



HWS HOUSING AND
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"System Impacted Youth/Individuals"

Multidisciplinary Approaches to End Homelessness

A Continuum of Care Division Webinar Series

Please sign in by typing your full name, title, and organization into the webinar chat box.

About the Webinar Series

PURPOSE

These Webinars provide an opportunity to engage with local and regional experts on best practices, advocacy tools and resources available to prevent and end homelessness.

RECORDED WEBINARS

After the live webinar has taken place, the recording will be added to our website.

UPCOMING WEBINARS

We are working on securing speakers for future webinars and would love to feature you or your agency.

Email CoC@rivco.org if interested.

Please sign in by typing your full name, title, and organization into the webinar chat box.

Today's Agenda

10:00 - 10:05 AM	Welcome	HWS - Continuum of Care Staff: Emma Perez-Singh , Administrative Services Manager
	Opening Remarks	Karen Roper CoC Chair, Corona Homeless Solutions Manager
10:05 - 10:30 AM	Riverside University Health System (RUHS)	Judi Nightingale DrPH, RN, Director, Population Health
10:30 - 10:55 AM	UC Riverside, Underground Scholars	Ismael Davila Abolitionist Educator
10:55 - 11:00 AM	Q&A: Please type your questions in the chat box. We will answer as many questions as possible at the end of the webinar.	

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Coordination of Care in the Justice Involved Population

Judi Nightingale, DrPH, RN
Director, Population Health
Riverside University Health System

What is Whole Person Care (WPC)?

- A State Funded Program (one of 4 components of the 1115 Medi-Cal Waiver), designed to assist complex, high needs clients.
- Riverside County chose to focus on the population transitioning out of incarceration.
- DHCS did not allow any services in jails.
- Each County designed their own unique program to incorporate the following key elements:
 - Value-Based
 - Care Coordination/Integration
 - Care Management
 - Population Health Management

Riverside County WPC

- Implementation-hired the following
 - 8 RNs to screen in all 9 probation sites, 2 Parole sites and 2 Behavioral Health Clinics.
 - 12 housing outreach specialists to provide assistance with housing and social service access.
 - 8 RN Case managers to ensure those who are referred, successfully receive services.
 - 2 RN Managers to oversee above personnel.
 - 1 Program Coordinator for data tracking and submission to the State.

WPC RN Screening, in Probation, for the Following:

- Health insurance coverage (m/cal)
- Mental health needs
- Medical conditions
 - (including TB, Hep C, HIV, Hgb A1C, BP)
- Medication needs
- Substance abuse
- Homelessness
- Additional support services

WPC → Enhanced Care Management (ECM) 2022



ECM Population of Focus #4: Adults & Children/Youth Transitioning from Incarceration

Individuals who:

(1) Are transitioning from incarceration or transitioned from incarceration within the last 12 months

AND

(2) have at least one of the following conditions¹:

- Chronic mental illness
- Substance Use Disorder (SUD)
- Chronic disease (e.g., hepatitis C, diabetes)
- Intellectual or developmental disability
- Traumatic brain injury
- HIV
- Pregnancy

1. This list of criteria is aligned with the eligibility criteria for pre-release coverage in California's 1115 Demonstration Amendment and Renewal Application (pg. 37).

<https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM-1115-Waiver-Renewal-Application.pdf>

Barriers to Care After Release

- **WPC Problem:**
 - Client doesn't have active Medi-Cal
- **WPC Solutions for follow up care @ release:**
 - Identification of inmates who are on medications >14 days during incarceration.
 - This list is provided to the WPC screening RN, when the inmate is released.
 - Communication and coordination of care between the "in-jail" team of probation officer, behavioral health worker, RN and substance use worker with the "community" equivalents.
 - Efforts to begin eligibility work for access to medi-cal services while incarcerated for at least clients with chronic health needs.
 - Extension of provision of medication, at release, from 3 days for *some* medications to up to 14 days for *all* "chronic" medications
 - Determine, and complete, eligibility/application for Medi-Cal

