of funding for the local Plan. When a contractor is using MDOC funds to acquire other sources of funding for their local MPRI Comprehensive Plan and can adequately justify the use of MDOC funds to administer these supplemental grants or revenue sources, then an increase in the administrative fee is approved. In some instances, the administrative fee is 11% - 20% of the total contact cost. This practice provides an incentive to contractors to seek other sources of funds to support their projects and allows for a locally-based assessment of the resources required to administer these additional resources. Because of this practice, in FY2008, contractors reported over \$13M in additional funding to support the local implementation efforts of MPRI.

Implementation of the Standard

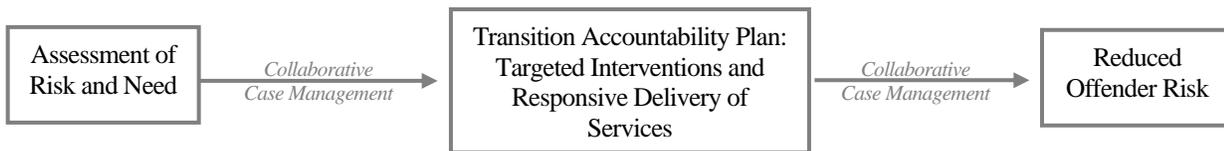
As each contract is renewed during FY2008, the administrative fee will be set at 10% for all re-entry related contracts. Exceptions to this standard will be made if the contractor's justification is adequate and results in additional resources to enhance public safety.

Minimum standard for reporting program results: Local program results are reported and quantified monthly using an OMNI-compatible spreadsheet (Attachment A) that codes the MPRI-funded services delivered to each offender.

Rationale

The MPRI Model is based on research that states that if criminogenic needs are resolved, then an offender’ risk of re-offending will decrease. The service areas included in the MPRI Data Collection Spreadsheet capture local programming responses to an offender’s criminogenic needs associated with reducing his or her risk of re-offending. MDOC developed these categories for reporting local program results in 2006 with local MPRI partners, and they are also reflected in the service areas funded through MPRI Comprehensive Plans.

Figure 1. Basic MPRI Logic Model



MDOC tracks the impact of MPRI through an ongoing study of MPRI cohorts that is reported to the Legislature pursuant to Public Act 331 of 2006 Section 406 (1), (2) & (3), Section 408 & 409, Section 1008 (1) & (2), and Section 1009. A summary of this analysis can be found in Attachment B, and more detailed information on the impact of MPRI can be found by following the link:

http://www.michpri.com/uploads/Reports/09-30-07_MPRI_Quarterly_Statue_Report__Addendum_215129_7.pdf

Implementation of the Standard

MDOC has continued to work with local partners to refine the quality of data captured in the MPRI Data Collection Spreadsheet. From the initial design of the spreadsheet, the intention of the spreadsheet was to be a preliminary mechanism to collect data until OMNI was web-enabled and local partners could use the OMNI interface as a case management tool, and managers and administrators could use the data collected to assess local program performance. MDOC has been working with the Department of Information Technology (MDIT) to web-enable OMNI for the last two years; however, barriers continue to persist to prevent the completion of this task. Once OMNI is web-enabled and partners are trained, the quality of data available to assess local program results will improve, and MPRI will become a data-driven system because it will possess the ability to “self-correct” as additional data is made available in real-time.

Minimum standards for the acceptable range of per-participant expenditures: Because services are delivered through a tailored plan based on the risk and needs for each individual offender, the minimum standard for the range of costs for services per participant is \$0.00 - \$20,000.

Rationale

The MPRI Model is founded on evidence-based principles of effective practice¹ which state that interventions are most effective when targeted at an individual's risk and need. Because of MDOC's commitment to implement an evidence-based, risk-reduction model of effective practice, each offender processing through MPRI is assessed using the COMPAS risk and need assessment tool. Then a Transition Accountability Plan (TAP) is developed with each offender based on his or her individual needs. Upon release, the individualized TAP is implemented.

The range of services provided to each participant is responsive to their risk and needs and therefore varies widely. The minimum standard for the range of cost per MPRI participant is typically \$0.00 - \$10,500. This range includes the costs for offenders with severe and persistent mental illness that participate in the MPRI Mental Health Demonstration Project. Medically fragile offenders with severe and chronic medical conditions will also be served by MPRI in 2008. The minimum standard for the range of per-participant costs will be established as \$0.00 - \$20,000.

Another way to track the costs of MPRI is by calculating the average cost per MPRI participant. Currently, the average cost for standard MPRI participants is approximately \$2,000. For offenders with mental illness participating in the MPRI Mental Health Demonstration Project, the average cost per participant is approximately \$7,000.

Implementation of the Standard

Currently, parolees without health insurance are referred to public health agencies to access the healthcare resources that are available to all other indigent community members. While parole agents take the lead in making these referrals, MDOC does not currently provide specific, dedicated funding for returning prisoners to manage their healthcare needs, and often parolees are left to coordinate and fund their own care. MDOC will expand on this minimum standard so that parolees have greater access to healthcare to meet their often chronic medical needs.

Through the Michigan Prisoner ReEntry Initiative (MPRI), MDOC has been piloting a re-entry healthcare program in partnership with the Muskegon Community Health Project (MCHP). This purpose of the pilot is to develop the referral and aftercare processes associated with establishing a medical care network for parolees with severe and chronic medical conditions through centralized administration in collaboration with local partners.

In August 2007, MDOC expanded this project to include a dozen medically fragile prisoners that were returning home to all parts of Michigan to examine the expansion of this preliminary system and test its statewide infrastructure. While the average per-participant cost is high, the costs of community-based care is significantly less expensive than providing care during incarceration. In 2008, MDOC is developing a statewide project to support the transition to the community for medically fragile prisoners based on what was learned during the pilot project.

