Transitions Clinic Network California Learning Collaborative: Transforming the Community Health System to Effectively Serve Individuals Transitioning from Incarceration

A funding and technical assistance opportunity for primary care clinics in California's Central Valley and Inland Empire to implement the Transitions Clinic Network program in preparation for CalAIM.

Applications Due: Monday, March 21, 2022

California Health Care Foundation

THE CALIFORNIA Wellness FOUNDATION

PARTICIPATION AT A GLANCE

What is the Transitions Clinic Network (TCN)?

Transitions Clinic Network (TCN) is a national network of community-based primary care clinics that serve individuals recently released from incarceration with chronic health conditions. TCN has supported 48 health systems in 14 states and Puerto Rico in implementing the TCN program, an evidenced-based model of care shown to improve health and reentry outcomes among formerly incarcerated individuals. TCN programs have served over 10,000 patients recently released from incarceration.

What is a TCN Program?

Founded on the belief that the people closest to the problem are also closest to the solution, each clinic that implements the TCN program dedicates a multi-disciplinary team that includes a community health worker (CHW) with a prior history of incarceration to work with eligible patients to address their healthcare needs and social determinants of health. TCN programs are bolstered by strong relationships with criminal legal system entities and community organizations. The TCN teams and CHWs are specially trained to promote healthy reintegration into the community, provide care coordination, behavioral health services, chronic disease management, prevent unnecessary emergency department utilization and hospitalizations, and reduce parole and probation violations. Importantly, **the TCN program is aligned with CalAIM's new Enhanced Care Management (ECM) benefit for adults transitioning from incarceration**.

Why Implement a TCN Program?

Every year, thousands of chronically-ill people return home from incarceration to communities in the Central Valley and Inland Empire (see Table 1 on next page). Half of those transitioning from incarceration have chronic physical conditions,[5] and the prevalence of behavioral health conditions is even higher. Additionally, upon release from incarceration, all of the social determinants of health – housing, employment, food, and family relationships – are simultaneously insecure for these patients. Unless their health and social needs are met, these individuals experience worsening health and a high risk of death.[1] TCN programs help individuals connect to services to address both physical and unmet needs, which is vital to successful reintegration.

People transitioning from incarceration are:

- ***12.7x** as likely to die in first two weeks post-release*[1]
- ***2x** as likely to be hospitalized*[2]
- ***10x** as likely to be homeless*[3]
- *Primarily low-income*[4]

By implementing a TCN program, primary care clinics improve patients' health, reduce recidivism, and create opportunities for meaningful employment. In a randomized controlled trial, the TCN program decreased its patients' emergency department visits by 50%, compared to patients receiving expedited primary care services.[6] TCN patients also have fewer parole and probation technical violations than other individuals transitioning from prison and as a result, spend 25 fewer days re-incarcerated. [7] In addition to supporting individual patients, TCN programs create employment opportunities for people with histories of incarceration, who may otherwise be excluded from working in the health system.

Through CalAIM, health plans will be required to contract with community health systems and organizations to deliver ECM for patient with chronic medical conditions returning from incarceration. This opportunity will support primary care health systems across the state who are stepping up to care for their community members transitioning from incarceration. The TCN learning collaborative is designed to build clinics' capacity to care for

these complex individuals.

By participating in the TCN collaborative, program sites also become members of TCN's statewide and national network. The network provides opportunities to share best practices, collaborate with colleagues, and be on the front line to create system change. Members participate in convenings, webinars, and networking events, and have access to TCN's training materials. CHWs with histories of incarceration hired to work in TCN programs are also provided with training and mentorship from TCN's Senior CHW.

Table 1. Number of Individuals Transitioning from Incarceration in the Central Valley and Inland Empire

County	State Prison Releases (Annual)[i]	County Jail Population (Daily Average)[ii]
Fresno	1,579	2,212
Kern	1,319	1,837
Kings	328	496
Madera	179	384
Merced	311	567
Riverside	2,887	3,598
San Bernardino	3,259	5,092
San Joaquin	836	1,436
Stanislaus	687	1,158
Tulare	523	1,207

[i] California Department of Corrections and Rehabilitation. Offender Data Points, January 2020. 2018 Releases from State Prison by Release County Map, p. 52.
[ii] Board of State and County Corrections. Jail Populations Trends Dashboard. Adult Daily Population (as of September 2020).

