



Justice Center

THE COUNCIL OF STATE GOVERNMENTS

Common Practices for Connecting to and Using Housing as a Diversion and Reentry Strategy

February 24, 2022



California Health Care Foundation

The Council of State Governments Justice Center

We are a national nonprofit, nonpartisan organization that combines the power of a membership association, serving state officials in all three branches of government, with policy and research expertise to develop strategies that increase public safety and strengthen communities.

Today's Agenda

- Introduction and Today's Overview
- Council on Criminal Justice and Behavioral Health
- Report Focus Area: Connect
- Connecting to Housing for Diversion and Reentry through Coordinated Entry
- Riverside County Whole Person Care Pilot Project
- Resources and Next Steps

Council on Criminal Justice and Behavioral Health

Brenda Grealish, Executive Officer






Webinar Series: Reducing Homelessness for People with Behavioral Health Needs Leaving Prisons and Jails

- Session 1: Building Partnerships between Housing and Justice Systems in California
- Session 2: Defining, Screening, and Assessing for Homelessness Risk
- **Session 3: Connecting to Existing Housing**
- Session 4: Developing New Housing
- Session 5: Rental Assistance and Supportive Services



Poll on Previous Webinars

Report Focus Area: Connect



Connect: Recommendations at a Glance

Recommendation	Challenges Addressed	Why it Matters
4. Connect people to the homeless assistance system.		Helps prevent “falling through the cracks” upon reentry
5. Quantify housing and service needs.		Supports funding requests and captures changing trends
6. Increase available resources to meet immediate housing needs.		Improves access to existing housing via financial assistance & incentives
7. Leverage supportive service investments to connect with housing opportunities.		Increases chances of securing and maintaining housing
8. Prioritize additional housing resources.		Reduces competition for scarce housing resources

Connect Action Items: Local Level

Local-Led Actions	Timing	Cost
<p>Pilot direct intake (referral or direct data input) into local CE systems.</p> <ul style="list-style-type: none"> ➤ Incorporate in jails that opt in to developing expanded in-reach capacity. 		\$ \$ \$
<p>Explore available private funding sources to help fund initial flexible housing subsidy pools on local level.</p>		\$ \$ \$

Connect Action Items: Local Level

Local-Led Actions	Timing	Cost
<p>Engage people with firsthand experience in the criminal justice and homelessness systems to provide housing case management and navigation services.</p> <ul style="list-style-type: none"> ➤ Potentially in tandem with other supports such as record expungement assistance 		\$ \$ \$
<p>Engage CoC leadership to strengthen prioritization of the target population in local CE systems and new project funding decisions.</p>		\$ \$ \$

Connect to What?

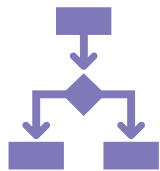
Reducing Homelessness through Housing First

Adopt Client-Centered Service Methods	<p>Client-centered services ensure that choice is available for people with complex needs and ensures their successes in housing and programming.</p>
Remove Barriers to Entry	<p>Barriers to entry often prevent vulnerable people from accessing necessary services, e.g., credit history, criminal records, and active substance use.</p>
Engage Landlords and Property Owners	<p>Landlords and property owners are critical partners in allowing service providers to have housing options for quickly housing vulnerable individuals and families.</p>
Use Data to Quickly and Stably House People Experiencing Homelessness	<p>Tracking data illustrates key outcome measures, such as common technical violations related to housing, to improve system efficiency and quality.</p>

“CoC Competition Focus: Housing First,” U.S. Department of Housing and Urban Development, August 2016, <https://www.hudexchange.info/news/coc-competition-focus-housing-first/>.

Options When Permanent Housing is Not Immediately Available

Low-Barrier Shelters, Transitional Housing, Recovery Housing, and Others



Based on choice

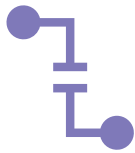


Plans around relapse for management, avoidance of revocations and eviction



Firm path to permanent housing

Success in Housing Rarely Depends on Criminal Records



Criminal records play little role in housing success.

11 of 15
record types have no
significant effect



What small effect there might be decreases over time for both felonies and misdemeanors.



Increased rental assistance may help decrease this even more.

Cael Warren, *Success in Housing: How Much Does Criminal Background Matter?* (Saint Paul, MN: Wilder Research, 2019), https://www.wilder.org/sites/default/files/imports/AEON_HousingSuccess_CriminalBackground_Report_1-19.pdf.

