The Older Adult Re-Entry Population & Social Security Benefits Access

Final Report

March 2023

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Medlin Workforce & Reentry Solutions

Founded in 2019 by CEO Meghan Medlin, Medlin Workforce & Reentry Solutions (MWRS) is headquartered in Orange County, California, and provides services nationwide, specializing in workforce development and re-entry. MWRS utilizes evidence-based methods to provide distinctive, lasting, and substantial assistance to entities and creates an environment that attracts, develops, excites, and retains exceptional and diverse people.

At MWRS, we focus on providing resources founded on expertise, lived experience, and data to enhance best practices and ensure equal access to opportunity.

United Way of Greater Los Angeles – Home For Good

This report was funded by Home for Good, powered by United Way of Greater Los Angeles.

The views expressed are those of the authors and should not be attributed to United Way of Greater Los Angeles, its trustees, or its funders.

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Executive Summary

California prison populations are projected to decrease in the coming years due to the closing of several prisons and law changes (Appendix A); however, those serving lengthy sentences continue to age within the system. Most of this population entered the system during the "era of mass incarceration" (1970's to early 2000's) and have been in the system for decades. Older adults in prison report a high incidence of chronic conditions, including physical and mental health disabilities and the inability to complete daily activities independently[1]. As laws change to release more of these individuals, their unique needs and ability to access services upon re-entry become critical to their successful integration back into society. During this re-entry period, the older adult population is highly vulnerable to experiencing homelessness, substance use disorders, and unemployment.

California is one of seven states with a larger than 9:1 ratio of Black/White incarcerated in the prison system, despite whites being considerably more represented statewide in the general public. Additionally, studies have shown that racial/ethnic minorities are sentenced more harshly than White people, even after legally relevant factors are considered, like the seriousness of the offense and prior criminal history. These lead to Black people being overrepresented in the prison system and serving longer sentences.

Demographic survey data found that among men experiencing homelessness for the first time, 51% had been incarcerated at least once in their lifetime; and 65% of men experiencing chronic homelessness had been incarcerated at least once in their lifetime.[2] Previously incarcerated older adults (50+) are at a higher risk of experiencing homelessness compared to other groups (roughly ten times more likely than the general population) due to barriers in accessing housing based on their conviction histories, challenges in getting employed, owing fees and fines, and/or having a lack of credit or poor credit due to their time incarcerated.

Under ideal conditions, all vulnerable older adults exiting incarceration would have timely access to public benefits they qualify for upon re-entry. This report seeks to understand when and how adults 50 years and older in Los Angeles County (LA County) access public benefit programs as they exit the California Department of Corrections & Rehabilitation (CDCR) prison system. It will identify the strengths, weaknesses, opportunities, and threats (SWOT) of the processes within the system and will suggest a program pilot designed to improve interagency communication, and to streamline and optimize the referral process for older adults exiting prison in accessing public benefits.

Through research and stakeholder interviews, findings uncovered referral systems in place having many strengths, including strong partnerships between county, city, and governmental agencies, overall staff knowledge of the system, and flexibility with assisting clients in obtaining their benefits. Weaknesses emerged in the connections between organizations as networks between re-entry and homeless services were found to be siloed or non-existent, and the data systems used for referrals are not helpful in bridging these gaps. Importantly, barriers specific to the older re-entry population (e.g., age-correlated diseases, technology gaps) were not found to be optimally addressed. Moreover, staffing shortages caused by the pandemic, burnout, and low pay pose a threat to this referral system. Organizations within this referral system can take advantage of opportunities to improve itself, such as strengthening connections between organizations and agencies, providing additional focus on serving the reentry population pre-release, and ensuring that this population is

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[1] Burke, G., Prunhuber, P., Phan, T., and Takshi, S. (May, 2022). Issue Brief: Reducing Barrier to Reentry for Older Adults Leaving Incarceration. Justice In Aging. Accessed on October 6, 2022, from: https://justiceinaging.org/issue-brief-reducing-barriers-to-reentry-for-older-adults-leaving-incarceration/

[2] Flaming, D., Burns, P., & Carlen, J., 2018.

educated about these benefits and services throughout the process.

Additionally, the information-sharing systems that these organizations use are a good conduit for making referrals, however, these systems exhibit significant weaknesses which inhibit processing times, delays in submission of referrals and lack of status updates. Additionally, since these systems do not "talk" to each other, duplications and data-entry errors can be rampant. Opportunities for improvement include creating a centralized database that houses all client information, documents, case notes, and referrals, building a website with current and accurate information specific to the older reentry population, and providing regular training on database and software to improve quality assurance of data.

Overview of Referral & Information System SWOT Findings

+ Strengths

- Dedicated partnerships between LA County non-profits, and governmental agencies
- Robust assessments to determine clients' needs
- Collaboration, cooperation, & communication among providers
- Knowledgeable about benefit access and requirements
- Flexibility with program deadlines
- Broad access to state-issued documentation (e.g., CA IDs, birth certificates, etc.)
- Close and extensive relationships among system personnel
- Sharing arrangements streamline and expedite benefits access
- Referrals are able to be made between organizations for various services and needs

- Weaknesses

- Primary focus on post-release activities
- Network siloed between re-entry & homelessness services
- Limits on who is served
- Barriers specific to the older re-entry population are not optimally addressed
- Smaller organizations not connected to the larger network or equitable funding resources
- CDCR in-reach is extremely limited
- Staffing shortages have affected referring system, response times, and client access to services
- Program time limits create barriers to continual care for clients
- Assessments for benefits are not automatic
- Data systems are limited in information that can be shared and stored, and there are inefficiencies in ways the systems interface

✓Opportunities

- Identify client needs and begin benefit applications pre-release
- Strengthen connections for improved handoffs & shortened application processing times
- Clarify services provided by organizations & educate on expectations
- Healthcare-specific workers to link appropriate services and acquire pertinent documentation
- Provide transportation services between prisons and home location
- Align intake processes, forms, and assessments
- Increase accessible options and accommodations
- Liaison between agencies to answer questions and provide updates
- Centralized database for records, case notes and referrals
- Build a website with current and accurate information specific to the older reentry population
- Regular training on database and software to improve quality assurance of data
- Clean current data to minimize duplication and incomplete data entries

! Threats

- Continued staffing shortages due to a lack of qualified personnel, burnout, low pay, and strict background checks
- Stigma associated with criminal records may pose barriers to services and housing
- Southern California's affordable housing crisis
- High incidence of chronic health conditions and mental health illnesses (e.g., trauma and PTSD)
- High incidence of substance use disorder (SUD) which are barriers to public benefits and housing
- Disconnect between the city of LA and LA County
- Proximity of prisons and local CBOs creates ineffective ability to conduct in-reach pre-release
- Limited computer literacy among older adults returning home after decades of incarceration
- Extended processing times from referral to access to benefits
- Lack of access to and trust in technology by the older adult reentry population
- Complications caused by the need to access and enter information into multiple data systems

Overall, these findings show that while there are robust and adequate programs to assist the older adult reentry population with their integration into society, the processes necessary to connect the population to these services need improvement. Many organizations provide necessary and important services to treat or address medical, mental, and substance use ailments, as well as link their clients to the necessary resources to gain employment and housing. Improvements can be made to streamline these processes to increase access to referrals, shorten processing times, and keep clients apprised of their status(es). Importantly, these processes should be introduced before the person's release from incarceration and continue after their release into the community. Data-information systems are important tools to ensure organizations have the information and documentation they need to obtain services and benefits for their clients. Additional efforts should be made to streamline and build these data systems to make them more accessible, robust, and accurate.

Introduction

California prison populations are projected to decrease in the coming years due to the closing of several prisons and law changes; however, those serving lengthy sentences continue to age within the system. Most of this population entered the system during the "era of mass incarceration" (1970's to early 2000's) and have been in the system for decades. Older adults in prison report a high incidence of chronic health conditions, including physical and mental disabilities, and the inability to complete daily activities independently[3]. As laws continue to change, releasing more of these individuals, their needs, and their ability to access services upon re-entry become critical to their successful re-integration into society.

During this re-entry period, the older adult population is highly vulnerable to experiencing homelessness. The Prison Policy Initiative found that formerly incarcerated individuals are approximately ten times more likely to become unhoused than the general public.[4] Connecting the returning population—especially those who are older and with significant health care needs—to housing-stabilization services and income supports are, therefore, critical interventions to prevent homelessness. Given that the homeless system in LA County is already substantially overburdened with one of the highest adult unhoused populations in the nation[5], prevention of homelessness is vital.

Residents of LA have access to several income support programs depending on their age, disability status, income, or other factors. These benefit programs include federal supports like Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI). SSI provides monthly payments to people with limited income and resources and is available to individuals over 65 or anyone with qualifying disabilities. SSDI is funded by FICA Social Security payroll taxes, with eligibility determined by work history or disability. For many, SSI/SSDI is their only source of income due to a lack of access to retirement savings and/or private pensions. This is especially true for people who worked low-paying jobs and who did not contribute to any type of savings, disproportionately affecting people of color and those who are system impacted.

According to the 2022 Greater Los Angeles Homeless Count, there were 15,125 people aged 55+ living unhoused in LA, making up almost a quarter of the total unhoused population[6]. Homelessness and poverty

16.3%
of the general older (65+) population lives in poverty

13.7%
LA County has the highest poverty rate in California

15,125 Adults
55+ were living unhoused in LA County in 2022

23%
Adults 55+ make up almost a quarter of the total unhoused population in LA County

[3] Burke, G., Prunhuber, P., Phan, T., and Takshi, S. (May, 2022). Issue Brief: Reducing Barrier to Reentry for Older Adults Leaving Incarceration. Justice In Aging. Accessed on October 6, 2022, from: https://justiceinaging.org/issue-brief-reducing-barriers-to-reentry-for-older-adults-leaving-incarceration/
[4] https://www.prisonpolicy.org/reports/housing.html
[5] https://www.theguardian.com/us-news/2022/sep/08/los-angeles-homelessness-unhoused-people-number
[6] https://www.lahsa.org/news?article=893-2022-greater-los-angeles-homeless-count-data. *Note, data is from the Los Angeles Continuum of Care Point in Time (PIT) Count, covering all of LA County except Pasadena, Glendale and Long Beach.*

are inextricably linked. Generally, when economic instability increases, so does the risk of homelessness. While poverty rates in California fell nearly 5 points between 2019 and 2021, rates for adults 65+ increased (16.3%), surpassing children (9.0%) and adults 18-64 (11.6%) – of which child poverty has been the highest for years. For adults aged 65+, poverty was highest among Black, Indigenous, and people of color (BIPOC) communities and less-educated adults. Additionally, LA County has the highest poverty rate in the state (13.7%) with studies showing that rates would be 13.1% higher if no safety net programs (e.g., CalFresh, SSI, SSDI) were in place[7]. Those returning from prison, and even more so the older population who may or may not have a disability, typically experience even higher levels of poverty due to the inability to obtain employment, housing, and/or public benefits due to access or their past convictions, putting them at an even greater risk of homelessness. Ensuring these individuals can access benefits they qualify for would have a profound impact on their ability to afford basic needs like housing and food.

Under ideal conditions, all vulnerable older adults exiting incarceration would have timely access to any type of benefit they qualify for upon release. This report seeks to understand when and how adults 50 years and older access public benefit programs as they exit the California Department of Corrections & Rehabilitation (CDCR) prison system. We evaluate the referral process to appropriate service providers, the communication between service providers, and ways the current system can be improved to connect older adults more effectively with benefits they qualify for upon exit from CDCR. With an improved system, poverty, homelessness, and disparities among BIPOC can potentially be reduced.

This report evaluates the current information-sharing and client referral systems utilized in LA County by CDCR, Los Angeles Countywide Benefits Entitlement Services Team (CBEST), and local community-based organizations (CBO's) and agency partners serving the re-entry population to determine how these systems can be strengthened for formerly incarcerated older adults. The evaluation focuses on providers in Service Planning Areas (SPAs) 4, 5, and 6, which include Metropolitan Los Angeles, West Los Angeles, and South Los Angeles (Appendix B). These SPA's were chosen as they have the highest rates of homelessness, poverty and BIPOC populations.