Who is Eligible to Participate?

This opportunity is made available through the generous support of the California Health Care Foundation and The California Wellness Foundation. Federally Qualified Health Centers (FQHCs), FQHC look-alikes, community health centers and behavioral health centers with primary care programs in California's Central Valley and Inland Empire regions are eligible to participate. **Sites must be willing to employ a community health worker (CHW) with a history of incarceration as part of the primary care team.** Each site must have demonstrated support from at least one high-level administrator and clinician. We will prioritize sites that are in a neighborhood disproportionately impacted by incarceration, have integrated behavioral health care services onsite, offer medications for opioid use disorder (MOUD/MAT) onsite, and have demonstrated commitment to employing and sustaining CHWs.

What is the Time Commitment?

All participating sites are required to have at least two dedicated staff attend:

- Monthly technical assistance and site coordination calls (2 hours/month)
- One daylong, in-person Program Lead Kick-Off meeting (with an optional tour on a second day)
- One two-day, in-person meeting (TCN's Annual Convening)

The CHW, once hired, is also expected to participate in:

- One daylong, in-person CHW Kick-off Meeting
- TCN's CHW Online Training (time commitment of 2 hours each week over a period of 12 weeks)

Sites are also expected to participate in program evaluation and quality improvement activities, and to work with TCN to develop a workflow for referrals from the TCN Reentry Healthcare Hub.[1]

How Much Will it Cost?

California Health Care Foundation and The California Wellness Foundation will support all training and technical

[1] The TCN Reentry Healthcare Hub coordinates care for patients transitioning from incarceration across the state, enabling our network to serve as a safety-net for this medically vulnerable population. The Hub provides patients with information about how to access clinics with TCN programs in their area, and when possible, provides warm handoffs to TCN CHWs.

assistance costs. Sites must be able to offer in-kind clinician support (MD, NP or PA) as well as a CHW supervisor (such as a LCSW or MSW) and have a funding mechanism to support the employment of a CHW beyond the program period.

Participating sites located in the Central Valley and Inland Empire[2] are eligible to receive up to $61,750 funding to support the implementation of their TCN program. Funds may be used to offset team travel expenses to in-person meetings, support focus groups and incentives for TCN program patients, and provide partial funding for CHW salaries and benefits.

How Does a Clinic Apply to Participate?

Interested sites must complete an online site assessment, brief written application, proposed budget, and letter of support from a clinic administrator. Sites must also participate in a brief informational interview after submitting their application. Application materials are available on our website: https://transitionsclinic.org/tcn-ca/

Where Can I Find More Information?

You can watch a recording of a webinar about this opportunity from fall 2018 for more background on the TCN program. We also plan on holding a webinar in February 2022. Please refer to our website for the date.

You may submit any questions to Liz Kroboth at elizabeth.kroboth@ucsf.edu or 415-514-4918.

[2] For the purpose of this program, the Central Valley and Inland Empire include Fresno, Kern, Kings, Madera, Merced, Riverside, San Bernardino, San Joaquin, Stanislaus, and Tulare counties. Sites located in other inland counties may also be eligible to participate. Please contact us to inquire.

INVITATION TO PARTICIPATE

The Transitions Clinic Network California Learning Collaborative is a joint effort of the California Health Care Foundation, The California Wellness Foundation and the Transitions Clinic Network (TCN).

Program Background

In 2018, over 10,000 people incarcerated in state prisons - and thousands more incarcerated in federal prisons and jails - returned to under-resourced communities in the Central Valley and Inland Empire.[8] This population is sicker than other members of the community, with higher rates of chronic physical and behavioral health disorders, and death.[1,5] These individuals also face additional barriers to care: homelessness, unemployment, and low literacy. Previously, most individuals cited the emergency department (ED) as their primary source of care.[9] While the Affordable Care Act offers increased enrollment in Medi-Cal, community clinics still struggle to engage patients into care and provide medical care that adequately addresses the needs of individuals returning from incarceration. Active recruitment, culturally responsive providers, and patient-centered services are essential to engage people returning from incarceration in care.[6] While engagement in care can impact recidivism, health outcomes and costs,[10] most health systems have not aligned financial mechanisms and practice delivery to provide services that successfully engage people returning from incarceration.

