California Health Policy Strategies, L.L.C.

Policy Brief

Overview of Reentry Focused Whole Person Care (WPC) Pilots

June 2018

Overview

The 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 healthcare system. Collaborative leadership and systematic coordination among public and private entities is used to meet this goal. The WPC Pilot entities identify target populations, share data between systems, coordinate care in real time, and evaluate individual and population progress – all with the goal of providing comprehensive coordinated care for the beneficiary resulting in better health outcomes among vulnerable populations.

The WPC is a five-year program, approved in December 2015 as part of the Medi-Cal 2020 waiver. The program provides up to $3 billion to support the Pilots. Reimbursement is not provided for services already covered by Medi-Cal. The California Department of Health Care Services (DHCS) held two application rounds. Pilot-lead entities (usually a county government or county hospital) submitted an application to DHCS. The Medi-Cal 2020 waiver established some minimum standards for participation, but applicants had considerable flexibility to propose programs that target different populations and provide unique services or interventions.

After both application phases, there are **nine approved WPC pilots (Contra Costa, Kern, Los Angeles, Mendocino, Placer, Riverside, San Mateo, Santa Cruz, and Small County Collaborative) that have specifically targeted the vulnerable formerly incarcerated population.** The criminal justice reentry population is at high risk of failing to connect with medical, behavioral health, and other services upon discharge from jail in addition to being at high risk for homelessness. Moreover, the reentry population has exceptionally high rates of medical and behavioral health problems. Improving health care delivery to this group of individuals is an important endeavor. However, not all these counties that have identified formerly incarcerated individuals as a target population in their DHCS applications are dedicating the same amount of programmatic attention to the reentry population. There are **four approved WPC pilots (Kern, Los Angeles, Placer, and Riverside) that are especially dedicated to serving individuals reentering the community post-incarceration and that have designed programs to directly engage local jails and/or probation departments.**

Pilots receive payment from DHCS based on their approved budgets and performance measures outlined in their approved applications. In year one, the Pilots were focused on infrastructure development and gathering baseline data. In years two through five, the Pilots are focused on providing services, implementing interventions, and achieving metrics. Pilots must submit reports

to DHCS and will receive payment based on achieving the metrics outlined in their application.

DHCS requires every Pilot to report universal and variant metrics both mid-year and annually. Universal metrics will be a same set of metrics required of all WPC pilots. Variant metrics will differ between pilots and will be tailored to the unique strategies and target population(s) of each Pilot. Universal metrics will assess the success of all WPC pilots in achieving the WPC goals and there are broad types of universal metrics (health outcomes and administrative). Variant metrics are derived through a standardized process and these metrics vary widely across Pilots. Each Pilot has a dedicated section of their application that details the both the universal and variant metrics for their program.

This brief delves into the details of how each WPC Pilot that has identified formerly incarcerated individuals as a target population plans to more effectively serve the needs of this vulnerable group. Specifically, this brief discusses the following points for each Pilot that is targeting the reentry population:

- Pilot implementation and size;
- Target population identification and engagement methods;
- Services and interventions.

The following Pilots are reviewed in this brief:

Contra Costa County	Legacy Pilot
Kern County	Legacy Pilot
Los Angeles	Expansion Pilot
Mendocino	New Pilot
Placer	Legacy Pilot
Riverside	Legacy Pilot
San Mateo	Legacy Pilot
Santa Cruz	New Pilot
Small County Collaborative	New Pilot

Note:

- *Legacy Pilot* – WPC Pilot approved in November 2016 during Phase I of application review. Implementation began on January 1st, 2017.
- *Expansion Pilot* – WPC Pilot originally approved in November 2016 during Phase 1 of application review. Implementation first began on January 1st, 2017, but the implementation of the expansion began on July 1st, 2017.
- *New Pilot* – WPC Pilot approved in June 2017 during Phase II of application review. Implementation began on July 1st, 2017

Contra Costa County

Legacy Pilot

Pilot Implementation & Size
The WPC Pilot for Contra Costa was approved in November 2016 during Phase I of DHCS review. Implementation for this program began on January 1st, 2017 and it is classified as a legacy pilot. The estimated five-year beneficiary count is 52,500 individuals and the total five-year budget is $203,958,160.