¹ National Institute of Corrections. Implementing Evidence-Based Practice in Community Corrections: The principles of effective intervention. <http://nicic.org/Library/019342>

Minimum standard for referrals to substance abuse treatment: Access to MDOC funded residential substance abuse treatment programs is restricted to cases for which such treatment has been pre-approved by the Substance Abuse Services Section (SAS). If SAS determines that residential substance abuse treatment is not justified, the offender is then referred to outpatient or other available alternatives.

Rationale

A centralized, standardized screening for referrals into residential substance abuse treatment ensures that the limited resources available for this intensive intervention are maintained for offenders with the greatest need.

Implementation of the Standard

Both Field Operations Administration and the Office of Offender ReEntry have described this referral process in memoranda that have been distributed statewide to ensure consistency. These memoranda are included in Attachment C. Additionally, a draft policy describing the process for managing waiting lists for substance abuse treatment is also included in Attachment C. This policy is currently being reviewed and refined before Department-wide adoption.

Minimum standard for referrals mental health treatment: The Parole Board refers prisoners with mental illness diagnoses into the MPRI Mental Health ReEntry Project. Once placed in the program, an extensive community-based aftercare plan is reviewed by the parole board and if approved, the prisoner is granted a parole.

Rationale

MDOC created the MPRI Mental Health ReEntry Project that utilizes the expertise of Lifeways Community Mental Health Authority to provide targeted case management and mental health treatment services for prisoners with mental health disorders as part of a seamless transition to the community. The project works with prisoners who have a diagnosis of mental illness by preparing a detailed Transition Accountability Plan (TAP) which describes how their needs for treatment and aftercare will be met upon release from prison.

Implementation of the Standard

Key steps in the referral process include the following:

- During the Parole Board interview, Board members determine that the prisoner with a mental illness diagnosis could be suitable for parole if the Board could be reasonably assured that the prisoner would receive the necessary treatment and supportive services. Board members can refer a prisoner to the Mental Health ReEntry Project by deferring a parole decision pending the development of a detailed TAP that describes the aftercare plans for the prisoner.
- The prisoner is then transferred to a designated correctional facility where the Transition Team, which includes members of his or her institutional treatment team and staff from the Lifeways develop the TAP including provisions for suitable residential placement, medication and other mental health treatment, and necessary supportive services.
- Upon completion, the TAP is forwarded to the Parole Board for its consideration. If the Board finds the Plan to be suitable, members may then vote to order a parole. If the Board is not satisfied with the Plan, members may vote to issue a continuance in which case the prisoner continues to serve his or her sentence in prison.
- If a parole is issued, Lifeways, the case management agency, continues to work with the prisoner and his or her community-based Transition Team, including the supervising parole agent, to ensure that provisions of the Plan are fully implemented immediately upon the prisoner's release to the community.

Minimum standard for referrals to healthcare for medically fragile offenders: As stated above (page 4), currently, the minimum standard for parolees without health insurance is to be referred to public health agencies to access the healthcare resources that are available to all other indigent community members.

Rationale

MDOC will expand this minimum standard in 2008. We are currently in the process of developing a statewide project for medically fragile offenders with severe and chronic healthcare needs that expands on a pilot project operated by the Muskegon Community Health Project (MCHP). A description of the pilot project is provided below:

In-Reach

The MCHP and/or its contractors conduct an initial “in-reach” to perform the following functions:

- Secure the medical record
- Conduct a Needs Assessment
- Determine calendar/release
- Identify “home” (what county- community)
- Provide benefit enrollment support

The Central navigation staff track all of the processes identified and develop reporting mechanisms for MDOC.

Centralized Enrollment

The MCHP centrally screen each parolee for eligibility in the following programs, develop applications and submit for assistance:

- Medicaid (including case management and physician documentation for CHORE services)
- Social Security benefits (using the SOAR evidence based practice)
- Veteran’s medical assistance, as well as any other benefits, including housing, nursing home and transportation assistance
- Food Stamp Program
- Pharmaceutical Assistance
- Adult Benefit Waiver
- Replacement of vital records/government based identification
- Inter-Tribal Council medical and other services for Native Americans
- Other – based on special needs

The Centralized Referral and Enrollment staff submit and monitor all applications and provide specialized enrollment support, especially in the area of applications for Social Security and Medicaid benefits. Specialized support through a single point of service reduce costs and result in higher success rates as seen through the implementation of the SOAR program for the application of Social Security benefits.

Medical Home Referral

The MCHP identifies medical homes for referral of parolees. The MCPH and its network use the 27 federally qualified health centers with 126 services sites and the 3 federally qualified health centers (look-alike) with 13 service sites, the Blue Cross free clinics, the Michigan 2007 Medicare Participating Provider/Suppliers – Rural Health Clinics and the donated medical practice models and hospitals. A portion of the funds available to each parolee is offered to providers in the event that the parolee is not immediately eligible for SSI or other government programs providing reimbursement for care. The payee is responsible for the payment of services and the payee is monitored by the MCHP. Every parolee is placed into a medical home in his/her home community. Medical homes will be determined based upon accessibility, appropriate services and demonstrated use of best practice models for disease management.

Local (Community Based) Navigation

The MCHP has entered into a unit-based subcontract with locally functioning health care consortia/networks that are able to develop and administer local navigational programs for parolees. Local navigators consist of community health workers who are responsible for locally-based advocacy and support to the parolee. Where possible this infrastructure will cover a regional area. Each navigator:

- Works with the medical home on behalf of the central system and parolee
- Helps coordinate support services to the parolee including housing, transportation, etc. Once housing is identified, the local navigator will assist in the negotiations of the rate and provide such information as needed for the MCHP to develop a contract for the housing
- Integrates him/herself into local MPRI activities (where possible) and access support community services through these networks

The local navigators ensure that:

- Appointments are kept
- Notification to MCHP of specific medical needs that will require additional contracts, i.e. physician services may need to be paid until the parolee is Medicaid eligible. The local navigator will negotiate for the best price and submit its recommendations to the MCHP for the contracted services
- Pharmaceutical assistance is in place
- Ensure that other medical services are in place
- Data is entered about the physical and dental health status of the parolee on a web based electronic record
- Link the parolee with faith-based organizations
- Link the parolee with education programs for disease management
- Meet with the parolee in their housing at least once per month to ensure that care is being adequately provided and that the contract requirements are being met by the provider of the housing

Support Services

MCHP enter into unit-based contracts with a contractor able to *supply housing with medical support* for parolees unable/unwilling to receive such care at home. The type of housing is based on the treatment needs identified in the initial assessment. The contractor will supply nursing home beds and other appropriate facilities for stabilizing the parolee's health.