The project consisted of **three** phases:

[7] Danielson, C., Malagon, P., Bohn, S. Poverty in California, PPIC. Fact Sheet October 2022. https://www.ppic.org/publication/poverty-in-california/

Phase 1

Background

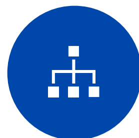
With older adults being one of the fastest-growing incarcerated populations (between 2000 and 2017, incarcerated populations aged fifty or older grew from 4% to 23%)[8], they also experience higher rates of chronic health conditions and mental and physical disabilities, which limit employment and housing opportunities and put them at risk of homelessness. These health and age-related factors should qualify them for SSI or SSDI benefits which would help them better afford housing and/or personal care. Given that adults coming from CDCR typically have served lengthy sentences (more than half are released after two years, and the rest are released after 3.5 years up to two or more decades)[9] and have limited access to or knowledge of how to use more modern technology (e.g., smartphones, computer, internet etc.), applying for or accessing assistance for applying to public benefits can be challenging. For those with mental health challenges, sobriety challenges, or physical disabilities, the challenges continue to compound.

To understand when and how LA County residents 50 years and older access public benefits programs (i.e., SSI and SSDI) as they exit prison, the scale of the need among these individuals first must be understood.

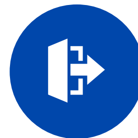
In Phase 1, MWRS researchers documented the current state of older adult incarceration in LA County and the present interagency information-sharing and referral systems for those exiting the system. MWRS contacted Countywide Benefits Entitlement Services Team (CBEST) stakeholders located within SPA's 4, 5, and 6 (Appendix B) who provide services to older individuals exiting prison or individuals who are experiencing homelessness with a history of incarceration, specific to utilizing CBEST to request SSI or SSDI.

Phase 1 Key Objectives:

Identify current coordination & communication processes



Develop Process Map of referrals and communication between stakeholders



Identify existing in-reach or outreach strategies promoting awareness of CBEST

Identify themes for collaboration and partnerships among stakeholders

Outreach was conducted via phone, email, and LinkedIn to 121 stakeholders representing forty-two different organizations/agencies. MWRS successfully conducted interviews with 19 individuals (16 total interviews – one being a group) representing 13 unique organizations via phone or virtual conference (e.g., TEAMS or Zoom). For those MWRS was unable to contact, outreach efforts continued into Phase 2 of the project.

[8] https://www.ppic.org/publication/californias-prison-population/
[9] https://www.ppic.org/publication/californias-prison-population/

Organizations interviewed included:

1. Arming Minorities Against Addiction & Disease (AMAAD) Institute
2. Housing for Health (HFH-CBEST)
3. Homeless Outreach Program Integrated Care System (HOPICS)
4. Los Angeles Department of Health Services (DHS)
5. *Office of Diversion & Reentry (ODR)
6. Developing Opportunities and Offering Reentry Solutions (D.O.O.R.S.)
7. CDCR (Palliative Care)
8. Countywide Benefits Entitlement Services Team (CBEST)
9. CDCR Department of Adult Parole Operations (DAPO)
10. Social Security Administration (SSA)
11. St Joseph Center
12. Volunteers of America Los Angeles (VOALA)
13. Whole Person Care (WPC)

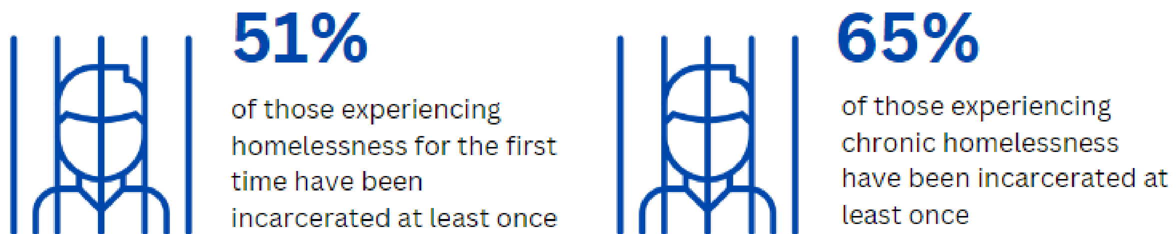
**Note: As of November 16, 2022, ODR has moved out from under DHS and is now known as the 'Justice Care and Opportunities Department' (JCOD). MWRS references this department as 'ODR' throughout the report.*

Whole Person Care (WPC) is not an identified CBEST stakeholder for this project. However, WPC was a program that helped Medi-Cal enrollees connect with health and social services and had a presence in the county jails conducting pre-release planning. This program was replaced with a new statewide program called CalAIM in early 2022. Interviewees from this program were included for their insight on communication between agencies, utilization of CBEST for clients, and potential system model recommendations given the in-reach planning that was happening within the local jails as a possibility to implement in the future with CDCR.

Obtaining concrete data such as number of system-impacted individuals served, those within the older adults population or applications processed from stakeholders proved challenging as most interviewees either did not immediately have access to the data, needed to ask another staff member for access, or did not think their agency tracked the specific metrics requested. MWRS was able to receive subjective data in the form of percentages or estimates (e.g., "most" clients are within the "X" demographic, or "Y%" are within the target population). For government agencies like CDCR and SSA, timely data requests were submitted through the Freedom of Information Act (FOIA) which resulted in data from CDCR received after Phase 2's conclusion. Despite numerous follow-up requests, data was not received from SSA or CBEST to include in this report.

Demographics of the Previously Incarcerated Older Adult Population

A study conducted by Flaming and colleagues (2018) analyzed multiple years of Los Angeles Homeless Services Authority's (LAHSA) Homeless Count and Adult Demographic Survey data and found that among men experiencing homelessness for the first time, 51% had been incarcerated at least once in their lifetime; and 65% of men experiencing chronic homelessness had been incarcerated at least once in their lifetime.[10]



[10] Flaming, D., Burns, P., & Carlen, J., 2018.

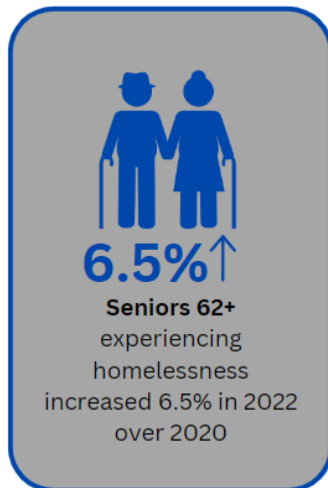
Previously incarcerated older adults are at a higher risk of experiencing homelessness compared to other groups (roughly ten times more likely than the general population) due to barriers in accessing housing based on their conviction histories, challenges in getting employed, owing fees and fines, and/or having a lack of credit or poor credit due to their time incarcerated.

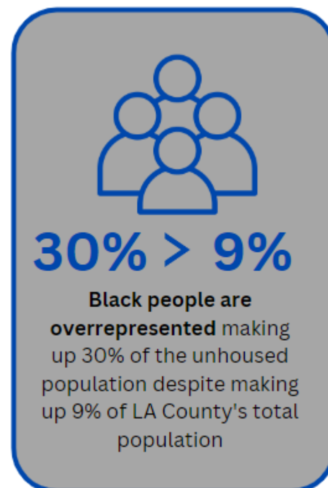
10x

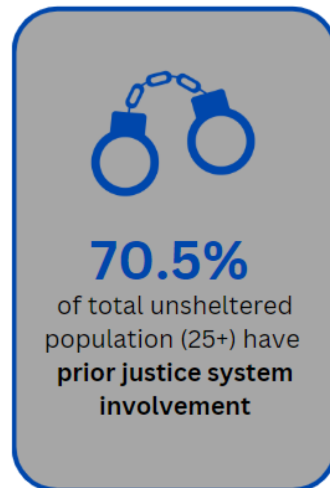
Previously incarcerated adults are 10x more likely to experience homelessness than the general population

California is one of seven states with a larger than 9:1 ratio of Black/White populations incarcerated in the prison system despite whites being considerably more represented statewide in the general public. Additionally, studies have shown that racial/ethnic minorities are sentenced more harshly than White people, even after legally relevant factors like the seriousness of the offense or prior criminal history are considered. These factors lead to Black people being overrepresented in the prison system and serving longer sentences – which eventually contributes to their being the majority of the unhoused older adult population in LA County after release.

The 2022 Point-In-Time (PIT) count conducted by the Los Angeles Homeless Services Authority (LAHSA) found that adults 62+ experiencing homelessness increased 6.5% from 2020 to 2022 (no PIT count was conducted in 2021 due to COVID-19). Black people were overrepresented among people experiencing homelessness, comprising 30% of the population, despite being only 9% of LA County's total population. The 2022 PIT count also reported that 31,405 individuals identified prior justice involvement, which reflected 70.5% of the total unsheltered adults (aged 25+)[11]. This data was supported by stakeholder interviews where staff acknowledged a noticeable shift in the demographics served by their organizations and expressed the ongoing and growing need for services to support these unique populations.







[11] Los Angeles Homeless Services Authority. (2022). *2022 Greater Los Angeles Homeless Count - Older Population - Los Angeles Continuum of Care.* Retrieved from https://www.lahsa.org/documents?id=6590-older-adults-55-hc22-data-summary.pdf.
*Note: *Data provided for system involvement through the PIT Count only includes unsheltered adults. Data does not include Pasadena, Glendale and Long Beach. Data also does not include unsheltered members of households headed by persons 25+ because the question about system involvement is only asked of the respondent.*
Los Angeles Homeless Services Authority. (2022). *2022 Greater Los Angeles Homeless Count - Adult Systems Involvement in the Los Angeles Continuum of Care.* Retrieved from https://www.lahsa.org/documents?id=6593-adult-systems-involvement-hc22-data-report.pdf
Los Angeles Homeless Services Authority. (2022). *2022 Greater Los Angeles Homeless Count - Los Angeles Continuum of Care*. Retrieved from https://www.lahsa.org/documents?id=6505-coc-hc2022-data-summary.pdf and https://www.lahsa.org/documents?id=6545-2022-greater-los-angeles-homeless-count-deck

Poverty is a leading factor in homelessness. In California, 20% of all people 65+ live in poverty, with BIPOC older adults experiencing poverty at twice that rate. LA County has the highest poverty rate in the state (13.7%) among all counties. In fall 2021, poverty in California was markedly higher for adults 65+ (16.3%) than children (9.0%), a reversal from prior years when child poverty was highest. Further, poverty is also higher among those who are less educated – close to 20% of adults aged 25-64 without a high school diploma live in poverty. Many reentering our communities after incarceration are less educated, making them highly susceptible to poverty and homelessness. According to the National Adult Literacy Survey, 70% of all incarcerated adults cannot read at a fourth-grade level[12]. In addition, formerly incarcerated people are twice as likely to not have a high school credential than the general population. Compounded with racial inequities and restrictions from former convictions, poverty and educational limitations create immense challenges for people exiting incarceration in obtaining employment, housing, or in accessing resources and services needed to get back on their feet.

California Department of Corrections and Rehabilitation (CDCR)

As of December 2022, 144,213 people were under supervision by the California Department of Corrections and Rehabilitation (CDCR), including those on state parole supervision. 36,500 of those in custody have a last legal residence of LA County.

In 2022, 5,443 people with a last county of legal residence of LA County were released on parole. 1,008 of those were 51+, with the majority being Black (405). 422 of those released had a developmental disability diagnosis with 288 aged 45+, highlighting the need for accessible benefits. By directly linking these individuals upon exit with benefits they qualify for and services, the chances of them becoming homeless is greatly reduced.