Target Population Definition
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 recent incarceration.

Target Population Identification & Engagement
Ongoing population identification will occur through two primary strategies in Contra Costa:

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, and
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, and advocacy.

Kern County

Legacy Pilot

Pilot Implementation & Size
The WPC Pilot for Kern County was approved in November 2016 during Phase I of DHCS review. Implementation of this program began on January 1st, 2017 and it is classified as a legacy pilot. The estimated five-year beneficiary count is 2,000 individuals and the total five-year budget is $157,346,500.

Target Population Definition
Kern County aims to target Medi-Cal beneficiaries who have a history of high emergency room or inpatient utilization and provide 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 & Engagement
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 be 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 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.

Los Angeles County

Expansion Pilot

Pilot Implementation & Size
The WPC Pilot for Los Angeles County was approved in November 2016 during Phase I of DHCS review. An expansion to this WPC Pilot was approved in June 2017 during Phase II of DHCS review. Implementation of this program originally began on January 1st, 2017 and the implementation of the expansion began on July 1st, 2017. The program is classified as an expansion pilot. The estimated five-year beneficiary count is 154,044 individuals and the total five-year budget is $1,260,352,362.

Target Population Definition
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 & Engagement
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 be 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 physical, psychiatric, and substance use exams/assessments;
b. Helping establish benefits, including Medicaid or available cash assistance programs;
c. Reconnecting 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.

Los Angeles County will leverage the WPC-LA Training Institute to promote reliable replication of reentry services and to develop the skills of our workforce, including training on care planning, medication review and adherence support, chronic disease self-management support, care transitions support, and the use of motivational interviewing, harm reduction, and trauma informed care principles.

Mendocino County

New Pilot

Pilot Implementation & Size
The WPC Pilot for Mendocino County was approved in June 2017 during Phase II of DHCS review. Implementation for this program began on July 1st, 2017 and it is classified as a new pilot. The estimated five-year beneficiary count is 600 individuals and the total five-year budget is $10,804,720.

Target Population Definition
The target population for Mendocino County's WPC Pilot broadly includes Medi-Cal beneficiaries with SMI. However, the pilot prioritizes those that are high utilizers of mental health and/or medical services and those with at least one of the following additional barriers: homelessness or housing instability, co-occurring SUD, and/or recent interactions with the criminal justice system.

Target Population Identification & Engagement
Mendocino Health and Human Services Agency (HHSA), the lead entity of the pilot, has identified their target population in collaboration with Behavioral Health and Recovery Services (BHRS), the Department of Social Services (DSS), Partnership HealthPlan of California (PHC), and Redwood Quality Management Company (RQMC).[1] Through this collaborative approach, the pilot was able to compile several datasets with mental health, physical health, and homelessness data. These datasets were then analyzed to identify the population of Medi-Cal beneficiaries with SMI who have incurred high costs. Throughout implementation of the pilot, HHSA and its partners will rely on this data-driven approach to identify and enroll clients who are eligible for WPC services. Within this broad category of high-cost SMI Medi-Cal recipients, formerly incarcerated individuals will be identified in the data.

Reentry Services and Interventions
Many of the services, interventions, and care coordination strategies implemented in Mendocino county are designed to for both the relatively small formerly incarcerated population with SMI and the broader target population in the pilot.