The MCHP provides limited funds via contracts with local physicians or durable medical suppliers until benefits are in place to reimburse for such services. MCHP through its central navigational staff identify special need cases for additional *wrap-around* including: HIV/AIDS; native and minority populations; those with mental illness and substance abuse history.

Implementation of the Standard

Following this pilot, MDOC is prepared an RFI that has been posted to help guide the Department in the development of a statewide process to ensure medically fragile prisoners have the healthcare services they will need when they parole. The Department is seeking a qualified vendor to coordinate statewide services for medically fragile parolees.

The purpose of the Medically Fragile ReEntry Project is to provide targeted case management services for medically fragile individuals upon their release into the community. This program is intended to reduce the number of medically fragile prisoners past their ERD by establishing services allowing them to be safely released to the community where their healthcare needs and public safety restrictions can be addressed. Often when a prisoner is released with these healthcare needs, he or she is eligible for Medicaid and, coupled with funding for community health care under this project, form the funding base for the Medically Fragile ReEntry Project.

ATTACHMENTS

Attachment A: Local Data Collection Spreadsheet

The following describes the fields that are currently part of the MPRI Data Collection Spreadsheet that local sites use to report program results.

- **Offender Name:** Field is automatically populated with an offender's name when an MDOC # is entered.
- **MDOC #:** Field for an offender's 6-digit identification number.
- **Date of Birth:** Optional field provided to sites.
- **Parole Date:** Optional field provided to sites.
- **Service Group:** Field consists of a drop down menu in which to specify an offender's service group. Choices are as follows: CRP, IRU, Max Out, MPRI, Parolee Increased Risk, TRV/IDRP
- **County:** Refers to the County in which the offender is being supervised.
- **Program Name:** Name of the service provider. Provider Names are presented in a drop down menu format. Providers are linked to the county selected in the prior field.
- **Program Type:** Refers to the area of service. Program Types are presented in a drop down menu format and are linked to specific program names. Examples: Employment, Shelter/Residential, Mental Health/Counseling, Substance Abuse Treatment, etc.
- **Service Type:** Describes the type of service being provided. Service Types are presented in a drop down menu format and are linked to Program Type. I.e., Program Type of Shelter/Residential – Service Types would include: Transitional Housing, Supportive Housing, Commercial Placement, Housing Assistance/Payment, etc.
- **Referral Date:** Initial date when an offender was referred to a provider.
- **Enrollment Date:** Date when a service began and/or was received.
- **Termination Date:** Date when a service was completed and/or terminated.
- **Termination Reason:** Field that contains a drop down menu of possible termination reasons. I.e., Absconded From Program, Absconded From Supervision, Death, Discharged from Supervision, Medically Ineligible, Poor Attendance, Refused to Participate, Successful Completion, etc.
- **Other:** Open field provided to sites for miscellaneous notes



Michigan Prisoner ReEntry Initiative

QUARTERLY STATUS REPORT

Pursuant to Public Act 331 of 2006
Section 406 (1), (2) & (3), Section 408 & 409,
Section 1008 (1) & (2), and Section 1009

December 6, 2007

Revision Log follows Table of Contents

F) PA 331, Section 406(2): Characteristics of Prisoners Enrolled in the MPRI

(UPDATE THROUGH 8/31/2007) Public Act 331 of 2006, Section 406(2) required that the department provide quarterly reports on the status and recidivism levels of offenders who participated in the MPRI and have been released, including a breakdown by the following offender types: drug, other nonassaultive, sex, and other assaultive.

The follow up of MPRI-related offenders who are released to the community is being done by systematically tracking individual offender release cohorts since the MPRI is being implemented in stages to build toward the full MPRI Model. For example, the Intensive ReEntry Units (IRU's) that were implemented in 2005 are actually "precursors" to the MPRI because while they serve as a testing ground for some MPRI practices, they had not implemented the full MPRI Model.

Similarly, the activity for the first and second rounds of official MPRI pilot sites has been concentrated on Phases II and III of the MPRI Model because the new, dynamic risk/needs assessment instrument (COMPAS) that is the lynchpin of Phase I at the point of reception into prison has not been fully implemented yet. Thus, as each cohort of MPRI-related cases transitions to parole with the escalating benefit of the MPRI Model in place, it is expected that progressively improving recidivism outcomes will be apparent.

In recognition of variable failure rates among offenders with different characteristics, and in light of the fact that the prisoners chosen for the MPRI by the Parole Board tend to be moderate to high risk for re-offense, the Office of Research and Planning has now developed matched comparisons, rather than just continuing to compare all cases to the overall baseline. While this complicated undertaking will continue to be refined, Office of Research and Planning analysts have already determined that the two most significant factors identified so far in the

differentiation between parole outcomes are a history of previous return to prison as a parole violator and county of release.

In the case of county of release, the differentiation is likely driven by local prosecutorial charging and plea bargaining practices as well as local issues such as economic/employment and housing prospects within depressed areas. The formal MPRI evaluation will eventually include examination of local community dynamics such as these.