Number with last legal residence of LA County or parole county of LA by age CY 2022	
Total (All Ages)	5443
50-54	332
55-59	286
60-64	204
65-69	96
70-79	60
80+	9

People 51+ released from CDCR to Parole with parole county of LA or last legal residence of LA by race	
Asian American/ Pacific Islander	8
Black / African American	405
Latin / Hispanic	300
Native American	5
Other / Unknown	50
White / Caucasian	149
Total	917

Number with LA County as last legal residence released to parole CY 2022 with Developmental Disability Program Code	
Total	422
Aged 45+	288

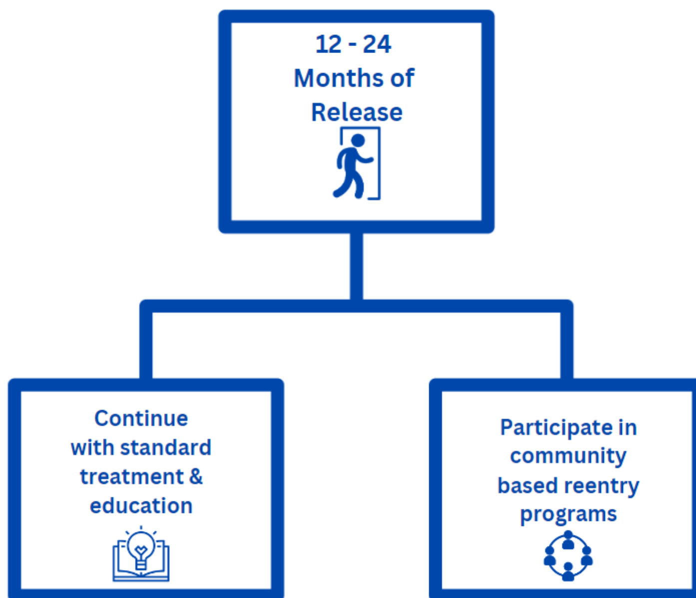
***Data provided through CDCR FOIA request. Data Source: SOMS as of January 31, 2023. Note: Age was captured based on earliest occurrence of that calendar year.*

[12] https://www.literacymidsouth.org/news/the-relationship-between-incarceration-and-low-literacy

People 51+ released from CDCR to parole with a parole county of LA or last legal residence of LA CY 2022 broken down by Sex (Male/Female)							
Gender / Age Group	51-54	55-59	60-64	65-69	70-79	80+	Total
Female	8	10	7	2	3	0	30
Male	254	276	197	94	57	9	887
Total	262	286	204	96	60	9	917

CDCR Pre-Release Programming

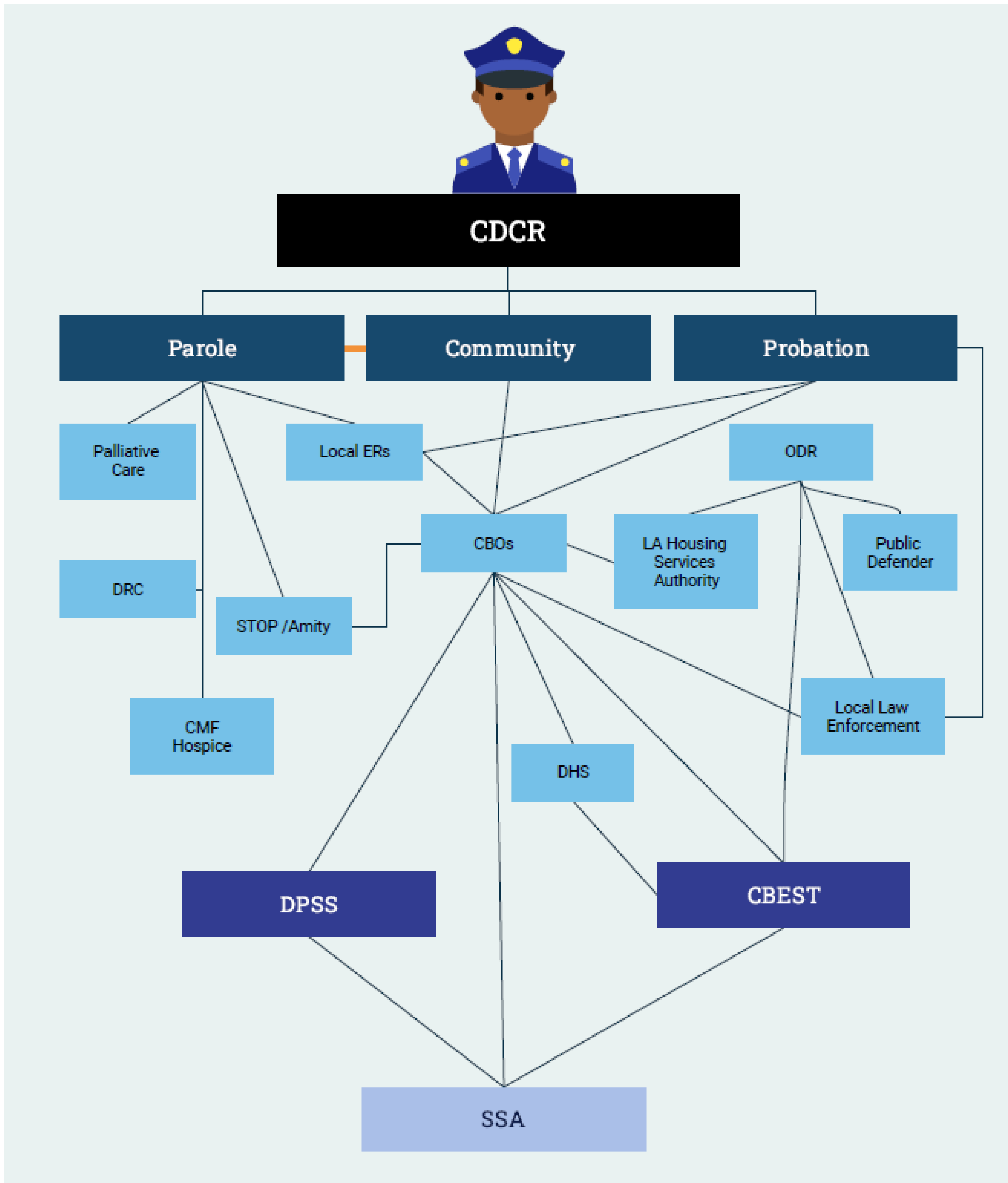
For individuals with more than 60 months remaining to serve, select prisons are more likely to focus on educational opportunities and recreational programs like diploma/GED programs or technical training. Individuals with 48 to 60 months remaining from their release receive educational and career development programming to help assist their re-entry. For individuals within 12 to 24 months of their release date, they are provided with two-prong programming options: (1) continue with standard treatment and educational opportunities; or (2) if eligible, elect to participate in community-based re-entry programs creating links to community-based providers, employment, and financial literacy, or in evidence-based treatments addressing mental and emotional health, and substance use. In 2022, 4,386 of those who were 51+ at the time of release had completed a release plan.



Number released CY 2021 and CY 2022, 51+ who completed a release plan at time of release		
2021	2022	Total
3,832	4,386	8,218

When a person is released from CDCR, they have three options for supervision: state parole (under DAPO), county probation, or no supervision/released on their own. Most people released on parole typically have some sort of substance use disorder (SUD) which qualifies them for Specialized Treatment for Optimized Programming (STOP) programming (explored further below). Those on parole who do not have SUD needs can access the local Day Reporting Center (DRC) to receive employment assistance, case management, referrals to services, and housing placement.

Map of Interagency Referral Systems



Pre-Release Agreements and In-Reach

Among stakeholders interviewed, CDCR DAPO has pre-release agreements within LA County with the Office of Diversion and Reentry (ODR), Reentry Intensive Case Management Services (R-ICMS)[13] department, and the local STOP provider, Amity Foundation. CDCR also shared that the Los Angeles Regional Reentry Partnership (LARRP) recently began in-reach with people in custody (specific to religious services) and that they are open to working with other providers for other types of services.

HOPICS representatives shared that they provided in-reach pre-pandemic in local jails and prisons (i.e., Twin Towers, CIW, Lancaster, Chino Men's Prison, and Chaparral). Currently, to connect with people in custody, HOPICS receives a list of people being released to SPA 6 from jail/CDCR. They then write letters to those individuals, working to establish a connection and develop a line of trust to link the potential client with services upon release. They shared that sometimes the person responds, and other times, they do not, making it challenging to directly connect individuals with services post-release.

Overview of Benefits Available to Older Adult Populations

For older adults exiting the carceral system, it is important that they receive are able to obtain public benefits available to them. Accessing these benefits can impact their likelihood of success and reduce their chances of becoming homeless. Two public benefits programs that are available specific to this population (SSI and SSDI) are summarized below. Additionally, barriers met by this population due to their age or extended time in the system are also highlighted.

SSI and SSDI Benefits

Supplemental Security Income (SSI) is a federal program that provides monthly payments to people with limited income and resources; it is available for people 65 or older, as well as people of any age who have a qualifying disability. For many, SSI is their only source of income due to a lack of retirement, pension, or other type of savings. This is especially true for those who have worked low-paying jobs and who did not or were not able to contribute to any type of savings. A large portion of these types of jobs include unpaid family caregiving or domestic work, which largely affects women, especially women of color, disproportionately.

The projected amounts for January 1, 2023, for SSI/SSP are $1,122.92 for an individual, whereas Social Security Disability Insurance (SSDI) (explained further below) is based on the average of your lifetime earnings before you became disabled. Payments range on average between $800 and $1,800 per month. Cost of living for a single person in LA County is $1,150.50 (without rent). Rent in LA County for a 1-bedroom apartment ranges (on average) from $2,031.94 to $2,638.43[14], making it impossible for a person to afford a place to live and support themselves in LA County if they are solely relying on SSI/SSDI benefits. However, these benefits can be the difference between homelessness and housing for someone with no income at all.

Of note, the State Supplementary Payment (SSP) program is a state program ran by SSA that augments SSI. If an eligible individuals qualifies for SSI, they also qualify for SSP. Individuals who are 65+, or blind or disabled, and who meet income and resource limits (and other legal qualifications), are eligible to apply. Due to California's high cost of living (relative to other states), SSP was designed to keep older adults and people with disabilities who receive SSI from falling into poverty. Unfortunately cuts to this program and the repeal

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[13] Root & Rebound Reentry Advocates. (2018). Reentry Planning Toolkit: for people in reentry & people with arrest and conviction records. Root & Rebound Reentry Advocates. (2018). *Who is Eligible for the CAL-ID Program?* Roadmap to Reentry.

[14] https://www.numbeo.com/cost-of-living/in/Los-Angeles#:~:text=Family%20of%20four%20estimated%20monthly,lower%20than%20in%20New%20York

of the Cost-of-Living Adjustment (COLA) during the recession in 2009 has resulted in more than 1 million Californians being pushed into poverty. Revisitation of this supplement is necessary to keep older adults housed and out of poverty.

SSDI is an insurance program funded by FICA Social Security payroll taxes, with eligibility determined by work history. Workers earn SSDI by accumulating work credits during employment. SSDI is provided for chronic disability or terminal conditions. Documents required for verifying SSDI eligibility include: 1) a history of income for the past two years; 2) demonstrated 40 work credits, 20 of which must be earned before the onset of the disabling condition; 3) a record of paying into Social Security for at least 5 of the past ten years; and 4) medical records including a medical statement verifying severity of the disabling condition. Children with disabilities may receive benefits and are claimed on their parent's Social Security record. Adults with disabilities (i.e., Disabled Adult Child (DAC)) that began before age 22 may be eligible for benefits if their parent is deceased or starts receiving retirement or disability benefits. It is not necessary that the DAC have ever worked as benefits are paid on the parent's earnings record[15].

Graphic Source: https://wardlawnh.com/blog/do-i-qualify-for-social-security-disability-benefits/

Social Security Administration (SSA)

For system-impacted individuals, applying for and accessing public benefits can be challenging. For those who received federal social security benefits before their incarceration, their benefits are suspended while they are in the custody of jail or prison. If an individual is released under 30 continuous days of incarceration, their benefits will be reinstated within the following month of documented release. Anything beyond 30 continuous days, a person must apply to have their benefits reinstated. For individuals in custody for 12

[15] Social Security Administration. Disability Benefits: How You Qualify. https://www.ssa.gov/benefits/disability/qualify.html#anchor7

consecutive months or longer, benefits are terminated altogether – which greatly impacts those in the CDCR system who generally serve lengthier sentences.

In the last several months of an individual's sentence, they may begin re-applying or applying for benefits for the first time. In order for someone to apply for benefits before release, the federal Social Security Administration (SSA) requires the individual to "appear likely to meet the criteria for SSI eligibility when [they] are released from the institution; and are scheduled to be released within several months of the date [they] file [their] application for SSI." While the federal SSA allows local Social Security offices to form pre-release agreements with prisons so that they can train staff on pre-release procedures for benefit applications, currently incarcerated individuals who wish to file applications for SSI benefits before release in Los Angeles must do so on their own because no such pre-release agreements have been established in the County. Additionally, CBEST stakeholders confirmed that they will not initiate collecting documentation and filing a benefits application until the client is released from prison due to the uncertainty of release time(s) and also access to the client.