Individuals reentering the community and participating in this pilot will have access to mental health resource centers. These are service hubs that provide a safe, supportive environment and an alternative to the ER for WPC enrollees experiencing less severe mental health crises, with licensed clinicians available to evaluate and assess immediate needs. Participants will also receive support through intensive care management, which seeks to support clients access medical, behavioral, and social non-medical services to address identified needs. The three services that will most frequently impact the lives of the reentry population are likely the Mobile Engagement and Prevention Services (MEPS), Assisted Outpatient Treatment (AOT), and peer extension

[1] PHC is the only managed care provider for the county's 38,000 Medi-Cal beneficiaries, and RQMC is the county's administrative services organization for mental health services.

workers. MEPS are provided by two-person teams with a mental health rehabilitation specialist and a sheriff technician to connect WPC participants with mental health support prior to their mental health needs becoming a crisis. AOT allows a select few WPC enrollees to be court ordered to participate in outpatient mental health treatment while living in the community. Peer extension workers seek to provide high intensity trauma-informed support to WPC enrollees. These peer workers will conduct engagement efforts to encourage people who are not participating fully in prevention and other services, build trusting relationships, encourage early intervention, and facilitate linkage to services. With the help of Prop 47 funding (application pending) this pilot will provide residential wraparound mental health services and SUDT for non-violent, non-serious offenders with a history of SUD and/or mental illness and a high risk of reoffending.

Importantly, this pilot aims to provide several co-located medical services. These co-located services will include county psychiatric care provided on clinic campuses, which fosters integration and collaborative care management of shared patients while streamlining participant access and support. This pilot also provides clinic liaisons and ER concierges. The liaisons ensure timely access to healthcare services and health homes for WPC participants referred to the clinic by other partners. Moreover, the ER concierges help identify and redirect WPC participants who are using the ER for social or other inappropriate support. Post-hospital medical care is offered through the pilots medical respite program to WPC participants who are homeless, in an unstable living situation, and/or too ill or frail to recover from physical illness/injury in their usual living environment (but not ill enough to be treated in a hospital or skilled nursing facility).

Formerly incarcerated individuals facing problems with finding or maintaining housing and integrating back into the community are also supported through this pilot. Housing coordination services include: tenant screening and assessment of housing needs, housing assessment, individualized housing support plans, assistance with housing applications, matching with appropriate housing service providers, and identification of resources to cover move-in expenses. Community integration efforts by the pilot includes include intensive work with participants to reconnect them with family members with whom they may have broken or difficult relationships and to re-establish those relationships. Where there is not family restoration, community integration services will help connect participants with new support systems in the form of informal “foster families” who may rent them rooms or small apartments after participating in program training and becoming In-Home Support Services (IHSS) providers where IHSS services are eligible. Individuals will also receive tenancy support. This pilot support include: tenant education and coaching, onsite intense care management services for tenants, landlord training and coaching, early intervention, and landlord dispute resolution.

Placer County

Legacy Pilot

Pilot Implementation & Size
The WPC Pilot for Placer County was approved in November 2016 during Phase I of DHCS review. Implementation of the program began on January 1st, 2017 and it is considered a legacy pilot. The estimated five-year beneficiary count is 450 individuals and the total five-year budget is $20,126,290.

Target Population Definition
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 people 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 & Engagement
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 with obtaining housing and developing daily living skills to support them in their new living situation. The Housing Services will be specifically tailored for each individual participant based on their Tailored Plan of Care.

Riverside County

Legacy Pilot

Pilot Implementation & Size
The WPC Pilot for Riverside was approved in November 2016 during Phase I of DHCS review. Implementation of the program began on January 1st, 2017 and it is considered a legacy pilot. The estimated five-year beneficiary count is 38,000 individuals and the total five-year budget is $35,386,995.

Target Population Definition
The Riverside University Health System (RUHS) WPC Pilot is targeting individuals with the following characteristics:

- new probationers,
- probationers who are on probation for at least one full year,
- probationers who are at-risk of or who are experiencing homelessness,
- probationers who have a behavioral health diagnosis, and
- probationers who have a physical health diagnosis.

Target Population Identification & Engagement
New probationers and individuals on Post-Release Community Release (PRCS) must report to their local Probation Department Office within 48 hours. A Nurse will be housed at each Probation Department Office. The Nurse will enroll the probationer into the screening part of the WPC and evaluate the individual for pilot eligibility. The probationer will be screened for the following: length of time on probation-minimum 12 months, at-risk of or experiencing homelessness, social needs, Medi-Cal eligibility, behavioral health needs, and physical health needs. The Nurse will screen rather than assess the participant using a new Whole Person Care Health Score evaluation tool.