Connecting to Housing

Diversion and Reentry through Coordinated Entry

Continuum of Care (CoC)

Definition and Role	Coordinates local responses to homelessness, coordinates assessments and prioritization of resources, oversees some rental assistance (e.g., rapid rehousing, permanent supportive housing).
Engagement	Ensure that everyone (at risk or experiencing homelessness) is assessed through the local Coordinated Entry process.
	Leadership of CoC can and should include criminal justice system, including probation and parole.
	CoCs receive a competitive funding boost by having criminal justice agency partnerships through NOFO process.

Coordinated Entry Assessment



- Assessment happens through Entry Points using **standardized assessment tools** (often VI-SPDAT).
- **CaAIM offers the chance** for in-reach services linked with Coordinated Entry.
- Community-wide assessment process that leads to **prioritization for HUD-funded resources** based on service need, “vulnerability,” and community priorities.

Coordinated Entry Prioritization



- Governed by written standards, which have some flexibility.
- HUD and local priorities determine who is prioritized for limited housing and supportive service assistance.
- Prioritization standards set by CoC boards at the local level.

Coordinated Entry Prioritization (cont.)



- Impacted by HUD's 90-day limit on stays in "institutions" (incarceration, in-patient psychiatric) for "chronic homelessness."
- People with lived experience can drive the prioritization process.

Limited Housing Assistance Available, but...

- People leaving incarceration **eligible for** EHV, and HUD encourages EHV use for this population.¹
- HUD has issued **guidance encouraging housing providers to lower criminal record barriers.**²

1. U.S. Department of Housing and Urban Development, *Notice PIH 2021-15 (HA)* (Washington, DC: U.S. Department of Housing and Urban Development, Office of Public and Indian Housing, 2021), <https://www.hud.gov/sites/dfiles/PIH/documents/PIH2021-15.pdf>.

2. U.S. Department of Housing and Urban Development, *Dear Public Housing Authorities, Continuums of Care, Multifamily Owners, and HUD Grantees* (Washington, DC: U.S. Department of Housing and Urban Development, Office of the Secretary, 2021), https://www.hud.gov/sites/dfiles/PA/documents/SOHUD_reentry_housing_letter.pdf.

Joining or Partnering with Your Local CoC

 Key point: We serve a shared population across systems

 Bonus points in the CoC Notice of Funding Opportunity (NOFO) for partnering with CJ

Leveraging Community Resources for Housing

Law Enforcement, Community Supervision, & Corrections	Sheriff & Probation Funding (Ex. First months' rent, application fees, etc.) CDCR Funding/Services (Adult Reentry Grants, STOP providers)
Behavioral Health	No Place Like Home Master-Leased PSH, other housing
Courts	Expungement Connection to eviction-prevention funds

Riverside County



Judi Nightingale, *Director, Population Health, Riverside University Health System*

Rhyan Miller, *Deputy Director, Behavioral Health Integrated Programs, Riverside University Health System*

Sonja Peverieri, *Behavioral Health Services Supervisor, Riverside University Health System*

Coordination of Care in the Justice Involved Population

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



Whole Person Care



What is Whole Person Care?

- A state-funded program (one of four components of the 1115 Medi-Cal Waiver), designed to assist complex, high-needs clients
- Five-year program funding scheduled to end in December 2020
- Funding extended to December 2021 due to COVID-19
- CalAIM went live in January 2022
- Each county designed its own unique program to incorporate the following key elements:
 - Value-Based
 - Care Coordination/Integration
 - Care Management
 - Population Health Management

Riverside County WPC Program

- **Focus**
 - Transition out of incarceration
 - Identify needs in releasing/newly released persons on probation/parole
 - Provide linkages to services
- **Goals**
 - Reduction in re-incarceration
 - Reduction in unnecessary ED usage
- **Method**
 - Communication about high-needs individuals released to the community
 - Upstream identification of needs for releasing justice-involved population
 - Warm handoff to partners providing needed services



Why Probation Population?