SSA prefers to receive benefit applications by fax or electronically as receiving applications electronically reduces delays in processing time. Before the pandemic, there was a CBEST liaison that would periodically visit the field office and drop off packages and share brochures. Interviewees shared that this is no longer happening but would be beneficial.

Per the SSA LA field office representative interviewed, application approval/decline notice is, on average, 120 days. However, some cases may not receive a determination for up to six months. An applicant may appeal the initial determination five times (for SSDI). This presents a challenge for individuals enrolled in a program that may have a shorter duration than the benefit timeline in that they may not have a program case manager to assist them with contacting/connecting with SSA. For those that need one and that go through CBEST directly, they are connected with a benefits case manager for the duration of their application. Unfortunately the applicant only has access through the CBEST hotline for follow up on their application status.

SSA also provides training to CBOs through an SSA initiative, *Vulnerable Population Application Program* (VPAP) or "People Facing Barriers," to learn how to assist clients in completing forms and applications. SSA expressed that "at this time of the year" [interviewed] (i.e., the end of the year), there usually is not a budget for the training as it has already been expended, but SSA can still conduct the trainings virtually for CBO's interested. To receive trainings or to join the initiative, SSA does not require a Memorandum of Understanding (MOU) or a certain number of cases processed by the CBO. To be eligible, the CBO must have the ability, capacity, and resources to assist clients with applications.

Programming Available to the Older Reentry Population

Several programs are currently available to the older reentry population to assist with applying for benefits and in accessing services. Each program provides different services based on a person's needs, ranging from medical and psychiatric care, housing assistance, substance use treatment, employment and education assistance, and case management and navigation services. The section below summarizes the services provided by organizations interviewed. Where available, specific data on the services provided and the populations they serve are included.

Los Angeles Countywide Benefits Entitlement Services Team (CBEST)

CBEST was created in April 2017 between LA County's Department of Public Social Services (DPSS) and DHS to provide services to General Relief (GR) participants at the 14 GR District Offices. DHS partners with eight (8) community-based organizations (CBOs). The goal of CBEST is to increase the income of disabled individuals who are experiencing homelessness or are at risk of becoming homeless by providing advocacy services to assist them with applying for either veteran's benefits, SSI, SSDI, or Cash Assistance Program for Immigrants (CAPI). CBEST is a comprehensive program that provides advocacy, case management services, and linkage to needed health, mental health, and SUD services (Appendix C).

CBEST Advocates work with participants to develop their SSI/SSDI application, assist with locating medical records and accompany participants to appointments related to benefits advocacy (e.g., medical, and mental health appointments). CBEST Advocates also assist with resolving non-disability-related SSI eligibility barriers, such as obtaining citizenship documentation, birth certificates, and identification required to complete the applications.

The Advocate remains in contact with the applicant and SSA throughout the application process. Through SSA, the Disability Determination Service Division (DDSD) makes disability determinations on applications for approval/denial. The Advocate helps the applicant comply with the SSI claim and acts as a liaison with SSA on behalf of the applicant.

CBEST Steps and Timeline			
Step 1	Outreach & Referrals Team	Client engagement and intake completion	1-day to 4-weeks
Step 2	Centralized Assessment Team	Screening clients for eligibility, linkage to care plan/housing/immigration services, referring for medical process or legal services	2-days to 18-months
Step 3	CARES Team	Medical screening for eligibility, records retrieval and assessment, greenlight or red light	1-week to 2-months
Step 4	Applications Team	Interviewing client, drafting application, review by Apps Team supervisor and ICLC	2 to 6-months
Step 5	Applications Team/SSA	Filing and following up on claim until disposition is issued	2 to 6-months
Step 6	Reconsiderations & Appeals Team/SSA	Legal services and referrals to legal services vendors for appeals cases	2 to 24-months

Until roughly mid-2022, an applicant only had access to a hotline number to call if they had not heard from their Advocate, which was not entirely adequate since they did not know when or how often to call. Interviewees shared that applicants are now provided upfront with an estimated timeline for their application in addition to the hotline number to increase efficiency. CBEST shared that they focus on a rigorous due diligence process to ensure applicants are contacted and informed of changes as soon as possible.

Primary pathways to CBEST are via SPA leads and referrals from linkage service programs. Before the pandemic, CBEST was co-located at DPSS offices. Outreach workers would transport people to the DPSS office to connect with CBEST. CBEST staff are also a part of the Homeless Initiative Office and are co-located at most sites like safe parking sites, tiny home villages, Project Roomkey/Project Homekey, etc. Staff rotate between these sites to meet with individuals who need to be connected with services. The average duration from referral to intake to admission within a CBEST stakeholder's program is three days and ranges from one to ten business days.

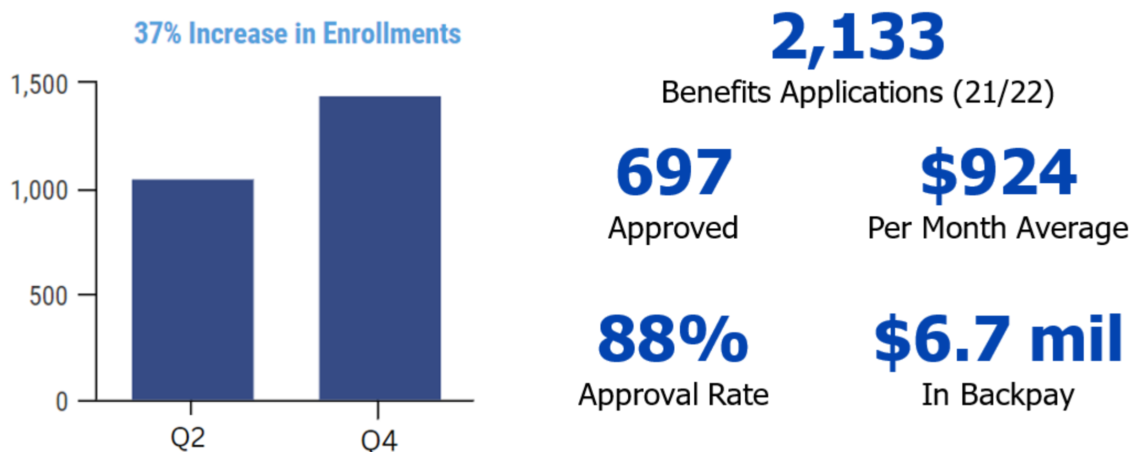
A CBEST contact shared that the majority of clients served are between 40-60 years of age, men are slightly overrepresented, as are Black/African American individuals, and they serve more clients who are at risk of becoming homeless versus those who are already experiencing homelessness. Many clients are GR or Medi-Cal recipients. Despite many attempts over the course of the project, MWRS was unable to obtain a concrete response from CBEST regarding these specific demographics and statistics to include in the report.

After the referral, CBEST receives an email with a single-page document that includes demographic and contact information, type(s) of reported disabilities and impairments, application history, current income, immigration/citizenship status, and the referring party's contact information. CBEST will then conduct an assessment with the applicant which occurs either in person or, since COVID, via telephone. For those that require a longer assessment, a member of the Targeted Outreach Team will meet with the applicant. This assessment generally takes about an hour and can be stretched over multiple sittings – which in turn can stretch out the timeline for the application process. Longer assessments include obtaining details on medical records and incarceration history to fully understand a client's needs.

CBEST staff shared that they tend to not to start an application until a person is released from custody due to the person's inability to receive SSI benefits while incarcerated. Any process created to identify individuals about to be released from CDCR would involve CBEST having access to the prison system or CDCR having access to external systems (neither of which are currently in place). Re-entry stakeholders shared that they are not often made aware in advance of an individual's release, or if they are, it usually does not line up with when the person is actually released, making it increasingly difficult to coordinate these types of services. However, post-release, CBEST can request prior medical records from CDCR and do so whenever an applicant mentions that they were incarcerated [and that they received medical treatment while incarcerated]. This information is then included as part of the applicant's medical review.

Once full intake assessments and consents are completed, the applicant's intake information is uploaded into the CHAMP database (explained further below), which is then reviewed by the Centralized Assessment Team. This review can take two to five days. Files are then sent to the clinical team to assess medical and clinical records, who then decide about the likelihood of a successful application. SSI is based on disability, and SSDI is based on work history. If needed, an applicant can be referred to immigration service experts who may gather additional documents to determine eligibility for alternative services. CBEST also assists with locating required documents and medical records, work history, and income information for applicants to apply for benefits or assistance.

After a redesign of the CBEST program in 2020/21, CBEST saw an increase in almost every level of service for clients served. Applications submitted increased from 1,564 in FY 2020/21 to 2,133 in FY 2021/22 (36% increase). In 2021/22, 697 applications were approved for benefits, which resulted in clients receiving (on



average) $924 more per month in benefits, and more than $6,273,000 (cumulative) in back pay. CBEST maintains an 88% overall benefit approval rating, and in 2022, experienced a significant increase in enrollments from Q2 to Q4 (1,054 in Q2 to 1,446 in Q4) which was attributed to an increased community presence, strategic partnerships, and targeted outreach efforts[16].

There are roughly 955,000 adults living in LA County over the age of 55[17] and 19,783 aged 50+ living unhoused per the 2022 Point in Time (PIT) Count. Additionally, there were 1,279 adults over the age of 50 released to LA County in 2022 from CDCR who also had a developmental disability classification and would qualify for CBEST services, exemplifying that there is a great opportunity to increase the capacity of service that CBEST provides to the community in order to link these individuals with benefits that they qualify for.

Stakeholders interviewed shared that clients often do not know what documentation they need for their application(s), so staff will assist the client in applying just to receive a denial letter. Once the denial is received, the client is then made aware of what documentation is needed and the provider will help the client locate these documents or assist in applying for other benefits (ex., Cash Assistance Program for Immigrants (CAPI)) if they do not qualify at all for SSI/SSDI. Several stakeholders shared that they connect clients to CBEST via DHS. For St Joseph Center, benefits services are no longer internal (as of 2021), so they send referrals via CHAMP to DHS, who then refers to CBEST. For clients who do not have an assigned case manager, DHS shared that they refer the client to CBEST, who then connects the client with a service provider who will then match them with a case manager.

Stakeholders also shared that there is no formal liaison or process between CDCR and CBEST, which can create challenges for clients applying for benefits. CBEST expressed a desire to put a partnership like this in place. There is currently an in-reach program in the LA County jails that allows applicants to begin the application process pre-release and get better connected to services post-release, but nothing similar [through CBEST] is currently in place with CDCR. Some potential reasons include 1) the proximity of CBOs to prisons throughout the state (given that most prisons are located in rural areas – see Appendix D) and 2) the timeframe that individuals are incarcerated in county jail (less than 1 year) versus state prison (more than 1 year) which affects their eligibility. Throughout interviews, CDCR/DAPO expressed an interest in better connecting with CBOs to link clients with these types of services upon release.

CDCR Transitional Case Management Program (TCMP)

The Transitional Case Management Program (TCMP) is a program under the Department of Adult Parole Operations (DAPO) that provides pre-release benefit assistance to all eligible individuals released to Parole or Post Release Community Supervision (PRCS) approximately 90-120 days before their release from prison. TCMP benefit workers provide Medi-Cal, SSA, and Veterans Administration benefit application assistance. In addition, for those eligible for SSI/SSDI, workers assist with beginning the application process. TCMP staff also assist people with applying for identification through the CAL-ID program.

The CAL-ID Program aims to streamline access to support services, such as medical, housing, and right-to-work documents post-release. Eligibility requirements include a Social Security Number, valid legal presence in the United States, identification by the California Department of Motor Vehicles (DMV) issued within the last ten years, and a residential address. In some instances, an individual may use the address of the correctional institution or parole office. Ineligibility criteria for the CAL-ID Program include the following:

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[16] Homeless Initiative Quarterly Report, No. 24, CBEST Data, pg. 16. **CBEST numbers reflect all application/benefit types processed and are not specific only to SSI/SSDI.*

[17] Los Angeles Population; Population U.com Source: https://www.populationu.com/cities/los-angeles-population

- DMV fees for one's previous identification or license
- No photo on file at the DMV from within ten years
- Any active felony holds, warrants, or detainers, including an active Immigration and Customs Enforcement (ICE) hold (which could lead to deportation)

Individuals who are ineligible for the CAL-ID program due to unpaid fees or out-of-date photographs may be able to access identification by applying through the standard DMV process post-release. However, this may delay obtaining other documents or in applying for housing, employment, or benefits. Additionally, since the DMV sends the new IDs to the prison, it is possible that due to release recalculation or other circumstances, the individual's new ID will not arrive before their release. In this situation, the prison will send the ID to the individual's provided address (which may be inaccurate or outdated) or their parole officer if the individual is on parole, creating further delays or barriers in obtaining the identification card.

