CALIFORNIA
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Reentry Health Policy Project:

Meeting the Serious Health and Behavioral Needs of Prison and Jail Inmates Returning to the Community

Final Report

October 2017

(Revised January 2018)

Submitted to:

California Health Care Foundation

L.A. Care

Reentry Health Policy Project
Final Report - October 2017 (Revised January 2018)

Executive Summary

Justice-involved populations tend to experience high rates of physical and mental health problems within complicated social contexts, including long term unemployment, chronic system dependence, weak social ties, and residence in economically-depressed areas. Consequently, many are high utilizers of multiple systems who pose unique challenges to the correctional, community health, and social service systems that are responsible for meeting their needs following incarceration. Those living with serious mental illness (SMI) and the medically fragile (MF) are two groups who face particularly serious challenges before, during, and after incarceration, and they frequently cycle between institutions while struggling to establish independence. Developing effective and cost-effective models for especially complex cases such as these provides the greatest promise for improving care while reducing costs to taxpayers.[1]

Public policy in California is at the center of national attention and federal scrutiny as the state reforms its massive criminal justice and health care systems, while simultaneously grappling with the fallout from several lawsuits aimed at improving healthcare in prisons. In addition, a series of criminal justice reforms - including AB 109 (2011), Proposition 36 (2012), Proposition 47 (2014), and Propositions 57 (2016) - has fundamentally changed the makeup of California's prison, jail, parole, and probation populations. Most notable has been the "realignment" of responsibility between counties and the state for people convicted of crimes within certain offenses categories, i.e. people convicted of nonviolent, non-serious, and non-sexual offense, now being supervised locally rather than sent to state prison. The legislation provided counties with new funding for managing the additional clients, and many have developed evidence based, innovative programming that can serve as models for other jurisdictions.

The passage of the Affordable Care Act (ACA) in 2010 allowed California to expand Medi-Cal eligibility for low-income childless adults, dramatically increasing the number of formerly incarcerated people who can access health coverage and care upon release. There remain technical, policy, system, and program barriers that hinder efforts to match people in reentry to coverage and services. Identifying and removing these barriers should help improve health outcomes and reduce the rate of recidivism.

[1] RAND. 2012. "Understanding the Public Health Implications of Prisoner Reentry in California." [PDF]

The potential for additional reforms to state and national health care systems only heightens the importance of understanding the impact they would have on the people who rely most on public benefits. It also highlights the importance of evaluating "what works" and developing efficient, effective, and sustainable models of care while Federal support exists. As described throughout this report, providing the most medically vulnerable Californians with appropriate health care and coverage is not only more humane than failing to do so, it is also more financially and legally sustainable.

Evolving reentry policies do not occur in a political vacuum, and policymakers cannot ignore current efforts by President Trump and Congress to "repeal and replace" the ACA. It remains unclear what, if any changes, might be made, and what implications any changes would have for reentry programs. This uncertainty has cast doubt on state and local efforts to pursue new strategies that rely on key elements of the ACA. Until the health reform dust settles, it must be acknowledged that the environment for new initiatives will remain uncertain. Nonetheless, inaction serves no one in light of the real challenges that California and other states face related to health care and coverage for criminal justice populations.

The Reentry Health Policy Project seeks to identify state- and county-level policies and practices that impede the delivery of effective health and behavioral health care services to people who are reentering their communities following incarceration in prison or jail. With funding provided by the California Health Care Foundation and L.A. Care, the project has been managed by California Health Policy Strategies LLC (CalHPS), which has engaged state and local policymakers and other stakeholders in a collaborative process, sharing lessons learned from reentry projects, and identifying best practices that can be replicated at the state and local level.

Phase I of the ten-month project has focused on better understanding of how health and behavioral health needs of individuals who are medically fragile (MF) and/or living with serious mental illness (SMI) are addressed as they return from custody to their communities. The project focused on the California Department of Corrections and Rehabilitation (CDCR), and three counties: San Diego, Los Angeles, and Santa Clara. This provided the opportunity to compare and contrast multiple approaches to responding to the growing number of physically and mentally ill individuals leaving jails and prisons, and also to consider ways to foster greater collaboration between state and county officials charged with managing these problems in the criminal justice system in a variety of criminal justice, social service, and health agencies.

Based on input from policy-makers, practitioners, and stakeholders, we identified the following issue areas, which became the focus of our report, and for which we offer our recommendations and suggested next steps:

1. **Eligibility Establishment** to help reduce the structural barriers that hinder an individual's ability to receive care based on insurance status at the time of their release.

2. **Care Coordination and Service Delivery** to reduce barriers to a smooth transition into county level care post-incarceration.

3. **Maximizing Federal Financial Participation (FFP)** to open up funding opportunities available primarily due to the Affordable Care Act.

4. **Release of Information (ROI)** to facilitate client data sharing across agency to promote communication and collaboration from the state to the county levels.

5. **Residential and Outpatient Treatment Capacity** to ensure an adequate supply of qualified service providers, licensing, and certifications.

6. **Housing** for SMI and MF reentry populations.

7. **Evaluation** of programs and services for people in reentry.

This report begins with a broad overview of the existing criminal justice, health care, and behavioral health policy landscape in California. We describe how recent reforms changed the composition of the jail, prison, and reentry populations in important ways and created opportunities to develop better models for balancing public safety and healthcare against the steep cost of each. We also note the particularly difficult situations that many SMI and MF face upon release, which complicate efforts to provide them with needed services.

After describing our approach to better understand these problems at "the ground level," the report then explores how the key barriers listed above shape the reentry process for formerly incarcerated people in our three target counties and the CDCR. These barriers diminish opportunities to capitalize on the opportunities provided by ongoing reforms in the criminal justice and health care systems. We describe how each jurisdiction currently responds to the challenges, we highlight effective policies and practices from around the State and nation that might serve as models for meeting the challenges, and we offer actionable approaches to address the need for reducing costs and recidivism while improving care and other outcomes for medically vulnerable people leaving jails or prisons in California.

Acknowledgements

The Reentry Health Policy Project would not have been possible without the funding and support of the California Health Care Foundation and L.A. Care, or the collaboration and feedback provided to CalHPS by various local and state policy makers and stakeholders. We would like to thank everyone for their time and work, as we grappled with some complex issues for this group of vulnerable Californians. CalHPS would like to extend extra gratitude to those who contributed to this report by reviewing a draft and submitting thoughtful (and, at times, highly detailed) feedback, which we incorporated into this final product.

Table of Contents

Executive Summary **1**

Acknowledgements **4**

Table of Contents **5**

The Landscape at the Intersection of Criminal Justice and Health **8**

A growing portion of the criminal justice population has physical and mental health problems 8

Historic reforms have transformed criminal justice processing in California 11

The reforms changed the makeup of incarcerated and community supervision populations in important ways 14

Reentry populations living with serious mental illness and who are medically fragile are particularly vulnerable and costly 15

Several recent health and social policy reforms provide opportunities to address and prevent related problems in policy and practice 21

Our Approach **27**

Findings and Recommendations **30**

1. Eligibility Establishment **31**

Overview 31

A. Pre-Release Planning 31

B. Establishing Eligibility for Medi-Cal 32

C. Supplemental Security Income (SSI) 38

D. CalFresh (Supplemental Nutrition Assistance or SNAP) 41

E. Obtaining a California ID (Cal-ID) 41

2. Care Coordination and Service Delivery **45**

Overview 45

Challenges to Effective Care Coordination 46

A. Transitions Between Systems and Programs 46

B. Provider Approach to Service Delivery 57

C. Unique Patient Needs 62

3. Maximizing Federal Financial Participation (FFP) **68**

Overview 68

A. Maximizing FFP for State and Local Justice System Administrative Activities 70

B. Obtaining FFP for Dispensing a 30-day Supply of Medication Upon Release 73

C. Maximizing FFP for Parolee SMI Services 74
D. Maximizing Medical and Elderly Parole 77

4. Release of Information (ROI) 82
Overview 82
A. Current Release of Information Practices and Directions 82

5. Residential and Outpatient Treatment and Capacity for Individuals with Co-Occurring Disorders (CODs) 86
Overview 86
A. Traditional Approaches to Service Delivery 87
B. What does an Integrated Model look like? 89
C. Examples of Integrated Service Models 93
D. Barriers to Achieving Integrated Treatment 94

6. Housing 100
Overview 100
A. Defining Homelessness 100
B. The Housing Debate 101
C. Why Housing First? 103
D. Current CDCR Housing Practices for the MF and SMI 104
E. Current Housing Practices for the MF and SMI in Target Counties 105
F. Barriers to Effective Housing for the SMI and MF 106

7. Evaluation 109
Overview 109
A. Evidence-Based Practices and Data Driven Evaluations 109
B. Looking Towards the Whole Person Care Integrated Evaluation Models 111
C. Barriers to Effective Evaluations 112

Collected Recommendations 114

The Reentry Health Policy Project Team 118
Appendix 1: List of Key Meetings 119
Appendix 2: Summary of Board of State and Community Corrections (BSCC) Proposition 47 Awards - SMI and MF Focused Programs 123
Appendix 3: Average Percentage of Annual County Jurisdiction ADP Receiving Psychotropic Medications, March 2014 - February 2017 in 45 California Counties 128
Appendix 4: Mental Health Services Act Funded Reentry Programs in Los Angeles, San Diego and Santa Clara Counties 130

Appendix 5: Whole Person Care (WPC) Pilots: Reentry Population Project Descriptions 132
Appendix 6: Public Hospital Redesign and Incentives in Medi-Cal (PRIME) Pilots: Reentry Population Project Description 137
Appendix 7: Health Home for Patients with Complex Needs 141
Appendix 8: Target County AB 82 Outreach and Enrollment Plans 142
Appendix 9: Summary of the CDCR's Benefit Application Process Outcomes for SMI inmates 145
Appendix 10: Full Description of Parole's Mental Health Services Continuum Program (MHSCP) Components 146
Appendix 11: University of Arizona Health Plans (UAHP) Reach In Program 150
Appendix 12: Santa Clara County Reentry Resource Center Authorization for Release of Confidential Health and Other Information 152
Appendix 13: AB 109 Evaluation Efforts in Target Counties 155
Appendix 14: Board of State and Community Corrections Organizational Mandates Regarding Data and Evaluation 158
Appendix 15: Abbreviations 159

The Landscape at the Intersection of Criminal Justice and Health

A growing portion of the criminal justice population has physical and mental health problems

The public health challenges associated with the unprecedented number of people returning to their communities following incarceration have drawn increasing attention to the important overlaps between corrections and health systems. Criminal justice populations are characterized by high rates of physical and mental health problems, and those with the most serious problems often struggle to meet their own needs following incarceration. A relatively small group of formerly incarcerated people consume a disproportionate share of available resources, and the size of this population has been growing for decades.

Nationally, there were around 6,741,400 people under some form of correctional control in 2015. This includes approximately 870,500 people on parole, 3,789,800 on probation, 1,526,800 in prison, and 728,200 in county jails.[2] California's criminal justice system alone includes around 200,000 people who are incarcerated and more than 400,000 who are under community supervision. About 36,000 people were released from California prisons annually over the past decade, and over a million people admitted and released from jails, with many cycling through the criminal justice system multiple times in a given year.[3]

"Criminal justice" and **"Justice-involved populations"** include people in state prisons, county jails, and those who are supervised in the community by state parole agents or county probation officers.

"Reentry" populations and **formerly-incarcerated persons (FIPs)** refer to people who have recently been released from jail or prison and who are under some form of community supervision.

Criminal justice populations are generally characterized by elevated rates of chronic physical and mental health problems relative to the general population.[4] A 2011 RAND study of the health status of prison populations in California revealed that 18% reported having hypertension, 14% asthma, 13% hepatitis, and 9% a sexually transmitted disease.[5] Behavioral health problems are also common among incarcerated people; the same California study found that 58% of inmates reported a problem with drug abuse or dependence, and many reported depression (19%), anxiety (8%), mania (10%), posttraumatic stress disorder (6%), and/or schizophrenia (6%).

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[2] Kaeble, Danielle and Glaze, Lauren. 2016. "Correctional Populations in the United States, 2015." Bureau of Justice Statistics. [PDF]

[3] For interactive map of California's county jail population, see this [Link] (Adobe Flash required)

[4] See Massoglia, Michael and William Pridemore. 2015. "Incarceration and Health." *Annual Review of Sociology,* 41(4) [Link]; and Schnittker, Jason, Michael Massoglia, and Christopher Uggen. 2012. "Out and Down: Incarceration and Psychiatric Disorders." *Journal of Health and Social Behavior,* 53(4). [Link]

[5] RAND. 2012. "Understanding the Public Health Implications of Prisoner Reentry in California." [PDF]

Around a third of the money spent to incarcerate each person in California is now spent on health care.[6]

Health and medical costs now form a major part of most corrections budgets, totaling about a fifth of all corrections expenditures nationwide and 31 percent in California.[7] These challenges are exacerbated in many systems by chronic overcrowding, as was the case in California, where the inability to meet the physical and mental health needs of the people in California's prisons is a major part of the ongoing crisis in the state's corrections system and the impetus for reform.

The profile of the criminal justice populations is growing older. For example, the portion of people age 50 years or older in California state prisons grew from 4% to 21% between 1990 and 2013, while the percentage of people age 25 years or younger decreased from 20% to 13%.[8] This reflects a national trend toward "greying" prison populations that is expected to continue,[9] due in large part to the historically long "tough on crime" sentences that have been being imposed for most street crimes since the early 1990s.[10] The aging trend among criminal justice populations is important for policymakers to consider because age is strongly associated with declining physical and mental health. This means older adults are far more costly to incarcerate compared to younger cohorts,[11] and prisons and jails are among the most expensive places to deliver care. Furthermore, one study of reentering adults, aged 55 or over, found that around 80% of males and 90% of females leaving prison had a chronic health condition requiring treatment or management, and about 40% of all reentering people had multiple conditions.[12]

These increased health needs have created serious challenges in prisons and the community

Communities across California have already been facing the serious health challenges associated with individuals leaving prison. For example, a 2007 study of over 30,000 people released in Washington State found that the adjusted risk of death was 12.7 times higher for people in the

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[6] Taylor, Mac. 2013. "California's Criminal Justice System." *California Legislative Analyst's Office*. [PDF].
[7] Pew Trust. 2014. "State Prison Healthcare Spending: An Examination." [PDF]
[8] Grattet, Ryken and Joseph Hayes. 2015. "California's Changing Prison Population." *PPIC*. [PDF]
[9] California's Legislative Analyst's Office observed nearly two decades ago that incarcerating people into old age creates major financial and legal challenges for decision makers charged with managing resources while maintaining public safety. See this [Link]
[10] Carson and Sabol. 2016. "The Aging of the State Prison Population." *Bureau of Justice Statistics*. [PDF]
[11] For example, research shows people age 50 years or older cost around three times as much to incarcerate compared to their younger peers, largely because of medical costs. See State of Florida Correctional Medical Authority. 2007. "Report on Older and Aging Inmates in the Florida Department of Corrections." [Link]; Anno, Jaye et al. 2004. "Meeting the Health Needs of Elderly, Chronically Ill, and Terminally Ill Inmates." [PDF]; Ahalt, Cyrus et al. "Paying the Price: The Pressing Need for Quality, Cost and Outcomes Data to Improve Correctional Healthcare for Older Prisoners." *Journal of the American Geriatrics Society,* 61(11). [Link]
[12] Williams, Brie et al. 2010. "Coming Home: Health Status of Older Pre-Release Prisoners." *Journal of General Internal Medicine,* 25(10). [Link]

two weeks following release compared to the general population. The leading causes of death was drug overdose, cardiovascular disease, homicide, and suicide.[13] A similar study that looked at hospitalization rates of Medicare eligible formerly incarcerated persons found that about one in 70 are hospitalized for an acute condition within seven days of release, and one in 12 by 90 days, a rate much higher than in the general population.[14] To our knowledge there has not been a relevant study conducted in California, but the state's performance on other post-release measures suggests the situation here is no better for people released from jails or prisons.[15]

Providing adequate medical care to criminal justice populations is often particularly difficult and costly because many are experiencing complex health problems in equally complicated social conditions.[16] Their illnesses and disabilities are often complicated by chronic poverty, long periods without health care, residence in a low-income community, and substance abuse.[17] As discussed below, rehabilitative programs are increasingly designed to provide "wraparound" services, but less attention has been paid to coordinating these services with healthcare for medically needy people.

Further, many incarcerated people have cycled through jails and prisons, homeless shelters, emergency rooms, drug treatment programs, psychiatric care, and other institutional settings for decades. They frequently lack the education, experience, and sometimes ability to maintain gainful employment. Chronic illness and disability limit other forms of independence.[18] Consequently, many become high utilizers of multiple systems. Despite the relatively small number of "high utilizers of multiple systems" in the justice system (e.g., those living with serious mental illness and medically fragile people in reentry), they are both vulnerable and costly. They consume disproportionately more resources in the criminal justice, health, and welfare systems than other groups, and their complex situations make full recovery difficult to achieve.

Typically justice officials are usually concerned primarily with outcomes related to recidivism. Definitions of recidivism vary somewhat, but it is broadly defined as a return to custody, either for a new crime or a technical violation of the conditions of release, within a period ranging from

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[13] Binswanger, Ingrid et al. 2007. "Release from Prison — A High Risk of Death for Former Inmates." *New England Journal of Medicine*, 356(2). [PDF]
[14] Wang, Emily et al., 2013. "A High Risk of Hospitalization Following Release From Correctional Facilities in Medicare Beneficiaries." *JAMA Internal Medicine*, 173(17). [Link]
[15] CDCR. 2008. "Final Report on the Mental Health Services Continuum Program - Parole Division." [PDF]
[16] Chief Probation Officers of CA. 2013. "Assessing Risks and Needs of Realigned Populations." [PDF]
[17] Human Rights Watch. 2012. "The Aging Prison Population in the United States." [PDF]
[18] Health professionals often discuss the health status of individuals in terms of their ability to perform activities of daily living (ADLs) including continence, bathing, eating, and other types of self care. See

one to three years following release from jail or prison.[19] However, the serious health and social problems that these groups manifest when leaving jails and prisons suggest that policymakers should include in their consideration of outcomes the success in mitigating these problems.

Historic reforms have transformed criminal justice processing in California

California's criminal justice system is undergoing major reforms that have dramatically altered state and local relationships and responsibilities for managing those who are arrested. In short, a greater number of people with felony convictions will serve their time in county jails and be monitored by county probation. This changing landscape provides the opportunity to develop innovative models for addressing the criminogenic and health care needs of justice-involved people.

In the following section, we describe how policy reforms are shaping the current prison, jail, parole, and probation populations in California. In short, tens of thousands of people who would have been in prison are instead serving their time locally or are in the community.

Public Safety Realignment, 2011 (AB 109, AB 117), the State's first and most sweeping attempt to reign in prison overcrowding, sought to do so by making categorical changes to the populations for which local and state agencies had responsibility. Prior to the passage of AB 109 and AB 117 in 2011, any felony conviction carrying a sentence of a year or more usually resulted in the individual being remanded to the custody of state prisons, and upon release they would be supervised by state parole agents. Any felony offender (or misdemeanant) given a sentence of less than a year remained in county jail and/or was released to county probation, if community supervision was ordered.

Following the passage of AB 109 and AB 117, offense type became more important than sentence length for determining the supervising agency, with state prisons and parole retaining responsibility over most people whose primary conviction was for a violent,[20] sexual, or otherwise serious offense. Meanwhile, the people serving time in prison for non-serious, non-violent, and non-sex offenses, the so-called, "non, non, nons," are released to Post-Release Community Supervision (PRCS) and supervised by county probation rather than parole. Furthermore, people sentenced pursuant to Penal Code Section 1170(h) for these "non-non-non" offenses now usually serve their time in county jails. The law also gives the sentencing judge the

[19] Differing definitions and data collection approaches among state and county system creates a challenge for understanding recidivism outcomes and trends.

[20] In California, it is defined in Penal Code Section 667.5(c). "Serious" felony offenses are defined in PC Section 1192.7 and 1192.8.

discretion to impose a straight sentence (jail only and no mandatory supervision) or split sentence (jail and Mandatory Supervision). Upon release persons subject to mandatory supervision will be under the jurisdiction of the county probation department. People convicted of these lower-level offenses are now incarcerated in jail instead of prison; parole violators now serve time in jail rather than being returned to state prison for custody.

Another change relates to parole violators who now serve their revocation time in county jail instead of prison with a maximum of 180 days. Local courts now have the responsibility for revoking parole for non life parolees.

The reform package also provided a dedicated and permanent revenue stream to counties through vehicle license fees and a portion of the state sales tax, which is intended to provide counties with the resources to supervise and manage the new populations. This amounted to $354 million for AB 109 programs in 2011-12, and it grew to over a billion dollars in 2016-17.

A number of voter-approved ballot initiatives passed since Public Safety Realignment have also changed the rules governing sentencing, affecting important characteristics of the incarcerated and formerly incarcerated populations:

- **Three Strikes Reform Act of 2012 (Proposition 36)** modified elements of California's 1993 "three strikes" law by limiting the imposition of life sentences for third "strikes" to people convicted of serious or violent offenses, and by authorizing re-sentencing for current "third strikers" whose life sentences followed from less serious, nonviolent crimes.[21] The bill caused a spike in older adults reentering communities across California after having served a decade or more in prison, and the associated demand for health care for formerly incarcerated people was felt by a variety of stakeholders.[22]

- **Reduced Penalties for Some Crimes Initiative (Proposition 47)** was approved by voters in 2014 and reduced certain non-violent, non-serious drug and property crimes from felonies to misdemeanors,[23] meaning penalties could no longer result in prison time and often would not result in incarceration at all. Proposition 47 also permitted re-sentencing for people currently serving time for any of the affected offenses following a risk assessment and "thorough review" of their criminal history to ensure they did not pose a threat to the public if released. The initiative also used the savings that resulted

[21] Stanford Three Strikes Project and NAACP Legal Defense and Education Fund. 2013. "Progress Report: Three Strikes Reform (Proposition 36)." [PDF]

[22] For example, Dr. Brie Williams, a geriatrician at UCSF and the founder of the UC Consortium on Criminal Justice and Health, organized the first known attempt to coordinate a citywide response to the influx of MF and SMI older adults who began showing up in emergency rooms, experiencing mental health breakdowns and other medical emergencies in public, and otherwise taxing resources available for indigent populations.

[23] The offenses included possession and use of most illegal drugs and most offenses related to theft and forgery when the value does not exceed $950.

from the reduction in number of incarcerated Californians (estimates range from $150 million to $250 million per year) to create the Safe Neighborhoods and Schools Fund; 65% of the savings is allocated to the Board of State and Community Corrections (BSCC) to support health and substance abuse services, and the remainder goes to the Department of Education (25%) and to Victim Compensation (10%).[24]

In June 2017, the BSCC awarded about $103 million in estimated Proposition 47 state savings to 25 applicants whose rehabilitative programs were deemed most promising. The criteria for the awards was established by language in the proposition, which directs 65 percent of the overall state savings to the BSCC to fund grants for speciality mental health and substance-use disorder treatment. Assembly Bill 1056 added housing assistance and job training to the mix of eligible funding criteria. The bill targets services for people "who have been arrested, charged with, or convicted of a criminal offense and have a history of mental health issues or substance use disorders."[25] See Appendix 2 for a summary of the awards.

- **Public Safety and Rehabilitation Act (Proposition 57)**, approved by voters in the November 2016 election, is the most recent piece of legislation to pass as part of this wave of reforms intended to improve public safety and rehabilitation programs using an evidence based approach. It establishes a parole consideration process for people convicted of nonviolent offenses who have served the full term for their primary criminal offense and who demonstrate that they should no longer be considered a threat to public safety. It also provides the opportunity for incarcerated people to earn additional credits for good behavior and participation in rehabilitative, educational, and career training programs so they are better prepared to succeed and less likely to commit new crimes when they reenter our communities.

TIMELINE: Major Corrections Policy Reforms Intended to Reduce Prison Overcrowding

Year	Reform	Effect
2011	**AB 109 - Public Safety Realignment** transferred responsibility from the State to counties for managing most people convicted of nonviolent, non-serious, and non-sex offense crimes; this reduced flow into prisons from new sentences and technical violations.	By June 2012, nine months into the post-realignment period, the prison population had declined by roughly 25,000 and county jail populations in many jurisdictions had increased. Additionally, parole caseloads fell, but probation caseload rose. On net, the overall

[24] BallotPedia. 2014. Proposition 47: Reduced Penalties for Crimes Initiative. [Link]
[25] Board of State and Community Corrections. 2017. "Innovative Rehabilitative Programs Awards." [Link]

		California incarceration rate (prisons and jails combined) has declined due to realignment.[26]
2012	**Proposition 36 - Three Strikes Reform Act of 2012** limited the imposition of life sentences for third "strikes" to people convicted of serious or violent offenses; authorized re-sentencing for current "third strikers" whose life sentences followed from less serious, nonviolent crimes.	By September 2013 over 1,000 "lifers" were released, with recidivism rates far below state and national averages (less than 2%).[27] Many people released were older and had served long sentences prior to release.
2014	**Proposition 47 - The Reduced Penalties for Some Crimes Initiative** reduced the seriousness of certain lower-level drug and property offenses so that those convicted of such crimes no longer were sent to prison, and many already in prison could apply for early release. The measure also allocated some of the associated cost savings to rehabilitation programs such as substance abuse treatment.	Over 4,600 inmates have been resentenced and released from prison; the majority (~75%) were placed on state parole supervision, causing an increase in the parole population after seven years of decline; the average daily population in jails dropped by ~10,000 between October 2014 and January 2015.[28]
2016	**Proposition 57 - The California Parole for Nonviolent Criminals and Juvenile Court Trial Requirements Initiative** increased the likelihood of early release for many convicted of nonviolent offenses by expanding eligibility criteria and by increasing opportunities to earn sentence credits for good behavior, participation in rehabilitative programs, or through educational achievements.	As of 2015, there were 30,000 individuals in state prison and 7,500 individuals admitted to state prison annually who would be eligible. Prop 57 is estimated to result in 1,959 fewer inmates in 2017-18, and 9,956 fewer in 2020-21.[29]

The reforms changed the makeup of incarcerated and community supervision populations in important ways

The incarcerated population in California peaked in 2006 at around 256,000 people, 163,000 of whom were in state prisons with the remainder in county jails. The reforms following from the legal cases against the CDCR resulted in a reduction of the prison population by about 50,000 people. However, the state's inmate population remains very close to the cap (137.5% of design capacity) ordered by the federal court. The Legislative Analyst's Office reports that the CDCR's prison capacity is currently 117,000, only about 2,000 beds above the current prison population.[30] This suggests additional efforts to manage the state prison population will be needed.

[26] Magnus Lofstrom and Steven Raphael. 2013. "Impact of Realignment." *PPIC*. [PDF]
[27] Stanford Three Strikes Project and NAACP Legal Defense and Education Fund. 2013. "Progress Report: Three Strikes Reform (Proposition 36)." [PDF]
[28] Grattet, Ryken and Joseph Hayes. 2015. "California's Changing Prison Population." *PPIC*. [PDF]
[29] "Prop 57 Impact." 2017. Senate Budget and Fiscal Committee [PDF] and Legislative Analyst's Office [Link]
[30] Correspondence with California Legislative Analyst's Office. April 2017.

County jail populations have also begun to swell in many places, which poses serious future challenges to local officials who must manage the new population with facilities not designed for long-term care.[31] Further, because recent reforms focus on releasing and not imprisoning people convicted of "non-non-non" offenses, most (~90%) of the people who remain in state prison have been convicted of violent crimes and are serving relatively long sentences.[32] It also means that the people leaving prisons will be older, more medically needy, and more system dependent than past cohorts, and this trend is expected to continue for years to come.[33]

In 2016, the average daily jail population (ADP) in California jails was about 72,000 people, about 36% of whom had already been sentenced. Jail stays are typically far shorter than prison sentences, and a jail's ADP does not convey information about the "flow" of people through jail beds. In 2012, for example, the average county jail stay in California was around 21 days, though most are far shorter.[34] Precise statewide information about releases from jail is not available, but there were an estimated 1.1 million admissions to jails in 2014.[35] One study found that three-quarters (72%) of people admitted to California jails were booked only once, while a small group (about 14,000 people) had five or more jail contacts over a one-year period.[36] Consistent with our description of the high utilizers of multiple systems above, many of these "frequent fliers" undoubtedly rely heavily upon public and community resources, unable to establish financial and other forms of independence between periods of incarceration; this is particularly likely to be the case for people who are managing serious mental health and medical problems.

Reentry populations living with serious mental illness and who are medically fragile are particularly vulnerable and costly

Our study focused on those living with serious mental illness (SMI) and the medically fragile (MF), two groups returning to California communities who are among the most needy and costly to incarcerate but who face serious challenges upon release. More medically fragile, living with serious mental illness, or otherwise medically vulnerable individuals than ever are now involved

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[31] Lofstrom, Magnus and Brandon Martin. 2016. "California County Jails." *PPIC.* [PDF]
[32] Grattet, Ryken and Joseph Hayes. 2015. "California's Changing Prison Population." *PPIC*. [PDF]
[33] Abner, Carrie. 2006. "Graying Prisons." *State News.* [PDF]
[34] McConville, Shannon and Mia Bird. 2016. "Expanding Health Coverage in California: County Jails as Enrollment Sites." *PPIC.* [PDF]
[35] Ibid
[36] Ibid. Extrapolating from the study, an estimated 640,000 individuals had contact with county jail systems at some point over the course of the year. PPIC's study of eight California jails found that about eight times the average daily population (ADP) had contact with county jail systems in the course of a year. We have extrapolated this finding to reflect that statewide ADP.

with the criminal justice system.[37] One 2010 study found there were three times as many mentally ill people in U.S. jails and prisons than hospitals.[38]

Besides direct costs associated with imprisoning them, those with mental illnesses serve longer sentences on average.[39] Further, a disproportionate number of people sentenced to life in prison under California's "three strikes" sentencing law are mentally ill, and people sentenced under this law are roughly twice as likely to be mentally ill as other people in California prisons.[40]

Upon release, their health status tends to compound the other challenges to successful reintegration, including problems finding employment and housing, establishing prosocial community ties, and learning to live outside of institutions.[41] They also frequently lack access to adequate resources for managing their own care, face delays being seen by a professional because of capacity and other issues, and are often released to the community without health coverage. Further, mental health problems often go unreported among criminal justice populations.[42] Among other reasons, this may occur when proper assessments are not conducted, when individuals do not disclose symptoms to correctional officers or health professionals, or when medical records are not shared across systems and agencies.

There are no uniform definitions of serious mental illness or medically fragile that are applied to manage prison and jail populations. For the purposes of our project, we use the following:

- **Serious Mental Illness (SMI)** is discussed here as a mental disorder that is severe in degree and persistent in duration, causes behavioral functioning that interferes substantially with the primary activities of daily living, and may result in an inability to maintain stable adjustment and independent functioning without treatment, support, and rehabilitation for a long or indefinite period of time. The most common diagnoses amongst adult clients in California are schizophrenia; schizoaffective disorder; bipolar disorder; anxiety disorders, including post-traumatic stress disorder; and major depression.

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[37] Stanford Three Strikes Project. 2014. "When Did Prisons Become Acceptable Mental Care Facilities?" [PDF]
[38] This is likely a conservative estimate because actual rates of mental illness are estimated to be around twice as high rates from self-report measures. See Torrey, Fuller et al. 2010. "More Mentally Ill Persons are in Jails and Prisons than Hospitals." *The Treatment Advocacy Center* and *The National Sheriff's Association.* [PDF]; and Mallik-Kane, Kamala, and Christy Visher. 2008. "Health and Prisoner Reentry: How Physical, Mental, and Substance Abuse Conditions Shape the Process of Reintegration." *Urban Institute Justice Policy Center.* [PDF]
[39] Stanford Three Strikes Project. 2014. "When Did Prisons Become Acceptable Mental Care Facilities?" [PDF]
[40] Ibid
[41] Williams, Brie et al. 2010. "Coming Home: Health Status of Older Pre-Release Prisoners." *Journal of General Internal Medicine,* 25(10). [Link]
[42] RAND. 2012. "Understanding the Public Health Implications of Prisoner Reentry in California." [PDF]

- **Medically Fragile (MF)**. There is not a consistent term that jails and state prison use to identify and track inmates with serious and chronic health conditions. We have used the term "medically fragile" in our report to generally refer to individuals with acute or chronic health problems that require ongoing therapeutic intervention and/or skilled nursing care during all or part of the day. MF problems include, but are not limited to, HIV disease, severe lung disease requiring oxygen, severe lung disease requiring ventilator or tracheostomy care, complicated spina bifida, heart disease, malignancy, asthmatic exacerbations, cystic fibrosis exacerbations, neuromuscular disease, encephalopathies, and seizure disorders.[43]

The CDCR Mental Health Services Delivery System (MHSDS) provides mental Health treatment and monitoring for mentally ill inmates with *current* symptoms and/or requires treatment for one or more of the following DSM-IV Axis I diagnosis: Schizophrenia (all subtypes) Delusional Disorder Schizophreniform Disorder, Schizoaffective Disorder, Brief Psychotic Disorder, Substance-Induced Psychotic Disorder (excluding intoxication and withdrawal), Psychotic Disorder Due To A General Medical Condition, Psychotic Disorder Not Otherwise Specified, and Major Depressive Disorders Bipolar Disorders I and II.[44] The SMI inmates are placed in one of the five level of care as shown in Table 0.1. This Table defines each category and provides descriptive statistics for people released to state parole or county probation under post-release community supervision (PRCS) status.

[43] See Health and Safety Code Division 2, Chapter 8.6. [Link]
[44] CDCR. 2009. "Program Guide: Overview Mental Health Services Delivery System." [Link]

Table 0.1. CDCR Housing Classification for People with Diagnosed Mental Illnesses by Release Type 2015		
	PRCS	**Parole**
Total Releases	18,281	18,654
Total Mentally Ill Releases	3,520 (18.8%)	4,320 (22.6%)
Department of State Hospitals Intermediate Care Facility (DSH-ICF): Patients in these State Hospital facilities receive longer term mental health intermediate and non-acute inpatient treatment that is not available in CDCR.	36 (.2%)	58 (.3%)
Acute Inpatient Hospital Care: Inmates with the most severe cases of psychosis whose conditions cannot be treated in outpatient settings or short term mental health crisis beds. Treatment is provided through a contract with the California Department of State Hospitals (DSH).[45]	16 (.1%)	75 (.4%)
Mental Health Crisis Beds (MHCBS): This program is for people with marked impairment and dysfunction in most areas (daily living activities, communication and social interaction) requiring 24-hour nursing care**.**	41 (.2%)	55 (.3%)
Correctional Clinical Case Management System (CCCMS). These inmates exhibit symptom control or may be in partial remission as a result of treatment. They are able to function in the general prison population.	2,985 (16.3%)	3,264 (17.5%)
Enhanced Outpatient Program (EOP): These inmates are unable to function in the general prison population as a result of acute onset or significant decompensation of a serious mental disorder characterized by increased delusional thinking, hallucinatory experiences, marked changes in affect, and vegetative signs with definitive impairment of reality testing and/or judgment.	442 (2.4%)	868 (4.7%)

Each of the three counties in our study defined their SMI population in different ways, making "apples to apples" comparisons challenging. However, we obtained the following information:

- **Los Angeles County Jail.** In 2016, the average daily jail population of SMI was described as follows: About 100 patients meeting criteria for acute inpatient psychiatric beds; 1,011 patients in High Observation Housing (roughly the equivalent to the CDCR's Enhanced Outpatient (EOP) classification; 3,482 patients are able to function in the

[45] Effective July 2017, these three DSH mental health facilities will be released and transferred to the CDCR and the California Correctional Health Care Services, known as "Lift & Shift." This would give the CDCR complete control and responsibility for the psychiatric programs and personnel located at those sites. [Link]

general jail population of incarceration people similar to CDCR's CCCMS category.[46]

- **Santa Clara County Jail**. According to the 2016-17 AB 109 spending plan for Santa Clara County, about 24% of jail inmates are living with serious mental illness.

- **San Diego County Jail**. 28-32% of jail inmates are taking psychotropic medications.[47]

Since 2002, the BSCC has conducted a monthly, quarterly, and annual survey (the Jail Profile Survey) to collect data regarding local agency jails and jail systems. County data is submitted on a monthly, voluntary basis. In this monthly survey, counties are asked to report population figures, including the total Average Daily Population (ADP) for their jurisdiction. Additionally, the survey requests counties report the number of inmates who are receiving psychotropic medication for identified mental health disorders on the last day of the month. In our analysis, we omitted jurisdictions that did not answer these two questions for at least two months during a given 12-month period. These omitted counties only accounted for roughly 5% the total ADP for the all the jails statewide during the 2016 calendar year. From these data we have calculated the percentage of inmates taking psychotropic medication, in our three target counties, from March 2014 to February 2017 (Table 0.2). Appendix 3 contains our calculations for this key statistic across 45 counties from March 2014 to March 2017. From these data it appears that approximately 20% of California jail inmates receive some psychotropic medication.