- High re-incarceration rate
- Poor physical health
- Mental health diagnosis
- Lack of health insurance
- Lack of housing

Data about People on Probation (Medi-Cal)

- More than 50 percent of people on probation need medical insurance. Many qualify for Medi-Cal but have not enrolled.
- Medicaid coverage can be **suspended** or **terminated** after the individual spends a full calendar year in jail or prison.
- Enrollment in Medicaid can be a burdensome process for most people released from incarceration, making the need to re-enroll or reactivate Medicaid enrollment a substantial **barrier** to treatment for people released from incarceration.
- A previous study found that a discharge planning program for people with serious mental illness who are incarcerated increased both **Medicaid enrollment and mental health service** use in three Oklahoma prisons.
- Another study in Washington State also showed that expediting Medicaid for individuals with severe mental illness was associated with increased Medicaid enrollment by 15 percent and **increased outpatient mental health service use by 13 percent in the 90 days following release.**
- Gertner et al., 2019 found that referral for expedited Medicaid increased Medicaid enrollment and increased community mental health and general medical services immediately after release from incarceration.

Data about People on Probation (Housing)

- **15 percent** of jail population experienced homelessness in the year prior to arrest, a rate **7** to **11** times higher than the general population.
- The disruption in social engagement during incarceration places individuals at an increased risk of housing instability and insecurity immediately upon their release from incarceration.
- Metraux and Culhane found that 23 percent of the sheltered people experiencing homelessness in the New York City **shelter** system had been **incarcerated** within the previous two-year period.
- Herbert and colleagues found that **high housing insecurity** rates among formerly incarcerated individuals were linked to **re-incarceration**.

Riverside County Whole Person Care Program

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 that people 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 use
- Homelessness
- Additional support services

Whole Person Care, CalAIM, and Coordinated Entry



Coordinated Entry and the Continuum of Care

- Coordinated Entry is a part of the Continuum of Care
- The Continuum of Care is housed under a County department: Housing, Homeless Prevention & Workforce Solutions (HHPWS)
- RUHS-BH subcontracts to HHPWS to operate the Coordinated Entry System (CES)
- Connects people with available housing and supportive services
- Tracks housing vacancies
- “By-Name list” (a list of those who are experiencing homelessness)

Entry Points for Coordinated Entry

- Where and how people get connected
- What local prioritization looks like

Planning Partner Collaboration

- 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



Coordinated Entry and CalAIM

- CalAIM Enhanced Care Management (ECM)
 - BH ECM
 - CHC ECM
- Coordination
 - Between BH and CHC
 - Between detention BH/SUD
 - Between detention physical health and CHC
- Problem-solving—monthly collaborative meeting

Outcomes

What Did We Measure?

Metrics summary:

- Total number of people on probation **offered vs. screened**
- Total number of people on probation referred vs. **enrolled in services** for:
 - Behavioral health
 - Physical health
 - Social/support services
 - Substance use
 - 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 people experiencing homelessness who acquired **housing**
- **Depression** remission

Outcomes

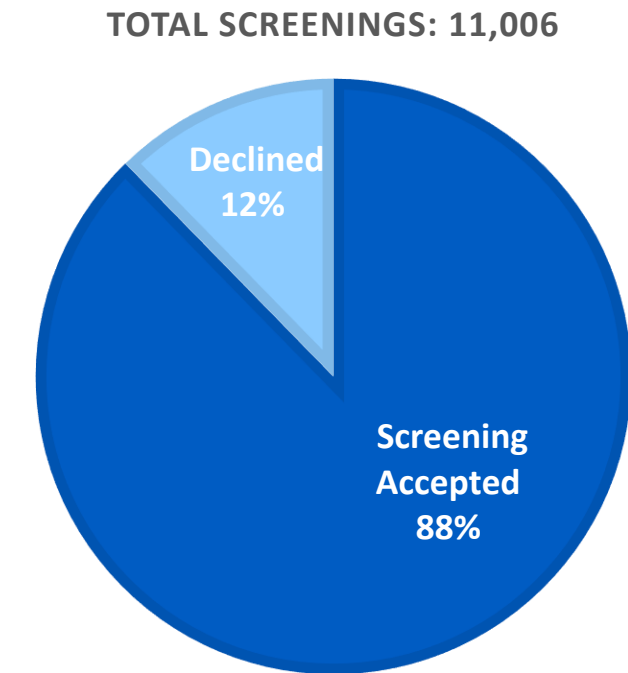
- Increase in active **Medi-Cal coverage**
 - Baseline ~5 percent
 - Highest point during WPC pilot >60 percent
- Medi-Cal as a proxy to obtaining **SUD and DBH** services
 - Those who received active Medi-Cal showed a statistically significant reduction in readmission due to SUD and DBH access
- For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

Outcomes (cont.)