Reentry Services and Interventions
Based on screening results, the Nurse will coordinate follow-up appointments with the appropriate department(s). These departments include DPSS for access to Medi-Cal, Cal Fresh, Welfare service, etc.; DBH for services related to serious mental illness and housing for those with mental illness; FQHC clinics for all identified medical and mild/moderate mental illness; Office on Aging for those who qualify for their services; and into the community for additional housing support.

The “warm hand offs” from one agency to another for the individuals needing services will occur via the Nurse. The Nurse will provide information directly to the referent agency. Each of the departments, above, have Care Managers who will provide personalized assistance that is specific to the resources being accessed in the individual department. The goal of the Nurse is to have specific appointments made and paperwork completed prior to the probationer exiting this visit with the Nurse. After the first encounter with the Nurse, and upon accessing services from the departments as outlined above, the probationer will be care managed within the department from which they are receiving services. There will be Care Managers, within the FQHCs, to provide

services for those with complex care needs.

Upon the request of the probationer, the Probation Officer will be a part of the team approach to ensuring the individuals' care is accomplished and communicate with the Care Manager. The nurse will seek to solve any issues related to access to care as identified by either the Probation Officer or the individual. If the probationer is able to access services without complication, the nurse's role will be complete.

Each pilot participant will also receive a personalized Wellness Map. The Wellness Map is an innovative technology-based tool that provides the recipient with local resources (either online or via a hard copy) to address their health and social service needs. Personalized to their location, the map will assist the probationer in accessing physical and behavioral health care, housing support, and other supportive services. After presenting at one of the ten FQHC clinics, probationers will receive their Wellness Map.

Understanding the need for carefully managing the expansive needs of new probationers, this WPC pilot will incorporate PRIME Complex Care Management (CCM) techniques. There will be an equal number of RN Complex Care Case Managers, clinical therapists and care coordinators at each of the FQHC clinics. An RN Complex Care Case Manager or a Complex Care Clinical therapist will be assigned to each FQHC. The role of the RN Complex Care Case Managers will be to facilitate care of the Complex Care needs probationers between primary care, behavioral health and additional supportive services/enabling resources and coordinating providers.

Understanding the importance of safe and stable housing, the RUHS WPC Pilot will create a housing bundle which will include a contract with DBH to perform the critical task of housing navigation for probationers diagnosed with a serious mental illness. DBH will work with the probationer to assist with housing needs and will determine their choice of housing. Some individuals may desire and/or need supportive housing, while others may seek to live independently. While the WPC prohibits rental subsidies, the RUHS WPC Pilot housing bundle will include financial assistance for non-rental support. Specifically, this money will be used to provide monies to landlords for up to a triple security deposit. The RUHS WPC Pilot is allocating over $900,000 for housing assistance.

A Care Management bundle will provide care management to all probationers with a severe mental illness (SMI) who also have at least five other health diagnoses. This population is consistent with the population being care managed within the Complex Care (CC) part of the PRIME portion of the 2020 waiver. This WPC pilot will require SMI probationers to qualify which the CC criteria will not.

San Mateo County

Legacy Pilot

Pilot Implementation & Size
The WPC Pilot for San Mateo County was approved in November 2016 during Phase I of DHCS review. Implementation of the program began on January 1st, 2017 and it is classified as a legacy pilot. The estimated five-year beneficiary count is 5,000 individuals and the total five-year budget is $165,367,710.

Target Population Definition
San Mateo intends to target individuals who meet one of the following characteristics:

- high-utilizers recently discharged from jail with severe mental illness or medical conditions that have been recently discharged from jail,
- high-utilizers transitioning from jail whose untreated SUD interferes with their capacity to manage other medical and behavioral conditions and maintain connections to their primary care medical home, and
- high-utilizers recently incarcerated that are not well-connected to their primary care medical home.