After meeting with the client in custody, TCMP reviews the client's age, the likelihood of finding full-time work, and the ability to care for themselves or be self-sufficient. Based on these mitigating factors, TCMP will determine whether to refer the client to palliative care, hospice, or STOP programs post-release.

Individuals in custody also receive an exit interview approximately 10-days before release and are provided with the following:

- Copies of the benefit applications submitted on their behalf;
- Current benefit application status; and
- External benefit reporting addresses and instructions (when necessary).

Receipt of benefit assistance program services is voluntary, and the client will need to continue and follow up with applicable agencies after their release on their own. CDCR/DAPO staff expressed that this is potentially an area of misunderstanding or disconnect with outside agencies who seem to think individuals do not receive these services while in custody. This was confirmed by the CBOs/outside agencies MWRS interviewed, not having knowledge of this process happening. With no direct connection to outside agencies post-release for continuing the application process (particularly CBEST stakeholders), it seems as if the client is left on their own to continue the process post-release, and for those experiencing homelessness or have health or disability needs, having the ability or interest to follow up on benefit applications on their own are generally not a priority.

Elderly Parole

Individuals eligible for Elderly Parole must at least be 50 years of age and continuously incarcerated for at least 20 years (or more). Individuals sentenced to life without the possibility of parole, sentenced to death, currently sentenced on their second or third strike, or persons convicted of first-degree murder of a peace officer or former peace officer during the performance of their official duties, are not eligible for consideration. However, in a February 2014 court order, individuals sentenced under California's Three Strikes law for a second or third strike are now eligible for elderly parole upon reaching 60 years old and having been continuously incarcerated for at least 25 years. If a person is granted parole at their hearing, they will be eligible for immediate release after applicable review periods, which can take up to five months.

Those granted elderly parole and who will be released, meet with TCMP workers prior to release to begin applying for benefits for which they qualify. Some may be referred to Specialized Treatment for Optimized Programming (STOP) if they are self-sufficient and able to work, while others are released to family or on their own.

Palliative Care

For persons approved for Elderly Parole with an identified need for palliative care, CDCR's medical team arranges for them to be sent to a skilled nursing facility upon parole, where that individual's Medi-Cal would support their placement. However, available referrals and placements are limited by the number of skilled nursing facilities that accept Medi-Cal only payments. A compounding limitation for placement is that an individual released from CDCR may be denied palliative care due to fear for staff safety. Often, individuals will be placed with social justice-oriented or religious organizations, as those organizations tend to be focused on providing services for system-impacted individuals.

Individuals not identified ahead of time and who are placed on standard [non-compassionate release] parole are frequently identified through local Emergency Rooms while seeking services, where they may be linked with supportive services or turned back out to the streets. According to one stakeholder, Assembly Bill 960 will expand the criteria for compassionate release to include a "terminal trajectory" starting in January 2023, simplifying, and expediting the release process. As a result, it will no longer sit under the Secretary of Corrections.

Specialized Treatment for Optimized Programming (STOP)

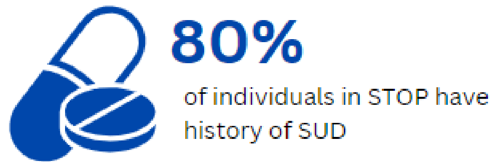
STOP is a comprehensive, evidence-based program with services available to individuals on parole to address substance use disorder (SUD) treatment, healthcare enrollment assistance, employment and educational services and referrals, and emergency housing services with six (6) locations throughout the state (Appendix E). All individuals on parole are eligible and must be referred by their Agent of Record (AOR), typically post-release. Information sent to the STOP provider includes the client name, CDCR number, and list of needs determined through the TCMP worker or from a Correctional Offender Management Profiling for Alternative Sanctions (COMPAS) assessment.

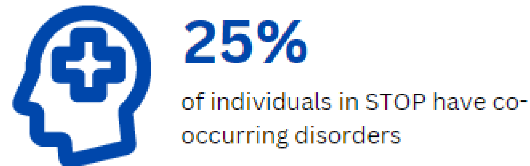
Staff interviewed shared that the COMPAS information received was lacking in that it primarily focuses on a person's education and the presence of a disability, and that the evaluation stays in the person's file with parole. Further, even if staff received the COMPAS, it may not be an accurate representation of where/how the person is currently functioning. For example, if a person entered prison at 16 and was assessed at that time, and then later was released at age 40, the scores no longer reflect where/how the person is functioning in present times. Aside from the time lapsed, simply being in prison can affect a person's scores due to the traumas, medical and mental challenges one may face while incarcerated. COMPAS also has been criticized for perpetuating systemic racial bias in the criminal justice system, and with BIPOC people overrepresented in the system, means this evaluation is not an accurate source of measurement for the majority of people.

LA County has 144 contracted provider locations (i.e., licensed residential treatment centers, detox centers, certified SUD providers, and re-entry and recovery housing) serviced by 48 unique organizations. Each provider has their own assessment that they use for clients. DRP only requires that the assessment be evidence-based. The most popular assessments used include the Ohio Risk Assessment (ORAS), the American Society of Addiction Medicine (ASAM), and the "TCU" Assessment.

Once a client is released, STOP coordinates transportation throughout the state for individuals to return to their home county and be linked with the local STOP provider. Handoffs between STOP providers happen for those continuing to counties past the boundary line of the initial provider. This is a successful model in that STOP providers pick up clients from the gate upon release and directly connect them to their home county with services that will be provided for them post-release.

The contracted STOP provider for LA County is Amity Foundation (Amity). Parole refers clients from all 32 prisons to Amity within 60-90 days of release via STOP. In addition to referrals from STOP, Amity conducts in-reach in 18 prisons in three regions throughout the state. Once the individual reports to the STOP provider, staff conduct an intake, seek services, and make referrals to meet the client's needs. STOP services are entirely voluntary and are provided for up to 180 days, with the possibility of an additional 185 days based on assessed need. Roughly 80% of individuals in STOP have history of SUD and around 25% have co-occurring disorders.





DAPO shared that STOP is not for individuals with a high level of need. For instance, if someone cannot get in/out of bed on their own or cannot transport themselves from their wheelchair to their bed, they would not be a good candidate for STOP. If a client does get referred to STOP and the person ends up not being a fit for the program (which tends to happen as a client may be self-sufficient while in custody, but with no medical assistance immediately available, they become "high needs" and are no longer able to care for themselves) staff will do their best to refer the client to an appropriate program more suitable for their needs, but also shared that these programs are hard to come by.

Additionally, Amity shared that they do not have much contact with CBEST. There is some connection with CBEST between their "Just in Reach" program (coordinated in county jails) and mental health programs, but outside of that, it is minimal. Amity also shared that most of their clients are at risk of or are currently experiencing homelessness. They rarely serve adults 65+ or who have disabilities.

DRP is also piloting a program with STOP providers specific to the older adult population to get them linked with transitional housing upon release so that they have a place to go. In combination with the TCMP program, individuals will be linked with benefit applications and then housing. DRP does not have an expected launch date for the pilot at the time of the report.

Los Angeles Department of Health Services, Office of Diversion and Reentry (ODR)

The Los Angeles Department of Health Services (DHS), Office of Diversion and Reentry (ODR)[18] oversees diverse programs and contracts vendors to provide coordinated services that promote successful re-entry and reintegration and reduce recidivism. Two notable programs include the Community Reentry Center (CRC): Developing Opportunities and Offering Reentry Solutions (D.O.O.R.S.) and Reentry Intensive Case Management Services (R-ICMS).

D.O.O.R.S. provides comprehensive supportive services to address the

Of Note:

The Division of Rehabilitative Programs (DRP), a division under CDCR that oversees all contracted rehabilitative programs (e.g., STOP), mentioned that most people exiting prison have some sort of SUD need, which is a requirement for STOP. Community providers highlighted challenges with SUD individuals applying for SSI/SSDI as SUD is not a recognized disability. In cases where the SUD could have caused or contributed to the disability, benefits tend not to be approved. For people who STOP does assist with services, they may not qualify for benefits based on their SUD diagnosis.

[18] Note: MWRS interviewed ODR while they were still housed under DHS. As of November 16, 2022, ODR moved out of DHS and is now known as Justice Care and Opportunities Department (JCOD). MWRS continues to refer to the department at ODR as they were the department interviewed. Both DOORS and R-ICMS programs will move under JCOD and out of DHS.

barriers to reentry for justice-involved individuals, their families, and the community. Services include housing, employment, legal aid, educational support, mental health assessment and linkage, substance use counseling, and health and healing through the arts. These services are provided by community-based organizations like HOPICS (housing/intensive case management), Chrysalis (employment), and Legal Aid Foundation of LA (legal support), among others. For individuals seeking SSI or SSDI, D.O.O.R.S. refers individuals within the community to DPSS for benefit navigation and assistance; they have no existing referral system to coordinate with CBEST. However, their clients seeking housing under the Housing Choice Voucher Program (HCVP) are referred to CBEST stakeholder, Housing For Health, who does refer to CBEST. After numerous outreach attempts over the course of the project, MWRS was unsuccessful in connecting with DPSS for an interview to learn about or compare their benefit application processes with CBEST's processes.

During the final phases of pre-release planning services, CDCR provides a pre-release notification to Reentry Intensive Case Management Services (R-ICMS[19]), which is a program not identified among CBEST's partnering agencies and programs, that serves adults with an arrest, charge, or conviction record with mild to moderate mental health and SUD, or those on active adult felony probation. Most of individuals on felony probation would be referred through county jail and not CDCR, though some are released on felony probation from CDCR. Notably, only 2.1% of clients referred between April 2018-August 31, 2021, were aged 65+.

R-ICMS, which falls under DHS, seeks to improve the health and well-being of system-impacted individuals by providing case management and service navigation (Appendix F). Community Health Workers (CHWs) with lived experience of system involvement support individuals by determining their needs and making connections to relevant organizations and services, including stabilizing needs, enrollment in social services, benefits establishment, physical and mental health, housing support, employment and education, cognitive behavioral interventions, arts and entrepreneurship programming, and SUD treatment. There are 29 community-based service providers with 100 CHWs located in 34 office locations throughout all 8 SPA's.

[19] Root & Rebound Reentry Advocates. (2018). Reentry Planning Toolkit: for people in reentry & people with arrest and conviction records.
Root & Rebound Reentry Advocates. (2018). *Who is Eligible for the CAL-ID Program?* Roadmap to Reentry.

According to R-ICMS, from April 2018 to August 31, 2021[20]:

TOP 3 SPAs Referred to R-ICMS: 1. SPA 4: 36.6% 2. SPA 2: 18.4% 3. SPA 1: 12.9%		Clients Referred by CDCR/Parole : 5,574 Enrolled: 4,741 Average Duration: 7 months	29 CBOs with 100 CHWs in 34 Offices throughout 8 SPAs
24,418 Clients Referred	18,895 Enrolled	Clients Referred by Whole Person Care : 18,844 Enrolled: 14,154 Average Duration: 2 months	

Notably, the majority of R-ICMS clients were between the ages of 26-39 (N = 204; 47.0%), followed by 40-64 (N = 165; 38.0%), with only 2.1% of clients aged 65 and older (N=9). The majority of enrolled clients were identified as cis-male (N = 352; 81.1%), followed by clients identifying as cis-female (N = 73; 16.8%). The majority of clients identified as non-Hispanic Latino (N = 209; 48.2%), followed by Black/African American (N = 149; 34.3%).

Interagency Information-Sharing & Referrals

Throughout the interviews, stakeholders mentioned three main databases used for referrals, storing client contact information, and program-related documentation like case notes. These databases[21] are:

- Comprehensive Health Accompaniment and Management Platform (CHAMP)
- Homeless Information Management System (HMIS) (also referred to as Clarity)
- Automated Reentry Management System (ARMS).