"They [Transitions clinic staff] don't judge you – they treat you like a human being, like you're still a person. That's something that prison takes away from you, and when you get out, society takes that away from you… I think that's what makes Transitions clinic so successful."

-SF Transitions Clinic Network program patient

Overview of California Transitions Clinic Network

The Transitions Clinic Network (TCN) supports a consortium of community-based primary care clinics that provide evidence-based, community-driven health care and reentry services to individuals recently released from incarceration with chronic health conditions. Using a set of specialized tools and trainings, TCN has provided 48 health systems nationwide with technical assistance (TA) on program implementation, evaluation, CHW integration, and sustainability planning.

In an effort to improve the health and reentry outcomes among Californians released from incarceration with chronic health conditions, TCN will support program implementation in an additional 5-8 primary care health systems in the Central Valley and Inland Empire regions.

Program Objectives

1. Improve capacity of Central Valley and Inland Empire health systems to effectively serve individuals returning from incarceration with chronic health conditions in preparation for CalAIM.
2. Enhance primary care provider and systems knowledge, skills and attitudes regarding care provision for communities impacted by the criminal justice system.
3. Create employment opportunities in the health care field and ongoing professional development for individuals impacted by incarceration.
4. Develop sustainable funding models to support TCN programs statewide.

5. Create statewide network focused on reducing the health impacts of incarceration and improving continuity of care between the state prison system and the community.

Program Structure

Program will begin spring 2022 and end spring 2023. Participants will receive structured, comprehensive technical assistance customized to their specific needs in order to achieve objectives stated above.

TCN will provide comprehensive technical assistance and implementation support, including:

- Two daylong meetings (in-person or virtual, depending on COVID-19)
- Monthly structured case-based technical assistance calls.
- Monthly statewide coordination meetings.
- Individual site visits and introduction to the model.
- Access to online toolkit and cultural humility manual.
- Online training for community health workers.
- Access to experts in health policy and fiscal sustainability.
- Evaluation and research support.
- Access to TCN's HIPAA-compliant mobile app for CHWs.

Participating sites must be committed to sending at least two people per site to in-person convenings, participating in monthly TA calls, allocating time for their CHW with a history of incarceration to complete the TCN online CHW training, and collaborating with existing and new TCN sites as well as criminal legal system entities, policy and advocacy groups and reentry service organizations. Participating sites must also be committed to maintaining support for the Transitions Clinic Network program at their site beyond the period of this grant.

Technical assistance content to include:

- **Assessing Clinic Strengths and Gaps:** Sites will complete a TCN asset and needs assessment to identify strengths and address potential gaps in services needed for this population.
- **Health System Transformation:** Support and coaching related to transformation of current primary care practice to meet the needs of chronically ill individuals returning from incarceration.
- **Hiring and Integration of CHWs:** Best practices in hiring, supervising, and integrating a community health worker with a history of incarceration into the primary care team.
- **Team Based Care:** Defining roles and assuring that all team members are working to the top of their professional capacities and addressing patients' needs.
- **Social determinants of Health (SDOH):** Promote understanding of SDOH particular to individuals returning from incarceration and best practices in addressing these from within the primary care setting.
- **Collaboration with Criminal Legal System:** Training and technical assistance in best practices related to collaborating with criminal legal system agencies as well as improving continuity of care between prison and jail and community health systems.
- **Cultural Humility Training:** Provide cultural humility training to sites as well as specialized training for CHWs in best practices in working with individuals with history of incarceration.
- **Data Collection and Evaluation:** Assess what standardized data sites should be collecting to measure impact, promote ongoing quality improvement and define evidenced based model of health care provision for this population in California.
- **Sustainability:** Best practices in leveraging existing funding and finding innovative opportunities to support sustainability of TCN programs.

Participation Requirements

This project will support primary care clinics invested in fully implementing a Transitions Clinic Network program that are located in the Central Valley or Inland Empire.