In the case of history of prior parole failure, supplementary analysis of the 1998 baseline recidivism data shows that parolees who have a history of being returned to prison as parole violators (for either technical violations or new sentences) have a 24% greater likelihood of again failing on parole when next released, compared to parolees with no prior history of parole failure. This is consistent with the risk principle, wherein if the risk, needs and strengths of past violators are not adequately addressed before again returning them to the community, then more often than not they will continue to fail until something changes. This repetitive cycle of misbehavior is precisely what the MPRI is designed to stop – via its features of dynamic risk assessment, transition accountability planning, program intervention and community in-reach in advance of the next release.

As proof of performance that the MPRI is targeting offenders who are otherwise likely to fail on parole, 68.3% of the MPRI and IRU cases paroled through August of 2007 had a history of prior parole failure, while only 34.5% of the 1998 baseline paroles had a history of prior parole failure. **When controlling for history of prior parole failure, the overall MPRI/IRU recidivism outcomes through August of 2007 currently show a 26% improvement in total returns to prison against the 1998 baseline (across all of the release cohorts as a group.) This translates into 400 fewer returns to prison so far when compared to baseline expectations (a numerical reduction that will grow considerably if these results are sustained over a full two-year follow-up period for all cases.)**

Table 3 shows the more detailed status and recidivism levels of the first ten offender release cohorts as of the end of August 2007. It is important to recognize that adequate follow-up time must pass before reliable recidivism outcomes can be established, since relatively few offenders are returned to prison during the first several months following release. As of the end of August 2007, only the first 248 IRU cases who paroled in 2005 had been released long enough to enable a full two years of follow-up, and this is only 3% of all MPRI/IRU releases to date.

Table 3: Quarterly Status/Recidivism Levels of Released MPRI-Related Participants

	Number of Cases To Date	Number Released Thru 8/31/07	Returned to Prison Thru 8/31/07		Baseline Returns Expected Within period		Improvement So Far Against Baseline	
			Number	Percent	Number	Percent	Number	Percent
IRU 1st Cohort (2005 IRU releases)	687	687	280	40.8%	332	48.3%	-52	-15.7%
IRU 2nd Cohort (2006 IRU releases)	1,412	1,412	345	24.4%	475	33.6%	-130	-27.4%
IRU 3rd Cohort (2007 cases so far)	642	642	41	6.4%	71	11.1%	-30	-42.3%
MPRI Pilot 1st Cohort (1 st round 1 st wave)	160	152	52	34.2%	62	40.8%	-10	-16.1%
MPRI Pilot 2nd Cohort (1 st round 2 nd wave)	806	806	212	26.3%	266	33.0%	-54	-20.3%
MPRI Pilot 3rd Cohort (1 st round 3 rd wave)	2,467	2,288	152	6.6%	228	10.0%	-76	-33.3%
MPRI Pilot 4th Cohort (2 nd round 1 st wave)	698	618	23	3.7%	46	7.4%	-23	-50.0%
MPRI Statewide	602	499	5	1.0%	11	2.2%	-6	-54.5%
MPRI Community Placement Program	658	503	13	2.6%	14	2.8%	-1	-7.1%
MPRI Mentally Ill Demonstration	567 parole 146 max out	250 parole 80 max out	11 0	4.4% 0.0%	27 2	10.8% 2.5%	-16 -2	-59.3% -100.0%

- An additional 1,346 MPRI cases beyond those reflected above have been identified/engaged as new FY 2008 cohorts.

First IRU Offender Release Cohort (2005 Releases)

All offenders released to parole from the IRU's in 2005 represent the first pre-MPRI offender release cohort that is being tracked. The first of these offenders transitioned to parole in February of 2005. Through August 2007, this first pre-MPRI offender release cohort has yielded a 16% improvement in returns to prison so far against the overall baseline when controlling for a history of prior parole failure, with long-term potential for a savings of up to 53 prison beds. This cohort will continue to be tracked with the expectation that, even if these results diminish over time, at least modest improvements in return to prison and time to failure will be maintained for this initial group.

Second IRU Offender Release Cohort (2006 Releases)

All offenders released to parole from the IRU's in 2006 represent the second pre-MPRI cohort to be tracked. There are 1,412 cases in this cohort, and less than 25% returned to prison through the end of August 2007. Although the numbers involved are too small to draw statistically significant conclusions this early, this represents a 27% improvement in returns to prison so far against the overall baseline when controlling for a history of prior parole failure.

Third IRU Offender Release Cohort (2007 Releases)

All offenders released to parole from the IRU's in 2007 represent the third pre-MPRI cohort to be tracked. This cohort of 642 released cases was closed out at the end of May because the IRU locations have been re-designated as "MPRI Statewide" pilot site facilities. Less than 7% had returned to prison through the end of August. Although the numbers involved are too small to draw statistically significant conclusions this early, this represents a 42% improvement in returns to prison so far against the overall baseline when controlling for a history of prior parole failure.

First MPRI Round 1 Pilot Site Offender Release Cohort

The first official MPRI pilot site offender release cohort consisted of 160 offenders (20 at each of eight pilot sites). Six of these offenders had their paroles suspended prior to release and received continuances instead; two due to pending charges, three due to institutional misconduct, and one due to failure to complete the statutory GED educational requirement. Two more of the original 160 were paroled, but ultimately as non-MPRI cases.

These first official MPRI offenders began paroling in November and December of 2005, and all had transitioned to parole by the end of April 2006. Less than 35% had returned to prison through the end of August 2007. Although the numbers involved are too small to draw statistically significant conclusions this early, this represents a 16% improvement in returns to prison so far against the overall baseline when controlling for a history of prior parole failure.

Second MPRI Round 1 Pilot Site Offender Release Cohort

The 2nd wave of first round MPRI pilot site cases began to be released in larger numbers in May 2006, and all 806 cases had transitioned to parole by the end of September. Through the end of August 2007, only about 26% had returned to prison. Although the numbers involved are too small to draw statistically significant conclusions this early, this represents a 20% improvement so far against the overall baseline when controlling for a history of prior parole failure. In total, over 1,800 prisoners were targeted (paroled/engaged/identified) for the MPRI in FY 2006, with each release cohort (4-6 month cycles) benefiting from fuller implementation of the complete MPRI Model – as have the newer FY 2007 release cohorts.