Barriers to Care After Release

- **Problem:**

- Client may have active Medi-Cal but no MCP-WPC could still screen and refer
- Without Managed Medi-Cal Partner (MCP-IEHP or Molina) the WPC solutions will not continue

- **ECM solutions**

- During 2022, PATH funding provided for screening and referral
- Without MCP no ability to screen and/or refer after 1/1/23

Homeless at release

- **15%** of jail population were homeless in the year prior to arrest, a rate 7 to 11 times higher than the general population.
- Probation screening nurses-
"Most clients coming out of incarceration are underhoused for at least 3-4 months although they report they are not, most are sleeping on someone's sofa or floor."

High Health and SDOH Risks Among Post-Incarcerated

- **40%** of individuals with serious mental illness have been in jail or prison at least once in their lives.*
- **45%** of inmates in local jails and state prisons have co-occurring mental illness and substance use disorders.*
- **Risk of Death**
 - One study found during the first two weeks after release, the risk of death among former inmates was **12.7 times higher** than among Washington State residents of the same age, race, and sex.⁶¹
 - The leading causes of deaths were from drug overdose followed by cardiovascular disease, and homicide.

High Health and SDOH Risks Among Post-Incarcerated

- **High rates of recidivism**

- Currently, 25% of inmates with a mental health diagnosis had three or more prior incarcerations (compared to 5% of inmates without a mental health problem).*
 - Data from Bureau of Justice 68% of released inmates were reincarcerated within 3 years
 - 38% of previously incarcerated are sentenced to another term with 3 years of release
- About half of all probationers in the county return to court within the first year as a result of substance/alcohol abuse.

High Health and SDOH Risks Among Post-Incarcerated

- **Dual Diagnosis SUD and SMI**
 - Study in Texas (over 6 years) showed that those incarcerated with both psychiatric and SUD had a significantly higher risk of multiple incarcerations than those with a single occurring disorder.
 - Individuals with SMI diagnosis return to incarceration at a higher rate and also return about 12 months earlier than those without an SMI diagnosis.
 - Those with SMI who participate in treatment, have a lower rate of reincarceration.
- **Poor Physical Health**
 - Disproportionately poor health is found in the previously incarcerated population.
 - Endure acute and chronic stressors from confinement, danger, and isolation.
 - High rates of asthma arthritis, cancer, CV disease, cirrhosis, diabetes, hypertension, and kidney disease.
 - Far higher rates of TB, Hep B and C, HIV and other STDs

What Happens to Medi-Cal while incarcerated



- Unlike private insurance, clients must re-apply annually for coverage
- Inmate cannot have active Managed Medi-Cal while incarcerated
- DPSS has shortened the application process in Riverside County
 - Installed direct dial phones in jails to DPSS to apply
 - Installed stations in probation offices for client to sign up with MCP
- Time for approval of application to MCP=3-4 weeks
- Application includes Medi-Cal, CalFresh, Cash-aid and dental coverage
- CWDA Policy Change Request

What is Being Measured?

Metrics summary:

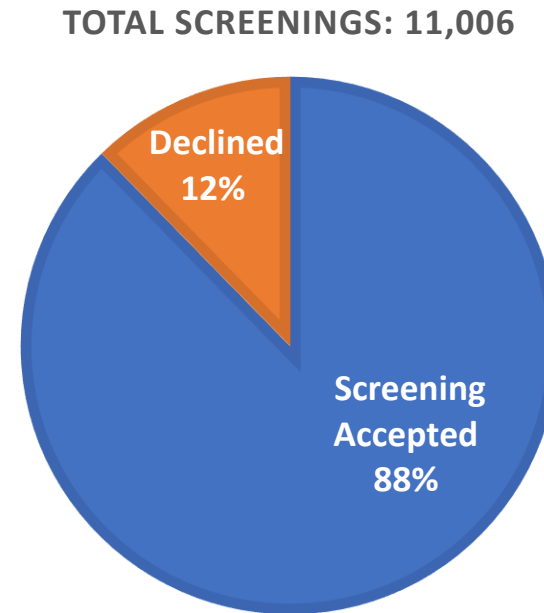
- Total number of probationers offered vs. screened
- Total number of probationers referred vs. enrolled in services for:
 - behavioral health
 - physical health
 - social/support services
 - substance abuse
 - housing needs
- Medi-Cal enrollment
- Jail recidivism
- Avoidable admission to psychiatric and primary care hospitals
- Avoidable emergency department usage for physical and behavioral primary care needs
- Number of homeless who acquired housing
- Depression remission