Table 0.2 Average Percentage of Annual County Jurisdiction ADP Receiving Psychotropic Medications, March 2014 - February 2017 in Three California Counties

	Mar 2014 to Feb 2015			Mar 2015 to Feb 2016			Mar 2016 to Feb 2017		
	Avg # on Meds	Annual ADP	% Annual ADP on Meds	Avg # on Meds	Annual ADP	% Annual ADP on Meds	Avg # on Meds	Annual ADP	% Annual ADP on Meds
Los Angeles	2,774	17,930	**16%**	2,858	16,469	**17%**	3,373	16,145	**21%**
Santa Clara	574	4,026	**14%**	629	3,597	**18%**	708	3,568	**20%**
San Diego	1,353	5,498	**25%**	1,277	5,015	**25%**	1,308	5,457	**24%**
State Sample[48]	*12,112*	*71,373*	***18%***	*12,760*	*66,313*	***20%***	*13,776*	*67,384*	***20%***

Source: BSCC Jail Profile Survey[49]

[46] Correspondence with LA Jail staff.
[47] Correspondence with Medical Services Administrator.
[48] The "State Sample" reflects data from 45 California jurisdictions.
[49] BSCC Jail Profile Survey-- Online Query [Link]

AB 1050 amended California Penal Code § 6027 to require the BSCC to "develop definitions of key terms, including, but not limited to, 'recidivism,' 'average daily population,' 'treatment program completion rates'." In September 2014, the BSCC released their definitions, which defines recidivism as a "conviction of a new felony or misdemeanor committed within three years of release from custody or committed within three years of placement on supervision for a previous criminal conviction." Prior to realignment, the CDCR consistently used the three-year return-to-prison rate, as its primary measure of recidivism. However, since realignment, the CDCR now uses the three year conviction rate as its primary measure.[50] The conviction rate is equal to the number of offenders in the release cohort who convicted during the follow-up period, divided by the total number of offenders in the release cohort, all multiplied by 100.

Using the State's definition of recidivism, Table 0.3 below shows the various conviction rates among individuals with different mental health classifications. The third column shows the three-year conviction rate, which corresponds to CDCR's primary measure of recidivism. Overall, rates of conviction within 3 years, for SMI inmates are significantly higher than the general inmate population. SMI inmates in the EOP, for example, have a conviction rate within 3 years that is roughly 20 percentage points higher than inmates without a mental health code.

Table 0.3. Conviction Rate by Mental Health Classification for Inmates Released in FY 2010-11

		One-Year		Two-Year		Three-Year	
Mental Health Classification	**Number Released**	**Number Convicted**	**Conviction Rate**	**Number Convicted**	**Conviction Rate**	**Number Convicted**	**Conviction Rate**
Mental Health Crisis Bed	36	10	27.80%	18	50.00%	19	52.80%
Enhanced Outpatient Program	914	209	22.90%	395	43.20%	473	51.80%
Correctional Clinical Case Management System	5,728	1,326	23.10%	2,382	41.60%	2,915	50.90%
Acute Inpatient	19	2	N/A	4	N/A	7	N/A
No Mental Health Code	29,093	5,816	20.00%	10,624	36.50%	13,082	45.00%
Total	***35,790***	***7,363***	***20.60%***	***13,423***	***37.50%***	***16,496***	***46.10%***

Source: CDCR 2017 Outcome Evaluation Report

Like SMI, Medically Fragile (MF) is a category that also defies common definition for incarcerated populations. In response to our inquiry, CDCR reported that there were 5,526 medically fragile inmates as of March 2017. In 2016, 638 of the people released from CDCR facilities were MF, including 95 people who required placement in a hospital or Skilled Nursing Facility (SNF) upon release. This represents about 1.7% of total releases. More than half (54%)

[50] CDCR Office of Research. 2017. "2017 Outcome Evaluation Report." [PDF]

of this group have ten or more prescription medications. Counties report similar numbers. Los Angeles County, for example, houses around 245 people with complex medical needs per month, while 658 of the people in San Diego County jails are prescribed more than five medications for either medical or psychiatric needs, translating to around 12% of the jail's ADP.

The people leaving jails and prisons with serious medical or mental health problems represent a relatively small portion of the overall criminal justice population, but they consume an enormous portion of the overall resources supporting people in reentry. Their complex and precarious social circumstances place them at high risk for poor outcomes related to health and recidivism alike.

Several recent health and social policy reforms provide opportunities to address and prevent related problems in policy and practice

The Affordable Care Act and recent state-level health and social policy changes created unprecedented opportunities to improve the physical and behavioral health of the reentry population by expanding coverage and encouraging the development of innovative models for delivering care.

Historically, Medicaid has played a limited role in funding health care services for the young and middle age males, the population most likely to be incarcerated. Under the Medicaid "inmate exclusion policy," federal matching funds are not available for people in prison unless they are patients in a non-prison medical institution,[51,52] so health care services in California jails and prisons are paid for almost entirely by California taxpayers. Further, prior to the implementation of the Affordable Care Act, even those released from custody were largely ineligible for Medicaid despite the fact that nearly all were poor, most were unemployed, and many homeless, because eligibility was limited to low-income adults in categories like pregnant women, parents of dependent children, the elderly, or the disabled. Consequently, most people in reentry at high risk for an array of health problems were dependent on the indigent care system in California, a system operated by each county with considerable variation in access to services across the State. Many of the reentry population went without the ability to access needed care until the next time they were arrested. For example, one 2008 survey of San Francisco county jails found that 90% of the people entering county jail had no health insurance.[53]

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[51] Gates, Alexandra et al. 2014. "Health Coverage/Care for the Adult Criminal Justice-Involved Population." *Kaiser Family Foundation.* [Link]

[52] The Medi-Cal Inmate Eligibility Program (MCIEP) allows for federal cost sharing for inpatient services at a medical facility located off the grounds of the correctional facility if a Medi-Cal eligible inmate has an expected stay of more than 24 hours. .

[53] Wang, Emily et al. 2008. "Discharge Planning and Continuity of Health Care: Findings from the San Francisco County Jail." *American Journal Public Health,* 98(12). [Link]

Although the ACA did not change the Medicaid inmate exclusion policy, the new health reform law provided states the option to expand coverage to low-income childless adults, providing the opportunity to dramatically increase access to healthcare for most people leaving jails and prisons. Under the new coverage option - which California has embraced - qualifying individuals with incomes below 138% of the Federal Poverty Level (FPL) are eligible for Medi-Cal in California.[54] The federal government initially provided 100% of the cost of coverage for the newly eligible, phasing down to a 90% match by 2020. In addition, subsidized coverage through exchange marketplaces – Covered California in California – is available on a sliding scale basis for those with incomes above 138 and 400% of the FPL. These two new coverage avenues are available to nearly everyone leaving prison.[55]

Several state-level policies have also changed the landscape for the delivery of health and behavioral health care services for the reentry population by restructuring service delivery to improve the treatment of problems or populations that are closely linked to incarceration, including mental illness, substance abuse disorders, and residential instability.

The Mental Health Services Act (MHSA) passed as Proposition 63 in 2004, generates about $2 billion through a one percent tax on personal income in excess of one million dollars for the support of specialty mental health services. These revenue are highly sensitive to changes in the economy and tend to be variable. The MHSA addresses a broad continuum of prevention, early intervention, and service needs as well as providing funding for infrastructure, technology, and training for the community specialty mental health system.[56] These funds supplement other public sources including Medi-Cal, federal block grants, and Realignment funds. About 97% of the MHSA funds are allocated directly to counties, which are largely responsible for deciding how the funds will be spent. Parolees are not eligible for services funded by the MHSA. Our review of MHSA-funded reentry program in San Diego, Los Angeles, and Santa Clara counties can be seen in Appendix 4.[57]

In 2014, California enacted legislation to provide mental health services for Medi-Cal eligible individuals with mild and moderate mental health needs. This was a new benefit for Medi-Cal beneficiaries that did not exist prior to the Affordable Care Act.[58,59]

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[54] See CA DHCS "Do You Qualify for Medi-Cal Benefits?" [Link]

[55] Somers, Stephen et al. 2014. "Medicaid Expansion: Considerations for States Regarding Newly Eligible Jail-Involved Individuals." *Health Affairs,* 33(3). [Link]

[56] CA DHCS. 2016. "Mental Health Services Act Expenditure Report, Fiscal Year 2016-17." [PDF]

[57] The MHSOAC does not currently report on aggregate MHSA spending on reentry programs; but a data base is now being developed to allow this information to be available.

[58] Senate Bill X1 1 (Hernandez, Chapter 4, Statutes of 2013), effective January 1, 2014. Mental health services included in the essential health benefits package adopted by the State, pursuant to Health and Safety Code Section 1367.005 and the Insurance Code Section 10112.27, and approved by the United States Secretary of Health and

The Department of Health Care Services has launched several major initiatives to improve the delivery of Medi-Cal services to persons with complex health care needs. This includes:

- **Whole Person Care (WPC) Pilots**
  Approved: December 2016

  The Medi-Cal 2020 Waiver provides at least $6.2 billion in ongoing federal funding to transform and improve the quality of care, access, and efficiency of health care services for Medi-Cal members. The Waiver allocates $1.5 billion over five years to counties that will match the funds to create pilot programs to demonstrate the effectiveness of coordinating physical health, behavioral health, and social services in a patient-centered manner. The nineteen recently-approved Whole Person Care (WPC) pilots all target particularly vulnerable high utilizers of multiple systems who are reliant on Medi-Cal, and they seek to improve care and efficiency through data and information sharing, real-time care coordination, and mechanisms for evaluating progress.

  There are ten counties that have included the reentry population in their pilots; and four include specific programmatic elements to engage jail and prison inmates as they return to their community: Los Angeles, Kern, Placer and Contra Costa. See Appendix 5 for a full discussion of the WPC pilots in these four counties. (See Table 0.4. below and Appendix 5.)

Human Services under Title 42, Section 18022 of the United States Code. Referenced in Hamblin, Allison et al. 2016. "Promising Practices to Integrate Physical and Mental Health Care for Medi-Cal Members." [Link]

[59] Arnquist, Sarah, and Peter Harbage. 2013. "A Complex Case: Public Mental Health Delivery and Financing in California." *California Health Care Foundation.* [Link]

Table 0.4. Summary of Reentry Focused Whole Person Care (WPC) Programs					
County	**Reentry Engagement**	**Complex Care Coordination**	**Housing Support**	**Social Services Support**	**Employment Support**
Kern	● Establishes clinic outside jail ● Comprehensive discharge planning ● Immediate wellness check & needs assessment ● Two-week medication supply	● Post release follow-up appointment ● Transition management ● Timely transfer of patient information ● Referral tracking and follow-up ● Health coaching ● Telephone visits ● Enhanced care for 90 days	● Tenant screening and needs assessment ● Transitional housing placement ● Housing search and application support ● Resource brokerage ● Move in assistance ● Eviction prevention and intervention	● Benefit identification and advocacy ● Cal Fresh ● SSI ● Housing	● Workforce training ● Resume building ● Job search support ● Interview coaching ● Child care funding ● Transportation support
Los Angeles	● In-custody telemedicine visit ● Immediate post-release contact ● 8 Regional Coordination Centers staffed by formerly incarcerated individuals ● Transition & discharge planning ● Warm hand-off to residential or treatment services	● Transfer of in-custody medical record ● Enhanced information sharing ● Comprehensive health assessment ● Medication adherence support ● Healthcare transportation	● Housing location and retention services ● Security deposit assistance ● Furniture and household goods ● Unit modifications for mobility challenges ● Move in assistance	● Food security ● SSI & SSDI Advocacy ● Child support & restitution services ● Peer Mentorship ● Assistance in obtaining legal documents	● Connection to employment support services ● Vocational training ● Tattoo removal
Placer	● Coordination with probation to identify candidates within 90 days of release from jail	● Comprehensive health assessment ● Tailored plan of care within 30 days ● Health education ● Medication adherence support	● Housing support & services ● Resource brokerage ● Environmental modifications	● Eligibility screening ● Benefits application support ● Legal document assistance	● Employment support services
Contra Costa	● In-custody data based analytic identification ● In-custody opt-in referrals	● Appointment scheduling ● Referral Monitoring	● Vulnerability assessments ● Landlord and property management engagement ● Assistance with rental applications ● Eviction avoidance assistance ● Resources for paying utility bills and moving expenses	● Legal support ● Life skill classes ● Translation services ● Eligibility screening ● Benefit identification and advocacy ● Support groups	● School application assistance ● Vocational school training ● Temporary mobile phones ● Transportation vouchers ● Money management assistance

- **Public Hospital Redesign and Incentives in Medi-Cal (PRIME).** The Waiver earmarks $3.7 billion over the five years to improve the quality and value of care provided by California's safety net hospitals and hospital systems. PRIME provides an incentive to focus on system reforms targeted to improve delivery of ambulatory care services, to ease the transition for inpatient care to home and to institute complex case management for high-risk medical populations.

  Four of the 57 recipients have chosen to focus on the post incarceration population for the provision of integrated care, including public hospitals in Kern and Los Angeles Counties and district hospitals in Tulare County (Tulare Medical Center) and San Diego County (Tri-City Medical Center in Oceanside). See Appendix 6 for a description of projects related to the reentry population.

- **Medi-Cal 2020 Waiver – Drug Medi-Cal**
  Approved: August 2016

  The Drug Medi-Cal Organized Delivery System is a program initially approved under the state's previous 1115 waiver and was renewed under the current 1115 waiver, Medi-Cal 2020. The program aims to develop a new paradigm for the organized delivery of health care services for Medicaid eligible individuals with a substance use disorder (SUD). The Drug Medi-Cal Organized Delivery System (DMC-ODS) will be offered as a Medi-Cal benefit in counties that choose to implement the pilot project. The Waiver makes significant improvements to the current configuration of services and provides an evidence-based continuum of care that may include outpatient treatment, intensive outpatient short term residential care, case management, medication assisted treatment, recovery services and physician consultation.[60] In addition to increasing accountability with greater administrative oversight, it creates utilization controls to improve care and the efficient use of resources. For purposes of this project, the DMC-ODS provides for more intensive services for the criminal justice population by recognizing the many challenges faced by this population. 40 counties have approved plans.[61]

[60] This modeled is on the American Society of Addiction Medicine Criteria levels of care.
[61] The full versions of the approved implementation plans in final or draft form may be found online. [Link]

- **Health Home for Patients with Complex Needs (HHPCN)**

  The Affordable Care Act created a new optional benefit for enhanced care management and coordination for individuals with chronic conditions. In addition to medical coordination, DHCS intends to focus on persons living with serious mental illness, persons experiencing housing instability, and those who are very heavy utilizers of the physical and behavioral health systems. The federal government provides 90% of the funding for the first two years, and 50% thereafter.

  Health Homes provides six core services:
  - Comprehensive care management
  - Care coordination (physical health, behavioral health, community-based LTSS)
  - Health promotion
  - Comprehensive transitional care
  - Individual and family support
  - Referral to community and social support services

  There is likely to be significant overlap with the reentry population, and we hope to determine if counties have specific plans to identify and address the unique needs of justice-involved individuals in their implementation.

  In April 2017, DHCS announced a phased implementation schedule to begin with the first cohort of counties in July 2018 for eligible beneficiaries with chronic physical conditions and SUD; and SMI beneficiaries to begin in July 2019. The second and third cohort of counties to begin implementation in 2019 and 2020. (See Appendix 7).

Our Approach

Many counties across California currently have strong collaborative efforts with law enforcement, probation, courts, county health and behavioral health agencies, health plans and other stakeholders to maximize the potential benefits of the implementation of Realignment and to take advantage of the Affordable Care Act for the justice-involved population. The California Department of Corrections and Rehabilitation (CDCR) is undertaking efforts to improve services and reduce recidivism by connecting parolees with health, treatment, and community services after being released from prison.

To help identify the policy barriers that impede effective reentry practices, The Reentry Project has employed a highly targeted approach, focusing on (1) inmates leaving jails and prisons with the most serious mental health and medical needs and (2) the juridical classifications that dictate which agencies have jurisdiction over the care of individuals after their release.

The Reentry Project is reviewing the statewide efforts of the CDCR and the California Department of Health Care Services (DHCS). We have also reached out to key statewide law enforcement and health and behavioral health related associations around California to identify model programs and best practices that can be replicated throughout the state. Recognizing that each county is unique, the project is also taking a "deeper dive" into the policies and processes of three counties: San Diego, Los Angeles, and Santa Clara. Specifically, the project seeks to do the following:

- Identify barriers that can be addressed by state statutory, regulatory, or administrative changes.
- Problem solve, through collaboration with local partners, state agencies, and other technical assistance providers; to develop options and strategies to resolve or, in some cases, mitigate the impact of these barriers.
- Help find short- and long-term solutions within complicated Medi-Cal rules and translate these solutions across various agency partners.
- Identify noteworthy best practices by counties and the State Department of Corrections and Rehabilitation.

Appendix 1 provides details on the meetings and discussions that have been held as part of the project. The following is brief summary of the highlights:

- **CDCR.** We have met with the Secretary and key departments to understand rehabilitation and reentry programming and healthcare services, with the aim of identifying gaps in the pipeline for our focus population's access to necessary medical and mental health care. Key meetings included the Division of Rehabilitative Programs, the Division of Adult Parole Operations/Parole Outpatient Clinic, and the Division of Health Care Services. Meetings were also held with the Southern Parole Region Management, Compton Parole and Mid-City parole unit staff and POC clinicians.

- **DHCS.** We have met with staff at DHCS responsible for the financial and eligibility aspects of inmate health care services payments, the processes used to suspend Medi-Cal eligibility while incarcerated, and the policies guiding the processing of Medi-Cal applications in anticipation of release. Key consultations included the Chief Deputy of DHCS and staff from several divisions including Utilization Review, Eligibility, and Safety Net Financing.

- **San Diego County.** We have reviewed the San Diego County Strategic Plan and met with key stakeholders throughout the county around issues of care coordination, service delivery, treatment capacity, licensing and certifications for service providers, residential treatment, and Medication Assisted Treatment (MAT). Key meetings included the San Diego Reentry Roundtable, Division of Public Safety, San Diego County Sheriff Medical Services, Adult Parole and Parole Outpatient Clinic, the Health and Justice Integration Committee, and a number of contracted service providers.

- **Los Angeles County.** We met with key stakeholders concerning the issues of warm handoffs of post-incarcerated individuals to the county health system, post-release access to necessary medications, barriers to individuals receiving their California IDs, maximizing Federal Financial Participation, alternative sentencing and diversion options for our target population, the role of Medi-Cal Managed Care plans, the use of Community Health Workers, and supportive housing. Key meetings included the LA County Sheriff's Department, the Probation Department, the District Attorney's office, and the Department of Mental Health. A New Way of Life, a community-based organization serving women returning from prison and jail, also organized a focus group discussion with former parolees.

- **Santa Clara County.** We have meet with key stakeholders regarding the issues of HIPAA and the Release of Information (ROI), Medi-Cal eligibility and suspensions of

incarcerated individuals, Medi-Cal Managed Care, eligibility issues for undocumented persons, and SSI eligibility. Key meetings included the Santa Clara County Reentry Leadership Team, Santa Clara County Counsel, and Santa Clara Probation. We also conducted a focus group discussion with a group of local former inmates to obtain a candid view of the issues they have faced in accessing services during their transition to the community.

Findings and Recommendations

Many people leaving jail or prison have serious health problems that not only impose a financial burden on the individual and the communities they return to, they can also lead to other undesirable outcomes such as homelessness, reincarceration, and untimely death. Nearly everyone reentering their communities is also indigent and, until recently, uninsured, making it difficult to obtain adequate care upon release. Although the Affordable Care Act provides an opportunity to meet these challenges by expanding eligibility, increasing the array of benefits, and providing funding for a broad array of physical and behavioral health needs, there are technical, policy, and programmatic barriers preventing counties from providing better care for formerly incarcerated people in their community. The following sections will cover various focus areas in the benefits-to-care pipeline, a description of the problems, and what is currently being done, followed by CalHPS recommendations and proposed next steps.

1. Eligibility Establishment

Overview

The chances of a successful reentry into the community can be improved by ensuring access to services available to support the needs of the reentering population. Cash assistance from SSI can help support the elderly or disabled population. CalFresh assistance can help pay for food. And given that a disproportionate share of this population has physical and behavioral health care needs, health coverage now available through the Affordable Care Act – either through Medi-Cal or through Covered California - is essential. CDCR and counties recognize this need and have adopted a variety of approaches to support enrollment of the reentering population in these programs.

A. Pre-Release Planning

At the CDCR, the process for assisting inmates to access health coverage, SSI, and other benefits upon release from prison begins with a reentry approach that is now being implemented in each of state's 34 prisons. The Division of Adult Parole Operations (DAPO) Transitional Case Management Program (TCMP) provides pre-release benefit assistance to all eligible inmates scheduled for release to state Parole supervision or county Post-Release Community Supervision (PRCS). This process begins approximately 90-120 days prior to release from prison. TCMP benefit workers provide assistance in completing applications for Medi-Cal, Social Security Administration, and Veterans Administration benefits[62]. The completed applications for Medi-Cal are faxed or mailed to a designated liaison in the human services department of the county to which the inmates will be returning who will make the eligibility determination. As of 2017, 100% of statewide inmate releases are screened for benefit eligibility.[63]

Many county jails also provide eligibility assistance to their inmates. These efforts have been supported by Medi-Cal eligibility assistance and outreach grants authorized by AB 82 (Ch 23/2013). This time-limited funding has been used in many counties to pay for staff that provide jail-based eligibility assistance for a variety of entitlement programs including SSI, and CalFresh. The program will expire on June 30, 2018. Through March, 2017, over $19 million of the $25 million that was authorized has been expended by counties that submitted outreach plans to specifically targeting vulnerable populations delineated in the statute (see Appendix 8 for Target County AB 82 Outreach and Enrollment Plans). One of the target groups is "persons who

[62] The services provided by the Veterans Administration are typically only available for individuals who were honorably discharged. This may exclude some veterans who have SUD and mental health issues.
[63] California Rehabilitation Oversight Board. 2017. "Annual Report." [PDF]

are in county jail, state prison, state parole, county probation, or under post release community supervision."

B. Establishing Eligibility for Medi-Cal

The eligibility establishment process for Medi-Cal has several unique issues. As noted earlier, CDCR's assistance to inmates releasing to Parole or Post-Release Community Supervision (PRCS) begins approximately 90-120 days prior to release. However, the actual release date can change due to unforeseen circumstances (e.g.: recalculation of credits). CDCR has seen significant progress as a result of efforts to improve the process.

The Department of Health Care Services (DHCS), CDCR, the County Welfare Directors Association (CWDA), and representatives from several counties have established a workgroup that meets monthly to discuss issues related to establishing eligibility for former inmates. The goals of this group are to "work collaboratively to resolve issues and develop best practices as needed," to "identify questions/issues, challenges, and opportunities for improvement," and to "identify deliverables and training as appropriate." This regular communication among key stakeholders in the eligibility process has positively impacted approval rates. Recent FY 2016-2017 data from the CDCR show that 86% of the 27,000 Medi-Cal applications submitted were approved before release.[64] In all cases, once released, the newly eligible person will need to select a local Medi-Cal managed care plan by responding to a plan selection questionnaire that is mailed to each new enrollee.

The jail personnel in counties reviewed for this study all work to identify inmates being released and to establish or reestablish Medi-Cal. Inmates with no prior connection to Medi-Cal will have to complete a new application to establish eligibility. For those who entered the jail while eligible for Medi-Cal, the county can suspend their eligibility for up to one year during their incarceration. In some scenarios, when inmates are released, county staff can then reactivate their eligibility by completing an online transaction in the Medi-Cal Eligibility Data System (MEDS) – a new application is not required. The suspended status can be released effective the day the county is notified of the inmate's release. The inmate, whether establishing new eligibility for Medi-Cal or reestablishing suspended eligibility, would have to select a health plan after release. Some counties reported that their suspended enrollees do not automatically resume coverage in the plan that they were participating in prior to eligibility being suspended.

Designated jail staff ("Sheriff's Assisters") or co-located eligibility workers from the human services department, work with a list of inmates who are scheduled to be released to begin the process of determining eligibility for those who have not previously received benefits. Some

[64] California Rehabilitation Oversight Board. 2017. "Annual Report." [PDF]

counties have had specialized units in place to ensure that this process can be completed as quickly as possible. For example, in Los Angeles, as part of their Whole Person Care (WPC) plan, Community Health Workers (CHWs) and/or Jail Custody Assistants (JCAs) will assist the inmate in the enrollment and plan selection process simultaneously early in the period of incarceration.

As part of its Whole Person Care (WPC) Pilot, Los Angeles County is also moving forward on a process that will ensure that inmates select a Medi-Cal managed care health plan prior to release. This is an effort to improve the seamless transition to a Primary Care Provider (PCP) in the community. In this process, the Health Care Options (HCO) application for plan selection is completed along with the application for Medi-Cal eligibility. The HCO application is then retained until the inmate is released. Prior to release, CHWs and/or JCAs will inform the selected PCP that a new patient will be seeking care; the PCP may receive initial payment for services through Fee-For-Service (FFS) Medi-Cal until the HCO application is fully processed, usually in thirty days or less. This new process is currently limited to WPC participants, but Los Angeles plans to expand services to all inmates by 2018.

Issues Identified in Eligibility Process

Our research has reviewed the efforts to enroll the reentry population in entitlement programs that can support them in the community. Several challenges have been identified that limit the effectiveness of these efforts. The following sections will separately address each program area in which issues were raised, and provide suggested recommendations and next steps.

a. Eligibility Suspension: One-Year Time Limit

Current state law provides that an inmate's suspended eligibility status can only be maintained for one year, after which a new application is required to re-establish eligibility. The establishment of the current eligibility suspension process in lieu of termination was an improvement, particularly for those in jail where lengths of stay are often less than a year. However, this policy does not address the issue for those who are incarcerated in prison or jail for more than one year.

Federal guidance on this issue permits not only suspension of eligibility, but also suspension of benefits. The suspension of benefits would not be time-limited, so that no new application would be required upon leaving the jail or prison. The current time limit requires a new eligibility determination to be completed for those inmates whose sentences last longer than one year. Maintaining eligibility also requires an annual eligibility review to determine if the inmate still qualifies for Medi-Cal, even though the provision of benefits is suspended while incarcerated.

Recommendation:

- **The current one-year suspension of eligibility should be replaced by an indefinite suspension of benefits.**[65] That suspension would be removed on the date the inmate is no longer incarcerated or otherwise eligible. This change is included in SB 222 (Hernandez) which also includes the development of a simplified annual redetermination process for those in jail or prison. The bill is currently being held in the Senate Appropriations Committee's suspense file. [Reco: (1.1)(a)]

b. Health Plan Selection

It is important that inmates with significant physical and mental health conditions establish a regular source of care upon release to make sure that there is continuity in the provision of needed services. For Medi-Cal, this requires the early enrollment in a managed care plan to establish that relationship as well as a regular source of care as soon as possible after release. The DHCS currently oversees the Medi-Cal plan selection process. However, some of the counties we contacted indicated that plan selection for Medi-Cal is currently a process separate from, and subsequent to, the eligibility process, and is accomplished by completion of plan selection packet that is mailed to newly eligible individuals. If the participant fails to return a completed response to the packet, they will be assigned to a plan by default. The time it takes to select a plan can be a barrier to an individual identifying a regular source of care or continuing the treatment programs that may have been under way while incarcerated. Until plan selection and plan enrollment is completed, Medi-Cal eligible services are reimbursed on a FFS basis for the first one or two months after the inmate is released to the community.

This plan selection process happens both for the newly eligible as well as those who were on suspended status. Several stakeholders commented that for those in suspended eligibility status, the inmate's prior managed care relationship does not stay in place, requiring a new plan selection process after he/she is released and eligibility has been reestablished.

[65] The National Association of Counties (NACo) also supports total suspension instead of termination or partial termination. [Link]

The health plan enrollment process underscores the importance of a person being prepared for release to the county where the inmate truly intends to reside. Inmates are usually released to their county of last legal residence[66], but there is also a process for them to petition to be released to another county. Moving to another county requires not only a transfer of the Medi-Cal case to the new county, but also enrollment in one of the plans available in that second county. This adds administrative steps to the process of establishing ongoing medical supervision. In cases where the intended county of residence is uncertain, deferring plan choice can at least provide the person with fee-for-service care if there are ongoing needs.

As with all enrollees in Medi-Cal managed care plans, FIPs are able to change their plan at any time, although there is an administrative lag for the enrollment process. For those establishing new Medi-Cal eligibility, plan selection should be facilitated prior to release as part of the pre-release application process.

Recommendations:

- **State policy should be changed or clarified so that formerly incarcerated persons (FIPs) who have had their Medi-Cal eligibility suspended can remain in the health plan they were enrolled in prior to incarceration, so long as they are released to their county of last legal residence.** [Reco: (1.1)(b)(i)]

- **Prior to an inmate's release from custody, the individual's health plan should be informed of the date of release, if there is an efficient transfer of medical records, and a PCP has been identified to ensure continuity of care where needed.** [Reco: (1.1)(b)(ii)]

- **Inmates who did not have Medi-Cal eligibility prior to their incarceration, or who may require a new health plan, should complete their HCO applications concurrently with their eligibility application.** This model is now being tried in Los Angeles County as part of their WPC Pilot. The HCO plan application is then held until the inmate is released from jail. Prior to release, the inmate can receive assistance in choosing a PCP in the community that will be in the provider network of the Medi-Cal managed care plans that is also selected. In cases where an inmate will return to a county with a County Organized Health System (COHS), no plan selection process should be required, and instead consideration should be given to an auto-assignment process prior to release.

[66] California Penal Code § 3003.

[Reco: (1.1)(b)(iii)]

c. Electronic Data Systems Approaches

During the course of our review, concerns were also raised that there is not a more automated process for suspending and unsuspending eligibility, thus making the current process time consuming and cumbersome.

As part of our research, we learned that the State of Arizona has built the technology interface to allow for automated data exchange between agencies that suspends Medicaid enrollment upon incarceration, and for the Department of Corrections and the State's counties to electronically send release dates for incarcerated persons, thus simplifying the process of transitioning them directly into care. Through this enrollment suspension process, care can be coordinated by county jails or prisons upon release for over 95% of of those involved in the State's criminal justice system.

Recommendation:

- **The DHCS, CDCR, and other stakeholders should examine the opportunities to develop the technological infrastructure for an automated process for suspending and unsuspending eligibility.** Discussions with Arizona staff and potentially other states would be useful in this effort. An automated process would result in a significant reduction in staff time for those involved in reentry efforts, both in the jails and prisons and in county welfare departments, and would expedite the approval process and the opportunity for former inmates to receive medical coverage. The potential for enhanced federal funding at up to 90% should also be explored. [Reco: (1.1)(c)]

d. Eligibility Redeterminations/Renewals for Those in Suspended Status

During our review, concerns were raised regarding the requirement to complete annual eligibility redeterminations for inmates in suspended eligibility status. Stakeholders noted the time required to complete these annual renewals and the difficulties that can occur in getting the needed information from inmates. In considering SB 222, the Senate Appropriations Committee analysis projected an annual cost of about $4 million to perform the additional annual redeterminations that would have to occur if the time limit

on inmates' suspended status was removed – this was the primary area of new cost identified in the analysis.

Recommendations:

- **The DHCS should hold discussions with stakeholders, and determine whether there are practical steps that could be pursued to improve the renewal process for inmates.** SB 222 would have required DHCS to work with stakeholders to develop and implement a simplified annual renewal process for individuals who are in a suspended eligibility status. The Department would have been required to seek any necessary federal approvals or waivers to implement changes agreed upon. [Reco: (1.1)(d)(i)]

e. The Potential for a Presumptive Eligibility Process

The State of Maryland has submitted a State Plan Amendment (SPA) to implement a 60-day period of presumptive Medicaid eligibility for those inmates who have not yet been determined to be eligible at the time of release. They intend to implement this provision on July 1, 2017. Former inmates in this status will receive a letter indicating their eligibility for coverage for this period of time. The State has noted that it may not receive the enhanced federal matching rate for these persons, so every effort will be made to determine eligibility during the pre-release process. Presumptive eligibility will be used as a safety net for those whose eligibility has not yet been completed in order to ensure post-release continuity of care.

Recommendation:

- **The DHCS and stakeholders in California should discuss and evaluate the possibility of establishing a short term presumptive eligibility period for former inmates whose eligibility has not been determined at the point of release from incarceration.** Such an approach would need to be evaluated in terms of potential cost (e.g. impact on federal match funding) and issues associated with transition to long-term eligibility status. Nonetheless, it could prove to be a very important approach to ensure that all former inmates have access to needed medical services. [Reco: (1.1)(e)]

C. Supplemental Security Income (SSI)

Establishing eligibility for cash assistance under SSI is critical, particularly for FIPs considered medically fragile (MF) and/or living with serious mental illness (SMI), because it can provide a funding source to pay for housing, transportation, and other non-health related expenses that are needed for successful community reintegration.

In 2015-16, CDCR had a 41% approval rate for applications sent to the Social Security Administration for either social security disability income or SSI. This approval rate is up from 34% in the prior year. The CDCR has been operating under a memorandum of understanding (MOU) with the Social Security Administration (SSA) since 2008 to support the SSI eligibility process for former inmates (See Appendix 9 for a summary of the CDCR's benefit application process outcomes for SMI inmates). In addition, the CDCR, the DAPO administration, and their SSA counterparts have an established business relationship, with frequent email contacts, and generally meet twice a year. At the prison level, the CDCR/DAPO TCMP benefit workers, work collaboratively with their local SSA office contact person. The SSA provides annual training to TCMP benefit workers, who have also completed the online training provided by the SSI/SSDI Outreach, Access and Recovery (SOAR) Program that is sponsored by the federal Substance Abuse and Mental Health Services Administration that works to improve the eligibility application processes for these income programs by training case managers on the requirements to quality and the application processes..

Local jails also make efforts to enroll their inmates in these federal benefit programs, but have not established agreements with the SSA similar to the state's MOU. Two of the counties we reviewed (San Diego and Santa Clara) have direct participation in the SOAR program training.[67]

Our review suggests there are a number of issues that could impact the likelihood of SSI application approvals for inmates upon release from incarceration and the extended timeframe for the approval process. More work will be needed to reach firm conclusions on the key problems, identify steps that need to be taken to produce better outcomes, and explore whether other states are experiencing similar approval rates. Our initial assessment points to the following barriers:

a. Eligibility Establishment Often Exceeds 90-120 Days

Stakeholders have indicated that the process for SSDI eligibility is a long one that often exceeds the the 90-120 day pre-release processing timeframe for those leaving CDCR

[67] The San Diego Sheriff's Department is not participating in SOAR at this time. However, there are members of the Reentry Roundtable who are trained.

custody. Lengths of stay in jails are generally shorter and the release date less predictable, so it is very difficult to manage to complete the application processing prior to release.

Recommendations:

- **Counties should consider initiating applications for those who can qualify on the basis of disability when the person enters the jail** to increase the chances it is successfully completed. [Reco: (1.2)(a)(i)]

- **All county jails should take advantage of the materials and training available through the SOAR program.** [Reco: (1.2)(a)(ii)]

b. Low SSI/SSDI Approval Rates for the CDCR

Having an MOU with SSA has been helpful in establishing a process with clear roles and responsibilities which has resulted in improved approval rates. CDCR staff now meet regularly for SSA representatives. However, additional efforts could yield better results. For example, CDCR staff are often unclear on the status of applications that have been submitted, or on the issues that ultimately lead to application denials. Broadening participation in the CDCR-SSA meeting to include other stakeholders may be an effective approach for raising eligibility concerns.

Recommendation:

- **The CDCR and SSA should include advocacy and other stakeholder organizations in their regular meetings**, to review data on SSI eligibility determinations for former inmates, and to discuss and resolve issues that have been encountered in submitting applications and securing approvals.
  [Reco: (1.2)(b)]

c. Documenting the Disability

The most challenging process in establishing SSI or SSDI eligibility is to determine the extent and future duration of the disability. A disability is defined by the SSA as the inability to engage in any substantial gainful activity (SGA) by reason of any medically determinable physical or mental impairment(s), which has lasted or can be expected to last for a continuous period of not less than 12 months, or which can be expected to result in death.

Often this process requires follow-up clarification requested by SSA on the medical conditions for those who have submitted SSI applications. Getting a prison physician to validate the future duration of an inmate's disability can be problematic. It has been reported that, at times, requests for additional information related to SSI applications are not responded to in a timely manner.

Recommendation:

- **CDCR's California Correctional Health Care Services (CCHCS) should consider conducting a workload analysis to evaluate the current timeline and staffing that supports the SSI application process and requests to SSA for disability evaluations.** This analysis could clarify current roles and responsibilities for responding to SSI requests for additional information or for doctor's assessment of disabilities. A workload analysis would help determine the extent to which CCHCS physicians have dedicated time in their schedules and the necessary support staff to manage the process and respond to requests for additional clarification. [Reco: (1.2)(c)]

d. Low SSI/SSDI Approval Rates for Jails

The County jails that were contacted for our study indicated that, like the CDCR, they have experienced low approval rates on SSI applications submitted by/for their inmates, and significant difficulty in obtaining information on the status of applications or the reasons why applications are denied. Inmates are not able to call the SSA 800 telephone number due to jail restrictions on 800-numbers.