Third MPRI Round 1 Pilot Site Offender Release Cohort

The 3rd wave of first round MPRI pilot site cases began to be released in October 2006, and 2,288 had paroled by the end of August 2007. Less than 7% of these cases had returned to prison by the end of August. Although the numbers involved are too small to draw statistically significant conclusions this early, this represents a 33% improvement so far against the overall baseline when controlling for a history of prior parole failure.

First MPRI Round 2 Pilot Site Offender Release Cohort

The 1st wave of second round MPRI pilot site cases began to be engaged with the seven new pilot sites in October 2006, and 618 had paroled by the end of August 2007, with less than 4% returned to prison by the end of August. Although the numbers involved are too small to draw statistically significant conclusions this early, this represents a 50% improvement so far against the overall baseline when controlling for a history of prior parole failure.

MPRI Statewide Offender Release Cohort (FY 2007)

In the first half of 2007, the IRU locations were re-designated as “MPRI Statewide” facilities, so a new offender release cohort was started in June 2007 for tracking MPRI paroles from those facilities. Through August of 2007, 499 MPRI Statewide cases were paroled, and only 1% had been returned to prison. Although the numbers involved are too small to draw statistically significant conclusions this early, this represents a 55% improvement in returns to prison so far against the overall baseline when controlling for a history of prior parole failure.

MPRI Community Placement Program Offender Release Cohort

The MPRI Community Placement Program (CPP) is a demonstration program composed of integrated transitional services coupled with rigorous drug testing and sanctions. The CPP is restricted to offenders who are serving active prison sentences for only drug crimes or other nonviolent, non-weapons-related crimes who are already past their earliest release dates due to either previous denial of parole or return to prison as violators of parole conditions.

The program consists of four phases which assess, refer, and place parolees into community-based transitional residential housing and services. The initial phase is the standard MPRI In-Reach phase, followed by placement in a community-based programming center, and then eventual transition to an approved home placement (with electronic monitoring as necessary) and access to programming, assistance and services. The final phase allows for

periods of return to the community-based programming center if necessary for reasons such as rule noncompliance, family conflict or loss of home status.

Paroles to the CPP began in June of 2007 and the total number scheduled to be paroled under the program is 658 (out of an initial potential offender pool of 2,539 that was reviewed for consideration by the parole board), all of whom are expected to transfer to parole status by the end of 2007. Through August 2007 there were 503 releases to the CPP, with fewer than 3% returned to prison so far. Although the numbers involved are too small to draw statistically significant conclusions this early, this represents a 7% improvement in returns to prison so far against the overall baseline when controlling for a history of prior parole failure.

MPRI Mentally Ill Inmate Demonstration Project

The first 713 mentally ill inmates have been engaged in this demonstration project (starting in January of 2006), with the first 330 released to parole status or discharged on the maximum sentence by the end of August 2007. The first 713 cases engaged in the demonstration project consisted of 567 potential transitions to parole and 146 discharges on the maximum sentence (with aftercare arranged proactively for the latter cases for the first time). These demonstration project figures do not include community referrals to provide funding for mental health services for separate cases who were already on parole.

Of the first 330 cases returned to the community, about three-quarters were paroled and the remainder discharged on the maximum sentence. Less than 5% of the parolees had returned to prison by the end of August 2007. None of the “max-outs” had returned to prison. Although the numbers involved are too small to draw statistically significant conclusions this early, this represents a 59% - 100% improvement so far against the baseline rate of return to prison for mentally ill offenders who have been released back into the community.

MPRI-Related Offender Release Cohorts by Crime Group

Table 4 shows the principal crimes for which sentences were being served among those offenders transitioned to parole (or discharged) so far from the first offender release cohorts. Sentences for drug and other nonassaultive crimes are understandably the most common for these initial offender release cohorts. After successes are achieved and parole board confidence in positive outcomes is increased, it is anticipated that the mix of offenses will gradually include a higher proportion of assaultive cases.

Table 4: Crime Groups for MPRI-Related Participants Released Thru 8/31/07

	Sex	Other Assaultive	Drug	Other Nonassaultive	Total
IRU 1st Cohort	42	202	127	316	687
(2005 IRU releases)	6.1%	29.4%	18.5%	46.0%	100%
IRU 2nd Cohort	65	451	226	670	1,412
(2006 IRU releases)	4.6%	31.9%	16.0%	47.5%	100%
IRU 3rd Cohort	33	197	117	295	642
(2007 cases so far)	5.1%	30.7%	18.2%	46.0%	100%
MPRI Pilot 1st Cohort	0	33	38	81	152
(1 st round 1 st wave)	0.0%	21.7%	25.0%	53.3%	100%
MPRI Pilot 2nd Cohort	31	217	147	411	806
(1 st round 2 nd wave)	3.8%	26.9%	18.2%	51.0%	100%
MPRI Pilot 3rd Cohort	108	783	384	1,013	2,288
(1 st round 3 rd wave)	4.7%	34.2%	16.8%	44.3%	100%
MPRI Pilot 4th Cohort	42	192	114	270	618
(2 nd round 1 st wave)	6.8%	31.1%	18.4%	43.7%	100%
MPRI Statewide	24	188	88	199	499
	4.8%	37.7%	17.6%	39.9%	100%
MPRI Community Placement Program	0	0	134	369	503
	0%	0%	26.6%	73.4%	100%
MPRI Mentally Ill Demonstration	30	123	24	153	330
	9.1%	37.3%	7.3%	46.4%	100%

Number: 2005-01 (REVISED)
Effective Date: 11/21/2007

FOA MEMORANDUM

TO: All Field Staff

FROM: John S. Rubitschun
Field Operations Administration

SUBJECT: Referrals to Residential Substance Abuse Treatment and Transitional Housing

Access to MDOC funded residential substance abuse treatment programs is restricted to those cases for which such treatment has been pre-approved by the Substance Abuse Section (SAS). If SAS determines that residential substance abuse treatment is not justified, the offender shall be referred to outpatient or other available alternatives.