Each of these databases is owned and utilized by different stakeholders. CHAMP and HMIS contain similar information but are used for different purposes. None of the systems interact or "talk" with one another, creating duplicative information which is vulnerable to input errors or missing information. The pros and cons of these systems are further explored in Phase 2 under the SWOT analysis.

[20] Los Angeles Department of Health Services, Office of Diversion and Reentry (ODR). (n.d.). *Reentry Intensive Case Management Services (RICMS) Data Dashboard.* Accessed on: https://dhs.lacounty.gov/office-of-diversion-and-reentry/our-services/office-of-diversion-and-reentry/ricms/

[21] Note: Another system mentioned in interviews was EXYM but did not seem to be widely utilized as it is specific to mental health agencies.

Table 1.1: Organizations interviewed and what database(s) they use.

Organization	CHAMP	HMIS	ARMS
AMAAD Institute	✓	✓	
Amity Foundation	✓		✓
CDCR			✓
HOPICS	✓	✓	
Housing For Health	✓		
LAHSA		✓	
Skid Row Housing Trust	✓	✓	
Union Station Homeless Services	✓	✓	
VOALA	✓		
St. Joseph Center	✓	✓	
LA DHS (ODR DOORS)	✓		
ViaCare	*Can View	*Can View	
VOALA	✓		
Whole Person Care	✓		

***Note, not every organization/agency interviewed is included due to needing clarification on access or not using these system(s).*

Comprehensive Health Accompaniment and Management Platform (CHAMP)

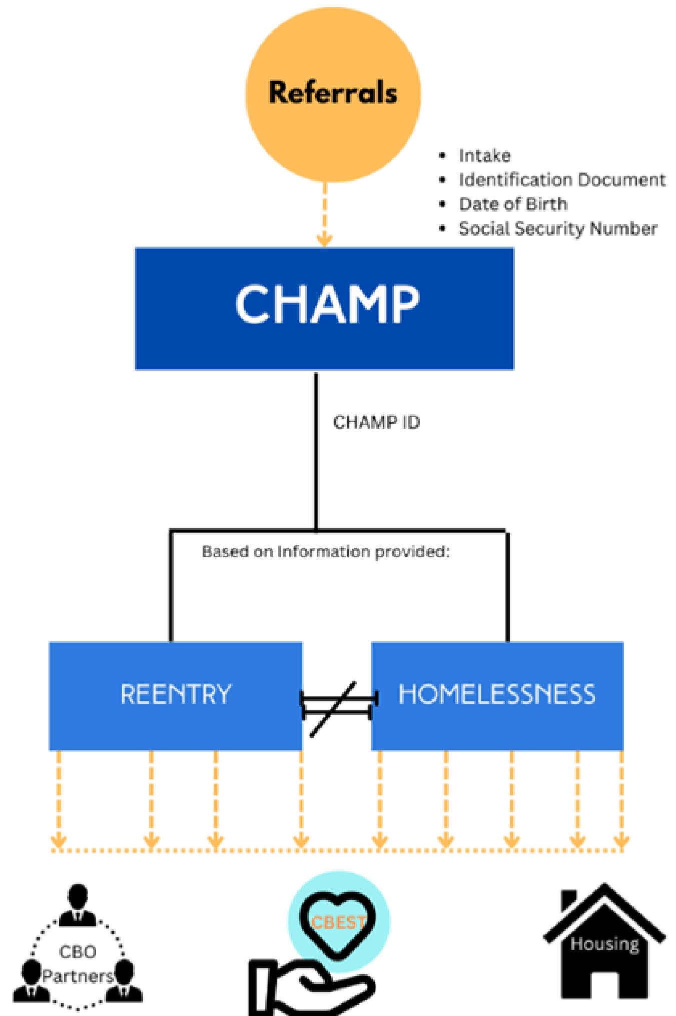
The Whole Person Care (WPC) program was launched in 2020 under LA's Department of Health Care Services (DHCS) through a five-year initiative to bring together health and social service delivery entities across LA County to deliver seamless, coordinated services to high-risk Medi-Cal beneficiaries. This program was designed to be the "connector" between county agencies, health plans, and providers. Due to clients having multiple case managers across multiple settings, the need for information sharing quickly arose. This was the start of CHAMP. This platform was designed to enable LA County's stakeholders to bridge gaps in services by incorporating the social determinants of health into healthcare decisions and the sharing of patient information across multiple agencies.

Housed under DHCS, CHAMP is a HIPAA-compliant online database for virtual information sharing, used primarily among CBEST stakeholders for client referrals and information sharing, especially specific to applying for benefits and case management. Referral tabs let stakeholders know where clients have been referred, services provided, and outcomes. Stakeholders interviewed who do not have access to CHAMP expressed that they generally refer to organizations that do, or in the case of LAHSA, refer directly to CBEST, who then uploads the client's information to CHAMP.

A case in CHAMP contains a specialized case number, social security identification number, date of birth, full legal name, general information, and case development. Case files in CHAMP are closed once an individual is connected to appropriate services or has received notification that their benefits claim was accepted. Once an SSI/SSDI application is approved, CBEST closes the application in CHAMP, and the CBO becomes the client's main contact. That CBO would need to reopen the application with CBEST in the case that benefits were discontinued or adjusted for some reason.

CHAMP requires all affiliated organizations to receive formal training in using the database. CHAMP is a large system, and internally there is a divergence in communication based on the individual case's categorization. Case managers working within smaller CBO's or across silos may not have the same access to a client's progress. As described by a stakeholder, there are two silos: housing and re-entry. Organizations can only view the selected case files within their dedicated resource category within CHAMP. For example, a client who receives services through a homeless provider and is entered into CHAMP will also likely get CBEST services, but the CBEST SSI/SSDI notes will not be visible to the individuals working on the Re-entry side of CHAMP. Stakeholders expressed a need to unify these systems to better serve clients.

ODR receives referrals through CHAMP from Public Defender staff seeking services for their clients. However, Public Defender staff may only send referrals if the CHAMP referral link is open and available, which is determined by the number of open slots in the program. In some cases, an opening slot is filled by reinstatements or clients that had been in the program before and have been re-arrested. With respect to referral capacity, stakeholders reported that slots may be unavailable for months at a time; currently, it has been unavailable for almost one year with no timeline to be reinstated. While ODR staff maintain active communication with the Public Defender Office to share information, there is a limitation in tracking referrals, and there is no current practice within CHAMP to track individuals who did not get referred while the "referral link" was down. Individuals not referred will proceed through standard legal processes and may seek services post-release.



Via Care (a non-CBEST partner) finds CHAMP useful for case management, but with having their own separate database and not having formal access to CHAMP, they find that limited information about a client comes through. For example, only a client name is provided, and often times a date of birth or other identifying/contact information is omitted. Via Care has to reach out to DHS to merge the data to make it visible to their team. Interviewees shared that additional complications arise with this workflow due to the differences between public and private hospitals within the referral network. In sum, having many different organizations/agencies with varying access types and databases/workflows can lead to confusion and lack of integration.

Homeless Management Information System (HMIS)

HMIS is a local information technology system used to collect client-level data and data on the provision of housing and services to individuals and families experiencing homelessness, and persons at risk of homelessness. Each Continuum of Care (CoC) is responsible for selecting an HMIS software that complies with HUD's data collection, management, and reporting standards.

In LA County, the HMIS system is housed under the Los Angeles Homeless Service Authority (LAHSA), which serves as the lead agency for the LA CoC. Data stored in HMIS is used to improve the ability to govern agencies, service providers, volunteers, and external stakeholders to provide access to resources and housing, which aids in the effort of ending homelessness. This database is accessible by homeless service providers throughout the LA CoC. This poses a challenge for re-entry providers who may have unhoused individuals or who are servicing clients co-enrolled in another program in that they cannot see client-level details and/or do not have the ability to share information or documents.

HMIS has a section for case manager notes to be uploaded. Case managers have been trained to access HMIS and upload materials and pertinent client information. The database includes meeting notes, follow-up information from the participant, case notes, and records of services (e.g., services offered, accepted, etc.). Each case has a specific code for accessing the file within the database. Individual participants must provide consent before any information is uploaded to HMIS and staff using HMIS must have a code case to access the database.

Challenges with the database that were shared throughout the interviews included the inability to upload HIPAA-related information, the inability to connect with other systems, it being limited to only homeless providers, and the cost for an agency to add multiple users.

Automated Reentry Management System (ARMS)

The Division of Rehabilitative Programs (DRP), within CDCR, houses and is the main operator for the ARMS system, a centralized, web-based data system that streamlines the life cycle of rehabilitative treatment. The system serves as a case management system providing rehabilitation treatment and case planning data for program delivery and oversight.

ARMS provides a common means for CDCR staff and contracted service providers to report activity and service data in a controlled and consistent manner. With this data, service providers are able to see the relationship between activities performed and the successful outcomes of their efforts – for example, if a client has successfully completed programming and is eligible for early release from parole. ARMS can also look across many programs to help in data collection to determine effective programming practices and how well the programs are adhering to the fidelity of the programmatic models. ARMS is available at all CDCR institutions and contracted community re-entry program sites.

DRP monitors ARMS to ensure providers comply with their service contracts. If a client is not keeping up with their program, the provider conferences with the parole officer, who will make a determination of where the person stays/goes and if they get sent back to custody for any reason.

Of the providers interviewed, only Amity Foundation had access to ARMS per their various prison based and STOP programs. Amity shared that within ARMS there is an in-prison version and a re-entry version that have different information in each. This system is not used for referrals to external programs but to track progress and case noting within existing programs. Per DRP, the STOP provider (e.g., Amity) is the one who will give access to ARMS for their subcontracted organizations. Within every contracted program, staff can access people assigned to their site, but do not have access to all STOP areas.

One program within Amity shared that they only use ARMS and do not have access to CHAMP. They work directly with CDCR, so all the information they share is relevant to CDCR (e.g., case manager notes, client progress, etc.). They shared that CHAMP and HMIS should connect in some way so you can follow a client's progress and outcomes no matter where the person goes within the system and that for clients who may want/qualify for SSI [and who are in their program], the client informs the staff member, who then reports it in the client's progress notes. Staff will sometimes help with applications or refer clients to CBO's that can help them apply.

Phase 1 Conclusion

While there is a growing need for services and access to benefits for the older adult, reentry population in LA County, programs specific to their needs are limited, and pathways to get to these services are disjointed and not linear, resulting in homelessness and individuals living without care they need to survive.

Phase 2

While there is a system currently in place to support older adults re-entering LA County from prison, as demonstrated in Phase 1 of this report, improvements to the system are critical and must be predicated on a complete picture of the internal strengths and weaknesses of the system, as well as the external opportunities and threats that the system faces.

In Phase 2, MWRS conducted 458 outreach efforts via phone and email to 121 unique CBEST and reentry system stakeholders. Of those contacted, 35 people were interviewed through 18 unique interviews (individual and group interviews took place) representing 17 unique organizations/agencies.

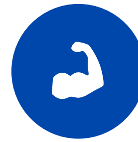
Organizations interviewed included:

- A New Way of Life
- Amity Foundation
- CDCR DAPO
- CDCR Division of Rehabilitative Programs (DRP)
- Chrysalis
- Corporation for Supportive Housing California State Policy (CSH)
- DHS
- HOPICS
- LAHSA – Justice Systems
- LAHSA
- SSA – Los Angeles
- Skid Row Housing Trust
- Law Offices of Matty Sandoval
- St Joseph Center
- Los Angeles County Homeless Initiative
- Union Station Homeless Services
- Unite Us
- ViaCare

The goal of the interviews was to identify the strengths, weaknesses, opportunities, and threats (SWOT) of when and how adults 50 years and older access public benefit programs as they exit the California Department of Corrections & Rehabilitation (CDCR) prison system, including the referral process to appropriate service providers, the communication between service providers, and ways in which the current system can be improved to move LA County closer to an ideal system where individuals are successfully connected with benefits they qualify for upon exit from CDCR; thus reducing poverty, homelessness, and disparities among BIPOC.

Phase 2 Deliverables to Include:

SWOT Analysis of Information Sharing & Existing Referral Systems



Identify Opportunities to Strengthen Partnerships & Referrals to Reduce Vulnerabilities

SWOT Analysis Results

Several strengths, weaknesses, opportunities, and threats (SWOT) emerged among both the referral systems and information-sharing systems (CHAMP, HMIS and ARMS). The following is the SWOT analysis of data sharing, referrals, and communications across these systems.