Recommendation:

- **A forum should be held with representatives of several county jails to discuss the experience they have had in submitting SSI applications on behalf of their inmates, and to brainstorm possible approaches to improving application approval rates and processing times.** It would be useful to have SSA representatives present to join the discussion and share ideas on how to achieve improved approval rates and shorter processing timeframes. Among the ideas that might be discussed would be the possible designation of a statewide organization that would establish an MOU with SSA to facilitate the SSI application process on behalf of inmates in local jails, similar to the MOU established by CDCR and SSA for state prison inmates. This would be an

organization that the jails could work with to obtain answers on questions that arise in the application process, and that would communicate with SSA on issues/problems that jails and inmates are experiencing in securing SSI approvals. An alternative approach would be for each jail to complete an MOU with the local SSA office for the same purpose. [Reco: (1.2)(d)]

D. CalFresh (Supplemental Nutrition Assistance or SNAP)

CalFresh (formerly the Food Stamp Program), California's version of the federal SNAP Program, provides assistance for low income persons to help buy food. It is our understanding that inmates now begin the application process when they begin the Medi-Cal application. However, CalFresh benefits do not begin until the FIP has a face-to-face meeting with a county eligibility workers. SB 708 (Skinner), introduced in the current session of the California Legislature, would require the State Department of Social Services (DSS) to submit a waiver request to the federal government to allow for the preenrollment of otherwise eligible applicants to the CalFresh Program up to one month prior to their reentry into the community from a state prison or county jail. If the waiver were approved, the bill would authorize County Boards of Supervisors or the CDCR to establish a policy to facilitate applications for CalFresh prior to release. This legislation has been held on the suspense file in the Senate Appropriations Committee. New York, South Dakota, and Vermont have obtained their waivers and conduct SNAP pre-enrollment. In addition, Montana has had their waiver since 2015, but has not implemented their program.[68]

Recommendation:

- **DSS should continue to seek the necessary authorization to request this waiver**, and work with CDCR and other stakeholders to determine whether the 30 day timeframe will be sufficient to process CalFresh applications prior to release. [Reco: (1.3)(i)]

- **DSS should work with counties and other stakeholders to explore simplifications that could be implemented to expedite the CalFresh enrollment process** for persons reentering the community in order to ensure that benefits are available upon release. These proposed simplifications could be added to the Department's federal waiver request if needed. [Reco: (1.3)(ii)]

[68] Burton, Ecaterina (2016). "Realignment: the policy opportunity for a CalFresh pre-enrollment program." [Link]

E. Obtaining a California ID (Cal-ID)

Having state-issued identification with a picture can be an important element in helping the reentry population access health care services, as well as function successfully once released. There are current processes in place that coordinate the application for the California Identification Card (or Cal-ID) to assist eligible offenders in obtaining State-issued identification (ID) cards. The processes and agreement between the CDCR and the DMV were instituted based on AB 2308 (Ch 607/2014) that mandated a process for obtaining an ID for prisoners with a recent photo on file with the DMV based on the issuance of a driver's license or ID prior to entering prison.

The process established under AB 2308 is limited to those with recent pictures on file at the DMV (i.e. less than 10 years old). According to information from DMV, this historically covered about 85 percent of the reentering, although recent changes in sentencing and release processes may have increased the average age or length of their stay in prison for those who are now exiting, decreasing the likelihood that the photo on file would be current. Between July 2015 and June 2016, 12,035 applications were sent to DMV for processing (less than half of the 27,000 applications for Medi-Cal that were submitted on behalf of released inmates during the same period). The DMV has approved and issued over 10,000 cards. Recent statistics drawn from a small sample from LA County indicate that about 37% of Post Release Custody Supervision (PRCS) arrivals have either a valid driver's license or ID (See Table 1.1.).

Table 1.1. Cal-ID Status of Individuals Released to LA County on Post Release Community Supervision during June 2016

Valid California Driver's License	10	10%
Valid California ID number	27	27%
Expired CDL	44	44%
No CDL or ID	12	12%
No information	7	7%

Source: Survey results from LA County Probation Department, 2017

We do not have a clear picture of what the important constraints are that limit the number that have IDs upon release. It appears that a sizable portion of the reentry population have to obtain

IDs after they arrive in their communities, the largest group being those who arrive with expired driver's licenses.

One issue could be the lack of a current photo in the DMV files. The date from Los Angeles shows that 27 percent have a valid California ID, a rate that corresponds roughly to the third of those released who obtain IDs through the Cal-ID process described above. The 44 percent with expired licenses are likely to also have an out-of-date photo on file. This would be the case if the expired license had a photo that was more than 10 years old. While some of the expired licenses might have more recent photos, it is likely that most of this 44 percent do not.

Certainly, longer average stays in state prison can increase the likelihood that the photo of a released prisoner would be older than the 10 years allowed under the program. Any outstanding fines on an individual's driving record can also hinder their ability to obtain a valid ID. Further work is needed to understand how to increase the share of individuals who can obtain valid identification prior to release.

With respect to the individuals reentering the community from jails, where the average length of stay is shorter than in state prisons, there is less of a need to obtain new identification documents. It is more likely that the driver's license will not have expired upon release, and if a new ID is needed, DMV is more likely to have a recent photo.

San Diego County, with coordination from the DMV, has created a program that provides state identification to inmates three to four months prior to release.[69] At approximately four months prior to an individual's release, the sheriff's department will send their name to the DMV to see if they are eligible for an ID. If the individual is eligible, the sheriff's department will provide assistance to the inmate with completing the application and sending the fee to the DMV. Inmates pay the fees out of their accounts, and the county is able to assist with some of the costs through the Inmate Welfare Fund.[70]

Los Angeles County has also worked with the DMV to establish a process for issuing IDs to individuals expected to be released.

LA County collects statistics on requests for replacement IDs for individuals it is releasing. Table 1.2. below shows the disposition of the total of 1,837 requests for new California IDs during 2016.

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[69] Stewart, Joshua (2015). "County, DMV to help inmates to get ID cards." The San Diego Union-Tribune. [Link]
[70] The Inmate Welfare Fund of the CDCR is a trust in which all proceeds from inmate canteen and hobby shop sales are deposited, and may be used to provide funding for these local programs.

Table 1.2. LA County Statistics on Cal-ID Requests (2016)			
IDs Approved		1,097	60%
IDs Denied	Individual did not have funds	473	26%
	Released prior to completing application	91	5%
	Lack of current photo or incomplete application	176	10%
Total Applications		**1,837**	100%[71]

Source: LA County Probation Department, 2016

Again, we have a good indication of the reasons that applications are denied, and the lack of a photo is less than 10% share of the overall applications submitted.

Recommendations:

- **A more detailed review of the effectiveness of the ID issuance process is needed** to determine the share of eligible applicants that are not able to get IDs and why. A substantial number of individuals receive IDs each year, but the numbers for 2015-16 suggest that a group of applicants cannot receive IDs, likely because photos at DMV are out-of-date. More work needs to be done to understand these statistics and why they don't include more of the reentry population. [Reco: (1.4)(i)]

- **Additional discussion is needed to consider alternative options for providing access to IDs for those who do not meet the requirements of AB 2408.** For example, for inmates with no prior record at the DMV, a process for initiating a new application for an ID and obtaining the required photo and fees is needed. In cases where there is a record at DMV but not a current photo, it may be worth exploring ways obtain current photos for these individuals. [Reco: (1.4)(ii)]

[71] Does not precisely add to 100% because of rounding.

2. Care Coordination and Service Delivery

Overview

Individuals released from prison and jail face multiple challenges for maintaining continuity of care, including coordinating health and behavioral health services in the community and facilitating the transfer of health care records. These challenges of coordination between systems often places the burden of care coordination and records management on the beneficiary. While State spending on prison-based health and mental health services has increased, the benefit of in-custody care may be temporary if it is not properly coordinated with service providers in the community as people are released from jails and prisons. This is an important consideration because delivering health care services in jails and prisons is particularly costly, especially compared to primary care delivered in the community.

Criminal justice populations are difficult and costly to serve, in large part because of their especially complex social circumstances. Mental illness, alcohol and drug addiction, homelessness, inadequate education and job skills, and a myriad of physical health conditions all characterize the challenges in providing services to these individuals. Casenotes from the Santa Clara County Superior Court puts a human face on these challenges:

> *Client is 32 years old. He was released from jail. He has been living in a makeshift tent on the banks of the nearby river. All his belongings were stolen when he went to jail and his tent was destroyed. He has no ID, and no Social Security Card. He never finished elementary school and can barely write. He has no health insurance. He waited in line to get General Assistance, but since he has no ID, he was denied help and told to go get ID. He was treated in jail for a broken arm that was not healing and for mental illness. He has nowhere to go for medical and mental health treatment, so he repeatedly goes to the emergency room and they repeatedly release him to the streets with no plan and no prescription. He was told that it is a 60 day minimum wait to see a physician at the County Hospital to obtain ongoing treatment for his arm. He has been rejected by several community treatment programs because of his poor hygiene. He went to a County Mental Health clinic to try to get his medications and was told that he could not see a county doctor for 3 weeks because they are backed up. He has no phone, no address, and goes to the window at Saint Joseph Cathedral to get peanut butter and jelly sandwiches to eat every day.*

This person's particular situation is unique, but it illustrates the difficulty formerly incarcerated people have meeting even basic needs as many reenter California's most disadvantaged communities or become homeless upon release. Such precarious circumstances can be alleviated

by providing appropriate public services, but the lack of access to primary and preventative care means that the services delivered will be unnecessarily expensive. Effective care coordination across the multiple health and public systems that will deliver the needed services can ensure appropriate services before the need for emergency or inpatient care. We discuss the challenges associated with meeting the health and behavioral health needs of FIPs in the context of three broad domains:

- Transitions between Systems and Program
- Provider Arrangements
- Unique Individual Needs

Challenges to Effective Care Coordination

A. Transitions Between Systems and Programs

Encouraging coordination between agencies as an individual transfers from one provider to another is particularly important for MF and SMI FIPs, who commonly have repeated contacts with multiple systems that become responsible for their care. The term "warm-hand off" is often used to imply that the client never loses contact with the referring provider until contact with the new provider is established. This warm hand-off boils down to some simple systems. These include:

- Sharing medical records as necessary,
- Providing needed prescription drugs and other treatment regimens continuously after release from or upon return to jail or prison,
- Providing individual served the information they need to to actively participate in managing their health problems as they cycle between systems needing care.

While a "warm hand-off" is conceptually ideal, organizing systems and programs for successful and consistent implementation can be challenging and complex.

While the exigent social circumstances that characterize much of the MF and SMI reentry population commonly frustrate seamless transitions, there are also programmatic and/or administrative structures that create barriers that can be mitigated through administrative change. Examples include:

- **Program Cliffs.** Transitions between multiple programs and services such as probation/parole, county behavioral health and health services agencies create barriers for seamless continuity of care, on-going access to providers and medication, and effective case management. The cliffs are created when there are gaps in eligibility when moving from one program to another (because of factors such as time-limited programs),

administrative barriers to enter a program (e.g application processing, eligibility requirements), and/or time spent on waitlists because programs are full. In general, as inmates move from prison to parole, or prison to county supervision (PRCS) or county supervision to jail (via a revocation or new offense), the change introduces a different administrative entity with responsibility for delivery of medical and specialty mental health services, each with different expectations, obligations and resources.

Consider the challenge of finding an appropriate community placement for state inmates who qualify for Medical Parole who require a skilled nursing facility (SNF) level of care. The CDCR now contracts with private SNF's, often paying in the range of $600 per day ($216,000 annually). According to the California Association of Health Facilities, this is more than double the average reported 2015 cost per patient day for a skilled nursing facility of $289 or ($105,485 annually). Moreover, these costs are significantly higher than the average Medi-Cal reimbursement rate of about $206 per day.[72] There is also no federal financial participation to offset the CDCR's cost.

What happens when inmates requiring SNF level of care are released on parole or return to the community under PRCS? Eligibility Assistance staff operate in 12 institutions, and include a nurse consultant program review (NCPR) staff who coordinates with family members and caregivers as well as Utilization Management (UM) nurses and transitional case management staff in the institution. Although California's Correctional Health Care Services (CCHS) eligibility assistance staff work to identify an appropriate SNF placement, they are rarely successful as will be described below. Less assistance and coordination is provided to high medical risk inmates—those who are medically fragile, but do not require SNF level care. There is no formal process between the State and the County to help them access health services after their release. There are similar program cliffs as individuals move from jail to the community.

- **Primary Care "Carve Outs"** for specialty mental health, substance abuse treatment and dental services add to the challenge of care coordination between the county systems of care. In the current Medi-Cal system, managed care plans are generally responsible for most health care needs of the plan members, including care for mild and moderate mental health issues. However, treatment provided to Medi-Cal beneficiaries living with serious mental illness or substance use disorders is provided through the county behavioral health systems. Coverage for specialty mental health and substance use disorder services are "carved out" of the managed care delivery system. Dental services are also carved out of Medi-Cal managed care and are provided, in most parts of the state, by providers that bill

[72] California Association of Health Facilities. 2017. "Guide to Long Term Care." [Link]

Medi-Cal on a fee-for-service. These carve outs can be frustrating for patients who must navigate multiple systems to get care. For example, if a formerly incarcerated person is being served at a clinic for a chronic health condition such as diabetes, that person's care would be financed by his or her Medi-cal managed care plan, which contracts with the clinic to provide the service. But if the person also sought treatment at that clinic for a serious mental illness, that care would have to be authorized and financed by the individual's county specialty mental health plan. Historically, alcohol and drug addiction services covered by Medi-Cal have been limited. The new Drug Medi-Cal Organized Delivery System in early stages of implementation, is another "carved out" service that is provided through county contracts with community providers. Due to the fragmentation between certain carve-out services and the health plans, the burden for coordinating services often falls on the beneficiaries and their families. The current system of carve-out services has created numerous coordination challenges for health plan members which can be particularly challenging for medically fragile and SMI individual.

- **Siloed Funding.** Statutory requirements and policy decisions can create funding silos that impair the care and coordination of justice-involved individuals. For example, there is a specific exclusion in the Mental Health Services Act (Proposition 63) that prohibits the use of fundings for services to parolees.[73] Counties use MHSA funds to help pay for the non-federal share of cost for Medi-Cal services as part of their specialty mental health service plans. To the extent other funds must be found for this cost for parolees, the Proposition 63 exclusion adds an additional fiscal complication for making these county services available to the parolee population.

  The MHSA parolee exclusion language has led some counties to establish a policy that explicitly excludes parolees from receiving any specialty mental health services. Prior to the passage of the Affordable Care Act, most parolees were not Medi-Cal eligible and not entitled to Medi-Cal specialty mental health and substance abuse treatment benefits. Counties adopted policies that reflected their limited resources and prioritized services to non-parolees. For example, the Los Angeles County Department of Mental Health takes the view that the responsibility for providing behavioral health services services for parolees rests with the State. On the other hand, Santa Clara County does not have such a policy, and advises us that parolees do receive specialty mental health services.

  Prior to the Public Safety Realignment Act of 2011, parolees returned to state prison if their parole was revoked by the Board of Parole Hearings (BPH). Recognizing the State's fiscal interest in reducing recidivism among SMI inmates, CDCR responded by creating

[73] Welfare & Institutions Code, Section 5813.5(f). [Link]

the Parole Mental Health Services Continuum Program (MHSCP) in 2000. This included the restructuring and expansion its own network of parole outpatient clinics (POC's), originally created in 1954, and the establishment of the Transitional Case Management Program (TCMP) for the mentally ill. Staffed by state employees, POCs manage the mental health treatments of a growing number of Enhanced Outpatient Treatment (EOP) and Correctional Clinical Case Management System (CCCMS) inmates who parole. The MHSCP was originally designed to include:

- Pre-release needs assessment of mentally ill inmates expected to be released on parole.
- Pre-release benefits eligibility and application assistance.
- Expanded and enhanced post-release mental health treatment for mentally ill parolees.
- Improved continuity of care from the institution's Mental Health Service Delivery System to the community-based parolee outpatient clinics.
- Increased assistance for successful reintegration into the community upon discharge from parole.
- A standardized program in all four parole regions.[74]

Today, the MHSCP has been modified and expanded to include the following program components:

1. TCMP
2. POC
3. Integrated Services for the Mentally Ill Program (ISMIP)
4. Case Management Reentry Pilot
5. Medication Assisted Treatment
6. Co-Occurring Mental Illness and Substance Abuse Program

Some of the original components of MHSCP are referenced later in this report, and are outlined in Appendix 10. Today, the coordination of treatment between the prison and the POC is enhanced because all POC offices now have access to the CCHS' Electronic Health Record System (EHRS).

Having a separate and largely independent Mental Health treatment network for parolees creates coordination and service delivery problems when the parolee is discharged from parole, and transition to county specialty mental health treatment needs to occur. When a SMI parolee is no longer the responsibility of Parole, a transition to county specialty mental health services would ensure continuity of care. This hand-off to the county would ideally occur 2-3 months before the

[74] CDCR. 2008. "Final Report on the Mental Health Services Continuum Program - Parole Division." [PDF]

parolee is discharged from the POC. However, some POC staff advised us that county specialty mental health staff are not willing to begin the process of transitioning and making future clinical appointments until the parolee has been officially discharged from parole. Delaying this transition result in gaps in MH treatment, that could result in the discharged parolee's relapse. Other POC staff told us it was "hit or miss" depending on the state clinicians relationship with county staff.[75]

CalHPS discussed this issue with Chief Deputy Director of the Los Angeles County Department of Mental Health, Robin Kay, Ph.D., and senior department staff. We were advised that the county does not have a policy that might preclude appointments from being made in advance of the parolee's discharge date to ensure continuity of care between POC and County Mental Health. This appears to be a problem that could be easily fixed with an instructional memo to LAC DMH Director to their treatment providers. When a SMI parolee is arrested and incarcerated in the county jail, there is also little communication between POC mental health clinicians and mental health clinicians in county jails.[76]

AB 109 has changed the parole revocation process. For most parolees today, the decision for revocation is made by the Superior Court, and the parolee serves their revocation period in the county jail, instead of prison. Therefore, Counties now have a greater interest in addressing the needs of parolees who without support might otherwise return to custody. This change may encourage better coordination between POC and jail MH clinicians.

- **Access to 30 Day Supply of Medication.** The continuity of care related to important medications, particularly for those living with serious mental illness, is a useful example of the issue related to care handoffs. A 30-supply of medication for individuals leaving prison and jail can help to reduce gaps in continuity and provide a window during which the former inmate can get an appointment with a community physician and new prescription. CDCR policy provides for inmates to receive a 30-day supply upon release. However, in the event that the parolee does not have the prescribed medication, a POC psychiatrist will write a prescription so the parolee can obtain it.

  Jail policies also vary. In May 2017, the Los Angeles County Jail began providing a 30 day supply of medication to women upon their released from jail and will soon do so for the men. However, San Diego County Jail provides SMI and HIV inmates with a 10-day prescription for medication, which is faxed to a local pharmacy. Whereas, Santa Clara

[75] Correspondence with POC staff.
[76] Legislation was introduced in 2017 (SB 350 - Galgiani) to require the disclosure of health and mental health information between jails and state prison to maintain continuity of care for an inmate being transferred between those facilities. The bill was held in the Senate Appropriations Committee.

County faxes a prescription for a 30-day supply to a local pharmacy where the FIP can pick it up. CalHPS is unaware of any tracking by County staff to determine whether jail inmates picked-up/received their medication upon release.

Current Efforts to Improve Coordination

State and local corrections systems have recognized the need for greater program coordination and have taken steps on multiple levels to address the coordination needs of FIPs. The CDCR/DAPO has established several programs to provide pre-release planning, case management, and mental health services. The programs described below are part of the Mental Health Services Continuum.

- **Transitional Case Management Program (TCMP) within 120 days of Release.** The TCMP has been expanded to assist all inmates in applying for entitlement programs such as Medi-Cal, Social Security, Supplemental Security Income, and Veteran Administration benefits, which are sent to the respective administering agencies within 90 days of the inmate's scheduled release date.

- **Parole Outpatient Clinics (POC)** are located within local parole offices, and are staffed with psychiatrists, psychologists, and social workers. They provide the following services: MH evaluations, medication management, individual and group therapy, crisis intervention, and case management. The POC administered the Medication Assistant Program for person with opiate addictions, and also makes referrals to the Integrated Services for Mentally Ill Parolees (ISMIP) providers, to receive additional MH and supportive services.

- **Integrated Services for the Mentally Ill Program (ISMIP)** provides wrap around case management and support services such as housing, for SMI parolees endanger of becoming homeless. The case management strategies for the program are designed to address mental disorders, developmental disabilities, homelessness, and/or joblessness, through the use of evidence based practices, such as the use of individual reentry plans, an emphasis on matching criminogenic needs with programs, the use of Interdisciplinary treatment teams (e.g. the assigned parole agents) and small clinician caseloads. The ISMIP is located in seven counties: Kern, Los Angeles, Sacramento, San Bernardino, San Diego, San Francisco, and Santa Clara.

- **Case Management Reentry Pilot Program.** Legislation in 2014 (Ch 26/2014, Sec. 27) requires CDCR to establish a "case management reentry strategy designed to address homelessness, joblessness, mental disorders, and developmental disabilities among

offenders transitioning from prison into the community. The Division of Adult Parole Operations (DAPO) is conducting this pilot in five counties: Los Angeles, San Diego, Sacramento, and San Francisco and, Kern. All parolees returning to the pilot counties are eligible to participate in this program, if slots are available. With case management services similar to the ISMIP program, the Case Management Reentry Pilot Program consists of three phases: Stabilization, Transitional and Substantiality. The program utilizes the Multnomah Community Ability Scale (MCAS) to assess an individual's ability to function in everyday life. There are 15 Case Management Reentry Needs assessed and tracked: Food, clothing, shelter, medication management, health benefits acquisition, medical/dental services, mental health services, substance abuse services, income (GR, SSI, employment, CalWorks), identification, life skills, productive activities, pro-social support systems, academic/vocational programs, and community reintegration/discharge sustainability plan.[77]

- **Medication Assisted Treatment (MAT) for Opioid Addiction** is a voluntary program administered by both California Correctional Health Care Services in the prison as a pilot, and POC for any parolee, who has an opioid dependency and wishes to address their addiction. The 2016-17 Budget package required the CDCR to establish a pilot program at one or more institutions to provide a medication assisted treatment model for inmates with a history of substance abuse problems and appropriated $2.5 million. These MAT participants are seen face to face by a POC psychiatrist or via video conference, accompanied by a social worker. The prescriptions (e.g. Vivitrol) are filled by local pharmacies and most are generally funded by Medi-Cal.

- **Co-Occurring Substance Abuse and Mental Health Disorder Pilot Program** is funded by a Second Chance Grant from Bureau of Justice Assistance (BJA). The funds will be utilized to enhance the POC Case Management Reentry pilot, add a mental health screening assessment tool and provide specialized treatment for parolees diagnosis with both a mental ill and substance abuse.

At the local level, efforts to coordinate services for the justice-involved population and incentivize collaboration has been spurred through the the Community Corrections Partnership/AB 109 Planning Process and Whole Person Care Pilots.

- **Community Corrections Partnerships (CPPs)**, as established by SB 678 (Ch 608/2009) bring together key local stakeholders to coordinate policy and practices. These

[77] The pilot is currently under evaluation by David Farabee, Ph.D., Professor-in-Residence of Psychiatry and Biobehavioral Sciences at the University of California, Los Angeles. Although it is too early to assess recidivism reduction, the program has shown much promise and a reduction in the community functioning factors as the parolee progress through the three phases of the program.

local partnerships now play a central planning role in advising the Chief Probation Officer on the implementation of SB 678. The Community Corrections Partnership also developed each county's public safety realignment implementation plan. The Chief Probation Officer of each county is the chairperson of the CCP. Members of the committee include the Sheriff; District Attorney; Public Defender; Directors of county health, behavioral health, social services; Police Chiefs, education and job training administrators; victims advocates, and other representatives from community based organizations. Although spending decisions are ultimately the responsibility of Boards of Supervisors, the Partnership creates a formal setting that brings the key players to the table. In our target counties, all three - San Diego, Santa Clara, and Los Angeles - have had criminal justice coordinating committees that bring all of the key players together, including parole. Although there is overlap, the opportunity for discussion and collaboration is available.

- **Whole Person Care Pilots.** Another catalyst for innovation and collaboration has been the Whole Person Care pilots, funded with county resources and matched by the federal government through the State's Section 1115 Medicaid Waiver. As noted earlier, four counties (Los Angeles, Placer, Contra Costa and Kern) have used this approach to target the reentry population with programs that bring together jail operations, probation, and county health, behavioral health and human services. A more detailed description of these pilots can be found in Appendix 5. Other counties, who have been approved during Round II of the Waiver, are also considering the reentry population as a potential target.[78]

Using Medicaid Managed Care Health Plans - What Other States Are Doing

Several other states have used their contracts with their Medicaid managed care health plans to provide specific assistance and support for inmates who are transitioning from custody to the community. Particularly for FIPs with complex and potentially expensive health conditions, Medicaid health plans have fiscal incentives for assisting transitioning inmates and are well positioned to help these individuals access a medical home, pharmacy services, and care coordination. These incentives relate to the capitated payments managed care plans receive for providing health care services to their enrolled members.

Mandatory enrollment in managed care for most Medi-Cal eligible populations also includes most FIPs.[79] The health plans may be willing to cover additional services if they are a

[78] Effective July 1, 2017. Seven new WPC applications were approved, but are not yet available for review. Additionally, eight counties approved during Round I have been expanded. [Link]

[79] For an overview of Medi-Cal managed care, see Tatar, Margaret et al. 2016. "Medi-cal Managed Care." *Kaiser Family Foundation.* [Link]

cost-effective alternative to paying for more expensive hospital or other health services that could otherwise be avoided.

Other states have negotiated provisions in managed care contracts to require health plans to engage with eligible people while they are still incarcerated to connect them to a managed care plan as part of reentry efforts and to conduct outreach and coordination upon their release.

- **Arizona.** In October, 2016, Arizona included a specific provision in its Medicaid managed care plan contracts requiring the plans to do in-reach for jail and prison inmates with complex medical needs. Staff with Arizona's Medicaid agency advised that that health plans were persuaded that the intervention would be cost effective, and would save money. No additional funding was provided. The contracts require plans to do the following:
    - Implement reach in care coordination for members who have been incarcerated in the adult correctional system for 30 days or longer, and have an anticipated release date.
    - Reach in care coordination activities shall begin upon knowledge of a member's anticipated release date.
    - Collaborate with criminal justice partners to identify justice-involved members in the adult criminal justice system with physical and/or behavioral health chronic and/or complex care needs prior to the member's release.
    - Collaborate with the member's behavioral health contractor if (if the member's care is not integrated).

  The University of Arizona Health Plans (UAHP) Reach In Program is designed to maximize the opportunity to engage incarcerated members prior to their release in order to coordinate their health care services, identify other needs for services and provide community referrals and linkages in order to promote their successful transition back into the community. Additional information can be found in Appendix 11.

- **Colorado.** The state requires behavioral health plans to "collaborate with agencies responsible for the administration of jails, prisons, and juvenile detention facilities to coordinate the discharge and transition" of enrollees. In addition to ensuring that enrollees leaving incarceration receive medically necessary behavioral health services, plans must propose innovative strategies to meet the needs of enrollees involved with the criminal justice system.[80]

[80] See Colo. Department of Health Care Policy & Financing, Contract with Behavioral Healthcare, Inc. for Behavioral Health Services Program 17.

- **Florida.** In Florida, Medicaid managed care plans are required to "make every effort…to provide medically necessary community-based services for Health Plan enrollees who have justice system involvement." Among other things, plans must: (1) provide psychiatric services to enrollees and likely enrollees within 24 hours after release from a correctional facility; (2) ensure that enrollees are linked to services and receive routine care within 7 days after release; (3) conduct outreach to populations of enrollees "at risk of justice system involvement, as well as those Health Plan enrollees currently involved in this system, to assure that services are accessible and provided when necessary." In addition, plans must work to develop agreements with correctional facilities that will enable the plans to anticipate the release of individuals who were enrolled prior to incarceration.[81]

- **Ohio.** The state is piloting the Medicaid Managed Care Prison Transition Program to assist with enrollment and coordination of services for former inmates. The enrollment process engages inmates 90 to 120 days prior to release to initiate the application process. These individuals are given 60 days to select from one of five managed care plans.[82] Additionally, the Ohio Department of Rehabilitation and Correction staff members assess their health records to determine if they might have a medical and/or behavioral health condition that would qualify them for case management. If enrollees have two or more chronic health conditions (including mental illnesses and substance use disorders) and qualify for the state's health home program, they receive an enhanced level of case management. These individuals with complex needs are given a transition plan prior to release, which includes having a video conference with a representative from their managed care plan, scheduling appointments with providers, and coordinating support services such as transportation.[83]

  Recognizing the unique needs of the justice-involved population, the state's Medicaid Managed Care plan contract also included certain changes to the benefit packages. For example, many behavioral health services that had previously been separately administered were integrated into the health plans to help improve connections to specialty mental health and substance abuse services for these individuals. This policy change has the potential to improve care coordination for individuals needing specialty mental health and substance abuse treatment.[84]

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[81] See Florida. Agency for Health Care Administration, 2012-2015 Health Plan Model Contract Attachment II – Core Contract Provisions 125.
[82] National Association of Medical Directors. 2016. "Ohio's Medicaid Managed Prison Transition Program." [PDF]
[83] National Academy of State Health Policy. 2015. "Ohio: Strategies to Enroll Justice Involved Individuals in Health Coverage." [Link]
[84] Ibid.

Recommendations:

- **Facilitate Reentry Learning Collaborative - Whole Person Care (WPC) Pilots and PRIME.** There are four counties that have specifically targeted the reentry population (L.A., Kern, Contra Costa and Placer) and have program designs that engage their jails and probation departments. As DHCS reviews Round II applications for WPC, there may be additional counties that intend to focus on the reentry population. A learning collaborative that brings together staff from these counties to share implementation approaches and experiences could improve outcomes and the overall success of the project. Additional participation in a potential learning collaborative could include the four public or district hospital systems that are focusing on the reentry population as part of their PRIME program. [Reco: (2)(a)(i)]

- **Helping CDCR Develop a Statewide Protocol for Transitioning Medically Fragile Inmates - Beginning with County Organized Health System (COHS).** When medically fragile, high cost and utilization Medi-Cal eligible inmates are released from prison, they will generally become enrolled in a Medi-Cal managed care plan. These plans should have a strong interest in providing care coordination and support as these inmates return to the community. As noted earlier, several states have required their Medicaid managed care organizations through specific contract provisions to assist with enrollment and planning prior to an inmate's release. For CDCR to move in this direction, a process will be needed to ensure that inmates can choose a health plan prior to release. However, in counties that are served by County Organized Health Systems (COHS), there is only one plan. COHS serves about 1.9 million beneficiaries through six health plans in 22 counties: Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Merced, Modoc, Monterey, Napa, Orange, San Luis Obispo, San Mateo, Santa Barbara, Santa Cruz, Shasta, Siskiyou, Solano, Sonoma, Trinity, Ventura and Yolo.[85] [Reco: (2)(a)(ii)

  Partnership Health Plan has already expressed interest and an on-going discussion with other COHS and CDCR could be fruitful in developing a protocol that ensures continuity of care for medically fragile inmates.

- **Improving State/County Coordination for SMI Parole Programs.** Counties now have strong interests in supporting the successful integration of SMI parolees who return to their communities. As noted earlier, under Realignment, most parolees now face incarceration in jail if their parole is revoked by a court. [Reco: (2)(a)(iii)]

  Better communication between POC and county specialty mental health staff may be able

[85] CA DHCS. 2014. "Medi-cal Managed Care Program - Fact Sheet" [PDF]

to address hand-off issues as SMI parolees are discharged from parole and become the responsibility of a county. Simply clarifying county policy, for example, could allow POC staff to make appointments with county specialty mental health clinicians for parolees prior to their discharge from parole.

Stronger collaboration between Parole, Probation and County Behavioral Health Departments could also yield more innovative and cost effective approaches for providing treatment and support services to the justice-involved population. Our project facilitated a discussion with DAPO, Alameda County Department of Behavioral Health, and Alameda County Probation Department to explore potential options. This initial discussion ultimately led to a proposal that was recently approved for $6 million in Proposition 47 funding from the Board of State and Community Corrections (BSCC). The funding will be used to: 1) implement a new, county-wide, intensive, multidisciplinary reentry team model to provide service for the target population who are experiencing moderate to severe mental health issues and/or substance use disorders; 2) augment contracts with existing community based SUD providers to increase numbers of people in the target community who receive their services; and 3) launch a new grant program designed to increase the number and ability of organizations in the County to provide comprehensive housing supports.

The Council on Mentally Ill Offenders could sponsor and provide technical support for these efforts of this kind in other counties.

B. Provider Approach to Service Delivery

Health and behavioral health care providers that serve FIPs have unique challenges. To be effective, providers should address the stigma associated with the justice-involved population as well as the need for appropriate partnership with parole and probation departments that are supervising their patients. However, much of the workforce has not been provided adequate training on the unique needs of the reentry population, including an understanding of criminogenic risks and needs.

- **Stigma.** Former inmates and justice-involved individuals often face a stigma that can also become a barrier for them to access health and behavioral health care services. Community-based providers and caregivers may have fears for their personal safety and may simply prefer to work with, or give priority to other non-justice-involved clients. Providers may also have concerns about how their other patients will react at sharing a hospital room waiting room with justice-involved individuals. Private SNF's are not required to accept former inmates and have little financial incentive to do so given the

low Medi-Cal reimbursement rates and the perception that other patients will object at the prospect of having a former inmate in the bed next to them.

When the inmate reaches his parole date, and the eligibility assistance staff are unable to find an appropriate placement, CDCR will transport the parolee to hospital emergency department in the parolee's county of last legal residence. CDCR will pay for the cost of an ambulance if medical transportation is needed. In the case of Los Angeles County, an MOU with CDCR establishes a protocol for transferring the former inmate to one of the county's public hospitals (e.g., Oliveview or Ranch Los Amigos).

- **Communication Gaps Between Health Care Providers and Parole/Probation.** Probation Officers may not have current information about the status or progress of treatment that their parolees or probationers may be receiving. In Los Angeles County, for example, we were informed that a probation officer does not routinely receive timely information about their client's treatment regimen or attendance at a treatment program. The officer does receive a progress report from County Mental Health indicating whether the probationer has been in "compliance" over the past ninety days. This is defined as receiving some kind of services within past 90 days. Probation can't get records from DMH due to HIPAA.

  Most AB 109 Plans have a process for referring SMI PRCS clients to specialty mental health treatment. However, once referred, probation officers do not generally get information about the frequency of a client's treatment sessions, or get timely notification when their client misses appointment(s).

Current Designs for Coordinating Care

At the provider level, a variety of approaches are being utilized to address the unique needs of justice-involved individuals who are transitioning from prison and jails. Key elements include establishing a medical home that provides patient-centered care and uses Community Health Workers (CHWs) who help facilitate a continuity of care as the inmates leaves custody and also helps the FIP to navigate the complex health and social service delivery systems in the community. Here are five examples of promising approaches to care coordination.

The Transitions Clinic Network

The Transitions Clinic Network has become a pioneer in developing a model that connects FIPs to primary care. First started in San Francisco, TCN is a national network of medical homes for individuals with chronic diseases recently released from prison.

TCN hires CHWs who have a history of incarceration and can therefore better appreciate their shared experiences with the criminal justice system. Gaining the FIP's trust can help improve communication and the ability of the clinical team to provide health and behavioral health care services. who are better able to understand and communicate the as part of the clinical team. The CHWs connect the inmates while still incarcerated and help with enrollment in Medi-Cal and care coordination when the inmate is released.

In addition to the success of transition clinics in connecting people to care, they can benefit the broader health care system by keeping patients out of emergency rooms and hospitals. A randomized controlled trial conducted at the Southeast Health Center, a transitions clinic in San Francisco, demonstrated a 14% reduction in emergency department use over 12 months, an average cost savings of $912 per patient.[86]

In Solano County, the TCN model is being replicated at the La Clínica's North Vallejo site. The program is partnering is partnering with Partnership HealthPlan of California, a Medi-Cal managed care plan, which recognizes the potential opportunity for addressing the unique needs of their justice-involved members.

To better understand how the model works for an individual, consider the case of 45-year-old parolee, Norman C. (*pseudonym used):

> While at a mandatory Parole and Community Team (PACT) meeting shortly after he was released from prison, Norman met a CHW from the La Clínica Vallejo Transition Clinic. He told her that he was done with the drugs and the violence that landed him in prison for 20 years. He said he was sure he was going to live the rest of his life as a free man, but he wasn't sure how to put his life back together.
>
> Norman had no idea how to go about finding a job in a world of cellphones and the Internet. He didn't know how to afford the healthy food he needed to keep his diabetes under control or what to do about a hernia that caused him pain whenever he tried to lift anything heavier than a coffee cup. The CHW immediately set him up with an appointment at the clinic. Norman has completed treatment at La Clínica for chronic hepatitis C and recently had his hernia repaired. He has kept his commitment to himself to stay away from drugs and alcohol and is now employed at a local food packaging facility.

[86] Wang, Emily et al. 2012. "Engaging Individuals Recently Released from Prison Into Primary Care." *American Journal of Public Health*, 109(2). [Link]

Sacramento WellSpace Health Medical Clinic Reentry Pilot — Using Federal Qualified Health Centers (FQHC's)

The WellSpace Health Medical Clinic in Sacramento is currently implementing a unique pilot with the Sacramento County Jail. The clinic is an FQHC that provides comprehensive health care services, primarily to Medi-Cal beneficiaries and the uninsured. In some clinics, these services include some behavioral health services including access to psychiatry and SUD treatment. These clinics are reimbursed through an all-inclusive, "prospective payment system" (PPS) rate. The PPS rate includes all Medicaid covered services and supplies during a base period and dividing them by the total number of visits.[87] Depending on the FQHC's scope, the bundled rates can allow specialty mental health and SUD services to be provided directly to patients without a referral to county carve outs.

The Sacramento Sheriff's Department contracts with WellSpace to provide a continuum of specialty mental health and SUD treatment for inmates who are leaving jail. Like the Transitions Network, Wellspace uses CHW's to engage jail inmates by phone while they are still incarcerated and can pick them up when released. Treatment focuses on the recognition of offender substance abuse issues, strategies to overcome addiction, and ways to maintain a clean lifestyle through recovery. Substance abuse treatment programs include Substance Misuse, Relapse Prevention, and The Vivitrol® Program.

Kedren Community Health Center — An Integrated Community Mental Health Program for SMI PRCS.