Target Population Identification & Engagement
The San Mateo WPC pilot identifies and engages participants in a variety of ways. Firstly, potential WPC members are identified via an intake form through several different sources, such as the San Mateo County Hospital System (SMCHS) Collaborative Care Team (CCT) and hospital discharge planners. Secondly, the pilot will engage potential WPC participants via out-stationed care managers in Psychiatric Emergency Services (PES), Emergency Departments (ED), the jail, detox centers, courts, and Primary Care Interface based clinicians. Lastly, this pilot expands the onsite and field-based SMCHS medical support connected to Service Connect, the jail reentry program.

Reentry Services and Interventions
In order for the pilot to successfully provide services to the target population, the WPC pilot will expand the following programs: Integrated Medication Assisted Treatment (IMAT), which assists clients with substance use disorders; the Health Plan of San Mateo's (HPSM) Community Care Settings Pilot, which assists clients within complex care and housing needs; Collaborative Care Team (CCT), which assists clients in locked facilities move back into community settings; Homeless Outreach Team, which assists homeless clients; and 5) Bridges to Wellness Team (BWT), which assists clients who over-utilize emergency departments and live on the streets and in shelters.

To address the need for housing and support among formerly incarcerated individuals, participants will be able to partake in the Housing Readiness Program, which provides accessible and housing support services as well as coaching to develop skills, tools, and resources that facilitate long-term housing. Participants will also have the opportunity to partake in classes focusing on self-management of a range of conditions from depression to diabetes and hypertension, with trained

peer mentors supporting sustained commitment to wellness and recovery. BWT will pilot the use of 60 SMART phones with members and will use these phones to provide automated reminders about appointments, self-care, and medication regimens. In addition, reentry participants will have access to peer mentors. BWT will partner with Mentors in Discharge and match peers with similar life experiences to new WPC members. In addition to outreach, peer mentors will provide ongoing support to members.

Outreach and care coordination conducted by the field-based outreach worker and Health Resiliency Specialists are described below under interventions and coordination.

Psychiatric Emergency Response Team (PERT): The PERT will pair a Sheriff's Deputy with an experienced BHRS mental health clinician. The PERT will conduct a field assessment of individuals experiencing a crisis and the mental health clinician will determine if BHRS knows the individual already, utilizing smart phones to access the individual's EHR. The PERT will stabilize the individual by adopting a non-threatening approach using motivational interviewing.

The Mobile Health Clinic (MHC) consists of a fully staffed clinic, based out of a mobile coach vehicle. The MHC serves the Service Connect site in San Carlos, where inmates released from the jail are targeted. Moreover, the MHC also serves the SMC Drug Court where nonviolent, diversion-eligible defendants who have been accused of a drug-related offense can enter treatment and, upon successful completion of treatment, have charges dismissed or reduced.

After engagement, the pilot participants will need to continue accessing the Health System at multiple points, receiving support with care coordination. BTW Field-based outreach workers and Health Resilience Specialists will be responsible for assisting these transitioning clients coordinate their care. These WPC pilot employees will visit jail and Service Connect to work with Correctional Health Services to initiate reentry planning and outreach to the Drug Court. Through these employees, pilot participants will receive assistance with linkages to Primary Care Medical services, transportation, county addiction services (IMAT). In addition, these formerly incarcerated clients will receive appointment reminders, health care advocacy, and assistance with prescription refills. These BTW Field-based outreach workers and Health Resilience Specialists will be responsible for supervising the peer Mentors-in-Transition team.

Santa Cruz County

New Pilot

Pilot Implementation & Size
The WPC Pilot for Santa Cruz County was approved in June 2017 during Phase II of DHCS review. Implementation began on July 1st, 2017 and it is classified as a new pilot. The estimated five-year beneficiary count is 1,000 individuals and the total five-year budget is $20,892,336.

Target Population Definition
Santa Cruz County intends to target Medi-Cal beneficiaries reentering the community. Specifically, this pilot is targeting individuals receiving Medi-Cal who are high-cost, high-utilizers, and who have been recently housed in an institutional setting or locked facility.

Target Population Identification & Engagement
Target population identification will be conducted by staff at County Behavioral Health and Clinics (CBHCs). These staff members will query their database systems to identify existing adult clients who are older than 18, Medi-Cal recipients assigned to the County of Santa Cruz, and recently (within 12 months) housed in a locked institutional setting such California state prison or county jail.