Residential substance abuse treatment programs that receive Office of Community Corrections (OCC) funding will not be managed under this system. Field agents should continue to access OCC programs as established by local guidelines.

Referrals to MDOC funded residential substance abuse treatment, Domiciliary Intensive Outpatient Program (DIOP) OR SAS Transitional Housing shall be documented in case notes and in the Transition Accountability Plan (TAP). Referrals are completed as follows:

- The supervising or referring agent shall complete the CFJ-306 in OMNI within Reports/Offender Booking Reports and then direct an e-mail to MDOC-OSAS@michigan.gov as notification of the referral. The subject line of the e-mail shall be "Referral" followed by the offender's name and MDOC number. Due to confidentiality laws, it is imperative that the referring agent forwards the CFJ-306 to the appropriate e-mail address as identified above.

Note: The CFJ-306 must be completed in OMNI before a referral is made. If e-mail is unavailable, the supervising agent shall fax notification of the referral to SAS at (517) 241-8490, using the subject information as noted above.

- SAS is responsible for screening all referrals to MDOC funded residential substance abuse treatment programs while reviewing the CFJ-306 and offender case notes in OMNI. For those offenders who carry the MPRI designation, SAS will review the goals and tasks in the TAP. To be eligible

for services the TAP must include goal and a task for housing or residential treatment.

Note: In order to guarantee availability of accurate screening data, the supervising agent shall ensure that offender information recorded in OMNI (e.g., case notes, SA test results, employment, residence, previous treatment, etc.) and the TAP is complete and up-to-date. This includes but is not limited to all tabs within Assessment/Case Planning, Offender Details and the Needs and Goals contained within the TAP.

- SAS staff will contact the supervising and/or referring agent once the screening is complete and will advise whether residential substance abuse treatment, DIOP, or SAS Transitional Housing is approved. If approved, SAS will provide the program referral information including treatment location, contact person, date and time of entry via e-mail. If residential substance abuse treatment, DIOP or SAS Transitional Housing is denied, SAS will provide the reason(s) for denial to the supervising and referring agent if applicable.
- As part of the MPRI process to address gaps in service capacity for parolees in need of residential treatment and/or transitional housing, Program Services Unit (PSU) staff within SAS will review referrals that were denied due to lack of existing financial resources. Referrals that were denied will be considered for placement with a provider (residential or transitional housing) only for those parolees designated to obtain MPRI services. Placements will only occur for those MPRI parolees who have a completed TAP which identifies the Need and a requested Task.
- The supervising agent shall document the SAS response in case notes and in the TAP within the Task field area ensuring the offender is either instructed to enter residential substance abuse treatment, transitional housing (as provided in the SAS program referral information) or referred for outpatient or other available alternatives. This includes processing the request to the Parole Board for added special conditions as needed. Supervising agents shall coordinate transportation to residential and transitional housing locations.
- Immediately upon receiving SAS approval for placement in residential substance abuse treatment, the supervising agent shall record the referral in the OMNI Offender Referral tab of Contract Management/Offender Referral Maintenance and create the CFJ-140 in OMNI within the Reports/Program Assignment Report. Agents shall also update the TAP within the Task field area.

SAS will assess for residential treatment placement and prioritize those placements based on established risk factors. Offenders that pose a significant risk to the public shall receive priority for residential treatment placement. Priority for the residential placement is based on the following criteria in identifying significant risk:

1. Offender type (i.e., prisoner, parolee or probationer).

2. The nature of the offense for which the offender is currently serving.
3. MDOC assault risk factors or COMPAS scores.
4. Type of drug abused (e.g. alcohol, heroine).
5. Substance use or abuse that is indicative of the need of substance abuse treatment in a residential setting in order to stabilize the offender (e.g., the offender is unable to maintain employment, has been evicted from their home placement or has been arrested regarding alleged criminal activity)
6. Prior residential treatment failures
7. Documented Need within TAP is required on all cases but will be applied only for those referrals initially denied but meet criteria above.

Examples of offenders that could receive priority:

1. Parolees serving for identified sex offenses
2. Parolees convicted of OUIL 3rd
3. Parolees with a MDOC assault screen of very high or high
4. Parolees with a COMPAS score of 8 to 10 on the violence and recidivism scales
5. Parolees with significant mental health history
6. Pregnant women
7. CRP prisoners

For offenders in need of emergency placement (i.e., an offender needing same-day placement due to medical needs or local detention limitations, etc.), the supervising agent or referring agent, when applicable; shall complete the CFJ-306 in OMNI within Reports/Offender Booking Reports and then telephone SAS at (866) 672-3800 to advise of the emergency referral. The remainder of the referral process shall be completed as indicated above. Note: If the need for emergency placement occurs when the agent does not have access to OMNI, SAS staff will complete the CFJ-306 in OMNI based on information provided during the telephone referral.

Once an offender is admitted into residential treatment, SAS staff will monitor the offender's treatment. While an offender is in residential treatment, the supervising agent shall establish the offender's appropriate supervision level at "CRP - Residential Drug Treatment" or "Parole Minimum Administrative" or "Probation Minimum Administrative".

SAS will make every attempt to advise the supervising agent/supervisor of the offender's estimated discharge date no later than two weeks prior to that date. The supervising agent shall ensure appropriate placement for offender success is arranged for all parolees but by coordinating with representatives from the MPRI Transition Team for all MPRI parolees. Supervising agents shall also ensure that reporting instructions are provided to the offender prior to release from treatment and documented in case notes.

Upon discharge or termination from residential treatment or transitional housing, the supervising agent shall immediately terminate the program referral in the OMNI Referral Termination tab in Contract Management/Offender Referral Maintenance as well as update the TAP within the Task area while also establishing the offender's appropriate supervision level.