Kedren Community Behavioral Health Center is a private, non profit Acute Psychiatric Hospital and Community Mental Health Program in South Central Los Angeles. Kedren Community Health Center operates as an FQHC providing comprehensive health care services to its patients. Kedren has a variety of contracts with Los Angeles County Department of Mental Health and currently provides services to about 268 SMI clients who are PRCS. Kedren has patched together a health home model for its patients through a variety of collaborative partnerships with SUD, housing, employment, legal service agencies. Specializing in serving the justice-involved population, Kedren recruits and trains staff, utilizes peer navigators, and volunteers, who are comfortable and competent in working with FIPs.

[87] Office of the Assistant Secretary for Planning and Evaluation. 2014. "Medicaid and Permanent Housing for Chronically Homeless Individuals." [Link]

Integrated Services for Mentally Ill Parolee-clients (ISMIP) Program at CDCR — A Model for Parolees.

CDCR's ISMIP Program is a comprehensive model provides varied levels of care, supportive/transitional housing, and an array of mental health rehabilitative services to assist with the development of independent living in the least restrictive environment possible. Parole Agents and POC staff refer parolees to contracted ISMIP providers for treatment and crisis care services. ISMIP services include assistance and linkage to: Crisis Care - 24/7/365 (including in-patient services), Mental Health Treatment, Substance Abuse Treatment, Case Management, Life Skills, Vocational training, Education, Housing, Benefit Entitlements, Transitional Plans for County Services, Medication Management, and Transportation. Mental health treatment is provided by ISMIP providers when the parolee has Medi-Cal or other resources established. Because ISMIP does not have access to the Prescription Authorization and Tracking System (PATS), medication management for non-benefited, ISMIP enrolled parolees is provided by POCs, as well as individual or group therapy, when unavailable from other funding sources outside of CDCR.[88] Once benefits can be established for these individuals, they are removed from POC services, and are only seen by ISMIP providers. Telecare also has a contract with Los Angeles County to provide similar services to the AB 109 population.

In this model, which costs about $63 per day, services begin after the inmate is released from prison. There is no warm hand-off from prison; in most cases, the parolee must navigate their way home and to the parole office without assistance. Following release from prison, the parolee must report to their parole agent within 48-72 hours, and SMI parolees are generally seen by a POC clinician that same day or soon thereafter. The local Parole office may refer a parolee in need of mental health services and case management to the ISMIP program. In Los Angeles, the contractor is Telecare, a statewide provider of community mental health services. Once a referral is made, Telecare has 24 hours to make contact with the parolee. To do so, Telecare is given the parolees last known address. ISMIP is voluntary, but only about 2/3rds agree to be enrolled when contact is made by a Telecare Personal Services Coordinator (i.e., an outreach worker).

The first priority for the program is to assist the parolee to achieve stabilization in the community. This includes looking at basic needs such as food, housing, identification through Cal-ID or DMV, appointment for psychiatric services, and health screening with a nurse. Telecare partners with a FQHC, which provides medical services at the Telecare facility two days a week.

[88] CDCR. "Mental Health Services Continuum Program." [Link]

Recommendations:

- **Convene a Focus Group of Health and Behavioral Health Providers that Serve the Reentry Population.** Providers that serve the reentry population face an array of challenges including staffing, coordination with law enforcement, stigma relating to justice-involved individuals, along with the overarching complexities of serving individuals with multiple health issues. There may be value in convening a group of providers to discuss common approaches and needs with the goal of identifying best practices that can be shared. [Reco: (2)(b)]

C. Unique Patient Needs

Justice-involved individuals, particularly those who have experienced lengthy periods of incarceration or who have otherwise been system-dependent, have enormous adjustments to make as they transition to the community. In addition to the challenges of finding housing, employment, food, transportation, and social supports, they must also learn how to navigate a complex health and behavioral health care system and, if necessary, maintain their status with parole or probation.

- **Individual Responsibility for Managing Health and Behavioral Health Care.** Individuals with histories of criminal justice involvement have particularly high rates of physical health disorders and behavioral health needs, but little experience with (or trust in) traditional health care systems. In their institutional setting, prison and jail staff provide care through regimented protocols that do not necessarily require the inmate's initiative. Medication, for example, is provided at specific times and directions for their use. Many who return to their community after lengthy periods of incarceration are often unaccustomed to taking responsibility for their own health care needs. For some soon-to-be released medically fragile and SMI inmates, their trauma is exacerbated by the uncertainty of how they will maintain their medications, and find a doctor who will take them.

  Further, the challenges of understanding how to navigate the complexities of the health and behavioral health care system can be daunting. Examples of these challenges include finding a provider, enrolling in a managed care plan, knowing when to go to an Emergency Room, getting transportation to a clinic for an appointment, and accessing other health and human service benefits and services (e.g., SSI, CalFresh, general assistance, housing supports.

- **Fear of the "System."** As might be expected, justice-involved individuals are wary of government in general, and law enforcement in particular. Coercive efforts to conjoin treatment and law enforcement supervision can have mixed results. Parole Outpatient Clinics, for example, provide mental health treatment as a condition of parole when their is a nexus between their mental illness and their criminal behavior. The POCs are co-located in parole offices and closely aligned with parole staff. While this relationship may improve compliance, one advocacy organization raised concerns that the modality is perceived more as punitive rather than therapeutic with penalties for non-compliance. "POC is used as a weapon," we were told. We were also told that some parolees would prefer to receive mental health services from the county because of their concerns about POC. DAPO has adopted a more flexible policy that allows a parolee to satisfy the treatment condition through non-POC alternatives, such as treatment provided by the county - if the county will serve them.

  Justice-involved individuals are often generally fearful of providing too much information to the government. For example, one advocacy organization told that us that some justice-involved individuals worried that signing up for Medi-Cal would result in information-sharing with child support enforcement authorities.

- **Trauma and Gender Issues.** Trauma theory posits that the effect of trauma and violence on women offenders is substantial and influences their criminality and response to justice system interventions. It does not suggest that women who have committed crimes should not be held accountable. Rather, trauma theory contends that understanding the role that trauma and violence play in an female offender's life can inform the implementation of services that will best address her issues and have the greatest potential to support resiliency and increase prosocial behavior.[89]

  Gender-responsive means creating an environment through site selection, staff selection, program development, content, and material that reflects an understanding of the realities of women's lives and addresses the issues of the participants. Gender-responsive approaches are multidimensional and are based on theoretical perspectives that acknowledge women's pathways into the criminal justice system. These approaches address social (e.g., poverty, race, class, and gender inequality) and cultural factors, as well as therapeutic interventions. These interventions address issues such as abuse, violence, family relationships, substance abuse, and co-occurring disorders. They provide a strength-based approach to treatment and skill building. The emphasis is on self-efficacy, a strength-based approach to treatment and skill building.

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[89] Bloom, Barbara et al. 2005. "Gender-Responsive Strategies for Women, A Summary Of Research, Practice, and Guiding Principles or Women Offenders.*" U.S. Department of Justice National Institute of Corrections*. [PDF]

A national profile of women offenders reveals they are:

- Disproportionately women of color.
- In their early- to mid-thirties.
- Most likely to have been convicted of a drug-related offense.
- Individuals with fragmented family histories; other family members also may be involved with the criminal justice system.
- Survivors of physical and/or sexual abuse as children and adults.
- Individuals with significant substance abuse problems.
- Individuals with multiple physical and mental health problems.
- Unmarried mothers of minor children.
- Individuals with a high school degree or GED, but with limited vocational training and sporadic work histories.[90]

Trauma also impacts the lives of other populations including men and LGBT individuals. A study of Pennsylvania state prison inmates and found that almost all of them had experienced traumatic events in their lives. Eighty-five percent reported being a victim of a crime-related event, such as robbery or home invasion. More than three quarters of the men had been physically or sexually abused. Virtually all experienced at least one general disaster in which their life or a life of a loved one was threatened or lost. Death, fear of death, and serious injury are particularly common events in the lives of these incarcerated men.[91]

Compounding these experiences for medically fragile and SMI FIPs include the additional life complications relating to hospitalization/intensive medical intervention, treatment side effects, homelessness, family issues, housing and financial problems. Trauma experiences often can overwhelm a person's coping resources, adding to challenges of providing health and behavioral health interventions.

Current Approaches to Meeting Clients' Needs

Engagement strategies that address the unique needs of the justice-involved population must be patient-centered, recognizing the fears and concerns of the individual. As noted earlier, Community Health Workers with shared, life experiences can be effective and supportive. As one clinician told, the CHWs are the "secret sauce" for transitioning inmates from custody to the

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[90] Bloom, Barbara et al. 2005. "Gender-Responsive Strategies for Women, A Summary Of Research, Practice, and Guiding Principles or Women Offenders." *U.S. Department of Justice National Institute of Corrections*. [PDF]

[91] Wolff, Nancy et al. 2014. "Screening for and Treating PTSD and Substance Use Disorders Among Incarcerated Men." *Center for Behavioral Health Services and Criminal Justice Research.* [Link]

community. CHWs provide guidance, help with navigating complex institutions, and often help make sure individuals get to critical appointments.

Hiring previously incarcerated individuals to become CHWs is the first step in a process that also includes training. The San Francisco-based Transitions Clinic Network has developed a 20 unit curriculum City College of San Francisco for post-prison CHWs. There is on-line training and on-site internships (128 hours) for CHW students mentored by seasoned CHWs. The performance-based curriculum is grounded in public health and social justice perspectives, and provides students with knowledge and skills for working in clinical and community settings, with individual clients and groups. Key competency areas include the ability to provide client-centered health education, counseling and care coordination services.[92]

Community behavioral health programs often use "Peers," who are also individuals with lived experience, who are employed by the county to serve in ways similar to that of CHWs. A process for peers to obtain certification is a option that should be considered. This certification is in place in many other states but not yet in California.

Trauma Informed and Gender Responsive Treatment

Gender-responsive means creating an environment through site selection, staff selection, program development, content, and material that reflects an understanding of the realities of women's lives and addresses the issues of the participants. Gender-responsive approaches are multidimensional and are based on theoretical perspectives that acknowledge women's pathways into the criminal justice system. These approaches address social (e.g., poverty, race, class, and gender inequality) and cultural factors, as well as therapeutic interventions. These interventions address issues such as abuse, violence, family relationships, substance abuse, and co-occurring disorders. They provide a strength-based approach to treatment and skill building. The emphasis is on self-efficacy, a strength-based approach to treatment and skill building. Gender-responsive approaches are multidimensional and are based on theoretical perspectives that acknowledge women's pathways into the criminal justice system. There are four fundamental theories for creating women's services: pathways theory, relational theory, trauma theory, and addiction theory.[93]

Recommendations:

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[92] Transitions Clinic. "Post Prison Health Certificate Program." [Link]

[93] Bloom, Barbara et al. 2005. "Gender-Responsive Strategies for Women, A Summary Of Research, Practice, and Guiding Principles or Women Offenders." *U.S. Department of Justice National Institute of Corrections*. [PDF]

- **Taking CHW's to Scale.** As we have seen, CHWs not only can serve as a necessary bridge to guide FIPs through the reentry experience, but on a personal level, they can help empower a justice-involved person with emotional support and mentorship. If Community Health Workers are the "secret sauce" to help the medically fragile and SMI reentry population navigate community health systems, a broader discussion is needed about how to integrate CHW's into the reentry process.

  Issues include the following:

  - Funding. Los Angeles is using their Whole Person Care pilot as a mechanism for funding their CHWs. Another option relies on a recent Medicaid regulation regarding which types of providers can be reimbursed for providing preventive services to Medicaid beneficiaries. The regulation allows state Medicaid programs to reimburse for preventive services provided by unlicensed professionals so long as the services have been initially recommended by a physician or other licensed practitioner.[94] Another potential model to explore involves the hiring of CHWs by FQHCs, as part of a contractual relationship with a Medi-Cal managed care plan.

  - Security Clearance for Accessing Prison and Jails. CHWs are likely to have criminal records that create barriers for them to enter a prison or jail. CDCR has an established protocol that has been used for its Residential Multi-Service Center Contracts. For example, an individual requiring clearance cannot have been arrested in the past 3 years and cannot be on parole or probation. Phone or video-conferencing options are another approach. As more jurisdictions move toward greater use of CHWs, protocols for accessing prison and jail must be addressed.

  - Training. As noted earlier, the San Francisco based TCN has already developed a curriculum that can be replicated in other areas. As CHW efforts grow, there may be a need for refining the training needs to reflect local needs.
    [Reco: (2)(c)]

[94] 78 Federal Regulation 42160: codified at 42 CFR 440.130 [PDF]

Toward a Comprehensive Model of Integration for FIPs Using Medi-Cal Managed Care Plans

As state and county governments embrace greater efforts to improve hand-offs, and coordinate care for FIPs, there is need for exploring new models that are sustainable and can be integrated into current health care delivery system's culture of coverage. The Whole Person Care pilots, for example, as provided through the state's 1115 Medi-Cal Waiver, are scheduled to end in 2020. There is value in starting now to find new approaches for sustaining the successes of these pilots and replicating them throughout the state.

Medi-Cal managed care plans might provide the foundation for a model of care that specifically targets the reentry population. As we have seen, these health plans already have responsibility and fiscal incentives for managing and coordinating the care of complex, high utilizing and costly Medi-Cal beneficiaries. Other states are already contracting with their Medicaid plans to undertake in-reach for prison and jail inmates who are medically fragile or SMI. The health plan could also coordinate the transfer of health records from prison and jail to the community provider and clinician. To further optimize these efforts, California could consider building on successful reentry programs to create a model of care and coordination for FIPs. Conceptually, the model could include the following elements:

- **Specialized Provider Network.** In recognizing the unique and highly specialized needs of FIPs, a health plan could establish a provider network to specifically provide a medical home for FIPs. For example, the Inland Empire Health Plan in Riverside and San Bernardino counties has a specialized network of providers to serve its beneficiaries in the foster care system. Ideally, FQHCs that both provide comprehensive health services and behavioral health care could offer a trusted, one-stop shop for the justice-involved population. A dedicated network of specialized providers would also make it easier to train staff on how to understand and coordinate with the criminal justice system, and the unique needs of the population being served.

- **Community Health Workers.** By providing the human connectivity between the FIP, the criminal justice system, and the local health and behavioral health systems, CHWs are an essential ingredient for this population and can help with the warm transition as inmates return to the community. As a managed care plan builds its specialized provider network, its contracts with FQHCs could include the inclusion of CHWs to help FIPs. Incorporating CHWs into a FQHC's clinical model is one approach for consideration.

- **Probation/Parole Engagement.** Probation Officers and Parole agents have a compelling interest in being part of the team that is coordinating treatment and care of the FIPs for whom they have supervision responsibilities. Both clinicians and public safety staff needs to understand and balance the appropriate needs for sharing information and supporting each other to enhance the FIPs success and maintain public safety.

- **Supplemental County Incentive Funding.** As counties spend more to provide expensive, health and behavioral health care services in jails - without FFP, a fiscal case could be developed to spend local funds to reduce recidivism for the medically fragile and SMI populations. In the same way that some counties are using local resources to provide the non-federal share of cost for the WPC pilots, there might be an interest in investing in a local managed care health plan that provides enhanced services for FIPs. Additional local funding could be used to provide incentive payments to providers in the specialized network to pay for the extra costs of the population and for services that are not otherwise matchable for FFP.

- **Data Sharing and Performance Metrics.** The model also requires a robust data sharing system to allow for the health plan to facilitate a warm handoff when inmates leave the prison or jail, and allow the sharing of health records. The data system should also allow for the collection of performance measures that are tied to evaluation and a feedback loop that leads to improvements.

3. Maximizing Federal Financial Participation (FFP)

Overview

The need for funding is always a significant constraint in developing, sustaining and expanding programs for the reentry population. However, the Affordable Care Act's eligibility expansion also opened opportunities for leveraging federal Medicaid funds to provide health and treatment services.

Before the Affordable Care Act, Medicaid eligibility was limited to low-income people who fell into specific categories such as children, pregnant women, parents of dependent children, and elderly and disabled adults. As noted earlier, these categories tended to exclude most of the justice-involved population who are most often non-disabled, childless adults under 65. By expanding eligibility to these individuals with incomes under 138% of the federal poverty level ($16,400 for an individual in 2017)[95], the health reform law now allows this population to be eligible for Medicaid — Medi-Cal in California.[96]

Generally, Medi-Cal is funded through a state-federal partnership in which the federal government generally matches half the cost. Referred to as Federal Financial Participation (FFP), this traditional matching rate continues for previously eligible categories. However, under the Affordable Care Act, there is an enhanced match for the costs of services for the new expansion population of low income childless adults. In 2017, the federal match for this population is 95%, declining to 90% in 2020.[97]

Although most inmates are eligible for Medi-Cal services when they are released from prison or jail, the so-called "Medicaid Inmate Exclusion" policy continues to prohibit the payment of federal Medicaid matching funds for the cost of any service provided to an "inmate of a public institution."[98] One exception to this policy applies to care delivered outside the institution, such as at a hospital or nursing home, when the inmate has been admitted for 24 hours or more. This program, the Medi-Cal Inmate Eligibility Program (MCIEP), was enacted in California in 2011 to provide additional FFP for these health care services previously financed entirely by the

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[95] Covered California Program Eligibility By Federal Poverty Level [PDF]

[96] It should be noted that the US Congress is actively considering significant change in the Medicaid program that would either eliminate Medicaid coverage for this expansion population or at least establish caps on Medicaid dollars provided to each state. Currently federal funding is not capped, so that when an agency increases its federal claiming, it is not at the expense of other programs that are using federal funds. Putting a cap on federal funds means that any increase in claiming in one area could require reduced federal funds availability for other programs.

[97] Rudowitz, Robin. 2014. "Understanding How States Access the ACA Enhanced Medicaid Match Rates." *Kaiser Family Foundation.* [Link]

[98] Gates, Alexandra et al. 2014. "Health Coverage and Care for the Adult Criminal Justice-Involved Population." *Kaiser Family Foundation.* [Link]

CDCR and jails without federal matching funds.[99] Under MCIEP, reimbursable health care services can receive at least a 50% federal match or the enhanced match (95%) if the inmate is part of the Affordable Care Act's newly eligible category.[100] Once released from being incarcerated, former inmates are generally eligible for Medi-Cal.

In April 2016, CMS issued new guidance to clarify the rules for drawing down FFP for the reentry population. Specifically, the guidance clarified that the following groups are NOT inmates of a public institution and can receive Medi-Cal coverage for all covered services if enrolled:

- Individuals on probation, parole, or community release pending trial;
- Individuals residing in corrections-related, supervised community residential facilities, unless the individual does not have freedom of movement and association while residing at the facility; and
- Individuals on home confinement.[101]

Some undocumented citizens may also eligible for state funded, full scope Medi-Cal services. This includes individuals classified as "Permanent Residence Under Color of Law (PRUCOL), and can include parolees.[102] In California, PRUCOL individuals include a variety of categories of individuals who are reside in California as refugees, asylees, or aliens who generally are not subject to active deportation actions). These individuals, referred to as PRUCOL, are recognized in California law and awarded state-funded full-scope Medi-Cal coverage. However, FFP is only available for emergency and pregnancy-related services. Because the state awards individuals classified as PRUCOL full-scope Medi-Cal coverage, services not considered emergency and/or pregnancy related must be financed fully by state funds.[103]

Following the enactment of the Affordable Care Act, many counties developed jail-based programs to assist, among other groups. inmates in obtaining Medi-Cal eligibility. Many of these services were funded through outreach and education grants provided through DHCS. The program was originally funded through a $12.5 million one-time contribution from the California Endowment, matched with federal funds, and distributed to support in-person assistance for Medi-Cal enrollment and county grants.[104] Recognizing the value of jail-based enrollment, many counties have used some of these funds to support these efforts. However, the one-time grant funding will be fully expended by 2018, As the funding runs out this year, alternative funding sources will be needed. As of June 2017, 70% of these funds have been expended.

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[99] CA DHCS. 2011. "Overview of the Medi-Cal Inmate Eligibility System." [PDF]
[100] Pew Trust. 2016. "How and When Medicaid Covers People Under Correctional Supervision." [PDF]
[101] Center for Medicaid and CHIP Services. 2016. "State Health Official Letter with Q&A." [PDF]
[102] Social Security Act §1614(a)(1)(B) - PRUCOL Legislation [Link]
[103] CA DHCS. 2015. "Medi-Cal's Non-Citizen Population: A Brief Statistical Overview." [PDF]
[104] CA DHCS. 2017. "AB 82, Section 70 - Medi-Cal In-Person Enrollment Assistance Payments." [Link]

A. Maximizing FFP for State and Local Justice System Administrative Activities

In addition to providing funding for direct health care services, Medi-Cal can help to pay for administrative costs, such as assisting in completing Medi-Cal applications. To the extent these administrative activities are currently being provided by public agencies without federal reimbursement, the opportunity to draw down matching funds leverages existing resources to bring in additional funding to either offset state or local costs or expand services. These administrative activities include:

- **Medi-Cal Enrollment:** Explaining Medi-Cal benefits and services to potentially Medi-Cal eligible individuals/families; referring individual/family to an eligibility worker/navigator to apply for Medi-Cal; assisting individual/family apply for Medi-Cal; assisting individual/family to re-enroll in Medi-Cal; performing translation/interpretation for the Medi-Cal enrollment process.

- **Referral to Medi-Cal Covered Health Services:** Making referrals to Medi-Cal covered health services, such as physician/clinic/nursing services, community clinics, doctors, hospitals, private providers, mental health services, substance abuse treatment services, prenatal services, well-child checkups; coordinating and monitoring the delivery of Medi-Cal covered services; working with providers to coordinate an individual's care, working with individual to ensure necessary care is received; and translation/interpretation or arranging translation/interpretation to access Medi-Cal covered services.

- **Transportation to a Medi-Cal Covered Health Service:** Arranging transportation to Medi-Cal covered services; coordinating with family members to drive individuals; coordinating with private transportation company to transport individual; giving out directions to the appointment; assisting individual to use public transportation to the appointment; providing transportation to Medi-Cal covered services; driving individual to appointment; assisting individuals by providing bus/taxi/van vouchers; paying companies like Uber to transport clients to appointments.

- **Contract Administration for Medi-Cal Covered Health Services:** Negotiating contracts with service providers for the provision of Medi-Cal covered health services; administering contracts with service providers for the provision of Medi-Cal covered health services; monitoring and oversight of service provider contracts for Medi-Cal covered health services.

- **Health Program Planning**: Gathering data, analysis, planning, and evaluation related to Medi-Cal covered health services; collaboration with others to identify and fill gaps in Medi-Cal covered health services; preparing proposals for new, improved or expanded Medi-Cal services; monitoring the health delivery system for Medi-Cal covered services; recruiting new Medi-Cal providers; developing resource directories for Medi-Cal covered services.

There are important limitations and rules about how these costs can be claimed. For example, at present, the only administrative activity that can be reimbursed while the individual is incarcerated is enrollment assistance, and only if that assistance is provided thirty days prior to release.

Other restrictions require the non-federal share to be funded with a Certified Public Expenditure (CPE) using public dollars. These are funds from a public source (e.g., state, local government, realignment, MHSA, etc.), however, entities using federal dollars have to be careful not to include in the CPEs funds that have already been matched or any federal funds the agency may have received (i.e., "double-dipping"). This would include local funds or federal funds that are supporting the Whole Person Care pilots authorized under DHCS 1115 Medicaid Waiver.

Another option for maximizing FFP relates to Targeted Case Management (TCM). This program provides FFP for case management services to help individuals gain access to needed medical, social, educational, and other services. TCM is claimable for specific target populations such as medically fragile adults, individuals at risk of institutionalization, and individuals in jeopardy of negative health and psychosocial outcomes; and individuals with a communicable disease.[105] Like the Medi-Cal Administrative Activities (MAA) claiming process, federal funds must be matched with CPE's, and it requires implementation of a tracking system to provide an accurate accounting of the time spent providing these services to Medi-Cal eligible clients.

County health, specialty mental health, social service programs and schools have long used MAA and TCM to maximize federal funds. Probation Departments have also used it, primarily to support their juvenile populations that have been Medi-Cal eligible prior to the passage of the Affordable Care Act. The health reform legislation's eligibility expansion warrants a new cost/benefit analysis to determine the potential value to Medicaid administrative activities now being provided by Sheriff Departments, Probation, Courts, Public Defenders, District Attorneys and others involved with the reentry population.

The Reentry Project collaborated with Ms. Gretchen Schroeder, a consultant with HealthReach Consulting, which specializes in assisting local government in maximizing federal Medicaid funds. This includes an assessment of their opportunities through a systematic process that

[105] CA DHCS. 2011. "Target Case Management: A Primer." [PDF]

identifies current staff who perform MAA; determines how much CPE funds are used for these personnel costs; and calculates the percentage of time dedicated to these activities. This assessment will help determine the amount of potential revenue and whether it justifies the establishment of an administrative process for claiming it.

Our project facilitated a meeting with Ms. Schroeder and key staff from Los Angeles County Sheriff's Department, Probation, Health Services, and L.A. Care to consider the opportunities for maximizing FFP for administrative activities. Staff from probation, sheriff's office, LA County DHS, and L.A. Care participated in a brainstorming session to consider options and untapped opportunities. Examples of ideas included:

- Non-emergency Transportation[106] (e.g., reimbursement for direct service) to medical service such as a mental health clinic).
- Case management services provided by the Public Defender's staff.
- Jail based Custody Assistants (CA's) who help with eligibility establishment.
- Probation's Community Resource and Reentry Center (CRRC). This a post release one-stop shop for job training, education, drug counseling, etc.
- Pre-Trial services (Probation).
- Probation services for collaborative courts; also services to support the Mental Health Court Linkage Program's Community Reintegration Program (CRP).

The briefing and brainstorming session yielded a variety of potential opportunities, with the acknowledgement that additional analysis and thought were needed to fully assess the specific proposals. In many cases, the county's Whole Person Care Pilot will provide FFP on behalf of the participants in that program for many of administrative services, including the use of jail-based Custody Assistants who work with inmates to help them with Medi-Cal eligibility. MAA may offer a future and sustainable source if the five-year Waiver is not renewed. Also, other counties that have not used their WPC pilot to fund these services or to serve these populations may wish to explore MAA as an alternative.

Recommendations:

- ➢ **Assess interest from statewide associations, including the Chief Probation Officers of California (CPOC), California Sheriff's Association, and the Administrative Office of the Courts (AOC), for hosting presentations or webinars that would disseminate information about MAA funding opportunities.** This could also be tied to a county-based learning collaborative in which counties could share information about

[106] Per AB 2394 (2016), Non-Emergency Medical Transportation and Non-Medical Transportation are covered Medi-Cal services for beneficiaries enrolled in a managed care plan, including for "carved out" services (e.g., SMHS, Drug Medi-Cal, and dental).

how they are using MAA funding to support their justice-involved population. [Reco: (3)(a)(i)]

- **Explore potential options for Medicaid administrative claiming with CDCR.** Many pre-release and parole services may be eligible for claiming. [Reco: (3)(a)(ii)]

- **Seek public or private funding to provide technical assistance to CDCR and counties.** This funding, which could be matched with federal dollars, could be used to contract with a consultant with MAA expertise to assist counties or county collaboratives in assessing opportunities. This use of one-time funding could be significantly jumpstart the ability of justice-involved agencies to assist and sustain programs that support the reentry population. [Reco: (3)(a)(iii)]

- **Ask DHCS to consider requesting CMS to clarify the claiming rules relating to MAA** to: (1) broaden the definition of administrative activities so that it can also includes, pre-release planning activities associated with post-release care coordination and not only eligibility assistance; (2) expand the 30-day window prior to release to reflect the need to begin these administrative activities earlier. [Reco: (3)(a)(iv)]

B. Obtaining FFP for Dispensing a 30-day Supply of Medication Upon Release

To ensure continuity of drug therapy as prisoners with ongoing medical needs are released or discharged to the community, CDCR and jails have adopted two general approaches: (1) provide a 30 day supply of medication when the inmate is released; or (2) provide the inmate with a prescription and/or voucher at a community pharmacy. The latter option increases the risk that MF or SMI former inmates will go without needed medication during the critical post-release period. To the extent FFP can be used to offset at least half the cost of medication, the best practice of providing a transitional medication upon release can be encouraged.

The CDCR has a policy of providing a 30-day supply of medication as the individual leaves prison. The policy also includes the availability of a consultation by appropriate licensed staff.[107] However, the CDCR is not currently claiming FFP for these services.

At the San Diego Central Jail, inmates are not handed a supply of medication when they are released. Instead, a prescription for a ten day supply of medication is faxed to a pharmacy *only* for inmates receiving psychiatric or HIV medication. The cost of the drugs is paid by the jail. Prescriptions for other medications are not provided. Previously, the Sheriff's Department paid for a 30-day supply of medication, but many filled medications were unclaimed by former

[107] California Correctional Health Services. 2015. "Parole and Discharge Medications Procedure." [Link]

inmates. To reduce costs, a decision was made to reduce the supply to ten days, however, this is likely to be adjusted to fourteen days.[108]

Through its WPC pilot, Los Angeles County has taken a different approach. As noted earlier, the county's five year, $900 million pilot proposes to target, among other groups, about 1,000 soon-to-be released inmates each month and will use community health workers to help them get the care and social services they need. The county is also working to get inmates released with a 30-day supply of medications. LA County DHS is now exploring the potential of obtaining FFP to offset much of this cost for its Medi-Cal eligible inmates. The federal match could be at least 50%, and 95% of the inmate is part of new expansion population under the Affordable Care Act.

To obtain FFP, the inmate must be have applied for Medi-Cal eligibility prior to release, and the medication must be obtained through a pharmacy that is an approved Medi-Cal provider. Reimbursement for Medi-Cal services, including pharmacy, can be obtained retroactively back to the date of release so long as the application for eligibility is filed prior to release. Currently, medication for incarcerated inmates is provided through the jail's own pharmacy, which is a Medi-Cal provider. The county is exploring to build a pharmacy outside the jail that could be licensed under Medi-Cal rules.

Recommendations:

- **Explore options for obtaining FFP for 30 day supply of medication issued by the prison.** To the extent that CDCR inmates have applied for, or have already been determined to be Medi-Cal eligible, the 30-day supply of medication may be reimbursable and eligible for FFP. [Reco: (3)(b)(i)]

- **Consider potential workarounds to allow a jail-based pharmacy to provide the 30-day supply of medication in lieu of building a new pharmacy outside the jail walls.** Additional analysis is needed to explore the possibility of certifying a correctional pharmacy as a Medi-Cal provider that would dispense medications to inmates upon release from jail. [Reco: (3)(b)(ii)]

C. Maximizing FFP for Parolee SMI Services

The Division of Adult Parole Operations (DAPO) Mental Health Services Continuum Program (MHSCP) provides parolees with a continuum of mental health care services after release from prison. The state spends about $31.5 million to support a variety of programs that provide

[108] Interview with San Diego Sheriff Department. 2017.

services to SMI parolees. Although most of the parolees are Medi-Cal eligible, few of these programs are currently drawing down FFP.

Table 3.1. below outlines the programs and state general fund allocation for these programs.

Table 3.1. Major Parolee Programs for the SMI	
Program	**2016-17 Budget ($ in millions)[109]**
Parole Outpatient Clinics (POCs). Assists parolees with their community reintegration by providing evaluations of mental illness, medication management, individual therapy, group therapy, crisis intervention, and case management. Collaborates with ISMIP providers to connect eligible parolees to additional outpatient services.	**$16.5**
Integrated Services for Mentally Ill Parolees (ISMIP). Provides comprehensive mental health and support services, including housing subsidies, to parolees who suffer from severe mental illness and are at risk for homelessness.	**$12.3**
Case Management Reentry Program (CMRP). Pursuant to California Penal Code Section 3016, the Case Management Reentry Pilot Program has been implemented for offenders who have been sentenced to a term of imprisonment and who are likely to benefit from a case management reentry strategy designed to address mental disorders, developmental disabilities, homelessness, and joblessness while serving a term of parole. (see SB 601-Hancock, Chapter 162/2015).	**$2.7**

Counties adopted policies that reflected their limited resources and prioritized services to non-parolees. Parolees, it was suggested, should receive their treatment services through state supported programs. This is one reason why parole created its own network of Parole Outpatient Clinics (POCs), rather than using the county specialty mental health programs. There was also a fiscal and programmatic rationale. When a parolee violated parole conditions and returned to custody as a parole violator, the cost of that short term incarceration was a state responsibility. This gave the state a financial incentive to invest in programs such as specialty mental health and drug treatment that would reduce recidivism.

Counties are responsible for the administration of specialty mental health services. They are responsible for delivering these services to people with and without Medi-Cal, as well as to indigent populations to the extent that resources are available. County Mental Health Plans (MHP's) pay providers for care at the time of service using mental health realignment funds from state, MHSA, and other local funding. By paying for specialty mental health services, MHP's

[109] $31.5 million total, out of California's total budget of $167 billion in FY 2016-2017 [Link].

incur certified public expenditures (CPE's), which are used to claim FFP through Medi-Cal for clients that are rerolled in Medi-Cal. The federal reimbursement that counties receive *is not* capped. However, the counties annual allocation of realignment revenue that can be used as the non federal Medi-Cal payment *is* capped. Therefore any costs for the Medi-Cal program that exceed the counties' realignment revenues must be paid for using county funds, MHSA funds, or other grant funding, to the extent allowable under law.[110] (As noted earlier, MHSA funds cannot be used for pay for parolee services.)

In the case of Medi-Cal eligible parolees who would otherwise qualify for county mental services because of the severe and persistent nature of their mental illness, counties would be responsible for paying the non federal share. For parolees who receive SSI, the non federal share might be 50%; for those in the newly eligible expansion population, the share might be only 5%, with the federal government paying the balance.

While a county policy that excludes parolees is understandable from a fiscal perspective, Public Safety Realignment has changed the state/local structural relationship related parolee recidivism. Parolees now serve time in county jails when their parole is revoked by a local court. Counties do not receive an additional marginal allocation to reimburse their jail for the costs of incarcerating parolees. That change may offer an opportunity for counties to reconsider policies that previously excluded parolees from receiving behavioral health services from the county funded services.

In May 2013, the Legislative Analyst's Office issued a policy brief on maximizing federal reimbursement for parolee mental health care. Based on their discussions with DHCS, several approaches were identified to allow CDCR to obtain FFP for these services, but the brief indicated that additional analysis was needed to identify an optimal approach. Four options were identified:

- Have POC become certified as a Fee-For-Service (FFS) Medi-Cal provider so that CDCR could submit Medi-Cal claims directly to DHCS;
- Incorporate POC into county Mental Health Plans so that the CDCR could submit Medi-Cal claims through MHPs;
- Have CDCR's network of POC certified as a new MHP so Medi-Cal claims could be submitted directly through DHCS;
- Set up a Certified Public Expenditure (CPE) program for POCs so that CDCR can submit claims directly to DHCS.[111]

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[110] Arnquist, Sarah and Peter Harbage. 2013. "A Complicated Case: Public Mental Health Delivery and Financing." *California Health Care Foundation.* [PDF]
[111] Taylor, Mac. 2013. "Maximizing Federal Reimbursement for Parolee Mental Health Care." *Legislative Analyst Office.* [PDF]

DAPO currently has interagency agreements with Santa Clara County and San Francisco, under which the state contracts with the county for the implementation of the Integrated Services for Mentally Ill Parolee (ISMIP) program. In this model, the state is able to use county-based Medi-Cal enrolled providers to provide mental health services and draw down FFP for Medi-Cal eligible services. In 2015-16, the total contract was $1.2 million, but the federal drawdown was only about $390,000.[112] This may reflect that not all of ISMIP services (e.g., housing) are reimbursable.

Discussions with other counties are ongoing, and there are opportunities for collaboration that may maximize FFP and provide better services for SMI parolees. Our project facilitated a discussion with staff from Parole, Alameda County Department of Behavioral Health, and Alameda County Probation regarding options for providing better services for parolees. One outcome of the meeting is a potential collaboration between Parole and the county for better coordination and case planning as parolees are discharged and become a county responsibility.

Recommendations:

- **Support efforts by the Council of Mentally Ill Offenders (COMIO)** to help facilitate discussions with state and local corrections officials and county specialty mental health leaders to develop policy recommendations for improving services to SMI justice-involved individuals. COMIO is well respected and well-positioned to take the lead in identifying opportunities for state/local partnerships and the potential for maximizing FFP with unmatched parole dollars. [Reco: (3)(c)(i)]

- **Suggest the establishment of a state-local workgroup to review the current CDCR contracts with San Francisco and Santa Clara** to better understand the pros and cons, and the potential of using those contracts as a template for other counties. This workgroup process could be under the auspices and leadership of COMIO in partnership with the County Behavioral Health Directors Association. [Reco: (3)(c)(ii)]

- **Review LAO options from 2013 to allow POC's and other eligible mental health services to bill Medi-Cal directly, and assist DHCS in developing the optimum approach.** [Reco: (3)(c)(iii)

D. Maximizing Medical and Elderly Parole

The CDCR has two programs to parole inmates who are either medically incapacitated or elderly and no longer a threat to public safety if released: Medical and Elderly Parole. Both can be an

[112] Personal communication with CDCR staff.

effective tool for reducing general fund expenditures and maximizing FFP. As noted in the Assembly Appropriations Committee fiscal analysis of the SB 1399 in 2010, the program was estimated to save "potentially in the low tens of millions of dollars, as a result of eliminating costly security for incapacitated inmates and making these inmates eligible for Medi-Cal."[113] The 2010 committee analysis cited the federal prison health care receiver's first year estimate of $30 million in general fund potential savings related to 32 inmates who had been identified as the most likely and immediate candidates for medical parole.