- 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 whom to contact to help high-needs clients—i.e., COVID-19
- **Grateful clients** who have turned their lives around

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%

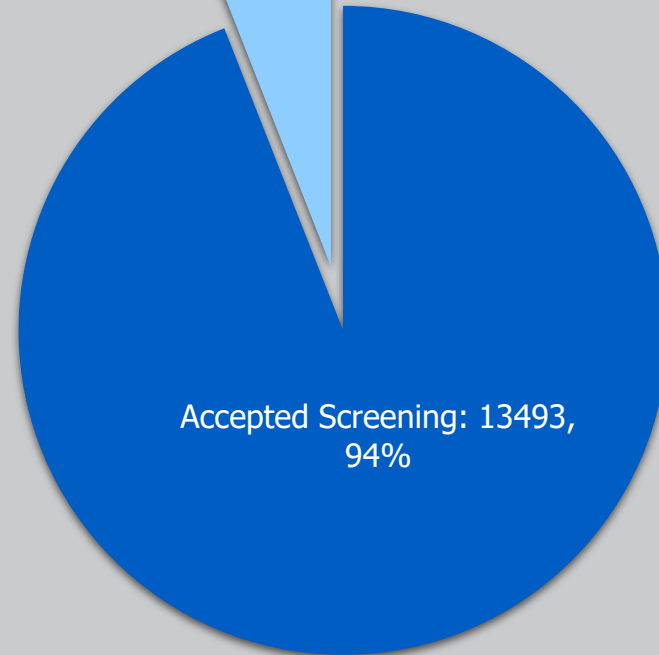


WPC Data: 10/6/2017–12/31/2021

Total Screening Offered: 14,349

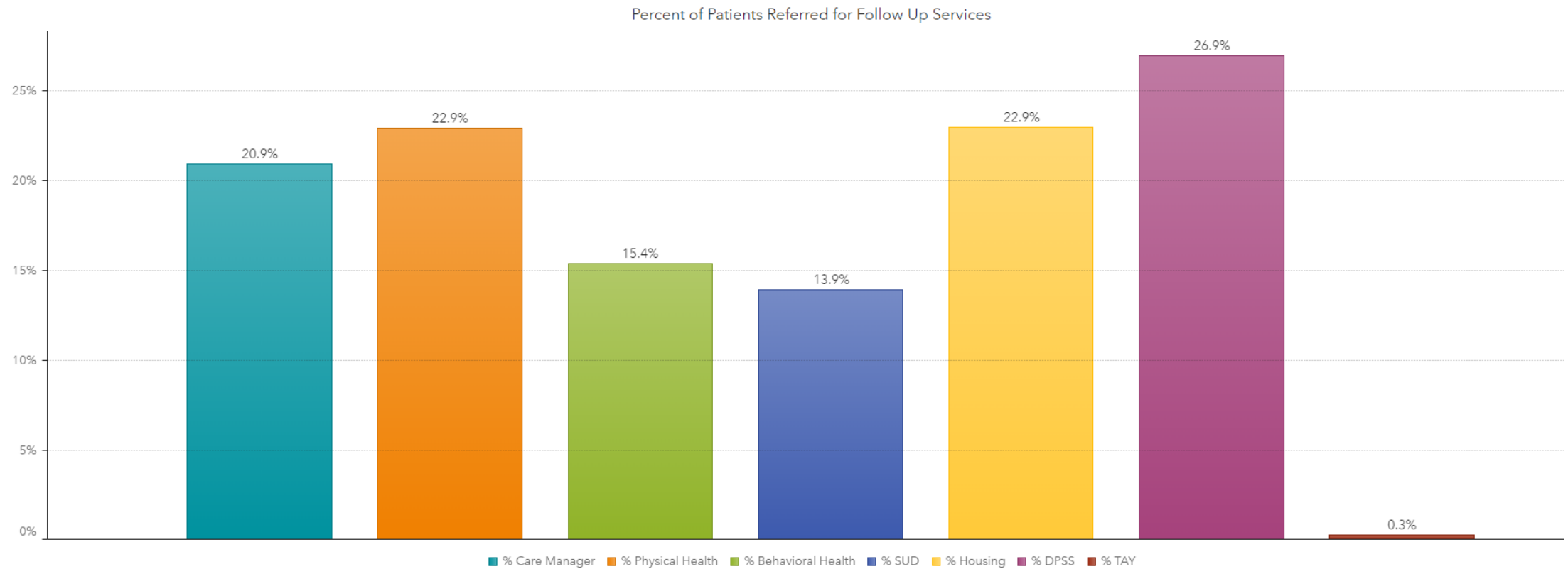
Declined Screening: 856,

6%



Accepted Screening: 13,493,
94%

WPC Data: 10/6/2017–12/31/2021



WPC Data: (10/6/2017–current)

Screening Site	Total Referrals	Care Manager	Physical Health	SUD	Behavioral Health	Housing	DPSS	TAY
BANNING	750	238	224	117	72	123	214	0
WEST	149	112	60	9	29	35	16	0
BLYTHE	13	4	2	1	2	4	4	0
EAST	129	75	28	7	35	42	17	0
MURRIETA	1,922	365	415	308	314	444	440	1
PALM SPRINGS	537	100	128	72	56	138	142	1
SAN JACINTO	4,935	776	1,457	501	699	1,148	1,127	3
INDIO	3,013	649	562	317	522	962	646	4
CORONA	1,263	413	411	185	173	178	309	7
MORENO VALLEY	2,870	948	511	612	471	659	603	14
RIVERSIDE	4,448	444	719	595	663	719	1,729	23
Totals:	20,029	4,124	4,517	####	3,036	4,452	5,247	53

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 percent 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 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 percent, and he no longer needs the external defibrillator. He also married his girlfriend.

Questions?

Contact:


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

Poll on Challenges and Lessons Learned

Resources and Next Steps

Series Companion Worksheets

An **optional, cumulative** companion document that builds on each session's goals and breakout questions to capture learning, discussion, and potential next steps



1. Building Partnerships Between Housing and Criminal Justice Systems

I Describe who will lead/support this effort, what their responsibilities will be, and a structure for ongoing collaboration.

Session Description

This webinar will introduce participants to strategies in building partnerships between criminal justice agencies and housing providers. Participants will learn about best practices in housing and services. Participants will hear from state leaders moving this work forward and hear from communities undertaking cross-system work.

Learning Objectives

(1) Overview potential housing partnerships, (2) Review strategies to collaborate in a community with a general lack of affordable housing, (3) Hearing from communities in the planning stages of cross-system work