Primary care sites will agree to: hire and integrate a community health worker with a history of incarceration into primary care team, develop integrated behavioral health and substance use disorder treatment, collaborate with criminal legal system agencies and reentry service providers, and work with TCN to develop a workflow for referrals from TCN's Reentry Healthcare Hub.[3]

Preference will be given to sites that are located in communities impacted by incarceration, have team-based care models, have electronic health records and quality improvement capacity, and those that have demonstrated institutional buy-in from their administration.

Each team must include:

- A clinician champion (MD, NP, or PA)
- CHW supervisor

Preferred key stakeholders:

- Administrative staff
- Human resources staff
- Criminal legal system agencies (e.g. parole, probation, jail, etc.)
- Social service or community based organization partners

Transitions Clinic Network Team:

Shira Shavit, MD, Executive Director. Shira has been providing health care to patients and families impacted by incarceration for over a decade. In addition to acting as Executive Director, Dr. Shavit locally directs the Transitions Clinic Network program at Southeast Health Center in San Francisco's Bayview Hunter's Point neighborhood. She worked as a consultant to reform healthcare systems in California State prisons with the California Department of Corrections and Rehabilitation from 2006-2011. Dr. Shavit is also a Clinical Professor of Family and Community Medicine at the University of California in San Francisco and received the Robert Wood Johnson Community Health Leader Award in 2010. She received her MD at Rush University in Chicago and completed her residency in Family Medicine at the University of California, San Francisco.

Liz Kroboth, MPH, California Program Manager. Liz Kroboth is TCN's California Program Manager, and leads TCN's technical assistance and training efforts in California. Liz's wealth of experience includes managing training programs at the San Francisco Department of Public Health, teaching research and writing courses at San Francisco State University, and working as a curriculum developer and project manager within health-focused nonprofits and market research organizations. Liz is a 2021-2022 Fellow with the Solís Policy Institute Criminal Justice Reform team.

Anna Steiner, MSW, MPH, Program Manager. Anna is TCN's Program Manager. Before joining TCN, she served as Program Advisor for the Office of Viral of Hepatitis Prevention as well as the Correctional and Women's Health Coordinator for the Sexually Transmitted Diseases Control Branch at the California Department of Public

[3] The TCN Reentry Healthcare Hub coordinates care for patients transitioning from incarceration across the state, enabling our network to serve as a safety-net for this medically vulnerable population. The Hub provides patients with information about how to access clinics with TCN programs in their area, and when possible, provides warm handoffs to TCN CHWs.

Health. Throughout her career, she has worked to promote health equity and build capacity among those facing systematic and institutional barriers to accessing health care, including people who inject drugs, formerly incarcerated and homeless individuals.

Joseph Calderon, Lead Community Health Worker. Joe is a TCN CHW who has served a navigator, mentor and advocate for countless formerly incarcerated individuals and their families. Joe's life work reflects his strong commitment to social justice and empowering the formerly incarcerated community. In addition to his work as a CHW, Joe served two terms here he sat on the SF Reentry Council and currently sits on the council's sub-committee for policy. As the CHW Lead, Joe lends his vital perspective to program planning, works to expand organizational partnerships, and mentors and trains formerly incarcerated CHWs, including those joining the Transitions Clinic Network as part of the California expansion project.

Emily Wang, MD, MAS, Evaluation Director. Emily is an Associate Professor in the Yale School of Medicine and directs the Health Justice Lab, a collaborative, innovative, interdisciplinary team focused on improving the health of individuals and communities who have been affected by mass incarceration. Dr. Wang has cared for thousands of individuals with a history of incarceration and is Co-Founder of the TCN. She has served on the National Academy of Sciences/Institute of Medicine's Health and Incarceration Workshop, Means of Violence Workshop, and the Steering Committee on Improving Collection of Indicators of Criminal Justice System Involvement in Population Health Data Programs. Her work been published in the Lancet, JAMA, American Journal of Public Health, and Health Affairs, and showcased in national outlets such as the New York Times, NPR, and CNN. Dr. Wang has a BA from Harvard University, an MD from Duke University, and a MAS from the University of California, San Francisco.

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