The 2010 estimate did not assume the enhanced matching rates resulting from the implementation of the Affordable Care Act. The committee analysis was predicated on a Medi-Cal matching rate of 50%, and did not reference the enhanced federal matching rate of 95% for the newly eligible Medi-Cal population under the Affordable Care Act. Many inmates under 65 years of age will be eligible for this enhanced match; and those over 65, who may be eligible for elderly parole, are likely to be dually eligible for both Medicare and Medi-Cal.

Is the state is maximizing the potential savings of these two programs?

Medical Parole:

In 2010, California's medical parole law was signed into law. (SB 1399 -Leno). The law applies to those inmates who have been declared by the head physician in the institute where they are housed, to be permanently medically incapacitated with a medical condition that renders him or her permanently unable to perform activities of basic daily living, and results in the prisoner requiring 24-hour care. The Board of Parole Hearings (BPH) must also make a determination that the conditions under which the prisoner would be released would not reasonably pose a threat to public safety.

On February 10, 2014, the federal Three-judge Panel in the Coleman/Plata class action lawsuit ordered an expanded parole process for medically incapacitated inmates as part of the effort to reduce the state's prison population.[114] Eligibility for expanded program included the following:

- The inmate suffers from a significant and permanent condition, disease, or syndrome, resulting in the inmate being physically or cognitively debilitated or incapacitated.
- The inmate qualifies for placement in a licensed health care facility, as determined by the Resource Utilization Guide IV (RUG IV) Assessment Tool.[115]

[113] SB 1399, Assembly Appropriations Committee Analysis. 2010. [Link]
[114] Memo from Prison Law Office. 2015. "Medical Parole." [PDF]
[115] The RUG IV is a tool used to evaluate eligibility for Medicare and Medicaid reimbursement for placement in a skilled nursing facility.

- The inmate will not pose an unreasonable risk to public safety if placed in a licensed health care facility.
- The inmate is not condemned or serving a sentence of life without the possibility of parole.

Prison medical staff determine if an inmate is eligible for medical parole placement. BPH makes the decision to grant medical parole or not. Before the decision is made, the parole agent verifies the suitability of placing the inmate in a designated skilled nursing facility. The agent's role prior to placement is to verify that the inmate's placement will not jeopardize public safety (such as being placed a facility near the victim's address or employment). Once the inmate is placed, the inmate is placed on electronic monitoring by the parole agent and is supervised similar to a regular parolee. The parole agent is responsible for notifying BPH if there are any changes in the inmate's condition that warrant return to prison.[116]

The BPH procedures for medical parole rely on hearings that are conducted by two or three person panels using the same structure as parole suitability hearings. A panel's approval of an inmate's placement in a licensed health care facility is conditioned upon the CDCR identifying a licensed health care facility that meets specified requirements identified by the panel. The panel can specify those facility requirements "deemed necessary for the inmate's placement to not pose an unreasonable risk to public safety. Facility requirements will address issues such as applicable statutory residency restrictions, facility security, limitations on visitation and contact with persons under the age of 18, and any other special care provisions rationally related to the inmate's prior misconduct." Once the BPH decides to approve a placement of an inmate in a licensed health care facility, the CDCR has 120 days to identify a facility that makes the specified requirements. If no such facility can be identified, the BPH decision becomes invalid and the inmates remains at the CDCR.[117]

As of February 9, 2017, BPH had held 94 medical parole hearings under the revised procedures. An additional 28 were scheduled, but were postponed, continued, or cancelled. As of April 14, 2017, there were 25 people on medical parole in skilled nursing facilities. They are under the jurisdiction of the CDCR and are on alternative custody in the licensed health care facility. There are currently five skilled nursing

[116] Senate Budget & Fiscal Review Subcommittee Hearing. 2017. "Issue #3 - Elderly and Medically Fragile Parole Update." [PDF]
[117] Memo from Board of Parole Hearings. 2014. "Expanded Medical Parole." [PDF]

facilities where medical parole inmates are housed, and no current medical parole inmate is housed in a private residence.[118]

The Senate Budget and Fiscal Review Subcommittee #5 recently tried to unravel the reasons why so few inmates are placed in medical parole. Staff from the BPH highlighted the overarching concern for public safety in determining which inmates might be appropriate for placement in medical parole. But complex legal issues were also identified. Specifically, medical parole is currently viewed as an alternative custody option, rather than as traditional parole. As an alternative custody option, the CDCR maintains responsibility for the medical parolee's health care, including transportation to medical facilities. This requires additional consideration of health care options and logistics. Further, if the medical parolee's health improves, medical parole could be revoked. In that circumstance, BPH staff testified that some parole agents are uncertain as to whether the medical parolee would return to prison or be sent to county jail, consistent with the process for parole revocations under Realignment.

Elderly Parole:

In addition to ordering an expansion of medical parole, the three judge federal court in 2014 also required the state to establish a process to facilitate the parole of elderly inmates. Under elderly parole, inmates age 60 and over who have served at least 25 years of incarceration to be considered for parole. The BPH implemented the program on October 1, 2014. AB 1448 by Assemblymember Weber is now pending in the legislature to codify the policy.

From February 11, 2014 through January 31, 2017, the board has held 1,780 hearings for inmates eligible for elderly parole, resulting in 465 grants, 1,181 denials, 134 stipulations to unsuitability, and there currently are no split votes that require further review by the full board. An additional 819 hearings were scheduled during this time period but were waived, postponed, continued, or cancelled.

The CDCR is exploring the potential of identifying more inmates who might qualify for elderly parole. The CDCR staff testified to the Senate Budget and Fiscal Review Subcommittee #5 that there were over 9,000 inmates over age 60; 200 over age 80, and several over age 100.[119]

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[118] Senate Budget & Fiscal Review Subcommittee #5 Hearing. 2017. "Issue #3 - Elderly and Medically Fragile Parole Update." [PDF]

[119] Senate Budget & Fiscal Review Subcommittee #5 Hearing. 2017. "Issue #3 - Elderly and Medically Fragile Parole Update." [PDF]

Recommendations:

- **Consider placement in private homes.** In the case of medical parole, the CDCR has expressed a willingness to consider placement at a private home with care provided by family members. This would require a change in policy that now requires that inmates released on medical parole be housed in a skilled nursing facility. [Reco: (3)(d)(i)]

- **Engage Medi-Cal Managed Care Plans and Counties to develop options.** Recognizing necessary public safety concerns, there may be additional opportunities to increase the number of inmates who qualify for medical and elderly parole. To do so, we need a much clearer understanding of the current barriers, particularly to the extent they relate to the availability of health care services and supports in the community. In addition, the relationship of medical and elderly parolees to Medi-Cal managed care plans should also be explored. The CDCR may also wish to engage Medi-Cal managed care plans and counties to identify community-based health care options.[120] [Reco: (3)(d)(ii)]

[120] There are variations in how benefits are provided amongst county level Managed Care Plans (e.g.: COHS counties cover Long Term Care, but non-COHS plans do not).

4. Release of Information (ROI)

Overview

During the initial months of our review, we frequently heard concerns about federal and state restrictions that prevent agencies from sharing important information about parolees and probationers involved in reentry efforts. Those in the reentry population regularly engage with multiple systems in their communities to meet their needs, and it was noted how burdensome it can be to interact with siloed systems and treatment programs that have unique mandates, policies, and bureaucracies with which to contend. Without the appropriate sharing of information, individual agencies are forced to work independently to address the issues faced by FIPs, jeopardizing their successful reentry into the community. For example, efforts to provide assistance with housing placements or employment can easily fail if program staff are unaware of mental health or substance abuse issues and the need for related services.

In order to promote successful reentry, departmental silos should be broken down, so that efficient information exchange can facilitate awareness of an individual's needs and lead to appropriate programming and treatment. Privacy constraints imposed by the Health Insurance Portability and Accountability Act (HIPAA), Lanterman–Petris–Short (LPS) Act, and federal substance abuse confidentiality regulations (42 CFR Part 2), the Confidentiality of Medical Information Act (CMIA), and state law are frequently cited as roadblocks to interagency coordination. In a December 2016 follow-up report on AB 109 Implementation, the California Mental Health Planning Council found that data sharing was a major barrier. In particular, the report stated that "data is not easily shared or accessible across county departments or within the state across jurisdictional lines."[121]

In a more recent development, the California Office of Health Information Integrity (CalOHII), with support from the California Health Care Foundation, has created the State Health Information Guidance (SHIG).[122] The SHIG is an authoritative, but non-binding guidance, from the State of California that explains when, where, and why mental health and substance use disorder information can be exchanged, and also provides clarification of state and federal laws. The high level, and non-binding, nature of the SHIG means that county and plan counsels may not be inclined to follow this guidance.

A. Current Release of Information Practices and Directions

While these privacy requirements are often viewed as a barrier to cross-agency partnerships in dealing with the reentry population, our study revealed effective approaches that are now being

[121] Wiseman, Dorinda. 2016. "AB 109 Implementation" *California Mental Health Planning Council*. [PDF]
[122] State Health Information Guidance (SHIG) on Sharing Sensitive Health Information [Link].

utilized that allow for the needed sharing of information while still being in compliance with Federal and State provisions:

The CDCR's ROI process is generally an effective process for parole agents to obtain performance and progress information regarding their parolee. When a parole agent refers a parolee to a treatment program, the agent has the parolee sign a ROI form, so that parolee information can be exchanged between the parole agent and the program provider(s). This form is attached to the referral document that is sent to the provider. Generally, the program referral document will provide information about the parolee's criminal history, any restrictions, and their Correctional Offender Management Profiling for Alternative Sanctions (COMPAS) Assessment[123] information, etc., if relevant to the referral. The ROI form authorizes the provider to give ongoing information about the parolee's program enrollment, participation dates, progress in treatment, results of substance abuse testing, program outcomes, etc.

Los Angeles County is planning to establish data and information sharing policies and procedures by Year 2 of their Whole Person Care Plan, across all participating entities (led by the Los Angeles Department of Health Services and includes all relevant social services programs, Sheriff's entities, corrections, Medi-Cal Managed Care Plans, Community Based Organizations, etc.). The County will be working with the Board of their Health Information Exchange (HIE) system, the Los Angeles Network for Enhanced Services (LANES), and other WPC participants to amend the LANES Data Use agreement to allow database access for analytics and evaluation purposes. LANES provides the data foundation for all WPC-LA activities. The LANES HIE is a non-profit organization whose mission is to improve healthcare delivery by providing a platform that enables cost-effective and secure electronic exchange of patient medical records among public and private health care providers and plans across LA County.[124]

San Diego County has developed a thorough, 'whole-person" approach to permit the sharing of important health-related information. The County's "ConnectWell San Diego" platform shares secure information amongst the nine systems of their integrated Health and Human Services Agency (HHSA), ranging from Self-Sufficiency/Eligibility to Mental Health, Substance Abuse, Child Welfare, Probation, Housing, 211, and the County's Community Resource Directory to allow for the full coordination of services and a more successful reentry process. The platform's six main functions are to (1) search and view customers, (2) run reports, (3) facilitate collaborative service teams, (4) electronic referral management, (5) secure messaging, and (6)

[123] A risk-need assessment system developed to assist corrections with placement decisions; the system incorporates a range of theoretically relevant criminogenic and/or other factors emerging from meta-analytic studies of recidivism.

[124] See page 64 of the LAC Whole Person Care Application [PDF]

alerts and notifications.[125] In addition, they also have a Multi-Agency Interface Criminal Justice Hub (connects all criminal justice entities and behavioral health), a Health Information Exchange (connects all hospitals and health care systems), and Community Information Exchange (shares data and information across various community providers, such as housing, EMS) data systems.

Santa Clara County has demonstrated how a close working partnership of the agencies involved in reentry can produce an approach that addresses what might appear to be unsolvable obstacles to the important information sharing needed to meet the needs of former inmates transitioning into their community. The Office of Reentry Services (ORS) under the County Executive Office, provides a high level forum for addressing operational and policy issues.

Recognizing the potential constraints posed by various federal requirements, the County Counsel's Office led a discussion with staff from the Health and Hospital system, Probation, Sheriff's department, Social Services and others to develop a form that would comply without placing clients in a confusing and cumbersome situation. The goal was to be able to clearly explain privacy protections, and not require sign offs on multiple release documents in order to permit the needed information sharing. The result was the "Santa Clara County Reentry Resource Center Authorization for Release of Confidential Health and Other Information" (Appendix 12), which the County began using in August 2015.

This form is shared with clients as they enter the County's Reentry Resource Center. Staff spend time carefully explaining the intent of the form to the FIP, the need for the client's separate approval in the various service categories, and their option to decline these authorizations. County Counsel indicated that they found clients to be initially confused by this information, so reentry staff has had to reevaluate their approach to put clients at ease and ensure they understood the intent of the form and their options.

Alameda County has undertaken a close partnership between the Alameda Probation Department and Health Care Services Agency to collaborate and provide behavioral health services, including coordinated drug recovery and treatment, and specialty mental health services, to AB 109 probationers. Knowing full well the complexity of privacy and information sharing protections across multiple systems, the siloed approaches to confidentiality, and the general lack of understanding amongst agents and practitioners, the two departments proactively collaborated on the development of a Memorandum of Understanding. The MOU clearly outlines the applicable state and federal regulatory frameworks for the sharing of program enrollment and billing data, statistical data, and client program data to achieve coordinated supervision and services. The MOU outlines the procedures for Consents for the Release of

[125] CSG Justice Center. 2017. "The Stepping Up Initiative: Behavioral Health Data and Information Sharing." [Link]

Information which adhere to 42.CFR.Section 2. It clearly defines that the Criminal Justice Case Management Team will collaborate with the Behavioral Health Services Providers to coordinate client services. The parameters for the enrollment and billing data exchange are covered. The proactive communication and problem solving is exemplary for navigating these challenging, multiple, and complex regulations, which at many junctures do not mesh well. This is clearly a results oriented pathway.

These approaches demonstrate the actions that can be taken to share important case information, while complying with State and Federal privacy requirements. The following recommendations would promote the sharing of these practices with other jurisdictions, and the possible discovery of other arrangements that could also be considered.

Recommendations:

- **Effective ROI approaches, such as Santa Clara's, could be shared through sponsored forums** that would demonstrate how organizations involved in reentry efforts can exchange information that would allow for a better coordinated case management and transition process, while still meeting state and federal privacy requirements. These forums should cover the process that was used to develop each county's approach, including the issues that had to be addressed; the documents, systems, and protocols that are now being used to share information; any gaps they have experienced in the sharing of information; and identify additional steps that may still be needed. Ideally, forum participants would include the Chief Probation Officers of California (CPOC), the County Welfare Directors Association (CWDA), and other stakeholders. [Reco: (4)(i)]

- **Steps should be taken to further explore and develop bi-directional sharing of information through HIEs and other technological infrastructures** that some counties (e.g.: San Diego, Santa Clara) have developed for data sharing approaches between all entities involved in the reentry process, including, but not limited to: corrections (custody and health related services), parole/probation, county level health services, licensed and certified treatment providers, etc., so that information about an individual can be readily shared and accessed by necessary stakeholders. [Reco: (4)(ii)]

5. Residential and Outpatient Treatment and Capacity for Individuals with Co-Occurring Disorders (CODs)

Overview

Residential and outpatient treatment for individuals living with serious mental illness is in short supply, and in particular, there is a serious need for integrated treatment programs that can address individuals with both SMI and a co-occurring substance use disorder (SUD). For the purposes of this report, the term co-occurring disorder (COD) refers to those who are identified as both SMI and SUD. Of criminal justice involved individuals with mental illness, 74% also have a co-occurring substance use disorder.[126] We acknowledge that many of these individuals also have physical health comorbidities.

Our discrete treatment systems are currently designed to treat only one presenting problem at a time. Research clearly supports the delivery of integrated specialty mental health and substance use disorder treatment concurrently.[127] This best practice, however, faces the challenge of relying on three distinct funding sources, each with their own administrative processes and requirements: the treatment systems for health, specialty mental health, and substance use disorders. Particularly for the reentry population, this can result in poor outcomes and costly, duplicative efforts.

For FIPs with CODs, these outcomes can result in higher recidivism rates and criminal justice system costs. Individuals with CODs are more likely to be rearrested—41% within one year of release, compared to 31% of those with only mental illness or a SUD. They are also more likely to violate the terms of community supervision and more likely to commit acts of violence.[128] Furthermore, research shows that individuals with CODs in treatment programs not designed for those with CODs are more likely to miss appointments, spend less time in treatment, and have higher treatment dropout rates.[129]

The Affordable Care Act reformed the health care system by using financial methods and managed care practices with the goals of reducing healthcare costs, improving the patient

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[126] Peters, Rogers et al. 2015. "Co-Occurring Substance Use and Mental Disorders in the Criminal Justice System: A New Frontier of Clinical Practice and Research." *Psychiatric Rehabilitation Journal*, 38(1). [PDF]
[127] Mueser, Kim et al. 2001. "Implementing Evidence-based Practices in Routine Mental Health Service Settings." *Psychiatric Services*, 52(2). [Link]
[128] Peters, Rogers et al. 2015. "Co-Occurring Substance Use and Mental Disorders in the Criminal Justice System: A New Frontier of Clinical Practice and Research." *Psychiatric Rehabilitation Journal,* 38(1). [PDF]
[129] Van Dorn, Richard et al. 2010. "The Relationship between Outpatient Mental Health Treatment and Subsequent Mental Health and Disorders in Young Adults." *Administration and Policy in Mental Health*, 37(6). [Link]

experience, and improving outcomes. This "Triple Aim" requires the coordination, if not integration, of the delivery of services across health, specialty mental health, and substance use disorder programs. Complicating the implementation of these goals is the fact that specialty mental health, SUD, and corrections hold discrete views of the details of assessment, interventions, and practices for the forensic population.

Many community based SUD programs currently admit and successfully treat FIPs with CODs by addressing mental health needs as they arise. However, the current standards of practice for SUD treatment are not uniform. Program approaches are not currently established through an evidenced-based consensus of cross-system standards. The projects that target the reentry population use a variety of evidence-based practices that are established through individual contract terms and conditions that are not consistent across programs. They have not been promulgated as statewide guidelines based upon a consensus of cross-system thought leaders and experts for the co-occurring forensic populations.

A. Traditional Approaches to Service Delivery

As in the past, publicly funded specialty mental health and alcohol and drug services are delivered by two distinct systems and are financed through arrangements separate from health care funding or each other, so called "carve outs." In order to provide services for co-occurring mental health and substance use disorders, providers must hold separate licenses, certifications, and contracts and deliver services under these two separately regulated systems. Alcohol and drug treatment programs were designed to treat substance use disorders, not mental health disorders, and are certified by DHCS under Title XXII regulations for general alcohol and drug treatment for adults. There are population specific assessment and/or treatment guidelines for adolescents and pregnant and postpartum women, but not for other special populations, such as the forensic population or individuals living with serious mental illness. The Drug Medi-Cal Organized Delivery System (DMC-ODS) 1115 Waiver establishes the use of an SUD assessment using the ASAM criteria, matching to ASAM levels of care based on medical necessity, and standards of care in counties that decide to participate in the Waiver. In addition, the DMC-ODS now permits Medi-Cal funding for community based residential treatment.

Traditionally, there have been two approaches[130] to serving the COD population. Both approaches use separate treatment providers for each disorder, with little coordination between them:

- Sequential Treatment. This model treats one disorder before addressing the other.
- Parallel Treatment. Individuals are enrolled into separate treatment programs simultaneously for each disorder.

[130] Mueser, Kim. 2003. "Integrated Treatment for Dual Disorders: A Guide to Effective Practice." *Guilford*. [Link]

These two approaches and their pitfalls are described in Table 5.1. below:

Table 5.1. Traditional Models of Treatment: Pitfalls of Each
Sequential Treatment
● Untreated disorder worsens the treated disorder, making it impossible to stabilize one disorder without attending to the other. ● Lack of consensus on which disorder should be treated first. ● It is unclear when the treatment of one disorder has been "successfully treated," so that treatment of the other disorder can begin. ● The patient is not consistently referred for further treatment.
Parallel Treatment
● Treatments of each disorder are not integrated into a cohesive treatment package. ● Treatment providers fail to communicate. ● Burden of integration falls on the patient. ● Funding and eligibility rules impose barriers to accessing both treatments. ● The incompatibility of different treatment providers' philosophies makes it difficult to design a coherent treatment approach. ● A patient can "slip through the cracks" and receive no services, due to the failure of either treatment provider to accept final responsibility for the patient. ● Providers lack a common language and treatment methodology.

Source: Adapted from Meuser (2003).

Responsibility for treatment of parolees and probationers is evolving. Until Public Safety Realignment, the reintegration of state prison inmates into communities and services remained the responsibility of the California Department of Corrections and Rehabilitation (CDCR). Counties were not responsible for services to parolees. As the prison SMI population increased, funding was committed to parolees through the Parolee Outpatient Clinics throughout the state. Transitional housing, along with board and care providers housed this parolee SMI population and services for their mental health disorders, continued under POC.

Starting in the 1990's, the CDCR developed and funded evidenced-based in-prison SUD treatment and community aftercare programs for inmates and parolees. These services were generally provided under direct treatment and reentry service contracts between treatment providers and the CDCR, known as the Substance Abuse Services Coordinating Agency (SASCA). Additionally, these services were provided through contracts between providers and the former Department of Alcohol and Drug Programs, known as the Parole Service Network. In many situations, CDCR paid higher rates for outpatient and residential substance abuse programs to SUD providers than many county Behavioral Health Services (BHS) Departments, and thus

the CDCR was more successful in acquiring treatment capacity than BHS. Community based treatment providers then and still today generally do not offer co-occurring services.

Many of the recent corrections grants have shifted from the therapeutic community model to cognitive restructuring for criminal justice rehabilitation. However, an expert consensus has not been reached on the most effective treatment approaches, nor do current policies reflect an integrated treatment approach to criminogenic, mental health, and substance use disorders to guide placement and practice. Integrated treatment modalities that can effectively address the needs of dual diagnosed individuals are in short supply. The mandate for managed plans to provide services for mild to moderate mental illness and coordinate with the county Specialty Mental Health Plans is a start but it is faced with many implementation challenges. Furthermore, although research supports the use of integrated treatment, the efficacy of these programs depends on their fidelity to the evidence-based practices that the treatment was built upon, and research also shows that program implementation is not always successful, and that the quality of high-fidelity programs sometimes declines over time.[131] These integrated models of care also depend on the sharing of data across systems as discussed in the previous chapter on the Release of Information.

B. What does an Integrated Model look like?

Research indicates that "assessments and interventions that target criminogenic needs must be implemented in a manner that to which individuals with mental illness can be maximally responsive."[132] The Council of State Governments (CSG) Justice Center, National Institute of Corrections (NIC), and Bureau of Justice Assistance (BJA) issued a report in 2012, entitled, "Adults with Behavioral Health Needs Under Correctional Supervision," that provides an integrated approach to treatment that may be helpful in the development of evidence-based practice programs for the justice involved mentally ill population.

This framework:

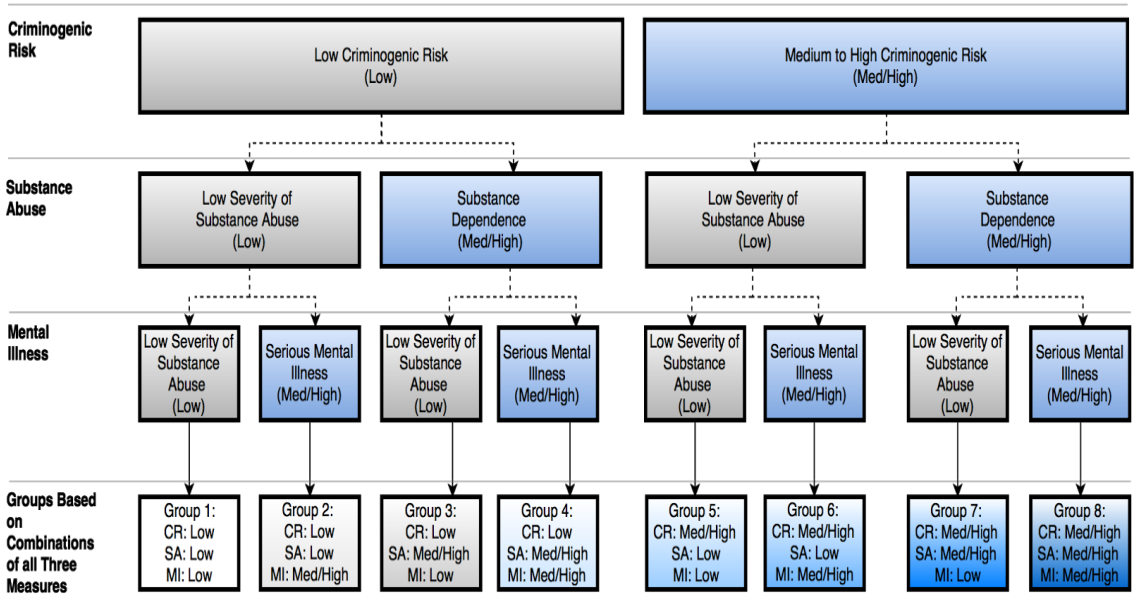
> *weaves together the science on risk and needs to provide an approach to achieve better outcomes for adults in contact with the criminal justice system with substance use disorders, mental illness, or both. This tool can be used at the corrections and behavioral health systems level to prioritize scarce resources based on objective assessments of individual's' risk of committing a future crime and their treatment and support needs. The*

[131] Torrey, William et al. 2002. "The Challenge of Implementing and Sustaining Integrated Dual Disorders Treatment Programs." *Community Mental Health Journal*, 38(6). [Link]

[132] Rotter, Merill and Amory Carr. 2013. "Reducing Criminal Recidivism for Justice-Involved Person with Mental Illness: Risk/Needs/Responsivity and Cognitive-Behavioral Intervention." *SAMHSA's Gain Center for Behavioral Health and Justice Transformation.* [PDF]

> *accompanying report emphasizes the importance of true collaboration between corrections staff and treatment professionals, using interventions both within prison settings and in the community.*[133]

Integrating Criminogenic Risk into baseline assessments advances the appropriate community placement of FIPs, yet it is not typically factored into the mental health and/or substance use disorder assessment. The framework of the Criminogenic Risk and Behavioral Health Needs Framework from the CSG report is shown in the figure below.[134]



Source: CSG Report, Criminogenic Risk and Behavioral Health Needs Framework[135]

Other research supports the delivery of integrated mental health and substance use disorder treatment.[136] A well-coordinated, integrated treatment program can reduce recidivism for FIP with CODs. For example, in a study of a modified Therapeutic Community in Colorado (see below), Sacks and colleagues (2003) randomly assigned inmates with COD to either the modified TC or standard mental health treatment and found an advantage for modified TC treatment on measures of criminal behavior, particularly when prison and aftercare TC treatment are combined, as reincarceration at 12 months post-prison release for this group (5%) was

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[133] Osher, Fred et al. 2012. "Adults with Behavioral Health Needs Under Correctional Supervision." *Council of State Governments Justice Center.* [PDF]
[134] Ibid
[135] Osher, Fred et al. 2012. "Adults with Behavioral Health Needs Under Correctional Supervision." *Council of State Governments Justice Center.* [PDF]
[136] Drake, Robert et al. 2001. "Implementing Dual Diagnosis Services for Clients with Severe Mental Illness." *Psychiatric services*, 52(4). [Link]

significantly lower (p<.02) than for the Mental Health group (33%).[137] Through its Center for Integrated Services, SAMHSA has provided funding, guidelines, technical assistance, education and training to guide agencies to an understanding of stages of the changes needed (See Table 5.2.).

One of the core values of effective integrated treatment is shared decision making in the treatment plans of a patient. The same clinical team provides treatment for mental illness and their SUD at the same time, incorporating the following core components: "integration of services, comprehensiveness, assertiveness, the reduction of negative consequences, a long-term perspective (time-unlimited services), motivation-based treatment, and the availability of multiple psychotherapeutic modalities."[138] Motivation based treatments are used because those who suffer from SMI tend to have lower motivation to stop substance use. Motivational enhancement therapy, 12-step facilitation, and relapse prevention are core addiction treatment psychotherapeutic approaches commonly blended into specialty mental health treatment to develop integrated psychosocial treatments.[139]

At the delivery level, integrated programs reduce the amount of navigational barriers for the client, as well as administrative and ROI issues between multiple treatment providers. At the clinical level, dually diagnosed SMIs with SUD need to be in programs that address the whole person. Currently, one program's priorities may not align with the second program's, and conflicts can result in harm to the client. For instance, those with SMI are typically treated with medications, while those with SUD are still sometimes referred to abstinence only treatment programs or do not have access to routine psychiatric medication evaluation and support services.

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[137] Sacks, Stanley et al. 2003. "Modified Therapeutic Community Program for Inmates with Mental Illness and Chemical Abuse Disorders." *Corrections Today*, 65(6). [Link]
[138] Mueser, Kim. 2003. "Integrated Treatment for Dual Disorders: A Guide to Effective Practice." *Guilford*. [Link]
[139] Ziedonis, Douglas. 2004. "Integrated Treatment of Co-Occurring Mental Illness and Addiction: Clinical Intervention, Program, and System Perspectives." *CNS spectrums*, 9(12). [Link]

Table 5.2. Models of Care for Individuals with Co-Occurring Disorders			
	Traditional Service Delivery	**Co-located Service Delivery**	**Integrated Service Delivery**
Key Element	Communication	Proximity	Practice Change
Administration	Separate administrative systems	Share scheduling/ some records	Function as one system
Provider Communication	Communicate periodically	Regular face to face interactions	Consistent system, team, and individual level collaboration
Roles & Culture of Care	Appreciate each other's roles as resources	Understand roles and culture	Shared concept of team care. Roles and cultures blend
Screening & Assessment	Screening & assessment according to separate practice models	Agree on specific screening & assessment tools and may share results	Consistent tools across disciplines which guide interventions
Treatment Plan	Separate Treatment Plans	Collaborative treatment planning for specific patients	One treatment plan for all patients
Division of Responsibilities	Separate responsibility for care	Some EBPs and care shared	Consensus & training on selected EBPs across disciplines
Patient Needs	Needs are treated separately but records are shared using consents	Needs are treated separately but collaboration occurs in handoffs	All patient needs are treated by a coordinated team generally with a single care coordinator
Referrals	Referrals are made/ access may be limited	Internally referred with better access & follow-up	Patients experience a seamless response and unified practice
Patient Information Sharing	Multiple definitions, formats, & data collection and limited sharing of patient information	Collaboration to minimize barriers to multidisciplinary services	Shared client outcomes necessitating uniform and shared records and data
Team Values	Values organization autonomy	Buy in to concept of integration and engage in mutual problem solving across systems	Integrated care components embraced by all providers
Financing	Separate funding/billing	Share grants/ some expenses but separate billing due to system barriers	Integrated funding based on multiple sources of revenue/billing maximized for integrated model

Source: Adapted from Heath B, Wise Romero P, and Reynolds K. A Review and Proposed Standard Framework for Levels of Integrated Healthcare: Washington, D.C. SAMHSA-HRSA.

C. Examples of Integrated Service Models

Fully integrated programs that serve those with CODs are difficult to find–even more rare are programs that cater to the reentry population. Most treatment programs were built using the existing foundation of various traditional SUD program models, and exist along a spectrum of integration of coordination and care. Many programs are still co-located and have been developed by blending various elements deemed necessary to treat the complex needs of this population. Given the existing barriers to achieving fully integrated coordination and care–to be discussed in the following section–current providers should be commended for these early attempts at providing integrated service. The following are a couple of promising national examples. Both of these programs start within correctional institutions, where individuals receive care coordination and treatment while they are incarcerated, and extend into post-incarceration through further case management and community aftercare services.

A Modified Therapeutic Community (TC) Model in Colorado

Personal Reflections is a program for inmates with mental illness housed in a separate unit at the San Carlos Correctional Facility in Colorado. Therapeutic community (TC) principles and methods provide the foundation for recovery and the structure for the program of substance abuse and mental health treatment, and for a cognitive-behavioral curriculum focused on criminal thinking and activity. A positive peer culture facilitates behavior change, while psychoeducational classes increase the inmate's understanding of mental illness, addiction, the nature of COD, drugs of use and abuse, and the connection between thoughts and behavior. These classes also teach emotional and behavioral coping skills. Those who complete the prison program are eligible for a TC program in community corrections on release (see Sacks and Sacks, 2003 for a full description of the program).[140]

Criminogenic Addiction Recovery Academy (CARA)

CARA is a gender-specific intensive 5½ week program at the Kennebec County Correctional Facility in Maine with between 10 and 12 participants at any given time. Inmates with an appropriate length of sentence for program completion with a history of significant substance abuse and repeated criminal behavior, will be considered for participation in the CARA. After referral, a comprehensive screening assesses criminal thinking, co-occurring disorders, treatment motivation, risk of relapse and re-offending. Corrections officers receive specialized training before being stationed in the facility and CARA is isolated from the general population. Programming runs from 7am to 7pm, five

[140] Sacks, Stanley and Frank Pearson. 2003. "Co-Occurring Substance Use and Mental Disorders in Offenders: Approaches, Findings and Recommendations." *Federal Probation*, 67(2). [Link]

days a week, and there are five primary program types, including:

1. Substance abuse
2. Criminogenic behavior/thinking
3. Problem-solving
4. Parenting
5. Work readiness

All programming is gender responsive and incorporates baseline and re-evaluation. The Criminal Thinking Scale and Tx Motivation Scale are both used in evaluating the participants. Inmates begin receiving reentry services during the first week of the CARA program. Case managers meet individually with inmates to identify their unique community reentry needs, and they complete the program with a 'portfolio' of resources available to them, aftercare appointments, and extended community supervision.

D. Barriers to Achieving Integrated Treatment

a. Integrated Treatment Capacity

Although opportunities are available through new reentry initiatives and funding streams, NIMBYism and the unpredictability of corrections funding streams both at the local and state level has prevented a significant growth in community based bed capacity to serve the dually diagnosed justice involved population. In order to meet capacity demands, probation contracts currently allow the use of outpatient services while living in unregulated sober living residences or six bed treatment facilities. Table 5.3. reflects the current DHCS information that is available about SUD treatment capacity.

The DHCS reports that service information is based on self-reporting by providers in an environment without specific guidelines for co-occurring or dual diagnosis services. DHCS does not currently collect information about services targeted to parolees or probationers.

Table 5.3. SUD Treatment Capacity	
Residential Treatment	
Residential Treatment Facilities	610
SUD Residential Treatment Beds	20,126
Self-Designated Dual Diagnosis Beds	**275**
Out-Patient Treatment	
Non-Residential Treatment Facilities	874

Source: DHCS Licensing and Certification Status Report 2016[141]

The inventory of programs and qualified providers to provide these integrated services is insufficient.[142] In 2016, there were 20,126 Title XXII licensed SUD residential treatment beds available across the state of California. Of these, only 275, or 1.3% self-identified as providing dual diagnosis treatment. The information collected by the DHCS does not capture the statewide treatment capacity that is available for COD services due to voluntary self-reporting by providers. In reality, there is even less capacity for FIPs suffering from CODs because many facilities exclude the reentry population. The range of specialty services for this population are also insufficient. Furthermore, there is a significant workforce deficit in qualified staff to serve this population.

One program licensed by the DHCS for 120 AOD residential beds that self-identifies as serving the COD FIP population is the Volunteers of America San Diego, Renaissance Treatment Center. The program is funded primarily through a mix of county realignment and the CDCR reentry residential treatment contracts. The program leadership reports that the referrals have changed dramatically over the past 10 years with an ever increasing number of individuals with co-occurring mental health and substance use disorders with varying levels of severity being ordered to placement. However, the current licenses, contracts, and funding streams create challenges for serving their clients. Providers do attempt to enhance services with limited funding, but there is need for a program design and staffing that can be tailored to the individual needs of the clients being served. The current CDCR contracting process, which relies primarily on low bid proposals (for the Residential Multi-Service Centers and Parole Service Centers) does not offer financial incentives for contractors to provide enhanced services to mentally ill

[141] CA DHCS. Licensing and Certification Status Report. [PDF]
[142] Peters, Rogers & Nicole Bekman. 2007. "Treatment and Reentry Approaches for Offenders with Co-Occurring Disorders. A chapter in "Public Health Behind Bars." *Springer New York.* [Link]

program participants. These enhanced services could improve recidivism rates, and reduce the revolving door of admissions for mentally ill parolees.

b. Siloed Funding

Funding for SUD and specialty mental health services is predominantly provided through separate funding streams. These funding streams are also separate from Medi-Cal capitation rates paid to Medi-Cal managed care plans, which are responsible for physical health services and services for beneficiaries with mild to moderate mental health conditions. Each funding stream has its separate administrative, accounting and fiscal requirements that providers must comply with. In addition, Realignment provided new funding for residential SUD programs for probationers. Specialty mental health services expanded under direct contracts to mental health outpatient programs. Community SUD providers entered into new contracts for AB 109 services. Transition and case management teams cropped up statewide using a variety of funds including Mental Health Services Act funds. The practice and operation of these programs are often duplicative and costly. They also generally fail to create needed regulatory flexibility so they can be replicated on a larger scale. Because of the carve outs, providers tend to specialize in one system or the other. This results in a ping ponging of clients between the two systems unless overtly addressed in program funding and design.

c. Siloed Treatment

A frustration noted by interviewed stakeholders is the revolving door that occurs because of clients leaving the programs before completion and/or expulsion due to the severity and complexity of their needs. SUD services are unique in their social model, peer based recovery approaches to treatment while specialty mental health provides clinically based and psychopharmacological services. Practitioners also view the recovery model as foundational for county specialty mental health programs as well, including the provision of community-based services. Counties do not see themselves as operating solely on the medical model and see this as an asset of the system for the beneficiaries they serve.