Who are the key housing partners in your area?	What housing resources do they control that can help address these barriers?
Local Public Housing Authority	
Continuum of Care	
Reentry Provider	

What opportunities are there to align resources and priorities locally between the housing, justice, behavioral health, and others?	
What connections can be made to existing local committees, policies, and initiatives?	

What are the greatest local housing barriers for people with justice involvement?	How can we start to address them?
Lack of available/affordable units	
Stigma/provider policies	

What strategies will you use going forward to engage your housing partners and meet your shared mission?	Responsible Parties	Date
Obtain buy-in from agency X to...	Local Public Housing Authority	
Draft joint funding application		
Etc.		

2

Webinar: Releasing People from Jail during COVID-19 Pandemic

This webinar describes how counties are working to safely reduce their jail populations while connecting people who frequently cycle between systems to community treatment and services.

<https://csgjusticecenter.org/events/register-now-for-webinar-releasing-people-who-are-high-utilizers-during-the-covid-19-pandemic/>

Webinar: Connecting People Who Have Serious Mental Illnesses to Care—Telehealth and Other Strategies

This webinar focuses on increasing connections to care in a changing world, featuring tips and strategies directly from counties.

<https://csgjusticecenter.org/events/register-for-webinar-connecting-people-who-have-serious-mental-illnesses-to-care-telehealth-and-other-strategies/>

Next Session

- Developing New Housing
- March 24, 12–1:30 p.m. (PT)

Thank You!

Join our distribution list to receive updates and announcements:

<https://csgjusticecenter.org/resources/newsletters/>

For more information, please contact Charley Francis at
cfrancis@csg.org.

The presentation was developed by members of The Council of State Governments Justice Center staff. The statements made reflect the views of the authors, and should not be considered the official position of The Council of State Governments Justice Center, the members of The Council of State Governments, or the funding agency supporting the work.

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