Information Sharing & Referral Systems SWOT Analysis

STRENGTHS

The older adult prison re-entry system has infrastructural strengths that create a foundation for scaling up benefits access moving forward which include:

Partnership - A network of dedicated partners providing both re-entry and homelessness services in LA County, including non-profits like AMAAD Foundation, Volunteers of America of Los Angeles (VOALA), Amity Foundation, and SSG/HOPICS, as well as governmental agencies like the LA County Departments of Health Services (DHS) and Public Social Services.

Assessments - Assessments are conducted to determine a client's needs and then used to refer the client to services within the system to provide support and resources to help the individual.

Collaboration - Collaboration among service providers was expressed as a particular strength in that providers have good working relationships with one another and are able to connect their clients to many types of services (e.g., CBEST). Stakeholders expressed cooperation and communication as being a highlight of working with DHS, especially for reviewing cases and offering assistance, and that CBEST is able to refer clients to case managers for those that do not have them. Reentry organizations like Amity, expressed a positive change in working with CDCR over the past few years. They have a more collaborative relationship including weekly calls and direct relationships with various levels of staff. While they shared that this relationship is an ongoing work of progress, there are continuous trainings and partnerships between the agencies including site visits, recommendations and planning new programs which are benefitting everyone involved.

Knowledge – Stakeholders expressed that it is easier to go through CBEST for accessing benefits. CBEST has a great knowledge of the social security system, how it works and what is required for applications. CBEST also maintains clear and direct communication of requirements.

Flexibility – Several organizations/agencies shared that they provide clients with program extensions to help clients eliminate gaps between entering other programs, or just to ensure that high need clients have access to services in lieu of releasing them to the streets. One program within Amity shared that while their program can only offer 30–90-day extensions, they have a senior client who has been there for almost four years while they assist them with basic needs and care.

Access – Organizations within the system have the ability to assist with establishing state identification, obtaining a social security card and birth certificates. Other assistance includes training on how to use cell phones or establish an email address, linkages to skills training/upskilling, education programs, employment assistance, benefit applications, or family reunification. Some providers (e.g., St. Joseph Center) provide transportation to assist individuals in connecting to services (particularly housing navigation) in an effort to reduce barriers. These all greatly improve a person's chance in applying for and obtaining benefits and services.

Relationships – Despite LA County being so large, the people within the system have close and extensive working relationships These working relationships create a system of better partnerships, referral times and responsiveness between agencies.

Electronic Databases: Having **electronic case management and referral systems helps to streamline referrals between organizations** and provides the ability to store and share documents that clients may not otherwise have access to or be able to store themselves. Referrals are made between organizations for a variety of services including housing, basic needs, and healthcare. Staff can send referral forms and generally have a fairly quick turnaround time to respond. **Medical records from prison are automatically shared by LA County** when individuals seek benefits. This bypasses the need to request from CDCR which historically has not been very successful.

WEAKNESSES

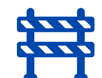
While the infrastructure to scale up benefits access for the older adult prison re-entry population exists, there are several weaknesses that must be addressed before a significant increase in the number of people served occurs:

Timing: The network of dedicated partners is primarily **focused on post-release activities**, which typically depend on clients' willingness and ability to follow-up. It is a commonly held belief among providers that benefits must be applied for, post-release. Per guidance from the federal Social Security Administration (SSA), this is simply untrue. Currently incarcerated individuals who wish to file applications for SSI benefits before release in LA County are able to apply but must do so on their own because the **County currently does not have prerelease agreements established between CDCR and the LA Office of the Social Security Administration**. Currently, scheduling an **intake or meeting with providers post-release can take several days**, which can dissuade clients from wanting to participate.

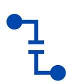
Siloed Services: The network is largely **siloed between re-entry and homeless providers.** This disconnect between providers can cause a lower prioritization rating in the system for sometimes the most vulnerable populations. Reentry clients may have a grave need [per the homeless prioritization system] in only one area (e.g., mental health) which, when entered in HMIS which prioritizes need based on multiple categories, puts them lower on the priority list for services. While the overlap in populations experiencing homelessness and those who have been impacted by the carceral system are substantial, the systems that serve these populations often treat them as distinct groups, rather than coordinating services to fit the profile of people who have both experiences. Additionally, **providers use different assessments** depending on the system they work within, which in addition to being cumbersome and repetitive for clients, are often also **not trauma-informed and can perpetuate racial bias.**

Conviction Restrictions: While the homeless system theoretically has a "no-wrong-doors" approach that seeks to impose as few barriers as possible on people experiencing homelessness, **some providers across the reentry and homeless systems, including landlords for housing, *do* limit who they will serve**. Screening criteria within these systems can include denying clients who served or are serving sentences related to violent crimes, convictions related to drug use or sales, or sexual offenses. In order to scale access to benefits, **barriers must be eliminated to the greatest extent possible.**

Barriers to Services: The system struggles to serve the older adult re-entry population, often reporting that **older adults face technological barriers** – such as not having access to a cell phone or to the internet, or lacking computer literacy – **and have higher health barriers,** including age-correlated diseases like dementia. When older adults lack access to technology, this can often bar them from completing documentation and staying in touch with their case managers and/or advocates. While providing cell phones to the older adult re-entry population is certainly an important strategy moving forward, this challenge points to the larger **need for pre-release benefits connections** so that technological literacy has virtually no bearing on benefits access in the first place.



Disconnection: The network is comprised of larger organizations and also **smaller "mom and pop" organizations who do good work but who are not connected to the larger network**. They also do not receive funding sources that others do which empower the network as a whole through their work. Assistance in formalizing their networks and **getting funding for these organizations is needed to enhance and grow the capacity of the system.** Additionally, **connections to CDCR to provide in-reach are extremely limited**. CBO's having access to clients pre-release would greatly enhance the ability to get connected to services and benefits post-release. Both sides (stakeholders interviewed and CDCR) expressed willingness and interest in partnering with the other.



Lack of Healthcare History: Those who have **more severe medical needs either from years spent incarcerated or on the streets tend to not have had regular contact with a primary care provider**, making it challenging for providers to obtain documents or a diagnosis when applying for benefits. This is also true for those who have previously resided out of state. Additionally, individuals and providers have a general lack of understanding of what documentation is needed when applying for benefits. Thus, applications are submitted often times with the purpose of identifying what documents are needed – prolonging the time in which a person will receive their benefits.

Staffing: Since the pandemic, **staffing shortages have affected the system** – both in referring and response times, and in the ability to access clients (e.g., while in custody). While some programs implemented (e.g., Project Roomkey) assisted organizations in partnering together and co-located to provide services, those programs are also now ending. Stakeholders expressed differences in programs like CBEST having diminished capacity and services since the onslaught of the pandemic. This has created a backflow of providers moving forward with the application process on their own while they wait for a reply from CBEST. Not all staff have training in this process or know what or where to acquire documents. SSA also noted a reduction in both contacts to their agency as well as applications among vulnerable populations since the start of the pandemic.

Programs are time limited creating barriers in providing a continuum of care for clients. Having to transition between programs – all of which require a different intake process – can be daunting for clients and can also make applying for benefits challenging when the length of time in a program and access to a case worker/advocate does not line up with the timeline of the application process. Added challenges include clients becoming re-incarcerated during the process in which case workers lose touch with them, or the application becomes further delayed due to the time spent incarcerated.

Assessments: Assessing older adults for benefit eligibility is not always automatic. Some providers noted that they only provide a referral to CBEST or DPSS if their client explicitly expresses that they would like to pursue re-accessing or applying to benefits for the first time. To ensure that everyone who qualifies for public benefits is supported in applying, assessments conducted by providers about eligibility should be automatic. Additionally, as referrals are made, providers require a system that updates in real-time about the latest status of their clients so that they can know if benefit applications were successfully submitted or approved, or that the client is progressing through the necessary steps. Many times, **the onus is on case managers to follow up repeatedly with agencies and/or clients to learn of their progress, rather than having an automated system that they can check.**

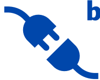
Information Sharing: CHAMP is limited in the information it can store and send and is further limited by the accuracy or quantity of information entered by staff across organizations. CHAMP also has two sides to the database (reentry and homelessness) which are separate and not accessible to people even with log-ins. **DHS and ODR have access to additional information in the diversion side of the database, but this is not readily available to other stakeholders.** Additionally, DHS tracks referrals in a spreadsheet, and once a client is enrolled, completes the intake process, and is assigned to a staff member, the client file is then uploaded into CHAMP, which can result in error due to the time elapsed since initial enrollment. There is also a referring system within CHAMP, but it does not send extensive

information or files to the referral organization, it is more of a note within the client file listing additional contacts and services. This process further requires a formal partnership between organizations to track referrals and add the referral organization as a provider for the client, of which creates disjointed service provision.

Inefficiencies: Lack of interface between systems creates duplication, repetitiveness, and opportunity for error. HMIS and CHAMP are the two main databases used across the system, with each having different purposes and types of providers/staff who utilize them. For staff who utilize both systems, they are required to enter information in both databases. Often times information is incomplete, lacking, or indecipherable for what client the referring organization is referring to. Staff who utilize both have to check each system separately to ensure they have not missed updates on clients, which creates inefficiency. Furthermore, both databases are generally not accessible by most reentry service providers – including CDCR who uses ARMS for their program management, creating gaps in the system.

OPPORTUNITIES

Given the interest and willingness of stakeholders to improve this system, there is great opportunity to create a more robust and effective system improving access to benefits and care for those exiting incarceration.



Connections: CDCR TCMP staff are already working with adults pre-release on identifying needs and beginning applications for benefits. Having direct connections between external CBO's and the CDCR staff would create an opportunity for warm handoffs to services and a shortened time in the benefit application process. People exiting could potentially be approved sooner for benefits which would still fall within the timeframe of the program they enroll in, thus shortening the time for them to qualify for and access housing.

Marketing & Training: While CBEST is known among SPA leads and immediate stakeholders, there is **not a lot of knowledge of the program within the reentry community.** Having a clear understanding of CBEST services and expectations could dimmish barriers that may delay receiving services or that unintentionally complicate the process; thus, reducing the number of participants that prematurely terminate their services. Having many types of service providers that could engage with one another across the network would only serve to help case workers and clients alike. As it is now, **providers work off of personal referrals/knowledge of services available and are constantly conducting outreach** to learn about new organizations which is time consuming and inefficient.

Skilled Workers: DHS implemented medical workers through the Whole Person Care model in the county jails. These workers were able to request most of the necessary documentation for SSDI, which expedited the process for CBEST. **Having trained and skilled workers specific to healthcare ensures clients are linked with appropriate services and that documents can be accessed in an expedited manner.**

Transportation: STOP providers pick people up upon release from the prison and transport them directly to their home county. Transportation is especially important for the older adult population as many may not have families or contacts to assist in their transition home. **By providing transportation between prison and home, and then between providers while at home will ensure individuals are able to access resources and services they otherwise would not have access to.**

Improve Communication: Several **organizations are already exploring programs and opportunities to better address homelessness and access to benefits** for the older adult reentry population. Having greater communication between stakeholders would increase the ability to implement these programs through pooled resources.

Dispelling myths about benefits among the older adult reentry population prior to being released from incarceration would help to decrease misinformation and increase applications. SSA previously participated in PACT meetings [prior to the pandemic] and found it beneficial to directly answer questions and provide information for those recently released.

Accessibility: SSA offers the "Second Tenant Program" where clients can meet virtually with SSA staff to have their initial appointment for a social security card. It serves as a beneficial accommodation for people with disabilities or for mental health reasons are unable to go in person or who lack transportation. If changes need to be made, then the virtual option is lost, and the client will need to meet in person. Currently only four SSA locations in LA utilize the program. **Having additional accessible options for benefit applications would enhance the ability for the most vulnerable clients to apply.**

Liaison: Having a **liaison between agencies** to answer questions and follow up on applications would be beneficial for clients and providers. Currently, if an organization participates in SSA's "People Facing Barriers" program, they will have access to a SSA liaison who helps with submitting claims and following up on incomplete claims, but others do not have this access and experience barriers while assisting clients. **Service providers having a direct line of communication with Social Services and the doctors who are diagnosing individuals with disabilities would help to speed up the process for contact and service procurement**. Also, having a liaison or direct line of communication between CBO's/CBEST and SSA to answer questions about disability claims, the application process and the extent of work required to submit an application would help to reduce questions and confusion about the process.