Both SUD and specialty mental health systems recognize the need for interventions to address the social determinants of impairments such as housing, employment, and social services; however, neither of these systems are equipped with the resources necessary to address these factors The health care system has not focused on criminogenic needs, social determinants nor prevention and behavioral interventions. Furthermore, the complex nature of utilizing multiple service providers creates yet another layer of navigational issues for those attempting to access treatment.

For example, there are currently separate risks and needs assessments, and program assessment protocols for the justice involved population and individuals with CODs. In 2002, the Substance Abuse and Mental Health Services Administration (SAMHSA) recognized the need for integrated treatment, and treatment programs to develop increased capability to clients with co-occurring disorders in its report to Congress on the Prevention and Treatment for Co-Occurring Substance Abuse and Mental Disorders. As a first step to taking on the challenges of building program capacity to integrate specialty mental health and substance use disorder services SAMHSA contracted for objectively rated instrument(s) for measuring co-occurring disorder treatment capability within any mental health program or service setting which have been updated as recently as 2011. The Dual Diagnosis Capability in Mental Health Treatment (DDCMHT) and its companion the Dual Diagnosis Capability in Addiction Treatment (DDCAT) have never been used broadly for policy or funding decisions in California.

d. Siloed Administrations

Although "NIMBYism" can impose significant challenges for siting new facilities, other potential siting bottlenecks include Conditional Use Permits (CUP), local business permits, complex zoning plans and ordinances, fire clearances and permits, lack of consistency between state and local service/use definitions and licensing and certification requirements. Add to these challenges inexperience with Medi-Cal structure and billing, dissatisfaction with fee-for-service reimbursement rates, administrative and billing burdens that discourage plan participation, dual licenses and certifications and complex, duplicative applications. Generally, there are minimal investment dollars available to providers to expand capacity and all risks are assumed by the providers. For these reasons, many choose not to become enrolled in the Medi-Cal program.

e. Siloed Culture & Practice

While there was not a significant growth in new capacity, reentry initiatives did create a network of providers with experience working with the criminal justice population with substance use disorders. However, the build out of services did not support services for co-occurring mental health and substance use disorder treatment leaving a "competency gap." A few AOD providers have became co-occurring "capable" by hiring a licensed or registered mental health practitioner (e.g.: psychologist, clinical social worker, etc.). In these programs, COD individuals are admitted that are deemed to be "stable" and can fully participate in the programs. In this model, psychiatry and medication support can only be accessed through referrals to the POC or the County Mental Health Department Systems. The availability of behavioral health treatment providers in the community who have the requisite skill set and experience to work with the reentry population is underdeveloped. Additionally, there is not a consensus among partners regarding the

philosophical approach to relapse and non-compliant behaviors.

f. Siloed Data and Definitions

The lack of data and standardized definitions across systems used to describe and categorize the forensic population service needs and delivery presents a significant barrier to planning, designing, funding and implementing services. For example, those with co-occurring diagnoses can be referred to as being "comorbid" or "dually diagnosed." Semantic differences across multiple systems creates burdensome linguistic barriers, resulting in fragmented data and disruptions to care coordination and treatment delivery.

Recommendations:

- **Exploring a new strategy for integrated COD services provided to the reentry population.** The unique needs of the COD reentry population may offer incentives for creating a more integrated approach for providing effective services that both reduce recidivism and provide better treatment. For example, funding from CDCR or through AB 109 Realignment funds could be leveraged to establish a model of care that is responsive the needs of the COD reentry population.

  The CDCR or county contracts with providers could require specific program elements that rely on evidence-based practices, such as an integrated assessment tool, staffing model, performance measures, etc. The contract could be funded through a combination of funding streams to simplify administrative activities, accounting and auditing.

  The BSCC recently provided $103 million for Proposition 47 grants to counties that emphasized both specialty mental health and AOD treatment for justice-involved individuals. This funding source will be used by Alameda County, for example, to pilot an integrated service model. Other counties could consider developing similar proposals for future Proposition 47 grants. The experience gained in operating and financing this new model could provide a foundation for developing treatment programs for other COD populations. [Reco: (5)(i)]

  Next Steps would include the following:

  - Assessing existing programs and capacity that serve the COD reentry population.

- Identify willing partners – counties, the CDCR, and providers – to help define a treatment and financial model for the COD reentry population. [Reco: (5)(ii)]

6. Housing

Overview

This section highlights key housing issues that relate to the SMI and MF reentry population. While the statistics illustrate that many formerly incarcerated people (FIP) experience some form of residential instability after incarceration, the SMI and MF frequent users of multiple health and human service systems are at the highest risk of housing loss and homelessness after release from jail or prison.

The issues related to housing for the SMI population have been well documented. For many who are justice system involved, the cycle of incarceration, homeless shelters, psychiatric hospitals, detox and drug treatment programs, and other emergency service systems result in immense public expense and with bad outcomes. The Corporation for Supportive Housing (CSH), a think tank that aims to advance effective housing solutions, reports that around 25% of the people in U.S. jails were homeless in the year prior to incarceration, at least 16% have a mental illness, 80% have a history of substance use, and homelessness was associated with a sevenfold increase in parole violations.[143] There is far less data and and fewer housing options for the medically fragile who are transitioning from prison and jail.

Establishing stable housing is an important first step to reduce both medical costs and recidivism rates among the MF and SMI reentry population. Moreover, without housing, the success of other supportive services, such as employment services, mentoring, and substance abuse counseling, is extremely limited. Without access to safe, affordable, and stable housing, FIPs reentering the community are likely to have little success.

A. Defining Homelessness

The Federal Department of Housing and Urban Development (HUD) maintains the most frequently used core definition of homelessness. This definition is used by CDCR in a variety of contexts and affects who is eligible for homeless assistance programs. HUD defines homelessness according to the following guidelines:

An individual is considered homeless if an individual or family lacks a fixed, regular, and adequate nighttime residence, meaning:

[143] Corporation for Supportive Housing, 2017. "Criminal Justice Involved Individuals Returning Home." [Link]

- An individual or family with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground;
- An individual or family living in a supervised publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters,transitional housing, and hotels and motels paid for by charitable organizations or by federal, State, or local government programs for low-income individuals); or
- An individual who is exiting an institution where he or she resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution.

B. The Housing Debate

Perhaps the most prominent debate about service delivery models for people experiencing homelessness during the reentry process revolves around the question: should housing come before or after treatment for people who are homeless and experiencing mental illness, substance use disorder (SUD), or behavioral issues?

"Housing First" is a model that advocates for the provision of housing for people experiencing homelessness before engaging homeless individuals in treatment for mental illness, SUD, or co-occurring disorders. Conversely, the "Treatment First" service model prioritizes the treatment of mental illness before the provision of housing for homeless individuals. The Treatment First model has influenced many service delivery models and public policy designs that require homeless people to provide evidence that they are prepared to live in permanent housing. The assumption underlying this policy and programming philosophy is that homeless people are not able to sustain tenancy and self-sufficiency without first receiving treatment for mental illness. In other words, sobriety and the active/consistent treatment of mental health disorders act as the necessary pre-conditions for housing.

Numerous studies have provided support for the idea that homeless people with mental illness and/or a litany of co-occurring physical and behavioral disorders are able to sustain tenancy when they are provided with appropriate support for their respective conditions.[144,145,146,147,148]

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[144] Busch-Geertsema, Volker. 2013. "Housing First Europe Final Report." [PDF]
[145] Padgett, Deborah et al. 2011. "Substance Use Outcomes Among Homeless Clients with Serious Mental Illness: Comparing Housing First with Treatment First Programs." *Community Mental Health Journal*, 47(2). [Link]
[146] Padgett, Deborah et al. 2006. "Housing First Services for People who are Homeless with Co-Occurring Serious Mental Illness and Substance Abuse." *Research on Social Work Practice*, 16(1). [Link]
[147] Tsemberis, Sam et al. 2004. "Housing First, Consumer Choice, and Harm Reduction for Homeless Individuals with a Dual Diagnosis." *American Journal of Public Health*, 94(4). [Link]

Most researchers have taken a comparative approach to studying these two service delivery models. Compared to individuals in "Treatment First" programs, individuals in "Housing First" programs are significantly less likely to leave their program and significantly less likely to utilize SUD treatment services. Other researchers have noted that "Treatment First" programs have markedly lower rates of client retention and higher rates of client substance use relapse.

Within this dichotomous debate between these intervention models, a variety of options exist. The following chart describes four different models of housing service delivery that exist under the umbrella of "Housing First" service delivery.

Table 6.1. Housing Models

Type	Duration	Description
Emergency Shelter	Short-Term (1-180 days, ideally under 30 days)	• Immediate access • Variation of intensity of service • No services for high-need
Rapid Rehousing	Medium-Term Subsidy & No Limit on Length of Stay	• Client has a lease for his/her own unit • Focused on housing stability • Appropriate for low to medium need
Transitional Housing	Medium-Term Subsidy & Limited Length of Stay in Housing	• Site-based living • Focus on future housing readiness • Often screens out high-need
Permanent Supportive Housing	Long-Term, no Limit on Length of Stay (focus on permanency)	• Client has a lease for his/her own unit • Focus on housing stability • Appropriate for high need only (ie. those who cannot access or maintain housing stability without services)
Residential Treatment	Variant Length of Stay, Depending on Necessity of Care	• Client supervision • Subject to licensure, with "6 and under" rules • No landlord/tenant rights apply

[148] Tsemberis, Sam. 2011. "Housing First: The Pathways Model to End Homelessness for People with Mental Illness and Addiction Manual." *European Journal of Homelessness*, 5(2). [Link]

C. Why Housing First?

The typical public cost for traditional residents in supportive housing is about $605 a month. The typical public cost for similar homeless people is about $2,897 a month, five-times greater than their counterparts that are housed.[149] These figures show that practical, tangible public benefits result from providing supportive housing for vulnerable homeless individuals. However, this estimate of the fiscal savings derived from supportive housing drastically understates the possible savings that could be derived from helping the MF and SMI population find and maintain housing. Given that this specific group uses a disproportionately high share of the available medical and psychiatric care[150] and is more likely to reoffend[151], the potential public savings from keeping these individuals away from these costly services are enormous. A recent randomized controlled study demonstrates that "Housing First" produces significant reductions in reconvictions compared to the "Treatment First" approach.[152] Another study has shown that the Housing First treatment approach can significantly reduce hospitalization for those with psychiatric disorders.[153] In light of this evidence, the "Housing First" service delivery models seems to hold large cost savings for communities.

Additionally, it seems necessary to implement the Housing First approach with the reentry MF and SMI population because prioritizing housing during their reintegration allows for the fragile individual to quickly get off the streets. Once off the streets, the individual can access key resources that meet their unique needs. In this sense, housing is a platform for the vital stabilization of this fragile population. Although counties and the CDCR have developed a number of programs for housing members of the general reentry population, only a few of these programs are adequate for the needs of the MF and SMI reentry population. Furthermore, the majority of programs designed for the MF and SMI population are only effective at serving the needs of those who are mentally ill, not medically fragile.

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[149] Flaming, Daniel et al. 2009. "Where We Sleep." *Economic Roundtable.* [Link]
[150] Allday, Erin. 2016. "The Street's Sickest, and Costliest: The Mentally Ill." *SF Chronicle.* [Link]
[151] Baillargeon, Jacques et al. 2009. "Psychiatric Disorders and Repeat Incarcerations: The Revolving Prison Door." *American Journal of Psychiatry*, 166(1). [Link]
[152] Somers, Julian et al. 2013. "Housing First Reduces Re-offending among Formerly Homeless Adults with Mental Disorders: Results of a Randomized Controlled Trial." *PLoS One,* 8(9). [Link]
[153] Gulcur, Leyla et al. 2003. "Housing, Hospitalization, and Cost Outcomes for Homeless Individuals with Psychiatric Disabilities Participating in Continuum of Care and Housing First Programmes." *Journal of Community Applied Social Psychology*, 13(2). [Link]

Funding Opportunity:

No Place Like Home Initiative (NPLH). Enacted as part of the 2016-17 budget, the "No Place Like Home Initiative," will divert a portion of Mental Health Services Act (MHSA) funds – established through Proposition 63 in 2004 – to provide revenue to support the issuance of $2 billion in bond funds for affordable housing to support the target population of homeless individuals or individuals who are at risk of homelessness and who are living with a serious mental illness. The funding will be used to finance the construction, rehabilitation, or preservation of permanent supportive housing units for individuals with mental health supportive needs who are homeless, chronically homeless, or at risk of chronic homelessness. The program will be administered by the California Department of Housing and Community Development (HCD) with funding awarded through a competitive process. The No Place Like Home Initiative could be used to provide supportive housing for the reentry population, including parolees.[154]

D. Current CDCR Housing Practices for the MF and SMI

The CDCR's Integrated Services for Mentally Ill Parolee (ISMIP) Program is a comprehensive model which provides varied levels of care, supportive/transitional housing, and an array of mental health rehabilitative services. Parole Agents and Parole Outpatient Clinic (POC) staff refer parolees to contracted ISMIP providers. ISMIP services include assistance and linkage to housing, transportation, crisis care, mental health treatment, substance abuse treatment, medication management, and transitional plans for county services.

The CDCR has also implemented a Clinical Case Management Reentry Pilot program (CMRP). This pilot program has been implemented in five counties at seven parole units statewide. The pilot site locations are Sacramento, San Francisco, Kern, Los Angeles, and San Diego Counties. Formerly incarcerated individuals with mental disorders, developmental disabilities, and/or homelessness are the target populations for this pilot. Immediately following the parolee's initial interview with his/her parole agent, the parolee assigned to the pilot program will meet with the assigned Clinical Social Worker (CSW). To ensure immediate basic needs are addressed and clinical symptoms are stabilized, all program participants will be assigned to the Stabilization Phase of the pilot program for a period of 45-60 days. During the Stabilization Phase, the CSW will work with all program participants to ensure immediate basic needs (including

[154] Email from HCD. 2017. "Persons on parole can reside in NPLH-funded housing as long as they otherwise qualify under the tenant eligibility requirements for the program. Parolee status does not prohibit someone from residing in an NPLH assisted unit. There is no specific prohibition in the NPLH Program statute prohibiting parolees from residing in housing financed with NPLH funds."

housing/shelter) are met and connections/linkage to mental health/medical service providers are initiated.

For the general population, CDCR administers Residential Multi-Service Centers (RMSC) in Fresno, Kern, Los Angeles, San Diego, and Yolo Counties. These centers serve parolees, and the program targets those who are living in at-risk environments. Services include housing, SUD treatment, literacy training, job preparation and placement, anger management classes, and individual and group counseling. Parolees may stay housed in the RMSCs for up to 180 days, with a 90-day aftercare component. The program does not exclude SMI but it does not offer specialized services for the SMI and requires them to be stable.

The CDCR also administers Parolee Service Centers (PSC) in Bakersfield, Fresno, Long Beach, Los Angeles, Oakland, San Diego, San Francisco, and Van Nuys. The centers offer voluntary live-in programs that provide housing and support services to parolees. The program focuses on parolee employment, job search and placement training, SUD education, stress management, victim awareness, computer supported literacy, and life skills. Services are provided for up to 180 days with the possibility of an additional 185 days, based on assessed need. These structured programs operate with very strict rules with supervision, curfews, visitor contact policies, and relapse policies. SMI are not excluded.

E. Current Housing Practices for the MF and SMI in Target Counties

Since 2015, Los Angeles County's Department of Health Services has administered a program entitled Breaking Barriers. The pilot rapid rehousing program serves probationers in LA County who are generally deemed to have a moderate to high risk of reoffending. The program is a unique collaboration between Chrysalis, Brilliant Corners, LA County Probation, the Corporation for Supportive Housing, and LA County Department of Health Services – Housing for Health Division. Breaking Barriers provides up to 24 months of rental assistance combined with housing retention services, intensive case management, and employment services. The goal is for clients to fully assume rental payments and "transition in place" by the end of the program. As of August 2016, the program had served 170 clients. The program will cost Probation $4.2 million of its own funds, which will be paired with a $2 million donation from the Conrad N. Hilton Foundation.[155]

The **Los Angeles County** Department of Mental Health (LACDMH) funds a program administered by Telecare that uses an Assertive Community Treatment (ACT) model for individuals living with serious mental illness that are being released from prison under AB 109. Eligible individuals are referred to the program by the LACDMH. Currently, the program has a

[155] See a full description of the Breaking Barriers Program [Link]

120 person capacity. The program uses transitional housing (e.g., hotel, sober living), but finding permanent housing is difficult. LACDMH contracts with Telecare, and the contract pays Telecare even if the bed is not used. This makes it easier for Telecare to work deals with landlords who don't have to worry about getting paid or evictions.

San Diego County provides some transitional housing for individuals upon reentry. The Post Release Offender (PRO) Division, which provides case management for AB 109 offenders, currently contracts with five housing providers, including 24 separate locations throughout the county. For calendar year 2015, a total of 120 beds were available for offenders under the PRO division.

In **Santa Clara County**, the Office of Supportive Housing provides scattered site rental housing (with tenant-based rent subsidies) and support services to 20 chronically homeless individuals with mental illness through contracts with community providers. Additionally, the Evans Lane Wellness and Recovery Center is a Behavioral Health Services Department (BHSD) facility that serves adults involved in the criminal justice system who suffer from mental health and substance use issues. The Center provides housing, 24-hour support, peer support, group counseling, and group activities support with the capacity to serve up to 56 participants with extended housing for up to one year. This program supports the participants by providing evening and weekend group activities which focus on integrating the participants into the community. These facilities provide custodial care to persons who, because of mental or emotional disorders, are not able to live independently.

F. Barriers to Effective Housing for the SMI and MF

a. Limited work histories, low incomes, and lack of affordable housing.

Most individuals who are reentering the community are unable to rent or purchase housing in the open marketplace.[156] MF and SMI individuals may be particularly unable to afford housing given their limited mental or physical capacities for work. Additionally, the majority of formerly incarcerated individuals return to communities within large metropolitan areas,[157] that are experiencing record shortages of affordable housing.[158] The Great Recession exacerbated the shortage of affordable housing, adding to the challenges for MF and SMI FIPs for finding and maintaining employment and affordable housing.[159,160]

[156] Bradley, Katharine et al. 2001. "No Place Like Home: Housing and the Ex-Prisoner." *Community Resources for Justice.* [PDF]
[157] Council of State Governments. 2005. "Homelessness and Prisoner Reentry." [PDF]
[158] Hammett, Theodore et al. 2001. "Health-Related Issues in Reentry." *Crime and Delinquency,* 47(3). [Link]
[159] Urban Institute. 2005. "Understanding the Challenges of Prisoner Reentry." [PDF]

b. Resistance by landlords and community members.
"Not in my backyard" (NIMBY) attitudes often impede the development of transitional and supportive housing for formerly incarcerated persons.[161] Additionally, researchers have demonstrated that community resistance to housing for formerly incarcerated persons is typically greatest when it is planned specifically for those with SUD or mental illness.[162] Landlords also often discriminate, which is particularly problematic for those individuals seeking housing in the private market. It is a routine practice for landlords to conduct criminal background checks or to call references. Those with past criminal convictions are the most likely to be rejected in tight housing markets, such as the present market in California.[163]

c. Lack of tailored supportive or transitional services from most housing options.
Once the individual is home or returns to the community, he or she may have additional needs related to completing activities of daily living, maintaining treatment and medication compliance, money management, transportation, and linkage to other community resources for basic necessities. The majority of current housing options for the SMI and MF reentry population are unable to serve these additional needs.

d. Formal restrictions on federal housing assistance and subsidization.
According to past studies, there is an overall shortage of federally subsidized housing. Long waiting lists and lotteries for public housing units or housing choice vouchers are exceptionally common.[164] Further, federal and local housing authorities' laws concerning eligibility for public housing often make it difficult for the formerly incarcerated to obtain federally subsidized housing.[165] Individuals with felonies are ineligible for federal housing for a minimum of 5 years.[166] These restrictions further limit the housing options for the MF and SMI reentry population.

e. Lack of immediate temporary housing upon release; and/or early post release housing placement assistance.

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[160] Gunnison, Elaine and J. B. Helfgott. 2010. "Factors That Hinder Offender Reentry Success: A View from Community Corrections Officers." *International Journal of Offender Therapy and Criminology*, 55(2). [Link]
[161] Visher, Christy and Jill Farrell. 2005. "Chicago Communities and Prisoner Reentry." *The Urban Institute*. [PDF]
[162] Roman, Caterina and Jeremy Travis. 2004. "Taking Stock: Housing, Homelessness, and Prisoner Reentry." *The Urban Institute.* [PDF]
[163] Ibid
[164] Council of State Governments. 2005. "Homelessness and Prisoner Reentry." [PDF]
[165] Roman, Caterina and Jeremy Travis. 2004. "Taking Stock: Housing, Homelessness, and Prisoner Reentry." *The Urban Institute.* [PDF]
[166] Human Rights Watch. 2004. "No Second Chance: People with Criminal Records Denied Public Housing." [Link]

Often, recently released prisoners have difficulties meeting their housing needs because they are not fully aware of the services available to them in the community. Upon release from prisons and jails in California, there a variety of different service providers with unique eligibility requirements and geographic positioning. MF and SMI formerly incarcerated individuals may especially experience difficulties navigating this web of reentry services, due to physical and/or behavior issues.

Recommendations:

For both SMI and MF reentry populations, there is a profound and chronic lack of short-term and permanent housing. The Housing First model appears to be promising for improving the outcomes of FIPs during reentry. However, there is a need to more carefully investigate the effectiveness of the Housing First model for specifically the SMI and MF under more widespread implementation. Additionally, there is a need to consider financing and other strategies to increase capacity.

- **Survey all existing housing options and programs statewide for the justice-involved SMI and MF.** This survey would help identify existing funding levels for targeted housing programs, the program models currently in use, and the metrics presently used to measure the effectiveness of these programs. [Reco: (6)(i)]

- **Study the metrics presently used by Housing First programs.** This will help identify which metrics should ideally be used to improve the lives of the SMI and MF upon reentry. These metrics, for example, could include retention rate, return-to-custody rate, compliance with a release plan, etc. [Reco: (6)(ii)]

- **Consider specialized housing for SMI parolees.** CDCR should consider developing a Residential Multi-services Center for SMI parolees or augmenting their existing RMSC program with on-site POC clinicians to better address the mental health and criminogenic needs of their SMI parolee population. [Reco: (6)(iii)]

7. Evaluation

Overview

In many ways ongoing evaluation of the reentry process was an important aspect of the design of the realignment change implemented in California in 2011. The program design was based on the idea that there are programmatic approaches to supporting the reentering population that have been shown by empirical evidence to be effective. The realignment reforms emphasize the use of evidence based approaches and encourage the continuing collection of data about the implementation of realignment programs to provide further evidence about effective ways to support released offenders. Beyond the need for local program planning and operational management, the structure of the realignment programs looks to ongoing evaluation as a way to inform policy makers at the state level about the success of the program and the need for adjustments as it matures and as new approaches are tested and found to be effective.

Active evaluation is an essential element of the design of realignment. The statutes defining the program have specific provisions that direct both the evaluation of each county's efforts but also specify the process and content for the early statewide evaluations of the program. The mandate for the use of evidence based practices (EBPs) and evaluations can be found in California's Penal Code[167], which specifies that county Chief Probation Officers (CPOs) must spend at least 5% of their budget (additional amounts at the CPO's discretion) on evaluations of their program. It is important to note that there are no guarantees that programs reported as successful in one jurisdiction are going to work in another place. Environments differ; evaluations are at best quasi-experimental. Program implementation can encounter unexpected constraints when trying to replicate a successful program at a new location; sometimes the most critical success elements cannot be duplicated.

A. Evidence-Based Practices and Data Driven Evaluations

The reforms of AB 109, SB 678, and related bills were founded on the idea that counties, given flexibility, could do a better job supporting successful returns to the community through implementing Evidence Based Programs, i.e., the establishment of proven practices, and adjusting the programs as knowledge improves. This need for effective EBPs has also driven the need for data collection and evaluations to assess the efficacy of programs in an environment of limited funding. Ideally, having access to high quality data on the reentry population and the services they receive will allow practitioners to make better informed decisions, based on an individual's needs and context, rather than prescribing "one-size-fits-all" treatments that do not

[167] CA PEN § 1229, 1230, 1230.1, 1231, 1232, 3451

take all critical information into account. These data would also allow for higher level evaluations of the efficacy of the efforts used to reduce recidivism and can be instrumental in better allocation of funding and program improvement.

Currently, many evaluations are undertaken as a mandated condition of various funding programs, such as AB 109 and the Whole Person Care (WPC) pilots. In order to fulfill evaluation mandates, counties have implemented (or are in the process of implementing) policies and procedures for data collection and reporting. The language and available guidance of the mandate for evaluation will inform the nature of the policies and procedures that stakeholders adopt. For example, when evaluation mandates are issued without guidance, then how the evaluations are undertaken becomes the responsibility of each evaluated entity. Although these efforts can (and do) yield useful information, the lack of standardization (of process, definitions, etc.) makes it difficult for results to be compared and prevents drawing cross-system and whole-system conclusions. However, when statewide guidance is provided (i.e., outlining data and information parameters, including universal metrics), then the data obtained can allow for comparisons across systems and counties, as well as assessments of the system as a whole.

In California, this guidance is the responsibility of the Board of State and Community Corrections (BSCC).[168] The BSCC was established in 2012, as a response to Realignment, replacing the former Corrections Standards Authority, and is intended to be an entity independent of the CDCR that helps provide statewide leadership, coordination, and technical assistance to promote effective state and local criminal justice efforts and partnerships. The BSCC is tasked with management of all data and conducting evaluations of corrections and related Realignment programs across the state (see Appendix 14 for relevant organizational mandates). They are the designated data repository for Realignment programs, so that local entities can have access to information on promising practices and innovative approaches. The primary data collected by the BSCC are Community Corrections Partnership (CCP) plans from each County, which include implementation plans of all Realignment programs. The BSCC is responsible for analyzing any data related to implementation of these local plans, as well as any outcome-based measures, and providing an annual report (by July 1st) to the Governor and Legislature.[169]

In order to support these data collection efforts, a Data and Research Standing Committee was formed in January 2013. Membership on this committee is comprised of state and local criminal justice stakeholders, as well as experts from universities and research institutions. The purpose of this committee is to help develop comprehensive data collection plans, to assist in the coordination of data collection efforts to reduce duplication, and to leverage the resources of various stakeholders focusing on similar data collection and research efforts.[170]

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[168] CA PEN § 6024 [Link].
[169] Community Corrections Partnership Plans. [Link].
[170] Data and Research Standing Committee. [Link].

In the case of AB 109 (see Appendix 13 for AB 109 Evaluation Efforts in Target Counties), some counties, like Los Angeles and San Diego, used a combination of ongoing internal evaluation and review processes, as well as contracted external entities[171] to conduct AB 109 evaluations. Other counties, like Santa Clara, only contracted external entities to conduct a comprehensive evaluation of their programming and services. Internal evaluation and review processes vary from the comprehensive quarterly reports provided to the Los Angeles County Board of Supervisors, to the development of integrated technology systems, like San Diego's Offender 360, which aids in information sharing and coordination efforts by justice partners. The development of these internal systems and procedures have the possibility of sustainability, as well as improvement and expansion as they are refined through regular assessments of needs. For example, San Diego County uses the Tribridge Offender 360 case management system to track program participation of their clients to meet their criminogenic needs while in custody. The system also helps custody staff make informed decisions when it comes to program and treatment placement.[172] AB 109 may have been the impetus for the adoption of Tribridge Offender 360, but the sustained use of this system will continue to benefit and improve reentry coordination and supervision efforts in the county, especially as an information feedback loop becomes normalized and used to inform practice.

Counties that did not establish processes and systems such as this are in a more dubious position in their capacity to benefit from ongoing evaluations of their programs and services. Although evaluation results and data collection efforts yield valuable information, it is unknown whether, and how, those information are used to inform practice.

B. Looking Towards the Whole Person Care Integrated Evaluation Models

Several counties participating in the Whole Person Care Pilot have chosen the reentry population as a target group. The overarching goal of WPC is the "the coordination of health, behavioral health, and social services in a patient-centered manner with the goals of improved health outcomes and more efficient and effective use of resources."[173] Funding for Whole Person Care pilots is tied to semi-annual reporting of interventions and activities to the California Department of Health Care Services (DHCS). As part of the Medi-Cal 2020 waiver, the DHCS is required to conduct midpoint and final evaluations of the WPC program.

[171] Los Angeles was in the process of contracting an evaluator at the time of their FY14/15 progress report.
[172] Tribridge is a technology services firm specializing in business applications and cloud solutions [Link]
[173] Tobey, Rachel et al. 2014. "Opportunities for Whole Person Care in California." [PDF]

The DHCS submitted a Draft Evaluation Design[174] for the Whole Person Care program to CMS on November 7, 2016, as required by Special Terms and Conditions section 211 of California's Medi-Cal 2020 Demonstration. The Draft Evaluation Design provides a overview of WPC goals and a comprehensive outline of evaluation methodology, data sources (i.e., from WPC semi-annual reports), and the requirements for the midpoint and final evaluations. Even in counties where WPC does not necessarily target the reentry population, its goals, as well as the mandates for data and evaluation, are paving the way towards new models that appear to be promising in their ability to improve the care coordination and treatments/interventions for these individuals.

The vision for WPC, especially its focus on care coordination, is helping participating counties overcome barriers to sharing confidential client information and build integrated data exchange and individual tracking systems across various institutions. Most importantly, data will be collected from these systems in an ongoing effort to evaluate the appropriateness and effectiveness of treatments and programs, so that care can be adjusted as needs change.

C. Barriers to Effective Evaluations

The following are a few major barriers we have found in this preliminary look into issues involving data and evaluation:

a. **Lack of quality, reliable relevant data collection and evaluation** is a recurrent issue, highlighted by all major reports/research[175].

b. **It is difficult to make cross-system and whole-system comparisons and conclusions** based on current evaluation results because of the inherent barriers to accumulating standard statewide statistics. Some reasons for this difficulty include:
   i. There are differences in definitions of population groups (e.g.: those living with serious mental illness or medically fragile), so programs aimed to assist these groups may be serving differing populations.
   ii. Program features may differ even when described with the same terms, a consistent problem with social science research.
   iii. The local environments may differ, so the same program can succeed in one place, but in fail another.
   iv. Population variations might explain different results for the same program.

[174] CA DHCS. 2016. "Whole Person Care Evaluation" [PDF]
[175] Tafoya, Sonya et al. 2014. "Corrections Realignment and Data Collection in California." *PPIC.* [PDF]

v. Data collected and reported are at a summary level, not at an individual level, so it is difficult to determine what drives differences and changes.

c. **The lack of consistent, reliable information/systems that tracks individuals through care coordination, as they move across systems and treatment programs** can hinder efforts to identify gaps in, or improve, treatment, and can result in individuals "falling through the cracks."

d. **The lack of integrated systems of information sharing and formative evaluation that can inform the ongoing refinement of coordination and treatment as individuals move between multiple systems and providers.** The shift in institutional responsibility for the released population from a simple system of state operated prisons and parole programs to a shared responsibility between state prisons, local probation, and local jails requires broader coordination to collect complete pictures of the actual outcomes of programs.

Recommendations:

There are many ongoing evaluation efforts that will continue to yield disparate products, unless there is some collaborative effort by State and local stakeholders to discuss, standardize, and operationalize the legislative and policy mandates driving evidence-based programs. Without a shared consensus on factors such as common definitions, outcome measures, etc., then implicit legislative and policy expectations cannot be met and programs cannot be compared across the system.

Next Steps towards more effective evaluations:

- **Consider a partnership between the Board of State and Community Corrections' (BSCC) Data and Research Standing Committee and COMIO** to assess the landscape and build common definitions specific to the mentally ill and medically fragile populations across the state. [Reco: 7(i)]

- **Institutionalize a formal process for dissemination of evaluations once they are completed to share results and best practices.** Explore existing information systems for viability and/or consider developing a platform to house and share evaluation results. [Reco: 7(ii)]

Collected Recommendations

GENERAL ISSUE AREAS	SPECIFIC ISSUES	RECOMMENDATIONS
(1.1) MEDI-CAL ELIGIBILITY ESTABLISHMENT	(a.) Eligibility Suspension Time Limit	The current one-year suspension of eligibility should be replaced by an indefinite suspension of benefits. The suspension should be removed on the date the inmate is no longer incarcerated or otherwise eligible.
	(b.) Health Plan Selection	(i). State policy should be changed or clarified so that FIPs who have had their Medi-Cal eligibility suspended can remain in their health plan prior to incarceration. (ii). Prior to an inmate's release from custody, a process would be needed to inform the individual's health plan with the date of release, allow the transfer of medical records, and identify a PCP to ensure continuity of care where needed. (iiI). Inmates who did not have Medi-Cal eligibility prior to their incarceration, or who may require a new health plan, should complete their HCO applications concurrently with their eligibility application.
	(c.) Electronic Data Systems Approaches	The DHCS, CDCR, and other stakeholders should examine the opportunities to develop the technological infrastructure for an automated process for suspending and unsuspending eligibility.
	(d.) Eligibility Redeterminations/Renewals for Those in Suspended Status	(i). The DHCS should hold discussions with stakeholders, and determine whether there are practical steps that could be pursued to improve the renewal process for inmates. (ii). The DHCS should determine whether it is necessary, or practical, to continue requiring annual redeterminations for these cases at all, if the reviews rarely discover significant changes in an inmate's circumstances.
	(e). The Potential for a Presumptive Eligibility Process	The DHCS and stakeholders in California should discuss and evaluate the possibility of establishing a short term presumptive eligibility period for former inmates whose eligibility has not been determined at the point of release from incarceration.
(1.2) SSI ELIGIBILITY ESTABLISHMENT	(a.) Eligibility Establishment Often Exceeds 90-120 Days	(i). Counties should consider initiating applications for those who can qualify on the basis of disability when the person enters the jail. (ii). All county jails should take advantage of the materials and training available through the SOAR program.
	(b.) Low SSI/SSDI Approval Rates for the CDCR	The CDCR should establish a process for regular meetings/dialogue with SSA, including advocacy and

		other stakeholder organizations, to review data on SSI eligibility determinations for former inmates, and to discuss and resolve issues that have been encountered in submitting applications and securing approvals.
	(c.) Documenting the Disability	CDCR's California Correctional Health Care Services (CCHCS) should consider conducting a workload analysis to evaluate the current timeline and staffing that supports the SSI application process and requests to SSA for disability evaluations.
	(d.) Low SSI/SSDI Approval Rates for Jails	A forum should be held with representatives of several county jails to discuss the experience they have had in submitting SSI applications on behalf of their inmates, and to brainstorm possible approaches to improve application approval rates and processing times.
(1.3) CALFRESH ELIGIBILITY ESTABLISHMENT	Obtaining CalFresh (Supplemental Nutrition Assistance or SNAP)	(i). DSS should continue to seek the necessary authorization to request this waiver, and work with CDCR and other stakeholders to determine whether the 30 day timeframe will be sufficient to process CalFresh applications prior to release. (ii). DSS should work with counties and other stakeholders to explore simplifications that could be implemented to expedite the CalFresh enrollment.
(1.4) CAL-ID ELIGIBILITY ESTABLISHMENT	Obtaining a California ID (Cal-ID)	(i). A detailed review of the effectiveness of the ID issuance process should be conducted to determine the share of eligible applicants that are not able to get IDs and why. (ii). Additional discussion should be entertained to consider alternative options for providing access to IDs for those who do not meet the requirements of AB 2408.
(2.) CARE COORDINATION & SERVICE DELIVERY	(a). Hand-Offs Between Systems and Programs	(i). A Reentry Learning Collaborative should be formed with representatives from counties with active WPC and PRIME pilots. (ii). The CDCR should receive help to develop a statewide protocol for transitioning medically fragile inmates, beginning with County Organized Health System (COHS) Plans. (iii). Stakeholders should work to improve State/County coordination for SMI parole programs.
	(b). Provider Approaches to Service Delivery	A focus group of providers that serve the reentry population should be convened.
	(c). Unique Patient Needs	Community Health Worker (CHWs) usage should be expanded and implementation of CHWs should be taken to scale.
	(d). Toward a Comprehensive Model of Integration for FIPs	Medi-Cal managed care plans might provide the foundation for a model of care that specifically targets the

	Using Medi-Cal Managed Care Plans	reentry population. The health plan could also coordinate the transfer of health records from prison and jail to the community provider and clinician. To further optimize these efforts, California could consider building on successful reentry programs to create a model of care and coordination for FIPs. Conceptually, the model could include the following elements: ● Specialized Provider Network. ● Community Health Workers. ● Probation/Parole Engagement. ● Supplemental County Incentive Funding. ● Data Sharing and Performance Metrics.
(3.) MAXIMIZING FEDERAL FINANCIAL PARTICIPATION	(a.) Maximizing FFP for State and Local Justice System Administrative Activities	(i). Assess interest from statewide associations, including the Chief Probation Officers of California (CPOC), California Sheriff's Association, and the Administrative Office of the Courts (AOC), for hosting presentations or webinars that would disseminate information about MAA funding opportunities. (ii). Potential options for Medicaid administrative claiming with CDCR should be explored. (iii). Public or private funding should be sought to provide technical assistance to CDCR and counties. (iv). The DHCS should be asked to consider requesting CMS to clarify the claiming rules relating to MAA to: (1) broaden the definition of administrative activities, and (2) expand the 30-day window prior to release.
	(b.) Obtaining FFP for Dispensing a 30-day Supply of Medication as Prison & Jail Inmates are Released to the Community	(i). Consider options for obtaining FFP with CDCR. (ii). Consider potential workarounds to allow a jail-based pharmacy to provide the 30-day supply of medication in lieu of building a new pharmacy outside the jail walls.
	(c.) Maximizing FFP for Parolee SMI Services	(i). Efforts by the Council of Mentally Ill Offenders (COMIO) should be fully supported to facilitate state-local discussions for improving services. (ii). A state-local workgroup should be formed to review the current CDCR contracts with San Francisco and Santa Clara. (iii). Review LAO options from 2013 to allow POC's and other eligible mental health services to bill Medi-Cal directly, and assist DHCS in developing the optimum approach.
	(d.) Maximizing Medical & Elderly Parole	(i). Consider placement of the medically fragile in private care facilities. (ii). Engage Medi-Cal Managed Care Plans and Counties to develop community-based health care options.
(4.) RELEASE OF INFORMATION	ROI	(i). Share effective ROI approaches, such as Santa Clara's, through sponsored forums.