16 Regional Partners Including

- Riverside County Probation Department
- Riverside County Sheriff's Department
- Riverside University Health System
 - Dept of Behavioral Health
 - Medical Center
 - FQHCs
- Riverside County Department of Public Social Services
- Riverside County Economic Development Office
- City of Riverside, Mayor's office
- Inland Empire Health Plan
- Molina Healthcare
- National Community Renaissance
- Health to Hope Clinics
- Coachella Valley Rescue Mission-housing
- Path of Life Ministries-housing

WPC Data: Prior to Pandemic (10/6/2017 – 4/30/2020)

Screening Site	Initial Screening Offered	Screening Accepted	Declined	% Accepted
BLYTHE	9	9	0	100%
WPC EAST	56	56	0	100%
WPC WEST	74	74	0	100%
PALM SPRINGS	211	181	30	86%
BANNING	600	439	161	73%
CORONA	745	672	73	90%
SAN JACINTO	1,337	1,190	147	89%
INDIO	1,464	1,343	121	92%
MURRIETA	1,539	1,450	89	94%
MORENO VALLEY	2,062	1,653	409	80%
RIVERSIDE	2,909	2,584	325	89%
Totals:	11,006	9,651	1,355	88%



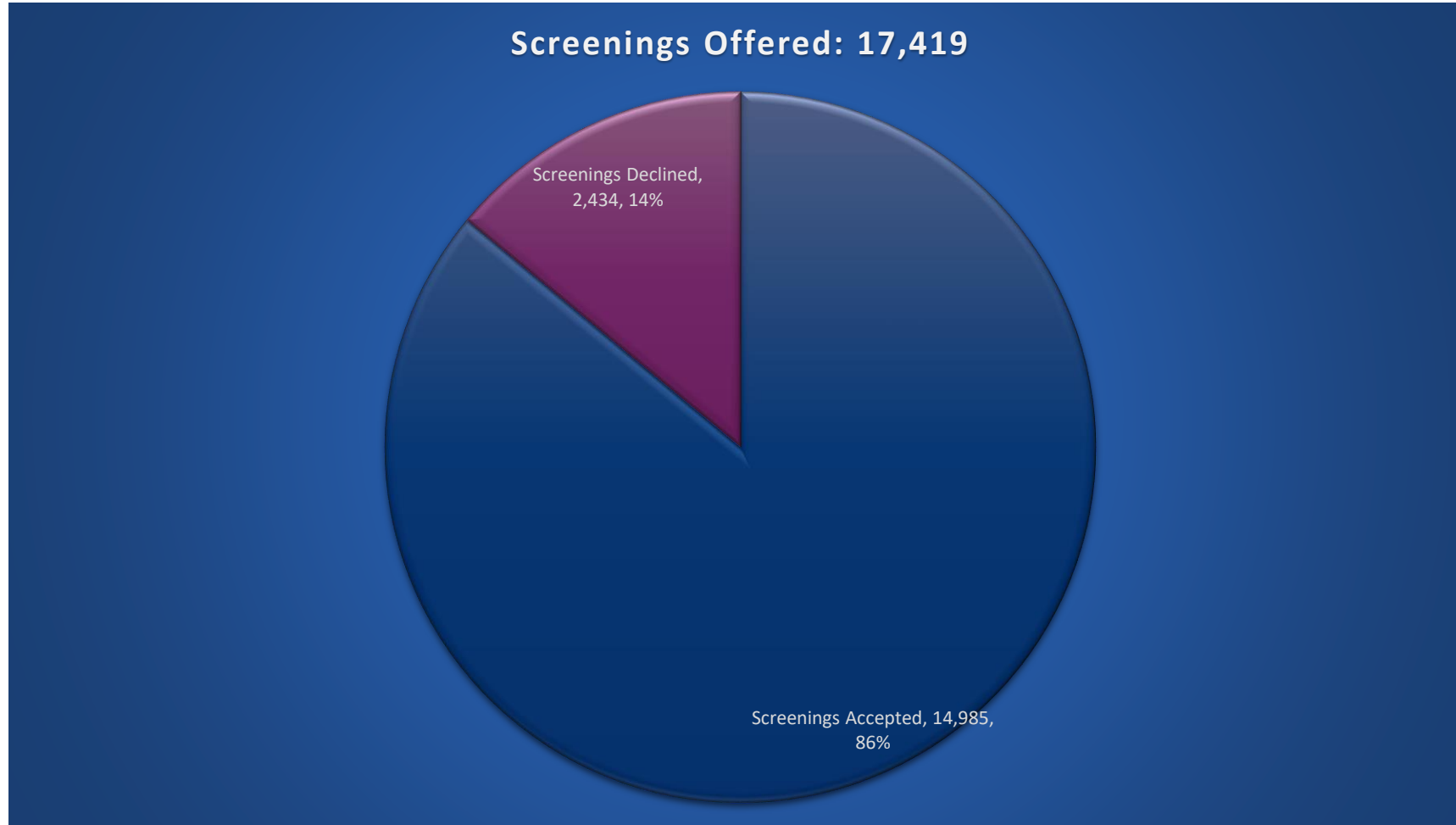
Outcomes

- Increase in active medi-cal
 - Baseline ~5%
 - Highest point during WPC pilot >60%
- Medi-Cal as a proxy to obtaining SUD and DBH services.
 - Those who got active medi-cal showed statistically significant reduction in readmission due to SUD and DBH access.
- For those referred to DBH who attended at least 1 appointment
 - Reduction in reincarceration >65% compared to those who did not attend an appt.
- For those referred to SUD who attended at least 1 appointment
 - Reduction in reincarceration >50% compared to those who did not attend an appt.