Reentry Services and Interventions
The Cruz To Health Connect Project will provide the following primary services:

1. permanent supported housing,
2. behavioral and physical health care monitoring/treatment, and
3. peer support.

The Cruz To Health Connect Project's multidisciplinary team will consist of staff who will support the individualized behavioral health, physical health, and recovery goals of formerly institutionalized individuals who are high-utilizers of multiple systems. This multidisciplinary team consists of Nurses, Medical Assistants, Case Managers, Occupational Therapists, Housing Coordinators, and Peer Support staff.

Housing Coordinators will provide intensive outreach, education, transportation, linkage, referrals, and support to participants involved with the justice system. Once housing is secured, Housing service providers will support participants successfully maintain tenancy by providing education and training to both participants and landlords. The assigned housing coordinator will provide coaching to the participant on how to maintain good working relationships with landlords, assist in resolving any disputes that arise between landlord and participants, and be hands on as needed to maintain tenancy. In addition, the Housing Coordinator will maintain an active relationship with the formerly institutionalized participants' case manager and their Probation Department case manager. Housing navigation and housing searches are not currently a reimbursable service, despite the need and success in having these services provided to the individuals.

This pilot also establishes the creation of several master-leased units. Specifically, residential

units' ongoing rents will be master-leased by contract partner(s) and funded through other local funding. Each unit will be equipped with an automated Remote Access Monitor following County procurement, and potentially other devices such as automated medication dispensing devices and wrist fall monitoring devices that will support the goals and objectives of the project.

Nursing staff will provide home-based medication compliance and educational support, tailored for each client based on education level, physical health, and behavioral health. Nursing staff will also provide the monitoring of the Remote Access Monitor device, linkages to medical appointments, linkages to psychiatric appointments, and continuity of care across the domains. The Medical Assistant will work with the Psychiatrist, Primary Care Physician and program participants to coordinate primary care services and provide support to the treatment team and family members. They will act as a primary point of contract for the Physician to utilize to coordinate work around the participant's primary health needs.[2]

This pilot also adds Case Managers to the County's Integrated Behavioral Health Program (IBH). The IBH program provides services to many formerly institutionalized individuals who have a mild to moderate mental illness, and/or substance use disorders, as well as other health conditions served by the County operated FQHC who are not eligible for case management services through the Specialty Medi-Cal mental health plan. The case managers will assist IBH clients in referral, linkage and monitoring for supports and services that the individual is receiving. This group of individuals will also be served by the Whole Person Care program and have access to case management services, individual and group therapy services, psychiatry services, and primary care services.

Peer Support staff will help stabilize the transitioning participants in their housing environment. Peers will provide monitoring of the participant's progress, assistance with community integration and community engagement, modeling for successful management of psychiatric symptoms and linkages to natural supports. This peer staff will work with the individuals in their homes to reduce barriers to engagement and accessing services using an evidence based Intentional Peer Support model. Peers will also be trained in the evidence-based practice of Illness Management and Recovery (IMR), and support IMR skill building activities in the client's residence.

The Connect pilot will also provide training to participant family members in the community and a member of the multidisciplinary team. The training will be delivered through a program specially designed for family members (the Evidence Based Practice Cognitive Behavioral Therapy for Psychosis or CBT-P) to provide early identification of issues needing the attention of the treatment team and tailored support to the participant from the family member.

[2] These services are provided by nursing clinical staff and not a billable Medi-Cal service as they are service oriented and do not meet FQHC requirements for provider level services.

Small County Collaborative

(Mariposa, Plumas, & San Benito)

New Pilot

Pilot Implementation & Size

The WPC Pilot for the Small County Collaborative was approved in June 2017 during Phase II of DHCS review. Implementation of the program began on July 1st, 2017 and it is classified as a new pilot. The estimated five-year beneficiary count is 427 individuals and the total five-year budget is $10,362,176.

