Coordination of Care in the Justice Involved Population

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What is Whole Person Care?

• A State Funded Program (one of 4 components of the 1115 Medi-Cal Waiver), designed to assist complex, high needs clients.
• 5 year program-funding scheduled to end in December 2020.
• Funding extended to December 2021 due to COVID
• CalAIM go-live January 2022
• 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 Program

• Focus is on Transition out of incarceration-identify needs in releasing/newly released Probationer/Parolee and provide linkages to services.
• Goals
  – Communication of high needs inmates releasing to the community.
  – Upstream identification of needs for releasing justice involved population.
  – Warm handoff to partners providing needed services.
  – Reduction in re-incarceration.
  – Reduction in unnecessary ED usage
2015 Riverside County Probationer Data

• On average, 350-450 probationers admit to being homeless at any single moment, (about 3% of the county’s supervised population). At release, the screening RNs believe most are homeless or at risk of homelessness.

• Most probationers are under-housed, staying with friends and/or family.

• About half of all probationers in the county return to court within the first year as a result of substance/alcohol abuse.
2015 Riverside County Probationer Data (cont.)

• More than 50% of probationers need medical insurance. Many qualify for Medi-Cal, but have not enrolled.
• According to national statistics, a large number of returning prisoners have communicable diseases including HIV/AIDS, hepatitis, and tuberculosis.
• Many probationers have co-morbid Behavioral and Physical health conditions (esp cardiac). Reduction in life span is est. at 20 years.
• Highest rate of suicide is within the first few weeks of release.
Netsmart Data

- **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.
- **High rates of recidivism**
  - Currently, 25% of inmates with a mental health problem had three or more prior incarcerations (compared to 5% of inmates without a mental health problem).
- **15%** of jail population were homeless in the year prior to arrest, a rate 7 to 11 times higher than the general population.
Riverside County Whole Person Care

- 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.
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)
- Substance abuse
- Homelessness
- Additional support services
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
Barriers to Care after Release

- **Problem:**
  - Expensive medications → noncompliance if client has to choose between food, shelter or medications.

- **Solutions:**
  - 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 medical 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.
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)

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

**TOTAL SCREENINGS: 11,006**

- Screening Accepted: 88%
- Declined: 12%
WPC Data: 10/6/2017-10/15/2021

Total Screening offered: 14,276

- Accepted, 12912, 94%
- Declined, 855, 6%
WPC Data: 10/6/2017-10/15/2021

Percent of Patients Referred for Follow Up Services

- % Care Manager: 21.2%
- % Physical Health: 23.2%
- % Behavioral Health: 15.5%
- % SUD: 13.9%
- % Housing: 22.0%
- % DPSS: 26.9%
- % TAY: 0.3%
## WPC Data: 10/6/2017-10/15/2021

<table>
<thead>
<tr>
<th>Screening Site</th>
<th>Total Referrals</th>
<th>Care Manager</th>
<th>Physical Health</th>
<th>SUD</th>
<th>Behavioral Health</th>
<th>Housing</th>
<th>DPSS</th>
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<td>122</td>
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<td>PALM SPRINGS</td>
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<td>957</td>
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<td>185</td>
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<tr>
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<td>609</td>
<td>468</td>
<td>656</td>
<td>600</td>
<td>14</td>
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<tr>
<td>RIVERSIDE</td>
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<td>714</td>
<td>595</td>
<td>661</td>
<td>713</td>
<td>1,720</td>
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<td><strong>Total:</strong></td>
<td><strong>19,954</strong></td>
<td><strong>4,115</strong></td>
<td><strong>4,498</strong></td>
<td>####</td>
<td><strong>3,025</strong></td>
<td><strong>4,436</strong></td>
<td><strong>5,223</strong></td>
<td><strong>53</strong></td>
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*Note: DPSS = Department of protective services, TAY = Transition age youth*
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.
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?

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