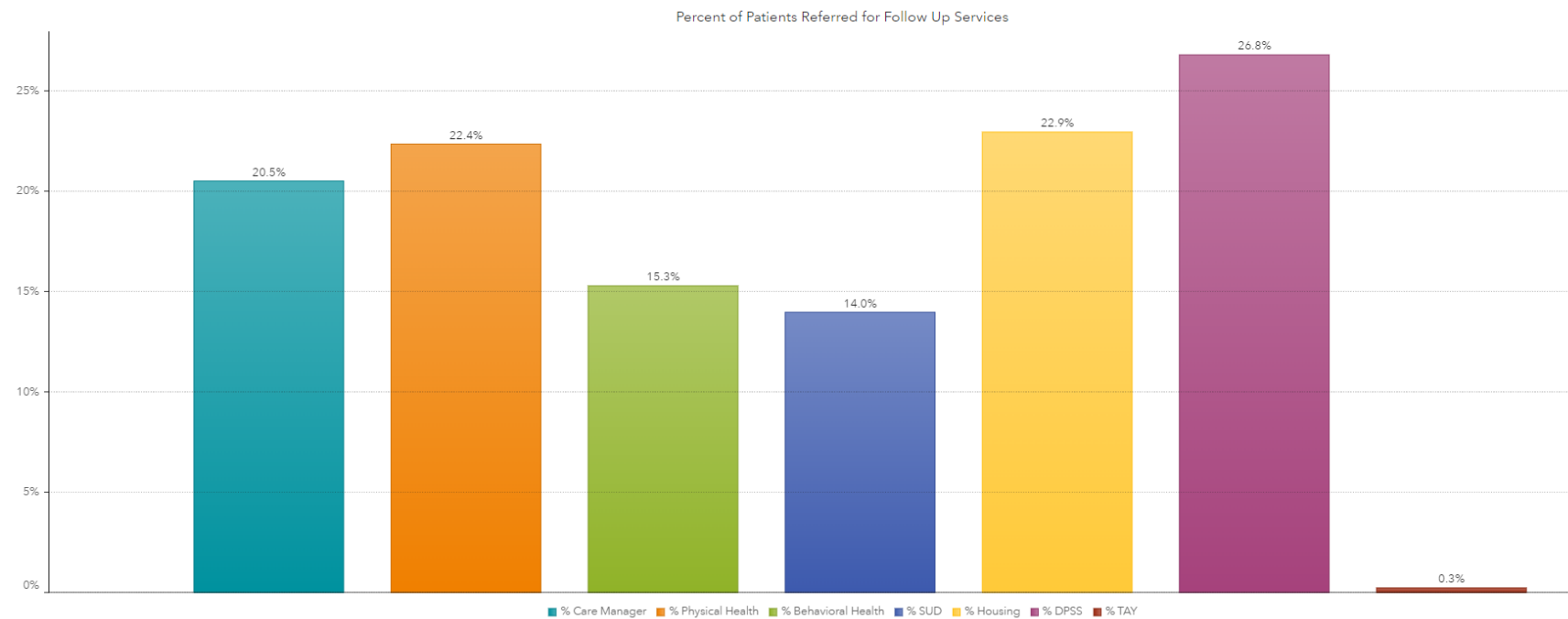
Outcomes-continued

- Improved integration among partners for Patient Centered care.
- Reduction in duplication of efforts by multiple departments
- Increased collaboration for other projects as a result of knowing who to contact to help high needs clients-ie: COVID
- Grateful clients who have turned their lives around.

WPC Data: 10/6/2017- 5/31/2022



WPC Data: 10/6/2017- 5/31/2022



WPC Data: 10/6/2017- 5/31/2022

Screening Site	Care Manager	Physical Health	SUD	Behavioral Health	Housing	DPSS	TAY	Total Referrals
RIVERSIDE	531	787	638	708	818	1,888	23	4,862
BANNING	254	225	122	75	138	227	0	787
INDIO	688	603	360	558	1,032	679	4	3,236
MORENO VLY	982	530	678	517	710	663	14	3,112
CORONA	421	449	200	186	183	350	7	1,375
PALM SPRGS	103	130	76	62	172	154	1	595
SAN JACINTO	787	1,489	526	728	1,219	1,168	3	5,133
MURRIETA	390	434	361	358	508	517	1	2,179
BLYTHE	4	2	1	2	4	4	0	13
WPC EAST	75	28	7	35	42	17	0	129
WPC WEST	112	60	9	29	35	16	0	149
Totals:	4,347	4,737	2,978	3,258	4,861	5,683	53	21,570

Taking care of a veteran's heart

- **Situation:**

- Client had multiple medical problems, including congestive heart failure, hypertension, atrial fibrillation, recent hospitalization for pneumonia requiring a thoracentesis. He was told that his heart was working at 10% from meth-induced cardiomyopathy. He was wearing an external life vest defibrillator and reported feeling recent shocks. He said the doctor gave him 6 weeks to live.
- Other diagnoses included were depression and anxiety. Client and longtime/supportive girlfriend were homeless, which made charging his defibrillator difficult.
- Client was not interested in going to a shelter due to crowds and the possibility of being separated from girlfriend.

- **Success:**

- WPC Outreach Team met with client and obtained information that the client was a Veteran. Client was placed in brand new Veteran housing within a month of screening.
- His health improved drastically. His heart function increased to 40% and he no longer needs the external defibrillator. He also married his girlfriend.

Questions?

Contact:

Judi Nightingale, DrPH, RN j.nightingale@ruhealth.org



Questions & Comments

Next Webinar: August 18th 2022