DKS/TLC/CT:11/07



JENNIFER M. GRANHOLM
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF CORRECTIONS
LANSING

PATRICIA L. CARUSO
DIRECTOR

Sent Via E-Mail

Date: November 30, 2007
To: MPRI Community Coordinators
From: Chris Trudell, Assistant Manager
Office of Offender ReEntry
Subject: Increased Residential Substance Abuse Treatment and Transitional Housing
Service Capacity for MPRI-Designated Parolees

Earlier this year, I gathered information from you with the goal of identifying funding and capacity gaps for residential treatment and housing. Many of you identified three general areas which needed improvement. These were the need for increasing capacity for both transitional housing and residential substance abuse treatment and the need for MPRI parolees to gain quick access to these services.

With this in mind, the Office of Offender ReEntry, Field Operations Administration and the Office of Substance Abuse Services, collaborated on a funding arrangement to address all three areas. This effort successfully increased capacity within our state-administered contract structure to support more beds for housing and treatment and improved procedures to streamline access to these services for MPRI parolees.

As most of you know, many parolees may not have received timely services due to a lack of resources in funding or bed capacity. This new resource will prevent that from happening.

This plan is not intended to supplant the existing Administrative Agency governance structure which supports meeting gaps through creating capacity at the local level. It is intended to provide a needed resource for eliminating gaps within our state-level system. Creating capacity is most effective when coordinated through the local level and our role, at the state level, can be most effective when supporting that effort through both improving our state-level system to be responsive to local needs and encouraging our local partners to target resources to create capacity where none exists. Consistent with this approach, funding for this fiscal year will be administered centrally within the Office of Offender Reentry specifically working through our existing state-level contract system to provide increased capacity to meet your local needs with the caveat that local efforts continue to create capacity where none exists.

With this effort, access to these services have been streamlined to ensure bed capacity is available to service MPRI parolees who would have otherwise not gained access due to capacity or funding limits. Our Department's Office of Substance Abuse Services will manage this process and an internal operating procedure has been established to ensure that all MPRI parolees will be streamlined quickly into care.

Every effort will be made to place parolees in the nearest available provider location, consistent with that provider's acceptance criteria and the services they provide, but we cannot guarantee a location. The last page of this memo contains a provider index which lists participating providers and the services for which we've increased capacity.

Documentation of these services has been improved consistent to a recently revised Field Operation Memo entitled; 2005-01 Referrals to Residential Substance Abuse Treatment and Transitional Housing (see attached FOA Memorandum). Improvements include requiring the Transition Accountability Plan (TAP) be updated as the basis for the referral and that continued documentation of these services occur through discharge.

As the year progresses, I will be in contact with each of you to see how this process has impacted your area as your continued feedback is essential.

Your comments, concerns and questions are always welcome. Please continue to contact me at any time @ (517) 241-5674 or e-mail @ trudelcm@michigan.gov.

Attachment - FOA Memorandum 2005-01 (Revised)

cc: Dinah Moore, Field Operations Regional Administrator
Mike Glynn, Field Operations Regional Administrator
Darlene Schimmel, Field Operations Administrator
Ken Brzozowski, Administrator, Office of Community Corrections
Le'Ann Duran, Manager, Office of Offender ReEntry
Beth Arnovitz, Executive Director, Michigan Council on Crime and Delinquency
Tom Combs, Manager, Substance Abuse Services
FOA MPRI Co-Chairs
MPRI Resource Liaison Team
James Yarborough, Policy and Community Development Administration
Yolanda Perez, Office of Offender ReEntry
Ontay Johnson, Office of Offender ReEntry
File

MPRI Capacity Provider Index			
Provider	County Location	MPRI Residential Treatment Beds	MPRI Transitional Housing Beds
Salvation Army Harbor Light - Detroit	Wayne County	Yes	Yes
SHAR	Wayne County	Yes	No
Detroit Rescue Mission	Wayne County	No	Yes
ARETE	Saginaw	Yes	No
CPI	Oakland	Yes	No
Saginaw Psychological Services	Saginaw	Yes	No
Salvation Army Harbor Light – Monroe/Macomb	Monroe/Macomb	Yes	No
Turning Point Recovery	Oakland	No	Yes
New Paths Inc.	Genesee	No	Yes
CEI House of Commons	Ingham	Yes	No
Great Lakes Recovery	Marquette/Chippewa	Yes	Yes
Harbor Hall	Petoskey	Yes	Yes
Project Rehab	Kent	Yes	Yes
Addiction Treatment Services	Grand Traverse	Yes	Yes
Kalamazoo Probation Enhancement	Berrien/Kalamazoo	No	Yes
Alternative Directions	Kent	No	Yes
Sunrise	Alpena	Yes	Yes

MICHIGAN DEPARTMENT OF CORRECTIONS DRAFT PROGRAM SERVICES UNIT	Revision Date: 11/7/07	Procedure Number 01.02
SUBJECT: Placement of offenders on the waiting list for Residential Services	Page: 1 of 4	

OBJECTIVE: To establish a procedure for the prioritizing the placement of offenders when financial capacity for residential services is reached. To ensure that Transition Accountability Plans for MPRI designated offenders are updated to accurately document the delivery of services coordinated through the Substance Abuse Services Section. To ensure that services managed by SAS, but financed through separate administrative funding streams, are verifiable through billing documentation and documentation within the Transition Accountability Plans.