Target Population Definition

Mariposa and Plumas, of the Small County WPC Collaborative (SCWPCC), intend to target individuals with a behavioral health condition (mental health, substance abuse, or co-occurring diagnosis) that have been recently released from an institution (e.g., hospital, county jail, institutions for mental diseases, skilled nursing facility, etc.) or are connected to the criminal justice system. Plumas and San Benito will target individuals who are homeless or at risk for homelessness and who have been recently released from an institution (e.g., hospital, county jail, institutions for mental diseases, or skilled nursing facility) or who have a connection to the criminal justice system.

Target Population Identification & Engagement Method

All three counties in the SCWPCC have agreed to common practices for Participant Engagement. Two pathways for participant engagement referrals will identify participants from the target population:

- Identification through community outreach conducted by members of the Participant Engagement Team. These outreach efforts will focus on going to participants where they are in their own surroundings, whether that is where they live, socialize, or go for support and services. The Participant Engagement Team will screen individuals for appropriate referrals to WPC or other programs.
- Referrals to the Participant Engagement Team from various referring agencies participating in or supporting the WPC program. These referring agencies shall include local hospitals, community health centers, county behavioral health and associated local nonprofit agencies, county social service and associated local nonprofit agencies, county probation, local housing agencies, and managed care plans.

Reentry Services and Interventions

The three counties in the SCWPCC have agreed to common practices for care coordination and similar practices for Housing Navigation.

Upon receipt of the referral by the Participant Engagement Team, further assessment will be conducted, and eligibility determined for WPC participation. Upon acceptance into the WPC Program, a Lead Case Manager will be assigned to work directly with each participant. Based on the participant's unique needs and barriers, the Case Manager will assemble a Care Coordination

Team that works collaboratively with each participant to develop a Comprehensive Care Coordination Plan (CCCP) that addresses the participant's barriers to achieving improved health outcomes.

After participants are screened/assessed for WPC eligibility, they will be "enrolled" in CCC and a Comprehensive Care Coordination Plans (CCCP) will be developed. Each CCCP will build on the participant's strengths and reflect the participant's own personal goals to ensure successful implementation, and CCC Team members will be assigned responsibilities based on the needs of the participant. Participants will be involved in regular meetings with their team, when appropriate. For reentry participants on probation, the CCCP will be coordinated with the participant's Probation Case Plan; and if the participant is enrolled in Mental Health or SUD treatment, it will be coordinated with their Behavioral Health Treatment Plan. For those participants referred to and linked with Housing Navigation and Supports, Housing Navigators will become part of the CCC Team to ensure continuity of care and case coordination.

Pilot participants who are transitioning back into the community will be provided housing navigation and supports through their various local infrastructures. Housing Navigation and Supports will commence upon referral to the Housing Navigator that is the contracted partner for these services. The Housing Navigator will work with the CCCT to ensure housing goals are included in the CCCP and there is a seamless coordination of services. Housing Navigation and Supports will include, for example, assisting individuals to search for housing and providing advocacy with landlords.

There are multiple existing programs and resources in the county that will be utilized to support WPC reentry participants. As part of the CCC Care Plan development, the team will identify which services and supports would be best to wrap around participants to support the most positive outcomes. For example, the Behavioral Health Court and Drug Court which has programs designed to engage individuals with criminal charges in treatment, may be leveraged to enroll participants in WPC through a deferred entry of judgment or diversion process. During the course of their participation, the courts may be involved in supporting continued participation.

About the Author

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About the Reentry Health Policy Project

This brief is part of the Reentry Health Policy Project, which seeks to identify state and county level policies and practices that impede the delivery of effective health and behavioral health care services for formerly incarcerated individuals who are medically fragile (MF) and living with serious mental illness (SMI), as they return to the community. The report also offers specific recommendations and best practices for addressing these barriers. The Reentry Health Policy Project was managed by California Health Policy Strategies LLC with support provided by the California Health Care Foundation and L.A. Care.

About California Health Policy Strategies (CalHPS), L.L.C.

CalHPS is a mission-driven health policy consulting group based in Sacramento. For more information, visit www.calhps.com.