		(ii). Steps should be taken to further explore and develop ways to share information through technological infrastructures.
(5.) RESIDENTIAL & OUTPATIENT TREATMENT CAPACITY FOR CODs	Residential & Outpatient Treatment Capacity for CODs	(i.) Explore a new strategy for integrated COD services provided to the reentry population. (ii). Next Steps should necessarily include the following: a. Assessing existing programs and capacity that now serve the COD reentry population. b. Identify willing partners–counties, the CDCR, and providers–to help define a treatment and financial model for the COD reentry population.
(6.) HOUSING	Housing	(i). Survey all existing housing options and programs statewide for the justice-involved SMI and MF. (ii). Study the metrics presently used by Housing First programs. (iii.) Consider specialized housing for SMI parolees.
(7.) EVALUATION	Evaluation	(i). Consider a partnership between the Board of State and Community Corrections' (BSCC) Data and Research Standing Committee and COMIO. (ii). Institutionalize a formal process for dissemination of evaluations once they are completed to share results and best practices.

CALIFORNIA
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Appendix 1: List of Key Meetings

CDCR:

- 8/10/16, CDCR Meeting with Agency Secretary Director, Director of the Division of Parole Operations (DAPO), Deputy Director of Rehabilitative Program, Chief Clinical Program Administrator, Parole Outpatient Clinics, and Associate Director of Health Care Services Division.
- 8/24/16, Phone call with the Chief Clinical Program Administrator.
- 8/23/16, Conference Call with Director of CDCR Research, Research Staff, and Chief Clinical Program Administrator.
- 9/2/16, Meeting with Deputy Director, DAPO, Chief Deputy Administrator and the Chief Clinical Program Administrator.
- 9/14/16, Phone call with SD District Administrator to set up meeting and tour.
- 9/19/16, Meeting at SD Parole Office with District Administrator, Parole Supervisor, Parole Agents Parole Services Assistants, psychologist, and clinical social workers.
- 9/29/16, CDCR Director's Stakeholder meeting advisory group meeting.
- 9/30/16, Chief Clinical Program Administrator.
- 10/4/16, Meeting at Compton parole Unit and at the Central Parole unit. Met with Parole Administrators Parole Supervisors, Mental Health Program Manager, Psychiatrist, Psychologist and clinical social workers.
- 10/14/16, Meeting with the Executive Officer of the Council on Mentally III Offenders.
- 10/26/16, CDCR, Division of Rehabilitative Programs In Person Meeting.
- 10/27/16, CDCR, Division of Adult Parole- Parole Outpatient Clinic.
- 10/28/16, CDCR, Victim Restitution.
- 11/3/16, Words to Deeds Conference.
- 11/7/16, CDCR/DAPO.
- 11/7/16, CDCR HCSD Deputy Director of Mental Health.
- 1/6/17, Meeting with Katherine Tebrock, Deputy Director for Mental Health for CDCR Prisons.
- 2/13/17, Meeting with Renee Kanan, MD, MPH, Deputy Director of Quality Management, California Correctional Health Care Services.
- 4/18/17, Kevin Hoffman, Deputy Director of Rehabilitative Programs, CDCR.

DHCS:

- 8/14/16, Communication with DHCS Chief Deputy regarding work with on issues related to services for reentry populations.
- 8/15/16, Clinical Assurance and Administrative Support Division.
- 9/14/16, Meeting with DHCS staff from Health Care Financing and Eligibility Divisions.

- 10/11/16 Conference Call with Marlies Perez, DHCS, MHSUDS Division Chief
- 10/11/16 Attended DHCS AOD Certification Standards Stakeholder Meeting
- 10/14/16, Communication with DHCS staff regarding Whole Person Pilots.
- 11/10/16, Communications with DHCS Provider Enrollment Division.
- 5/5/17, Conference call with Deputy Director of Health Care Benefits and Eligibility and Chief of the Eligibility Division.
- 6/16/17, Meeting with DHCS Eligibility and Managed Care staff.

Los Angeles County:

- 9/6/16, Dave Meyer, COMIO Member, Former Deputy Director, LA County Dept of Mental Health.
- 9/6/16, LA County Sheriff's Department: Terri McDonald, Assistant Sheriff and Karen Dalton, Director, Custody Services Division.
- 9/6/16, Susan Burton, A New Way of Life; also attending were Claire Arce and Rod Wright.
- 9/7/16, Reaver Bingham, Deputy Chief of LA Probation.
- 9/7/16, Pete Espinoza, Terri McDonald, and Tracey Whitney (LA DA's office).
- 10/4/16, Robin Kay, Interim Director, LA County Department of Mental Health; also, Flora Krisiloff, Dr. Rod Shaner and Mary Marx.
- 10/5/16, LA Jail Mental Health Unit - Tim Belavich, Joe Ortego, Mary Whaley.
- 10/5/16, A New Way of Life Focus Group with former parolees.
- 10/6/16, LA County Probation: Randall Pineda, Probation Director Special Services Bureau, John Baima, Executive Staff Assistant, Field Services Division, Mark Garcia, Senior Probation Director – AB 109 Bureau.
- 10/31/16, L.A. Care: Meeting with Alison Klurfeld, Jessica Jew, and Christina Vane-Perez.
- 11/1/16, Conference call with Dr. Susan Turner, Director, Center for Evidence-Based Corrections; University of California, Irvine.
- 12/14/16 Conference Call with Dr. John Griffith, CEO Kedren Health Care and Behavioral Health Care Center
- 12/16/16 Meeting with Kedren Health Care and Behavioral Health Care Center management team.
- 5/8/17, Conference call with Dennis Hsieh, LA Department of Health Services & Jessica Jew, L.A. Care.

San Diego County:

- 8/2/16, Meeting with Dorothy Thrush, Chief Operations Officer, Public Safety County of San Diego Administrative Services.

- 8/3/16, Meeting with Barbara Lee, Medical Services Administrator, Dr. Alfred Joshua, Medical Director, San Diego County Sheriff Medical Services.
- 9/11/16, Presentation and meeting with the San Diego ReEntry Community Leadership Roundtable Meeting
- 9/16/16, Presentation and meeting with the San Diego County Public Safety Offender Treatment Roundtable under leadership of Dorothy Thrush and Susan Bower, Deputy Director of HHSA. All public safety departments were represented this meeting.
- 9/19/16, San Diego Reentry Roundtable, community based stakeholder meeting. Met with Chair, Charlene Autolino, Outreach Consulting Services. Faith based programs and ministries are well represented at this meeting.
- 9/19/16, Christine Brown, Reentry Services Manager, SD Sheriff's Department and Dorothy Thrush, Public Safety Division, SD Administration.
- 9/19/16, Telecare Intensive Case Management Services (contractor).
- 9//20/16, Volunteers of America, Residential Men's Multi-Service Center.
- 9/20/16, National Crossroads, Residential Women's Multi-Service Center
- 9/20/16, BI Incorporated Day Reporting Center.
- 9/30/16, Phone Call with SD POC clinical social worker.
- 10/24/16, Meeting with Alfredo Aquirre, Director and Holly Salazar, Deputy Director of the San Diego County HHSA, BHS Division. Susan Bower, Deputy Director of HHSA 10/24/16, Meeting with the San Diego Court Administrator, Scott Brown
- 10/24/16, Meeting with Julie Gibson, Deputy Public Defender and her legal team.
- 10/25/16, Meeting with JJ Anderson and team, District Attorney's Office
- 12/6/16 Conference call with San Diego Care Center team
- 5/22/17, Call with Barbara Lee, San Diego Sheriff Medical Administrator.

Santa Clara County:

- 8/10/16, Met with Reentry Services Leadership Team (includes leadership of the various county agencies involved in providing Reentry services)
- 11/2/16, Santa Clara County Probation staff
- 11/9/16, Santa Clara County Counsel staff, regarding ROI form and process.
- Conducted phone meetings with Toni Tullys, Director of the County Department of Behavioral Health Services, and Laura Garnette, Chief Probation Officer
- 3/20/17, Focus group with former inmates.

Other Stakeholders:

- 8/2/16, Meeting with Lisa Pratt, MD, MPH, Director of Jail Health Services and Tanya Mera, LCSW, Director of Jail Behavioral Health Services, San Francisco, CA.
- 8/2/16, Meeting with Steven Rosenberg, President, and Daniel J. Mistak, J.D.General Counsel**,** Community Oriented Correctional Health Services, Alameda County, CA.

- 11/28/16, Meeting with Wendy Still, Chief Probation Officer, Alameda County, and Manuel Jimenez, Director and Janet Biblin, MPP/MPH, Management Analyst, Alameda County Behavioral Health Care Services, CA.
- 1/5/17, Webinar "Whole Person" Care: Connecting County Health and Justice Systems for Better Inmate Care and Lower Costs, sponsored by National Association of Counties.
- 2/15/17, Meeting with Senate Health Committee staff.
- 2/17/17, Meeting with Senator Skinner's Chief of Staff, Marvin Deon.
- 2/22/17, Meeting with Alameda County's Chief Probation Officer, Wendy Still.
- 2/22/17, Meeting with Root & Rebound staff, Oakland, CA.
- 3/1/17, Conference call on FFP issues – Stan Dorn and Gretchen Schroeder.
- 3/3/17, Jonathon Porteus, CEO, Sean Benedict, Program Manager, Co-Occurring Continuum of WellSpace FQHC & members of the California Senate Health Committee, Sacramento, CA.
- 3/15/17, Site visit of the Rio Consumnes Correctional Center (RCCC) and their Medication Assisted Treatment program, Galt, CA.
- 3/29/17, Conference call with Root & Rebound Reentry Legal Resource Center regarding eligibility establishment issues, Oakland, CA.
- 3/31/17, Conference call with Corporation for Supportive Housing staff (Danielle Wildkress, Whitney Lawrence).
- 4/6/17, Urban Institute webinar.
- 4/6/17, Conference call with TeleCare's Financial Services Technician (benefits specialist).
- 4/17/17, Conference call with Michal Rudnick, Project Manager with the Arizona Health Care Cost Containment System (AHCCCS), state Medicaid agency.
- 4/24/17, Connecting Criminal Justice to Health Care (CCJH) Learning Collaborative Conference call (Urban Institute and Manatt Health Consulting).
- 4/28/17, Conference call with Dan Mistak, Community Oriented Correctional Health Services (COCHS).
- 4/28/17, Meeting with Department of Motor Vehicles staff.
- 5/4/17, Conference call with Debbie Rupert, Maryland's Department of Public Safety and Correctional Services regarding presumptive eligibility.
- 5/15/17, Phone call with Virginia Herold, Executive Officer of the California Board of Pharmacy.
- 5/26/17, Call with Dr. Mark Netherda, Partnership Health Plan.
- 6/13/17, Conference call with San Francisco Transition Clinic staff, Dr. Shira Shavit and Anna Steiner.
- 6/22/17, Call with John Peterson, Legislative Analyst's Office.

Appendix 2: Summary of Board of State and Community Corrections (BSCC) Proposition 47 Awards - SMI and MF Focused Programs

Agency	Project Title	Funds	Program Description
Alameda County Health Care Services Agency	ACProp47	$6,000,000	The purpose of this project is to support residents who are involved in the justice system and who have a mental health issue and/or substance use disorder (SUD). ACProp47 project funds will be used to augment and expand services under the County's coordinated reentry plan.
LA County Health Services, Office of Diversion and Reentry	Prop 47- Mental Health Services, Substance Use Disorder Treatment and Diversion Programs for People in the Criminal Justice System	$20,000,000	This project will expand substance use disorder (SUD) treatment housing, enhance access to specialty mental health services, and develop new reentry-focused intensive case management, housing, and wraparound services to improve health and employment outcomes and reduce recidivism among justice involved individuals with mild to moderate substance use and mental health disorders. Services will include SUD treatment services administered by the Department of Public Health, specialty mental health services provided by the Department of Mental Health, and workforce development services provided by Workforce Development, Aging, and Community Services.

Monterey County Health Department, Behavioral Health Bureau	No Zip Code Left Behind: Addressing Inequities through Collaborative Partnerships	$6,000,000	This project will implement new Substance Use Disorder Treatment services, and expand existing specialty mental health services in a culturally relevant manner using evidence-based interventions in underserved South Monterey County. The County will establish two new service sites in King City, South County's largest city, to provide substance use disorder treatment to a minimum of 100 individuals yearly. Also funded will be a centrally located Sobering Center, job training, civil legal services, restorative justice, and case management.
Orange County Health Care Agency	Orange County Community Supported Reentry Program	$6,000,000	This project will be a collaboration between community and County partners. To address needs identified by the community, this project will address four primary initiatives: 1) expand jail in-reach and reentry planning for those released from booking or custody; 2) develop a Community Support and Resource Center; 3) expand the Community Counseling & Supportive Services (CCSS) program; and 4) increase access to and availability of housing. This innovative program will provide a wide array of needed services including intensive case management, transportation, and access to a continuum of housing, for underserved populations in our community.

Pasadena Police Department	Vision "20/20" Reintegration Project	$2,511,537	The proposed project will provide new and expanded comprehensive reentry services to individuals in Pasadena and Altadena. Services will include substance use and mental health disorder treatment and supportive services to include housing, education, job skills/career preparation, case management, and more. Services will be provided in three phases over 12 months with Phase One focused on stabilizing substance use and mental health disorders and providing critical services like housing. Phases Two and Three will incrementally add other services as needed, while continuing treatment. The Pasadena Police Department will provide organizational oversight.
Plumas County District Attorney	Prop 47 Project	$1,000,000	This project will one day expand the ASP Bridges Program for offenders transitioning from incarceration. Specifically, the project will address service gaps by providing a comprehensive array of pretrial diversion and reentry services for transitioning offenders including mental health and alcohol and drug services, housing and related supports, intensive case management and job skills training through community partnerships that work to complement and leverage existing resources, promote a regional approach and are trauma-informed and recidivism reduction minded.

San Bernardino County Department of Public Health	SAFE-T Net (Support and Advocacy For Reentry and Transition)	$6,000,000	SAFE-T Net will provide voluntary, comprehensive, client-focused, and culturally-competent services to 300 unduplicated clients over 38 months including post-incarcerated and at-risk adults in San Bernardino County. 100% of SAFE-T Net clients will receive substance use and/or mental health services plus other services, as needed, and peer-driven case management/service navigation services. A multi-disciplinary and culturally-diverse subcommittee of the San Bernardino County Reentry Collaborative will serve as the Local Advisory Committee. SAFE-T Net addresses: 1) needs outlined in a recent county-wide reentry strategic plan; and 2) recommendations from a recent pilot project funded by the U.S. Department of Justice.
San Diego County	Community Based Service and Recidivism Reduction (CoSRR) with San Diego Misdemeanants At-Risk Track (SMART)	$6,000,000	The County of San Diego will collaborate with the San Diego City Attorney's Office to oversee implementation and integration of two projects: the expansion of the City's San Diego Misdemeanant At-Risk Track (SMART) Diversion program, and a new County program for Community Based Services and Recidivism Reduction (CoSRR). All direct services will be provided by community-based organizations (CBOs). It is anticipated that this project will change the lives of participants by identifying and addressing complex needs at the root of criminogenic behavior, by advancing wellness and healing, building skills for self-sufficiency and strengthening connections for participants to individuals and organizations to support recovery, rehabilitation and success of those participants in the community.

San Francisco Department of Public Health	PRSPR: Promoting Recovery and Services for the Prevention of Recidivism	$6,000,000	This project aims to interrupt the cycle of substance abuse, unaddressed mental health issues, homelessness, and incarceration by increasing the availability of residential substance use disorder (SUD) treatment for criminal justice system-involved adults who may also have co-occurring mental health (MH) issues. All participants, under the guidance of case managers or Peer Navigators, will have access to the city's system of care including behavioral health services, physical health services, employment, and the newly formed Department of Homelessness and Supportive Housing, which coordinates all of the city's housing resources through one agency.
Solano County Health and Social Services	Prop 47 - Expanding Service Continuum for Drug Treatment and Continued Supports for Improved Outcomes	$6,000,000	This project is intended to deepen the capacity to provide residential drug treatment and the many services necessary throughout the continuum of recovery in order to sustain treatment achievements. Creating in-County resources will improve the ability for our residents to sustain the gains they make when they are in residential treatment. For others who do not need or will not accept residential treatment, it is critical that they are in a safe and supportive living environment while engaged in outpatient services; for this reason the project also emphasizes transitional housing and sober living environments.

Appendix 3: Average Percentage of Annual County Jurisdiction ADP Receiving Psychotropic Medications, March 2014 - February 2017 in 45 California Counties

	Mar 2014 - Feb 2015			Mar 2015 - Feb 2016			Mar 2016 - Feb 2017		
Jurisdiction	**# on Psych Meds**	**Annual ADP**	**% on Psych Meds**	**# on Psych Meds**	**Annual ADP**	**% on Psych Meds**	**# on Psych Meds**	**Annual ADP**	**% on Psych Meds**
Amador	10	96	11%	16	89	17%	16	88	18%
Butte	52	584	9%	51	579	9%	59	581	10%
Calaveras	13	79	16%	15	93	16%	20	93	21%
Colusa	13	77	17%	19	80	24%	14	83	17%
Contra Costa	274	1,521	18%	284	1,403	20%	306	1,440	21%
Del Norte	25	95	26%	22	94	24%	23	104	22%
El Dorado	55	391	14%	102	391	26%	80	381	21%
Fresno	261	2,806	9%	614	2,679	23%	585	2,846	21%
Glenn	9	101	9%	7	93	8%	8	85	8%
Humboldt	55	340	16%	61	347	18%	54	376	14%
Imperial	62	543	11%	69	529	13%	77	486	16%
Inyo	8	65	13%	9	69	14%	12	56	19%
Kern	723	2,545	28%	718	2,311	31%	613	2,245	27%
Kings	92	577	16%	72	493	15%	114	450	25%
Lake	115	332	35%	87	278	31%	82	283	29%
Los Angeles	2,774	17,930	16%	2,858	16,469	17%	3,373	16,145	21%
Madera	29	451	6%	28	387	7%	36	417	9%
Mariposa	13	43	30%	8	42	18%	9	41	22%
Mendocino	43	298	15%	46	299	15%	43	306	14%
Merced	91	889	11%	99	690	14%	106	687	15%
Monterey	192	970	20%	249	923	27%	235	904	26%
Napa	57	208	28%	50	170	30%	64	203	32%
Nevada	50	229	22%	45	224	20%	50	200	25%

	Mar 2014 - Feb 2015			Mar 2015 - Feb 2016			Mar 2016 - Feb 2017		
Jurisdiction	**# on Psych Meds**	**Annual ADP**	**% on Psych Meds**	**# on Psych Meds**	**Annual ADP**	**% on Psych Meds**	**# on Psych Meds**	**Annual ADP**	**% on Psych Meds**
Orange	837	6,406	13%	693	5,762	12%	693	6,085	11%
Placer	116	654	18%	126	636	20%	182	699	26%
Plumas	4	49	9%	6	51	12%	6	50	13%
Riverside	1,091	3,935	28%	1,019	3,789	27%	1,172	3,770	31%
Sacramento	865	4,250	20%	831	4,036	21%	854	3,808	22%
San Benito	23	132	18%	15	122	12%	22	122	18%
San Bernardino	550	5,596	10%	757	5,182	15%	990	5,452	18%
San Diego	1,353	5,498	25%	1,277	5,015	25%	1,308	5,457	24%
San Francisco	220	1,232	18%	272	1,209	23%	256	1,290	20%
San Mateo	128	979	13%	104	866	12%	106	962	11%
Santa Barbara	106	937	11%	113	918	12%	158	1,016	15%
Santa Clara	574	4,026	14%	629	3,597	18%	708	3,568	20%
Santa Cruz	75	412	18%	63	394	16%	58	403	14%
Shasta	66	334	20%	56	328	17%	55	338	16%
Solano	265	926	29%	353	896	40%	275	992	28%
Sonoma	313	1,020	31%	325	1,054	31%	344	1,066	32%
Stanislaus	108	1,143	9%	112	1,121	10%	127	1,229	10%
Trinity	12	51	23%	13	52	25%	10	50	21%
Tuolumne	66	141	47%	52	145	36%	43	144	30%
Ventura	192	1,653	12%	216	1,626	13%	266	1,633	16%
Yolo	91	432	21%	119	384	31%	116	380	31%
Yuba	41	397	10%	80	398	20%	48	370	13%
Total	*12,112*	*71,373*	*18%*	*12,760*	*66,313*	*20%*	*13,776*	*67,384*	*20%*

Source: *BSCC Jail Population Survey*[176]

Notes: *The "Total" reflects the 45 counties that consistently responded to the pertinent BSCC JPS questions. These 45 counties accounted for approximately 95% of the annual ADP for the all the jails statewide during 2016. The following 12 jurisdictions are excluded from this analysis: Alameda, Lassen, Marin, Modoc, Mono, San Joaquin, San Luis Obispo, Sierra, Siskiyou, Sutter, Tehama, and Tulare.*

[176] BSCC Jail Profile Survey-- Online Query [Link]

Appendix 4: Mental Health Services Act Funded Reentry Programs in Los Angeles, San Diego and Santa Clara Counties

The passage of Proposition 63 (known as the Mental Health Services Act or MHSA) in 2004, provided an opportunity for the California Department of Mental Health (DMH) to support county mental health programs by increasing funding for personnel and key resources. The broader purpose of the act is to improve and monitor the mental health of children, teens, adults, older adults, and families statewide. The MHSA imposes a 1% income tax on personal income over $1 million. The revenue from this tax is distributed to counties' mental health programs to fund programs consistent with their unique local plans. The three counties that this report focuses on (LA, San Diego and Santa Clara County) all have developed complex plans with programs that specifically engage the mentally ill (MI) re-entry population.

Los Angeles County

Los Angeles County has developed a Jail Transition and Linkage Services program designed to perform outreach and engage mentally ill adult individuals involved in the criminal justice system. The goal is to successfully link them to appropriate community-based services upon their release from jail. The program addresses the needs of individuals in collaboration with the judicial system by providing identification, outreach, support, advocacy, linkage, and interagency collaboration. Jail transition and linkage staff work with the MHSA Service Area Navigators as well as service providers to assist incarcerated individuals with accessing appropriate levels of mental health services and support upon their release from jail.
Official LAC Program title: JAIL TRANSITION & LINKAGE SERVICES

San Diego County

San Diego County has developed two programs serving incarcerated and post-incarcerated persons with mental illness.

One of those programs (entitled Juvenile Forensic Services Stabilization Treatment and Transition or JFS-STAT) provides mental health screening to youth detained in the four County Juvenile Detention Facilities and identifies youth with a diagnosed mental illness for treatment and release to appropriate mental health services. The goal of this program is to ensure that probation children and youth have access to mental health services, to improve successful reintegration back into the community and to reduce recidivism.
Official SDC Program title: Juvenile Forensic Services Stabilization Treatment and Transition

San Diego County's other program (entitled Project In-Reach) assists those living with serious mental illness, who are presently or formerly incarcerated attain housing and stability in the community. The goal is to provide pre and post-release case management services, pre-release group therapy interventions, and post-release linkage and transportation for adults who are the most severely ill and most in need due to severe functional impairments. In this program,

particular attention is paid to serving African-American and Latino individuals.
Official SDC Program title: Project In-Reach

Santa Clara County

Santa Clara County has developed two post incarceration programs/pilots targeted at those living with serious mental illness.

One of their projects serves adults with concurrent mental health and substance abuse problems who also are involved in the criminal justice system. A continuum of intensive and comprehensive services is offered to clients based on their individual needs. These services include residential, outpatient, and aftercare linkage and case management.
Official SCC Program Title: CRIMINAL JUSTICE SYSTEM JAIL AFTERCARE FULL SERVICE PARTNERSHIP PROGRAM

The other project in Santa Clara County is a pilot aimed at developing and testing a service needs assessment and delivery model. Ideally, this model will facilitate interagency coordination with Probation, Custody Health Services, the Department of Alcohol and Drug Services, and the Social Services Agency. This improved interagency coordination will in turn allow for the more effective assessment and provision of relevant and effective re-entry services for incarcerated adults exiting prison and jail settings.
Official SCC Program Title: RE-ENTRY MULTI-AGENCY PILOT ALSO KNOWN AS "RE-ENTRY MAP"

Appendix 5: Whole Person Care (WPC) Pilots: Reentry Population Project Descriptions

The California Whole Person Care (WPC) Pilot program is designed to coordinate health, behavioral health, and social services to improve the health outcomes of Medi-Cal beneficiaries who are high utilizers of the health care system. Through collaboration and coordination among county agencies, health plans, providers, and other entities, the WPC Pilots aim to improve care for vulnerable populations. There are four counties that have specifically targeted the vulnerable reentry population (Los Angeles, Kern, Placer, and Contra Costa) and have designed programs that directly engage their jails and/or probation departments. This brief will delve into the details of how each county plans to more effectively serve this specific population of high-utilizers who are reentering their communities.

Los Angeles County

Los Angeles County (LAC) aims to target five specific high risk groups with their WPC. One of the identified target groups is "Medicaid-eligible justice system involved individuals who are at highest risk of deterioration from chronic medical and/or behavioral health conditions during the period of reentry into the LAC community from custody."

Target Population Identification Method

Individuals eligible for the reentry intervention may be identified at several entry points throughout Los Angeles County, including at the time of release from LAC jails, LAC courts and State Prison. At each point of entry, WPC-LA reentry program staff will use a point-of-care risk assessment tool that uses medical, psychiatric, and social factors to evaluate potential candidates for the program.

a. From LAC jail, individuals identified by jail health staff will directed to WPC enrollment teams stationed directly outside the jail.
b. LAC courtrooms with historically high volumes of cases with defendants possessing serious mental illness or substance use disorders will host WPC-LA reentry program enrollment teams to assist with immediate enrollment into the program.
c. With CDCR, LAC plans to build on existing partnerships so that WPC enrollment teams meet paroles at the time of release.
d. Finally, the WPC-LA reentry project team plans to work closely with reentry focused community based organizations to identify eligible clients for the program within days of their release.

Reentry Services and Interventions

At the time of release, the individual will be meet with the WPC-LA reentry team for creation of the transition/discharge plan and navigation to their primary care medical home and other community based health and social service providers. Enhanced care coordination activities will be carried out by medical case workers (MCWs), community health workers (CHWs), and social workers (SWs), who are responsible for coordinating care management and reentry planning activities and engaging individuals on the day of release and the days following.

At the initial visit, a member of the WPC-LA reentry care coordination team (probably the CHW) will meet with the potential participant and perform a comprehensive assessment of

medical, mental health and substance use issues, family/social support, benefits eligibility, housing stability and transportation needs to develop a care plan to support successful reentry. The enhanced care coordination team will work with an extended array of interdisciplinary health and social service professionals, including CHWs, MCWs, SWs, registered nurses (RNs), custody assistants (CAs), housing specialists, and SSI advocates based on the needs of each client, to ensure adequate support will be in place soon after release. Members of this enhanced care management team will support each participant by:

a. Conducting the physical, psychiatric, and substance use exams/assessments.
b. Helping establish benefits, including Medicaid or available cash assistance programs.
c. Re-connecting with pre-incarceration primary care, if agreeable to the client (to best preserve continuity of care and the patient-provider longitudinal relationship).
d. Supporting each enrollee to access a 30-day supply of medications.
e. Transferring in-custody medical records to the client's community-based provider(s).
f. Communicating with the community-based provider(s).

When possible, LAC jail health services will provide a "coordinated release" to inmates who enroll in the WPC-LA reentry program. A coordinated release involves a direct release of an individual to a community-based service provider, which in most cases is for residential substance use disorder treatment or for a mental health or medical condition. In a coordinated release, an inmate will be released at a designated time with a warm handoff to a community-based service provider, who is waiting to transport and link the individual to needed residential or treatment services. A CA is responsible for coordinating with the community-based program and making sure the client has necessary medication before being released. The CA escorts the client to the release area and walks the inmate outside of security to meet with program personnel.

Kern County

Kern County aims to target Medi-Cal beneficiaries who have a history of high emergency room or inpatient utilization and provide a additional services to those in this group who are homeless or at risk of homelessness and who have been recently incarcerated. The enhanced services are intended to directly address the health risks faced by these groups.

Target Population Identification Method

The pilot will initially receive referrals from the two large (and local) managed care partners and from Kern Medical Center, who contracts with the County for correctional medicine services. These beneficiaries will asked to opt-in to the WPC program.

Reentry Services and Intervention

To address the needs of this target population, Kern County will establish a clinic directly outside of the jail so that upon release, prisoners who have obtained presumptive Medi-Cal eligibility can obtain an immediate wellness check. Pharmacists in the clinic will provide medication reconciliations, medication education regarding chronic diagnosis management, and ensure that these individuals have two weeks of prescriptions and means to retrieve these prescriptions. Two registered nurses will work in the clinic to provide comprehensive discharge planning. The nurses will complete a full health risk assessment, provide any specialized medical training, and

evaluate needs for durable medical equipment. Working closely with office staff, the nurses will provide for a smooth transition of care to the primary care environment through scheduling a two-week checkup. Office staff in the clinic will assist the beneficiaries in identifying and applying for programs for which they are eligible, enroll the individuals in WPC and facilitate the scheduling of a follow-up appointment.

In coordination with the Health Education Department, Kern County will offer a variety of Life Skills Transition Classes geared towards lowering recidivism. In conjunction with an initial post incarceration visit, a post incarceration liaison will be added to the care coordination team to help assess the member's specific transitional course needs. The post incarceration liaison will be tasked with tracking the status of Life Skills Transition class enrollment and attendance, transportation needs, and reincarceration status

Placer County

Placer County aims to target those with a history of repeated ER use and avoidable hospitalizations, those with two or more chronic health conditions, those with a mental health diagnosis and/or substance abuse disorder, and the homeless or at risk of homelessness. To the extent that those recently released from incarceration meet these criteria they can be referred by probation officers for services in the pilot.

Target Population Identification Method

The Placer County Probation Department has dedicated Probation Officers to work closely with the Health and Human Services (HHS) Social Work Practitioners. These specialists will work closely with the WPC Team to identify individuals who are within 90 days of scheduled release from jail and who also meet one or more of the WPC target population criteria. The Probation Officer will identify those individuals who are interested in working with the WPC Team to receive the support needed to transition back to the community.

Reentry Services and Intervention

Placer County Probation will work closely with the Engagement Team and the Comprehensive Complex Care Coordination (CCCC) Team to engage WPC members in services; conduct a full assessment; and develop a Tailored Plan of Care to identify goals for the patient's recovery and wellness.

Most persons referred to the WPC pilot will receive initial welcoming services from the Engagement Team. Engagement services include screening and assessment, case management, linkage to appointments including providing transportation, medication reconciliation, and nursing/health care for any health conditions. Individuals will be supported in the process of obtaining necessary paperwork for applying for entitlements (birth certificate, ID, free phone). Once the person is engaged, the individual will be linked to the CCCC Team for ongoing services.

The CCCC Team will offer the core array of services including a full assessment of health, mental health, substance use, and housing needs. The CCCC Team will utilize a comprehensive Health Assessment tool to measure several aspects of the individual's life. This tool will help

assess and identify the most critical needs and expedite access to services. A Tailored Plan of Care will be developed with each WPC member within the first 30 days to provide a blueprint for needed services; identification of involved entities; a timeline for accessing services; and identified outcomes to meet each individual's needs. Other core services offered by the CCCC Team include mental health and/or substance use treatment services, case management, Peer Advocacy services, linkage to appointments including providing transportation, medication reconciliation, and nursing/health care for any health conditions.

The Housing Services will be bundled and provide comprehensive housing services to those reentering the community who may be homeless or at risk of homelessness. These housing transition services will assist the individual obtain housing and develop daily living skills to support them to remain stable in their new living situation. The Housing Services will be specifically tailored for each individual participant based on their Tailored Plan of Care.

Contra Costa County

Contra Costa County target population consists of patients who are Medi-Cal recipients and who are primarily and repeatedly accessing health care services in high-acuity settings due to the complexity of their unmet medical, behavioral health and social needs The services offered under the pilot will include those that can address the specific needs this high risk population when they have a history of recently incarceration.

Target Population Identification Method

Ongoing population identification will occur through two primary strategies in Contra Costa County:

a. Monthly data runs to identify patients who are entering the target population based on utilization and claim charges.
b. Opt-in referrals for previously unidentified high-need patients as identified by Contra Costa Health Services (CCHS) or partner providers.

Reentry Services and Intervention

Post-Incarceration services will be primarily available to patients through:

a. The CCHS Reducing Health Disparities Initiative.
b. The Reentry Success Center, an outside contracted agency.

Services from these two centers will include support groups, appointment scheduling monitoring, and general care coordination for social and health services. The CCHS Transitions Clinic (targeting formerly incarcerated individuals) will serve as the primary care site for coordination of services, interpersonal skill development, life skills coaching, social services linkages and money management. Contra Costa aims to have this staff trained in motivational interviewing, anger management and cultural competency. Services will ideally be gender-responsive and tailored to support clients' ability to make positive and healthy choices.

Housing services provided to recently incarcerated patients unable to find housing or at risk of losing their housing will include vulnerability assessments using the VI-SPDAT tool, landlord and property management engagement and relationship development, assistance with rental applications, resources for paying utility bills and moving expenses, eviction avoidance

assistance, and continued support to recently housed reentering patients.

Legal support will be provided through the participation of Bay Area Legal Aid (BayLegal). Legal support is an identified need for many in this target population. BayLegal will provide enrolled patients with free legal assistance, including advice and counsel, brief services and full legal representation, outreach and education, and systemic advocacy.

Appendix 6: Public Hospital Redesign and Incentives in Medi-Cal (PRIME) Pilots: Reentry Population Project Description

The PRIME program supports California Designated Public Hospital (DPH) systems and District/Municipal Public Hospitals (DMPHs) to implement pilots aimed at accelerating efforts to change care delivery in their hospital and broader health systems. Using evidence-based, quality improvement methods, the initial work will require the establishment of performance baselines followed by target setting and the implementation and ongoing evaluation of quality improvement interventions. Under the PRIME program, each participating health care system can opt to participate in as many as seventeen defined projects, which may be focused on improvements in ambulatory care, behavioral health integration, high-risk populations, or resource efficiency. Public health care systems must select at least nine projects, six of which are required. Four of the participating hospitals and health systems have selected to target integrating care for individuals post-incarceration as one of their projects. This brief will delve into how each of these participants plan to undertake this project.

Kern Medical Center (KMC)

Kern Medical Center (KMC) is presently the health care provider to all inmates in the Kern County correctional facilities. During an average month, roughly 70 percent of the inmates in Kern County receive services either through site based clinics or at the Kern Medical Center. For their PRIME pilot KMC has selected to focus on integrating care for individuals post-incarceration.

Target Population

The initial target population of this PRIME pilot will include two groups:

a. Incarcerated individuals nearing release who are actively engaged with medical services.
b. Individuals identified through pre-discharge screening assessment to be over 50 with at least one chronic condition.

Care Coordination/Protocol Development and Care Delivery Improvement

KMC plans to review their current processes to ensure that inmates pending release obtain the information and support they need to access health services post-release. Additionally, the medical center plans to develop a Transitional Care Collaborative (TCC), which will be tasked with expanding the current provision of transitional services to individuals leaving incarceration. The TCC will also be responsible for developing and establishing new protocol that is more efficient for the procurement of patient-required Durable Medical Equipment (DME) and prescribed medications. KMC plans to also develop pre and post-assessment screening tools, to better connect patients with the necessary health services and resources.

KMC will incorporate physical and behavioral health screening tools and care coordination services into all tiers of pre and post-correctional health care delivery. Additionally, KMC aims to eliminate gaps in care transition, improve disparities in care integration, and reduce costs by leveraging real-time data analytics. Overall, under this pilot, incarcerated individuals once released will obtain access more integrated health services that will be primarily focused on

successful matriculation to a supportive primary care setting.

Los Angeles County Department of Health Services (LACDHS)

Los Angeles County has recently rolled out a newly integrated jail health services approach which will centralize the leadership of jail medical and jail mental health services. Los Angeles County Department of Health Services (LACDHS) now runs the operations of both health services and mental health providers. For their PRIME pilot LACDHS has selected to focus on integrating care for justice involved individuals.

Target Population

The initial target population of this PRIME pilot will include two groups:

a. Incarcerated individuals nearing release who are over the age of 50 or have at least one chronic health condition.
b. Recently incarcerated individuals released during the past six months who are over the age of 50 or have at least one chronic health condition.

Care Coordination/Protocol Development and Care Delivery Improvement

LACDHS will establish a pharmacy at all six LAC jail discharge centers to ensure that individuals have their required medications upon release. A new central health clinic will also be developed specifically to serve individuals reentering their communities. Community health workers will also be rotated through the jails to facilitate linkage to medical homes and social services upon release. LACDHS will also set out to improve Medi-Cal enrollment among inmates at the time of release and will assist these individuals in establishing benefits.