INFORMATION:

- A. The Department of Corrections' Substance Abuse Services (SAS) Section contracts with residential service providers to provide a variety of services to offenders identified by the Department's Field Agents. The SAS Manager is responsible for establishing an average or target bed count that is sustainable, given the financial resources available for residential services. The SAS Manager shall communicate this target bed count to the Program Services Unit (PSU) supervisor. The PSU supervisor shall monitor the actual bed count on a regular basis. Should the actual bed count be at or lower than the target bed count, then the residential services network shall be in OPEN status. If the actual bed count is higher than the target count the network shall be in WAIT LIST status. The PSU supervisor shall be responsible for keeping the PSU coordinators informed of the network status.
- B. SAS prioritizes treatment placements based on the department's risk screening instruments, the offender's status, their history of substance abuse and degree of incapacity due to substance abuse or mental health status. Some offenders are considered a priority for immediate placement in a residential substance abuse treatment facility based on their criminality, mental health or medical status. These Priority Placement offenders include:
1. Paroled Sex Offender
 2. Parolees convicted of OUIL 3rd
 3. Parolees with a MDOC screening Very High or High Assault Risk
 4. Parolees with a COMPASS score of 8 to 10 on the violence and recidivism scales
 5. Parolees with significant mental health history
 6. Pregnant women
 7. CRP prisoners
- C. Offenders that are not considered Priority Placement shall receive a Secondary Placement designation. Secondary Placements shall be placed on the waiting list for services when the network is in WAIT LIST status. While on the waiting list for services, PSU placement coordinators shall assign the offender to one of the following four categories:
1. Category One
 - a. Parolees completing IDRP or TRV with a SASSI score of 4 or a SASSI score of 3 and commercial placement.
 - b. Parolees with significant and current alcohol or drug use
 - c. Area Manager ordered treatment with evidence of drug dependence.
 - d. Parolees whose drug of choice is highly addictive (e.g., heroin, cocaine, methamphetamine)

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2. Category Two
 - a. Evidence of frequent use of drug of choice (other than marijuana).
 - b. Parolees with two or more positive urine samples in the last three months.
 - c. Completed residential treatment in the last twelve months with current frequent use.
 - d. Area Manager order treatment with evidence of regular use.
3. Category Three
 - a. Parolees with little evidence of regular drug use but with a history of alcohol or drug dependence.
 - b. Parolees with Low assault risk with erratic pattern of use.
 - c. Parolees with current noncompliance or poor prognosis in outpatient treatment but no evidence of significant current use.
 - d. Parolees with positive drug tests results for marijuana only and history of other drug dependence.
4. Category Four
 - a. Parolees with Marijuana as the only drug used.
 - b. Probationers.

D. While waiting for placement in residential services, Secondary Placement offenders may participate in outpatient substance abuse treatment services. For offenders with co-occurring substance abuse and mental health disorders, treatment services for mental health problems are available through the offender's community mental health resources. These services shall be facilitated by the offender's agent.

PROCEDURE:

<u>Who</u>	<u>Does What</u>
Field Agent	<ol style="list-style-type: none"> 1. Completes the CFJ-306 in OMNI. Forwards an e-mail to the MDOC-OSAS GroupWise address requesting placement in residential substance abuse treatment, Domiciliary Intensive Outpatient Program or transitional housing services. For offenders that carry the MPRI designation, updates the Transition Accountability plan consistent with FOA Memorandum 2005-1 which requires referring agents to add a GOAL for both housing or residential treatment and a task with each goal.
PSU Coordinator	<ol style="list-style-type: none"> 2. Screens CFJ-306 and agent's case notes to determine initial program placement based on risk factors, substance abuse treatment needs, special needs, housing needs, offender's availability and offender's supervision location. 3. For Priority Placement offenders, immediately contacts the appropriate service provider, schedules the offender's intake date and notifies the supervising agent of the program location and intake date.

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4. For Secondary Placement offenders, placement shall depend on the status of the network:
 - A. If the network status is OPEN, immediately contacts the appropriate service provider, schedules the offender's intake date. PSU staff updates the TAP by:
 1. Updating the "TASK" for the appropriate GOAL (either housing or residential treatment) by entering the projected admission date in the "Start Date" window and entering the name and address of the provider in the "Provider" window.
 2. Notifies the supervising agent of the program location and intake date and advises them that TAP has been updated to reflect this.
 - B. If the network status is WAIT LIST, determines if the offender is designated as MPRI. Takes the following steps based on offender designation.
 1. Places non-MPRI offenders in the appropriate category on the PSU waiting list, informs agent that the financial resources are not currently available to secure immediate placement.
 2. For MPRI designated offenders, checks the Transition Accountability Plan (TAP) to ensure the goals and tasks identify the need for residential services. Should the TAP identify a need for service, immediately contacts the appropriate service provider, schedules the offender's intake date. Notifies the provider that this offender carries the MPRI designation and that they should invoice services for this offender under the "96" prefix on Admission Form CAH-280. PSU staff enters "MPRI Parolee – Provider Notified" in the "Notes" window within the "TASK" on the TAP. . Informs the supervising agent of the program location, the intake date, and that the TAP has been updated.

PSU Supervisor

5. Continues to monitor network status and the number of offenders that are on the PSU waiting list. Should the network status be OPEN and offenders present on the waiting list, informs PSU coordinators to begin placing offenders from the waiting list.

PSU Coordinator

6. After receiving authorization for waiting list placements, attempts to place Category One offenders. Once the Category One list is exhausted, proceeds to place offenders in Category Two. Continues down the list of categories until all offenders are placed or the network is returned to WAIT LIST status.

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|----------------------------|--|
| PSU Billing Specialist | <ol style="list-style-type: none"> 7. Receives monthly billing packet from provider, checks the PSU database to ensure the charges are consistent with what has been authorized. 8. For those services charged to MPRI, provides a summary to the Office of Offender Reentry broken out in two parts for housing and residential treatment. Other information included will be offender specific. |
| Office of Offender ReEntry | <ol style="list-style-type: none"> 9. OOR will periodically audit billings to verify that parolee meets criterion #4B above with the TAP TASK window, under notes, entry made by PSU authorizing placement as an "MPRI Parolee-Provider Notified". 10. OOR forwards approved or amended PSU summary to Finance for processing. Only services outlined under Section 4B of this procedure will be reimbursed through OOR. Communicates to the SAS manager the dollar amount of the charges that were authorized by OOR. |