Tri-City Medical Center, Oceanside (TCMC)

Tri-City Medical Center (TCMC) has decided that they wish to improve the care available to individuals post-incarceration. TCMC will achieve this objective by working with the San Diego Sheriff's Department to identify the patient target population. Then these individuals will be linked with the appropriate medical and social resources in a more timely manner. By engaging a community health worker functioning as the liaison between the clinic and the detention facility, seamless care and transition services/resources will be provided.

Target Population

The initial target population of this PRIME pilot will focus on currently incarcerated individuals with an anticipated release date who are over 50 or have at least one chronic health condition.

Care Coordination/Protocol Development and Care Delivery Improvement

TCMC plans to develop a new care transition clinic specifically reserved to serve those individuals reentering the community. The staff at this new clinic are scheduled to receive training on the unique needs of this target population. Post incarcerated individuals who have successfully reintegrated into society will be identified and employed as liaisons between the releasing correctional facility and the new transitional care clinic. TCMC also aims to work with other local resources to bring housing and employment services into the new transitional care clinic.

The transitional care clinic will offer referrals to local specialists for treatment of chronic conditions, referrals to behavioral health and substance abuse services, and access to prescription medications and teaching.

Tulare Regional Medical Center, Tulare (TRMC)

Tulare Regional Medical Center (TRMC) has identified the growing population of prisoners older than 50 and a high number of prisoners with serious physical or behavioral health conditions as primary reasons for focusing on creating an effective care transition program. TRMC will work with Tulare County Jail to identity the target population and will partner with other community health and social service providers.

Target Population

The initial target population of this PRIME pilot will include adults 18 years of age or older, who are due to be released from the county jail and plan to establish residency in Tulare County after release.

Care Coordination/Protocol Development and Care Delivery Improvement

TRMC has planned their transition to integrated care for those recently incarcerated in three logistical groupings. TRMC's pilot relies heavily on having a trained workforce dedicated to directing healthcare activities of this target population.

First, they have planned to enhance enrollment among the target population for health care coverage. They plan to meet this goal by employing an outreach care coordinator to work alongside county jail personnel. Individuals nearing release, who are in need of medical coverage, will be assigned to the outreach care coordinator. Individuals who do not meet the criteria for coverage will still be able to work with the outreach care coordinator, but will be introduced to a TRMC medical home as a "self-pay patient."

Secondly, TRMC's outreach care coordinator will work with jail medical/health staff to transition the individual into new health services. TRMC aims to (1) introduce the recently released individual to a medical home, (2) help establish appointments for primary care providers, and (3) educate the individual about services offered by TRMC, such as alcohol, drug, and employment programs.

Thirdly, TRMC's outreach care coordinator will work to identify the preventive care needs of individuals once they have established a primary care provider. Throughout the individual's engagement with their primary care provider, the provider team will help track the needs of patients, supported by a population management data system. The information gleaned from this analytic population monitoring will allow TRMC to assist the local Tulare County primary care providers more effectively address the needs of the target population.

PRIME: Summary of Core Component	KMC	LADHS	TCMC	TRMC
2.5.1 Develop a care transitions program for those individuals who have been individuals sentenced to prison and/or jail that are soon-to-be released/or released in the prior 6 months who have at least one chronic health condition and/or over the age of 50.	✓		✓	✓
2.5.2 Develop processes for seamless transfer of patient care upon release from correctional facilities, including: a. Identification of high-risk individuals (e.g., medical, behavioral health, recidivism risk) prior to time of release. b. Ongoing coordination between health care and correctional entities (e.g., parole/probation departments). c. Linkage to primary care medical home at time of release. d. Ensuring primary care medical home has adequate notification to schedule initial post-release intake appointment and has appropriate medical records prior to that appointment, including key elements for effective transition of care. e. Establishing processes for follow-up and outreach to individuals who do not successfully establish primary care following release. f. Establishing a clear point of contact within the health system for prison discharges.	✓	✓	✓	✓
2.5.3 Develop a system to increase rates of enrollment into coverage and assign patients to a health home, preferably prior to first medical home appointment.		✓	✓	✓
2.5.4 Health System ensures completion of a patient medical and behavioral health needs assessment by the second primary care visit, using a standardized questionnaire including assessment of social service needs. Educational materials will be utilized that are consistent with the cultural and linguistic needs of the population.			✓	✓
2.5.5 Identify specific patient risk factors which contribute to high medical utilization. Develop risk factor-specific interventions to reduce avoidable acute care utilization.			✓	✓
2.5.6 Provide coordinated care that addresses co-occurring mental health, substance use and chronic physical disorders, including management of chronic pain.		✓	✓	
2.5.7 Identify a team member with a history of incarceration (e.g., community health worker) to support system navigation and provide linkages to needed services if the services are not available within the primary care home (e.g., social services and housing) and are necessary to meet patient needs in the community.		✓	✓	
2.5.8 Evidence-based practice guidelines will be implemented to address risk factor reduction (e.g., immunization, smoking cessation, screening for HCV, trauma, safety, and overdose risk, behavioral health screening and treatment, individual and group peer support) as well as to ensure appropriate management of chronic diseases (e.g., asthma, cardiovascular disease, COPD, diabetes).				✓
2.5.9 Develop processes to ensure access to needed medications, DME or other therapeutic services (dialysis, chemotherapy) immediately post incarceration to prevent interruption of care and subsequent avoidable use of acute services to meet those needs.	✓	✓	✓	✓
2.5.10 Engage health plan partners to pro-actively coordinate long-term care services prior to release for timely placement according to need.		✓		✓
2.5.11 Establish or enhance existing data analytics systems using health, justice and relevant community data (e.g., health plan data), to enable identification of high-risk incarcerated individuals for targeted interventions, including ability to stratify impact by race, ethnicity and language.		✓	✓	
2.5.12 Implement technology-enabled data systems to support pre-visit planning, point-of-care delivery, population/panel management activities, care coordination, and patient engagement, and to drive operational and strategic decisions including continuous QI activities.				
2.5.13 To address quality and safety of patient care, implement a system for continual performance feedback and rapid cycle improvement that includes patients, front line staff, and senior leadership.				
2.5.14 Improve staff engagement by: a. Implementing a model for team-based care in which staff performs to the best of their abilities and credentials. b. Providing ongoing staff training on care model. c. Involving staff in the design and implementation of this project.	✓		✓	
2.5.15 Engage patients and families using care plans, and self-management education, including individual and group peer support, and through involvement in the design and implementation of this project.				
2.5.16 Participate in the testing of novel metrics for this population.		✓	✓	✓

Appendix 7: Health Home for Patients with Complex Needs

(County Implementation Schedule)

Counties		Implementation date for members with eligible chronic physical conditions and SUD	Implementation date for members with SMI
Group 1	Del Norte, Humboldt, Lake, Marin, Mendocino, Napa, San Francisco, Shasta, Solano, Sonoma, Yolo	July 1, 2018	January 1, 2019
Group 2	Imperial, Lassen, Merced, Monterey, Orange, Riverside, San Bernardino, San Mateo, Santa Clara, Santa Cruz, Siskiyou	January 1, 2019	July 1, 2019
Group 3	Alameda, Fresno, Kern, Los Angeles, Sacramento, San Diego, Tulare	July 1, 2019	January 1, 2020

Source: CA DHCS[177]

[177] [Link]

Appendix 8: Target County AB 82 Outreach and Enrollment Plans[178]

Target County AB 82 Outreach and Enrollment Plans			
County & Lead Agency	**Grant Amount**	**Target Populations**	**O&E Summaries**
Los Angeles - Los Angeles County Department of Public Health	$7,005,664	● Persons who are homeless ● Persons with mental health disorder needs ● Persons with substance use disorder needs ● Persons who are in county jail, in state prison, on state parole, on county probation, or under post-release community supervision ● Young men of color ● Persons with limited English proficiency ● Families of mixed-immigration status	Los Angeles County will develop, negotiate, and finalize contract amendments and augmentations with subcontractors. The county will also plan and conduct trainings on Medi-Cal screening, enrollment, troubleshooting, and retention, along with training on various data collection databases. The county will meet with community stakeholders and board of supervisors' district offices to discuss the county's implementation plan, reaching the target populations, addressing gaps in outreach, and achieving enrollment goals. Summary of outreach and enrollment activities: • Conduct enrollment activities through scheduled community events. • Assist individuals with with enrollment and/or enrollment verification at service planning areas and community assessment services centers. ● Hire additional staff to fulfill DHCS grant personnel requirements detailed in the work plan. ● Initiate application assistance activities with individuals screened as Medi-Cal eligible. ● Utilize print media and other marketing channels to reach young men of color. ● Obtain Medi-Cal educational materials and post/provide at intake centers and inmate housing units. ○ Custody assistants will educate inmates, answer questions and check records for eligibility. ● Conduct renewal assistance for clients at all service planning areas in the county. ● Conduct a sample survey of Medi-Cal beneficiaries enrolled through the

[178] [Link]

			outreach and enrollment grant after 14 months to determine if they remained enrolled.
San Diego - Health Care Policy Administration	$668,005	● Persons who are in county jail, state prison, state parole, county probation, or under post release community supervision	San Diego County Health Care Policy Administration will prepare data systems and reporting tools to monitor activities and outcomes of outreach and enrollment efforts. Prior to hiring application assisters for outreach and enrollment activities, the contract between San Diego County and ASO will be amended to to add funding for application assisters. Additionally, background checks and Medi-Cal enrollment training will be provided for ASO and CBO staff. San Diego County will coordinate meetings between ASO and CBOs to track progress. Summary of outreach and enrollment activities: ● Distribute informational materials on Medi-Cal health care options through ASO and CBOs. ● Attend one-on-one and group enrollment sessions at the Sheriff-operated facilities and Probation Field Offices with ASO and CBOs. ● Enroll an estimated 295 individuals from Sheriff facilities into Medi-Cal. ● Enroll an estimated 165 individuals from Probation Field Offices into Medi-Cal. ● Collect data on education and enrollment activities and prepare a monthly submission through ASO and CBO efforts. ● Retain 147 beneficiaries originally contacted in Sheriff facilities. ● Retain 83 people originally contacted in Probation Field Offices.
Santa Clara - Santa Clara Valley Health and Hospital System (SCVHHS)	$1,776,336	● Persons with mental health disorder needs ● Persons with substance abuse disorder needs ● Persons who are homeless ● Young men of color ● Persons who are in county jail, state prison, state	SCVHHS will work closely with the Santa Clara's Social Service Agency (SSA) as well as the Department of Corrections (DOC) to develop workflows and identify staffing classifications for enrolling county inmates into Medi-Cal. Summary of outreach and enrollment activities: ● Conduct outreach and enroll

		parole, county probation, or under post release community supervision ● Families of mixed-immigration status ● Persons with limited English proficiency	● 1,400 homeless individuals and/or individuals moving toward or residing in permanent supportive housing ● Identify inmates who are 30-60 days pre-release, screen them for Medi-Cal eligibility, and submit applications for those inmates who are potentially eligible. ● Submit 5,000 Medi-Cal applications for county inmates prior to release with the assistance from the DOC and SSA. ● Perform outreach and enroll 1500 individuals on parole, probation, post-release community supervision. ● Conduct outreach and enroll 1,300 individuals in the remaining five targeted populations through CBO efforts. ● Retain at least 70% of individuals who enroll in Medi-Cal during the period of this outreach and enrollment initiative via phone, letter, email, text, or in-person.

Appendix 9: Summary of the CDCR's Benefit Application Process Outcomes for SMI inmates

Benefit Applications Outcomes Mental Health Population (FY 2016-17)							
SMI Population		Jul-Sep 2016	Oct-Dec 2016	Jan-Mar 2017	Apr-Jun 2017	Total	
Medi-Cal							
	Submissions for EOP	296	311	245	188	**1040**	**100%**
	Pending	37	37	35	27	**136**	**13%**
	Approved	259	273	210	160	**902**	**87%**
	Denied	0	1	0	1	**2**	**0%**
	Submissions for CCCMS	1517	1491	1388	975	**5371**	**100%**
	Pending	164	151	146	107	**568**	**11%**
	Approved	1353	1339	1241	867	**4800**	**89%**
	Denied	0	1	1	1	**3**	**0%**
SSI							
	Submissions for EOPs	250	273	224	161	**908**	**100%**
	Pending	131	172	132	109	**509**	**56%**
	Approved	52	44	35	17	**148**	**16%**
	Denied	67	57	57	35	**216**	**24%**
	Submissions for CCCMS	296	284	338	335	**1253**	**100%**
	Pending	119	144	200	221	**684**	**55%**
	Approved	106	101	95	71	**373**	**30%**
	Denied	71	39	43	43	**196**	**16%**
VA							
	Submissions for EOPs	n/a					
	Submissions for CCCMS	24	41	28	24	**117**	**100%**
	Pending	10	34	20	15	**79**	**68%**
	Approved	5	4	3	6	**18**	**15%**
	Denied	9	3	5	3	**20**	**17%**

Source: California Rehabilitation Oversight Board, 2017, page 55.

Appendix 10: Full Description of Parole's Mental Health Services Continuum Program (MHSCP) Components

Parole's Mental Health Services Continuum Program: Original Design and Description

The MHSCP was designed to reduce the symptoms of mental illness among parolees by providing timely, cost-effective mental health services that optimizes their level of individual functioning in the community thereby reducing recidivism and improving public safety.

The MHSCP is designed to include:

- Pre-release needs assessment of paroling mentally ill inmates.
- Pre-release benefits eligibility and application assistance.
- Expanded and enhanced post-release mental health treatment for mentally ill parolees.
- Improved continuity of care from the institution's Mental Health Service Delivery System to the community-based parolee outpatient clinics.
- Increased assistance for successful reintegration into the community upon discharge from parole.
- A standardized program in all four-parole regions.

Population Served

The MHSCP target population consists of parolees who were receiving mental health treatment in the institutions under the Mental Health Services Delivery System prior to release to parole. The MHSCP target population also consists of those parolees who have been in a Mental Health Crisis Bed and those releasing from any Department of Mental Health facility.

The criteria for admission to both the institution's and parole's mental health treatment programs is a diagnosis of one or more of the following Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) psychiatric disorders:

- Schizophrenia (all subtypes)
- Delusional Disorder
- Schizophreniform Disorder
- Schizoaffective Disorder
- Substance-Induced Psychotic Disorder (exclude intoxication and withdrawal)
- Psychotic Disorder Due To A General Medical Condition
- Psychotic Disorder Not Otherwise Specified
- Major Depressive Disorders
- Bipolar Disorders I and II
- Medical Necessity (any other major mental illness diagnosis which requires treatment due to the acuity or severity of the illness)

The following mental health designations are used to determine the level of treatment need for inmates/parolees who require mental health services delivered by POC:

1. **Correctional Clinical Case Management System (CCCMS)** designation requires one or more of the above-referenced DSM IV diagnoses, and:
   - Stable functioning in the community;
   - Global Assessment of Functioning Score (GAF) above 50.

2. **Enhanced Outpatient Program (EOP)** designation requires one or more of the above referenced DSM IV diagnoses, and:
   - Acute onset or significant deterioration of a serious mental disorder characterized by increased delusional thinking;
   - Hallucinatory experiences, marked changes in affect and vegetative signs with definitive impairment of reality testing and/or judgment;
   - Dysfunctional or disruptive social interaction including withdrawal, bizarre or disruptive behavior, extreme defensiveness, inability to respond to instruction, provocative behavior toward others as a consequence of a serious mental disorder;
   - Impairment of Activities of Daily Living (ADL) including eating, and personal hygiene, maintenance of dwelling, and ambulation as a consequence of a serious mental disorder.
   - Global Assessment of Functioning Score (GAF) of 50 or less.

3. **Mental Health Crisis Bed (MHCB**) designation:
   - An inmate experiencing a mental health crisis may be placed in a MHCB for inpatient, treatment and stabilization;
   - Length of stay may be up to 10 days, unless the inmate is approved for a longer stay by the chief psychiatrist, or designee;
   - Criteria for removal from the MHCB include stabilization and the ability to function in a less restrictive environment; i.e. EOP or CCCMS.

4. **Priority of Services:**
   - EOP inmates
   - MHCB inmates
   - Department of Mental Health facility releases on medication and receiving clinical treatment
   - CCCMS inmates receiving only clinical treatment
   - CCCMS inmates not on medication AND who did not receive clinical treatment within six (6) months prior to release will NOT receive services from the MHSCP

According to the MHSCP design, regional Transitional Case Management Program—Mental Illness (TCMP-MI) social workers are to conduct face-to-face assessments with eligible inmates within 90 days of the inmates' EPRD, and update this assessment information within 30 days of the inmates' EPRD. The TCMP-MI social worker then merges the assessment information into the Parole Automated Tracking System (PATS) database. This information is verified by the TCMP-MI liaison and forwards this information to the appropriate POC headquarters. Once received, a POC-MHSCP liaison consults with the inmate's parole agent of record (AOR) and schedules an initial appointment. For EOP parolees, this appointment is scheduled to occur within 3 working days of release; for CCCMS parolees, the initial appointment is scheduled to occur within 7 working days of release.

In general, the jurisdictions of the TCMP-MI social workers are divided into northern and southern regions, with Kern County Department of Public Health serving as the headquarters for the northern

region, and the University of California, San Diego serving as the headquarters for the southern region. Some exceptions to this regional approach (e.g., including San Quentin State Prison in the southern region) were made to achieve balance between the regional caseloads and to reduce costs.

Upon leaving the institution, parolees return to one of four parole regions (typically based on the county of commitment). The headquarters for these regions are located in Sacramento (Region I), Oakland (Region II), Los Angeles (Region III), and Diamond Bar (Region IV).

Source: UCLA, 2006. Final Report on the Mental Health Services Continuum Program of the California Department of Corrections and Rehabilitation—Parole Division, pg 7-9, [PDF].

CDCR: Division Of Adult Parole Operations: Mental Health Services Continuum Programs						
Program	**Transitional Case Management Program**	**Parole Outpatient Clinics (POC)**	**Integrated Services for the Mentally Ill Program**	**Case Management Re-Entry Pilot Program**	**Medication Assisted Treatment (MAT)**	**Co-occurring Mental Illness and Substance Abuse Pilot Program**
Program Services CDCR has MOUs in place that establishes the application processes for the Entitlement Programs listed below: 1. Department of Health Care Services (Medi-Cal) 2. Social Security Administration (SSA/SSI) 3. Veteran Affairs (VA)	Provide application assistance, if eligible, for: ● Medi-Cal ● Cal-Fresh ● SSI ● SSA ● Title XVI ● Veteran Benefits	Provide the following mental services: ● Individual & Group Therapy ● Crisis Intervention ● Psychotropic medications and medication management. ● Collaborate with ISMP to connect eligible parolees to additional outpatient services ● Makes referrals for mental health conservatorship ● Transition inmates to county mental health services prior to discharge from parole	Provide Integrated & wrap-around case management services for mentally ill that includes: ● Assessment of parolee needs and goals ● Development of parolee driven personal services plan (PSP) ● Linkage to appropriate community services ● Housing referrals ● Discharge planning and linkage to services	Provide assistance to: ● Address Criminogenic needs, community functioning and responsivity factors ● Reentry planning ● Housing referrals ● Linkages to community services ● Discharge planning	Provide assistance on a voluntary basis to: ● Parolees with co-occurring disorders	Augment existing pre-release/reentry processes by conducting American Society of Addiction Medicine assessments, provide post-release EBPs, integrated treatment for SUD & MIs and: ● Target higher-risk ● Enhance intrinsic motivation ● Target criminogenic needs ● Determine dosage and intensity of services ● Medication assistance ● Collect & report recidivism indicator data
Timeframes	Begins 120 days prior to scheduled release date	Begins upon release from prison or at any time during parole	Begins upon release from prison or at any time during parole	Three Phase Program: ● Stabilization ● Transitional ● Sustainability	Begin once released from Prison and report to POC.	Begins 120 days prior to scheduled release date
Target Populations	All inmates who will be released to Parole or PRCS.	● Parolees with a DSM-V, Axis 1 Diagnosis, who have a special condition of parole to participate in treatment. ● ALL parolees are eligible.	Parolees with a DSM-V, Axis 1 Diagnosis, who have been referred by POC or parole agent.	Parolees who are: ● Developmentally disabled ● Homeless ● Jobless ● Mentally ill ● Have a SUD	Parolees with Co-Occurring Mental Health / Substance Use Disorders	Parolees with a DSM-V, Axis 1 Diagnosis, with Substance Abuse.
# Served Annually & Budget	35,200 ADP Budget:12.6 million	~6324 ADP Budget: $16.5 million	575 ADP Budget: 12.3 million	964 ADP Budget: $2.7 million	ADP: Unavailable Budget: Unavailable Funded through Medi-Cal	600 ADP Budget: Second Chance Grant = $640,197 and CDCR in-kind = $489,900
Program Locations	● Prisons ● Camps ● Modified Community Correctional Facilities ● State Hospitals	● Co-located at Parole Offices throughout the state ● Telemedicine in rural locations	● Kern ● Los Angeles ● Sacramento ● San Bernardino ● San Diego ● San Francisco ● Santa Clara	● Kern ● Los Angeles ● Sacramento ● San Diego ● San Francisco	Located statewide at all POC locations	● Kern ● Los Angeles ● Sacramento ● San Diego ● San Francisco
Service Providers	**Contracted Staff:** University of San Diego: ● 65 Benefit Workers (BW) ● 5 BW Supervisors	**POC Staff:** ● Chief Psychiatrist ● Psychiatrists ● Clinical Psychologist ● LCSW/MSW	**Contracted Staff:** ● HealthNet 360 ● TeleCare ● Quality Group Homes ● Westcare	**Contracted:** ● HealthNet 360 ● TeleCare ● Quality Group Homes ● Westcare	**POC Staff:** ● Psychiatric ● Clinical Psychologist	**Contracted Staff:** ● HealthNet 360 ● TeleCare ● Quality Group Homes ● Westcare

Appendix 11: University of Arizona Health Plans (UAHP) Reach In Program

Target Population Criteria for Reach In Program Enrollment

Potential members for Reach In coordination will be identified on the state's enrollment file that indicates members suspended eligibility status and county location of incarceration. Each week, claims and referral data on members identified as incarcerated are automatically reviewed in order to assess their risk according to our criteria. All members meeting one or more of the criteria will be deemed in need of Reach In coordination 30 days prior to anticipated release date.

Reach In Process

1. Report is generated to identify members who have had their Arizona State Medicaid (AHCCCS) suspended due to incarceration.
2. Receive members known release dates from stakeholders.
3. Justice System Liaison will identify which members meet the criteria, determine the current facility and send the member the UAHP Member Re-Entry Kit.
4. Liaison will then refer the member to Case Management to initiate Reach In.
5. The Case Manager contacts the facility health care vendor/staff to coordinate care.
6. Case Manager sends the member a letter notifying them of their follow up PCP appointment.
7. The Case Manager conducts a health history questionnaire and develop a care plan.
8. After the member is released, the Case Manager will continue to follow up with member.
9. Case Management will be ongoing with the member as needed.

Member engagement

Member Re-entry kit includes:

- Details about the health plan
- Health history questionnaire
- How to access benefits
- Additional Resources
    - Job assistance
    - Family support services
    - How to connect to services in the community
    - Substance abuse programs
    - Behavioral health services
    - Transportation
    - Housing

Continued Case Management

The Case Manager will continue to conduct high touch case management with the member and their providers. If appropriate, members can be enrolled in Disease Management Programs:

- Diabetes
- Asthma
- Cardiovascular Health
- Depression
- COPD

Members are not disenrolled from the Reach In Case Management Program until they have reached medical/behavioral stability and have not been re-incarcerated for at least 12 consecutive months.

Source: Banner Health Network webinar and presentation, May 24, 2017

Appendix 12: Santa Clara County Reentry Resource Center Authorization for Release of Confidential Health and Other Information

SANTA CLARA COUNTY REENTRY RESOURCE CENTER
AUTHORIZATION FOR RELEASE OF CONFIDENTIAL HEALTH AND OTHER INFORMATION

I, _____ (PRINT NAME), am participating in programs and/or seeking services through the County of Santa Clara Re-Entry Resource Center ("Re-Entry Center"). The County and State departments participating on the Re-Entry Center team are Social Services Agency, Behavioral Health Services Department, Office of Re-Entry Services, Custody Health Department, Probation Department, California State Parole Agency, Office of the Sheriff, Department of Correction, the Office of the Public Defender, and Valley Homeless Healthcare Program.

I authorize the below listed County and State departments to disclose to the members of the Re-Entry Center team the following information about me for the purpose of coordinating services and making referrals to appropriate Re-Entry Center programs and services.

Medical Information:

I hereby authorize (check as appropriate):

□ **Custody Health Department**, 150 West Hedding Street, San Jose, CA 95110; 701 South Abel Street, Milpitas, CA 95035. Telephone number: (408)808-5200; (408)957-5360.

□ **Valley Homeless Healthcare Program**, 751 South Bascom Avenue, T-25, San Jose, CA 95128. Telephone number: (408)885-3328.

to release to the Re-Entry Center the following information:

- Screening and referral information. _____ **(initial)**

Mental Health Treatment Information:

I hereby authorize **Behavioral Health Services Department**, (828 South Bascom Avenue, Suite 200, San Jose, CA 95128; Telephone number: (408)885-5770) to release to the Re-Entry Center the following information:

- Screening, referral and treatment information. _____ **(initial)**

This authorization form has been approved by the Santa Clara County Office of the County Counsel (8/17/2015)

Alcohol/Drug Treatment Information:

I hereby authorize **Behavioral Health Services Department**, (828 South Bascom Avenue, Suite 200, San Jose, CA 95128; Telephone number: (408)885-5770) to release to the Re-Entry Center the following information:

- Screening, referral and treatment information. _____ **(initial)**

Public Benefits:

I hereby authorize **Social Services Agency**, (Department of Employment and Benefit Services 1919 Senter Road, San Jose, CA 95112; Telephone number: (408)758-3100) to release to the Re-Entry Center the following information:

- Public benefits information. _____ **(initial)**

Housing Information:

I hereby authorize **Office of Supportive Housing**, (3180 Newberry Drive, Suite 150, San Jose, CA 95118; Telephone number: (408)793-0550)) to release to the Re-Entry Center the following information:

- Housing assessment and housing information. _____ **(initial)**

In addition, I understand that the County will keep, maintain and report information regarding referrals and outcomes of participants in Re-Entry Center. I understand that any information that is disclosed outside of the Re-Entry Center team participants will be statistical only and will contain no identifying information about me except as required by law.
MY RIGHTS: I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits. I have a right to receive a copy of this authorization.

I may revoke this authorization at any time, but I must do so in writing and submit it to the following address:

Re-Entry Resource Center
151 W. Mission Street
San Jose, CA. 95110

This authorization may be revoked verbally for records relating to drug/alcohol treatment or mental health.

This authorization form has been approved by the Santa Clara County Office of the County Counsel (8/17/2015)

My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.

I understand that Medical, Mental Health, and Drug and Alcohol records are protected under various Federal and State Regulations, including California Welfare and Institutions Code Section 5328, Confidentiality of Medical Information Act, California Civil Code Section 56.10 (CMIA), the Health Insurance Portability and Accountability Act, 45 C.F.R., parts 160 and 164 ("HIPAA"), and the Federal Regulations Governing Confidentiality of Drug Abuse Patient Records, 42 C.F.R., Part 2. Information disclosed pursuant to this authorization could be redisclosed by the recipient. Such redisclosure is in some case not prohibited and may no longer be protected by HIPAA. However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless specifically required or permitted by law.

I expressly authorize my information disclosed pursuant to this authorization to be further disclosed by the recipients listed above for the purposes of coordinating services and making referrals to appropriate Re-Entry Center programs and services.

Signature: _____
(Client/Legal Representative)

If signed by other than client, indicate relationship: _____

and print name: _____

Date: _____

Time: _____AM/PM

EXPIRATION: This authorization expires on (date) _____.

This authorization form has been approved by the Santa Clara County Office of the County Counsel (8/17/2015)

Appendix 13: AB 109 Evaluation Efforts in Target Counties

AB 109 Evaluation Efforts[179] in Los Angeles, San Diego and Santa Clara Counties	
Counties	**Evaluation Efforts**
Los Angeles	**Evaluating Entity:** ● Internal
	Reports/Data: ● **Quarterly Reports on Public Safety Realignment** are submitted to the County Board of Supervisors. These reports provide updates on Public Safety Realignment objectives and whether they are being met. The reports also discuss programs and services that are being offered and how effective they are. The following are also included: ○ **Quarterly Performance Measures Report** is updated by departments and tracks the progress that they are making throughout the fiscal year in meeting their stated goals. ○ **Monthly Data Report** provides information on relevant numbers concerning Public Safety Realignment and their trends over time.
	How are the reports/data used? ● The effectiveness and results of programs and/or services – in addition to programmatic needs identified by departments – are considered when funds are allocated.
	Continuing evaluation efforts? ● As of FY14/15, the county was in the process of contracting with a researcher to conduct an AB 109 Evaluation. This evaluation will cover the entire extent of Public Safety Realignment in Los Angeles County, from the time of implementation in October 2011 up to the present. Among other tasks, this project will evaluate the effectiveness of programs and services that are funded with the Public Safety Realignment allocation.
San Diego	**Evaluating Entity:** ● The San Diego Association of Governments (SANDAG)
	Data Sources/Systems: ● The County of San Diego justice partners including Probation, the District Attorney's Office, Sheriff's Department and the Health and Human Services Agency have implemented a multi-agency data warehouse known as the "data hub". ● Within the Sheriff's Evidence-Based Practice System (EBPS) is a module called **Offender 360**, which was developed by Tribridge using the Microsoft Dynamics CRM.

[179] AB 109 Evaluation Progress Reports (FY14/15).

	Scope/Purpose: ● **SANDAG** is conducting a process and outcome evaluation of programs and services related to the implementation of AB 109. SANDAG is also tracking the characteristics of who receives services, and will relate this data to outcomes. ● **Offender 360 EBPS** will allow the County of San Diego's justice partners to collect, share and analyze programming information to measure the success of reentry services by offender, population and program agency. Six different populations of offenders are tracked and analyzed; pre-trial, summary probation, formal probation, PC 1170(h), Post-Release Community Supervision (PRCS) and Parole.
	How was the evaluation/data used? ● The county considers all available outcome data and evaluation results in combination with data on assessed needs, when prioritizing available funding. ● **Offender 360:** ○ The system allows authorized users to make more informed decisions regarding the implementation of reentry services. ○ Users can track the success and challenges of offenders attending reentry programming while in the community or incarcerated. ○ The system tracks and identifies the number of offenders returning to custody and the program they attended. This information will aid in identifying the success rate of various programs and assist in ascertaining the average cost of programming per offender. ○ By collecting and analyzing the aforementioned data, the county will be able to refine how they define, report, understand and manage recidivism within each member agency and across all member agencies.
	Continuing evaluation efforts? ● **AB 109 specific:** Unknown whether additional evaluations are planned, post-SANDAG. ● The **Offender 360** in-custody is fully operational and all Sheriff's Reentry Services Division and the County Parole and Alternative Custody Unit staff began using the system July 2015. The county is continuing to work with the vendor on enhancements for provider access and the availability of analytics.
Santa Clara	**Evaluating Entity:** ● Resource Development Associates (RDA) ● 24 month ($299,310) contract with the Board of Supervisors.
	Scope: ● This is a comprehensive Public Safety Realignment (AB 109) outcome measurement and process evaluation report covering period from October 1, 2011 to December 31, 2014. The report entails recidivism rate for AB 109 population and impacts on programs and services funded by realignment resources. This process and outcomes evaluation seeks to examine ways in which service provision informs the rates of recidivism among the county's AB 109 population. AB 109 population characteristics, types of services and programming being

	accessed, and the impacts of services and programming on recidivism. It also includes an overview of AB 109 clients', service providers', and county staff members' perceptions of the reentry system. The full report includes a complete account of process and outcome evaluation findings as well as background information, a detailed description of the methodology used and further recommendations.
	How was the evaluation used? ● Results have shown that ensuring clients receive appropriate services based on need helps to reduce their risk of recidivism. ● Assessments are used to determine program referrals. The county evaluates the length between referral and intake, service engagement and completion of programs to determine which programs are more viable and successful at reducing recidivism. ● The evaluation is used to identify which services have the greatest impact and use these outcomes to secure more services in this area. ● Results are used to help pinpoint gaps in services and put more resources in areas that are needed.
	Continuing evaluation efforts? ● No, contract ended on June 30, 2015.

Appendix 14: Board of State and Community Corrections Organizational Mandates Regarding Data and Evaluation

California Penal Code Section 6027

6027(a): It shall be the duty of the Board of State and Community Corrections to collect and maintain available information and data about state and community correctional policies, practices, capacities, and needs, including, but not limited to, prevention, intervention, suppression, supervision, and incapacitation, as they relate to both adult corrections, juvenile justice, and gang problems. The board shall seek to collect and make publicly available up-to-date data and information reflecting the impact of state and community correctional, juvenile justice, and gang-related policies and practices enacted in the state, as well as information and data concerning promising and evidence-based practices from other jurisdictions.

6027(2): Identify, promote, and provide technical assistance relating to evidence-based programs, practices, and promising and innovative projects consistent with the mission of the board.

6027(3): Develop definitions of key terms, including, but not limited to, recidivism, average daily population, treatment program completion rates, and any other terms deemed relevant in order to facilitate consistency in local data collection, evaluation, and implementation of evidence-based practices, promising evidence-based practices, and evidence-based programs.

6027(9): Conduct evaluation studies of the programs and activities assisted by the federal acts.

6027(11): The board shall collect from each county the plan submitted pursuant to Section 1230.1* within two months of adoption by the county boards of supervisors. Commencing January 1, 2013, and annually thereafter, the board shall collect and analyze available data regarding the implementation of the local plans and other outcome-based measures, as defined by the board in consultation with the Administrative Office of the Courts, the Chief Probation Officers of California, and the California State Sheriffs Association. By July 1, 2013, and annually thereafter, the board shall provide to the Governor and the Legislature a report on the implementation of the plans described above.

[*Section 1230.1 mandates the following: Each county local Community Corrections Partnership shall recommend a local plan to the county board of supervisors for the implementation of the 2011 public safety realignment.]

Source: PEN § 6027 [Link].

Appendix 15: Abbreviations

Full List of Abbreviations Used Throughout Report (Alphabetical)	
AB	Assembly Bill
ACA	Affordable Care Act of 2010
ACA	Patient Protection and Affordable Care Act
ACT	Assertive Community Treatment
ADP	Average Daily Population
AOC	Administrative Office of the Courts
BHS	Behavioral Health Services
BJA	Bureau of Justice Assistance
BPH	Board of Parole Hearings
BSCC	Board of State and Community Corrections
CA	Custody Assistant
CCCMS	Correctional Clinical Case Management System
CDCR	California Department of Corrections and Rehabilitation
CHW	Community Health Worker
CIE	Community Information Exchange
CLM	California Logic Model
CMRP	Clinical Case Management Reentry Pilot program
COD	Co-Occurring Disorder
COMPAS	Correctional Offender Management Profiling for Alternative Sanctions
CPE	Certified Public Expenditure
CPOC	Chief Probation Officers of California
CSG	Council of State Governments
CUP	Conditional Use Permits
CWD	County Welfare Department
CWDA	County Welfare Directors Association
DAPO	Division of Adult Parole Operations
DDCAT	Dual Diagnosis Capability in Addiction Treatment
DDCMHT	Dual Diagnosis Capability in Mental Health Treatment
DHCS	Department of Health Care Services
EBP	Evidence Based Practice
EOP	Enhanced Outpatient Program

Full List of Abbreviations Used Throughout Report (Alphabetical) (cont.)	
FFP	Federal Financial Participation
FFS	Fee-For-Service
FIP	Formerly Incarcerated Person
FPL	Federal Poverty Line
FQHC	Federal Qualified Health Centers
HHPCN	New Health Home for Patients with Complex Needs
HHSA	Health and Human Services Agency
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act
HUD	Housing and Urban Development
HUMS	High Utilizers of Multiple Systems
ICF	Intermediate Care Facility
ISMIP	Integrated Services for Mentally Ill Parolee-clients
JCA	Jail Custody Assistant
LPS	Lanterman–Petris–Short Act
MAA	Medi-Cal Administrative Activities
MAT	Medication Assisted Treatment
MCIEP	Medi-Cal Inmate Eligibility Program
MEDS	Medi-Cal Eligibility Data System
MF	Medically Fragile
MHCBS	Mental Health Crisis Beds
MHSA	Mental Health Services Act
MOU	Memorandum of Understanding
NCPR	Nurse Consultant Program Review
NIC	National Institute of Corrections
NIMBY	“Not in my Backyard”
NPLH	No Place Like Home Initiative
PCP	Primary Care Provider
PCRRC	Probation’s Community Resource and Reentry Center
PCS	Parole Service Centers
POC	Parole Outpatient Clinic
PRCS	Postrelease Community Supervision
PRIME	Public Hospital Redesign and Incentives in Medi-Cal

Full List of Abbreviations Used Throughout Report (Alphabetical) (cont.)	
PRO	Post Release Offender
PRUCOL	Permanent Residence Under Color of Law
RMSC	Residential Multi-Service Centers
RNR	Risk Need Responsivity
ROI	Authorization for Release of Protected Health Information
ROI	Release of Information
SAMHSA	Substance Abuse and Mental Health Services Administration
SASCA	Substance Abuse Services Coordinating Agency
SB	Senate Bill
SGA	Substantial Gainful Activity
SMI	Serious Mental Illness
SNF	Skilled Nursing Facility
SNSF	Safe Neighborhoods and Schools Fund
SSA	Social Security Administration
SUD	Substance Use Disorder
TC	Therapeutic Community
TCM	Targeted Case Management
TCMP	Transitional Case Management Program
UM	Utilization Management
WPC	Whole Person Care