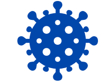
Centralized Referral System: With so many different entities involved with various aspects of service for the target population (e.g., corrections, reentry, homelessness) **there is a need for a centralized database that houses all client information, documents, case notes and referrals**. Within the current systems (i.e., CHAMP, HMIS), there are duplicate or incomplete entries which leads to confusion when making referrals and/or servicing clients. Merging or cleaning up these entries in addition to providing training to stakeholders on usage will create a more efficient system. This would also enable providers to better assist clients by having the ability of knowing where a process was begun/terminated in the instance of a client who was reincarcerated or who lapsed in accessing services.

Centralized Information System: Having **a dedicated website or central place with current and accurate information** specific to the older adult reentry population would be beneficial. As it is now, websites for stakeholders either do not provide this type of information, phone numbers are not in service, or information is difficult to find. This would enable clients, service providers and family members of clients to locate and access information in one convenient location. Additionally, while the hotline process through CBEST has been updated to provide a tentative timeline to clients upon application, having some sort of system in place where clients or case workers can check the current status of applications would help **reduce inefficiencies and redundancies.**

Streamline Processes: Revisit intake processes for service providers and align forms and assessments. Each organization has their own intake process which, in some instances, can take up to a week to schedule an initial visit or get assessed for a client. Delaying access to services can lead to individuals getting turned off from the process, getting re-arrested or having escalated health issues which winds them up in the emergency room. Ultimately these delays can result in increased healthcare utilization and expense to the system.

THREATS

COVID 19 Impact: The implications of the **COVID-19 pandemic significantly impacted existing systems of care and coordinated services**. During the pandemic, jails, prisons, government organizations, and community-based organizations coordinating reentry or homeless services were modified to reduce risk of exposure and infection, and new programs were developed to coordinate housing and benefits navigation. Several of these programs (e.g., Project Roomkey) were temporary due to funding and are no longer in existence despite having aspects that worked well.



Staffing Challenges lead to longer processing times. Stakeholders reported CBEST had previously requested a pause on new referrals due to low staffing. CBEST also started outsourcing their referral process which has caused roadblocks for clients when the community-based workers are not as knowledgeable or proactive with the referral process. Finding qualified and trained individuals for open positions, coupled with burnout in the field and comparatively low pay, compounds the challenges in recruiting and remaining fully staffed. A number of **organizations are hiring individuals with lived experience which enhances trust and rapport** and positively impacts open, ongoing communication with clients who are typically difficult to reach. Individuals with lived experience encounter barriers in passing background checks or getting clearance into the carceral system to provide in-reach services. Without relaxing these requirements, finding qualified staffing will continue to be a challenge.

Stigma associated with conviction histories prevent older adults from equitably accessing the tools for successful re-entry like housing and employment. People tend to have a general hesitancy to disclose convictions for fear of it being a barrier to services. This stigma against the backdrop of Southern California's affordable housing crisis makes for often-insurmountable barriers for older adults returning to the community from prison. Additionally, **convictions that are drug related**, which affects many of those reentering, **remain a disqualifier when applying for housing and for benefits**.

Health Conditions: Older adults in prison report a high incidence of **chronic conditions,** including physical and mental disabilities, and the inability to complete daily activities independently[22]. Roughly 80% of individuals in STOP have history of SUD and around 25% have co-occurring disorders. Many also possess prominent levels of trauma and PTSD. Severely mentally or physically ill individuals are usually screened out of STOP services due to higher level of care needed. Providers try to provide temporary assistance and linkages to resources for these individuals, but **there is a lack of providers who can take in these types of cases, or the wait times for enrollment extend past the time the referring provider can provide services**, resulting in discharging the client back to parole or out on their own. There are also challenges with SUD individuals applying for SSI/SSDI as **SUD is not a recognized disability, and cases where the SUD could have caused or contributed to the disability, benefits tend to not be approved**, meaning the people STOP does assist with benefits may not qualify based on their SUD diagnosis.

Government Disconnect: Stakeholders conveyed a disconnect between the city of Los Angeles and the County. City council districts have direct control over the beds and services they pay for, creating additional steps in the process. **CDCR needs to have a direct connection to the city council districts, or the process as a whole needs to be adjusted** so that LAHSA/CBO's have direct control instead of needing to coordinate with representatives from each council district.

[22] Burke, G., Prunhuber, P., Phan, T., and Takshi, S. (May, 2022). Issue Brief: Reducing Barrier to Reentry for Older Adults Leaving Incarceration. https://justiceinaging.org/issue-brief-reducing-barriers-to-reentry-for-older-adults-leaving-incarceration/

Location: The proximity of CDCR prisons and local CBO's (Appendix B) **creates an inability to provide effective in-reach to people pre-release.** The majority of CDCR prisons are located in rural areas throughout the state. With CBO's already having limited resources, being able to visit these locations and meet with clients would not be realistic.

The Social Security Administration imposes substantial documentation requirements before individuals can access disabilities benefits. Obtaining documentation and storing documentation are significant barriers for the older adult prison re-entry population. Many older adults are returning home after decades of incarceration which complicates where documentation might be located as systems have changed throughout the years. Further, accessibility and struggles with computer literacy make data storage for clients challenging once the documents are located.

The time it takes to go from being referred to benefits access support to finding out the status of one's application is substantial. For some, it can take six months just to find out they were denied and then they must go through the cumbersome process of appealing their claim. There is also the added challenge of providers utilizing several different databases that do not talk to one another and have information sharing limitations due to HIPAA. These challenges create **workflow complications, duplication of information and inefficiencies** for staff accessing and entering data as well as clients needing to receive updates on their applications or files.

Technical challenges plague the older adult reentry population. Clients tend to lose their cell phone and do not have access or the ability to access the internet which creates challenges when following up on services, checking the status of applications, or for storing information. Compounding these challenges, the older adult reentry population tends to not trust the internet and prefers to speak to people over the phone creating the need for a dedicated liaison for benefit applications.

Phase 2 Conclusion

Despite the robust services available in LA County for those returning home from incarceration and who face homelessness, there are many challenges in accessing these services, creating unintended roadblocks for people who require the greatest assistance. Many themes emerged throughout the SWOT analysis which were explored in Phase 3 through a future system design recommendation.

Phase 3

Phase 3 consisted of summarizing findings from the focus groups, interviews and the SWOT analysis to identify existing resources, processes and opportunities to enhance referrals and information-sharing, streamlining access to services. Proposed recommendations are reflected a comprehensive future state design.

Future State Design

Housing circumstances and recidivism are directly linked for those returning from prison. Studies show that for those exiting prison, while most exit to live with parents or family members, nearly one third face some sort of housing instability, and about 10% experience homelessness in the year following release[23]. For LA County, these numbers are much higher (70.5% of total unsheltered adults aged 25+ are formerly incarcerated[24]). With the increasing number of older adults exiting prison who are not able to work or who are barred from work because of their age, conviction(s), health conditions or disabilities, and who may or may not have ties with loved ones to return to, the number of people living unhoused will continue to increase exponentially. These factors make identifying and creating linkages to benefits and programs that will assist them in obtaining housing and basic needs, imperative to their survival.

Launched in 2007 by the National Institute of Corrections (NIC) and Urban Institute, the Transition from Jail to Community (TJC) model was initially piloted in six jurisdictions nationwide, including neighboring Orange County, California. The model was designed to advance coordinated and collaborated relationships between jail and local community organizations[25]. Findings from the initial pilot suggested developing and using an effective case management process to include a strong community handoff component, ensuring continuity of care between in-jail and community-based programs and services helps to reduce recidivism.

Since development of the TJC model, a Transition from Prison to Community (TPC) model was implemented to encourage strategic system changes to reduce recidivism and future victimization, to enhance public safety and to improve the lives of communities, crime survivors and those with conviction histories. Model components include:

- **Mobilizing** interdisciplinary, collaborative leadership teams,
- Engaging in a rational planning process to define goals and **developing a clear understanding of reentering populations** and their needs,
- **Integrating stages** of processing for previously incarcerated people from the carceral system all the way through release and supervision into the community,
- **Involving non-correctional stakeholders** to provide services and support,
- Assuring that people transitioning from custody are provided with **basic survival resources,**

[23] Dong KR, Must A, Tang AM, Beckwith CG, & Stopka TJ (2018a). Competing priorities that rival health in adults on probation in Rhode Island: Substance use recovery, employment, housing, and food intake. BMC Public Health, 18(1), 289–299. 10.1186/s12889-018-5201-7

[24] https://www.lahsa.org/documents?id=6593-adult-systems-involvement-hc22-data-report.pdf

[25] National Institute of Corrections. Transition from Jail to Community (TJC) https://nicic.gov/projects/transition-from-jail-to-community

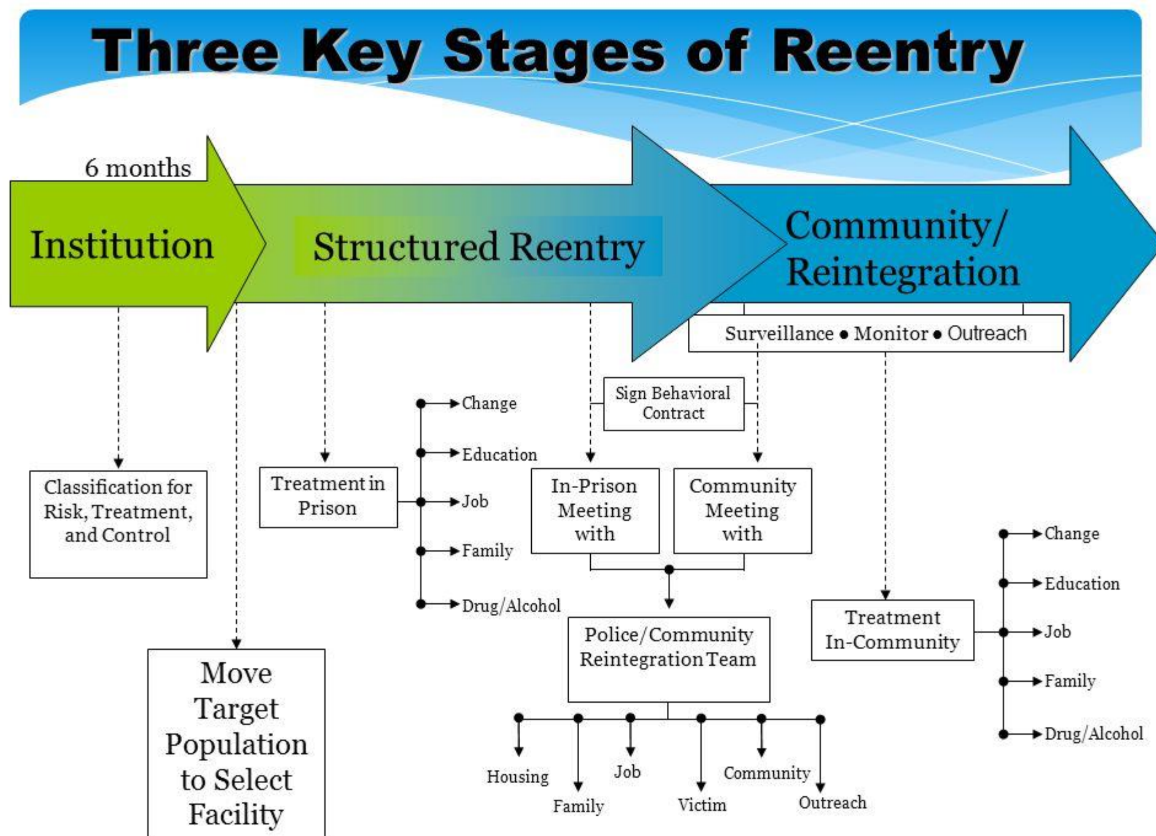
- Implementing **valid assessments** as people move through the system,
- Targeting **effective interventions**; and
- **Expanding traditional roles** of correctional staff to engage people in the process of change and developing the capacity to measure change towards specific outcomes that can be used for future improvements.

Essentially, the TPC model divides the transition process into three distinct phases, the institutional phase, the reentry phase, and the community phase. The institutional phase begins at admission and last until 6-12 months prior to release. During this time, CDCR would need to conduct initial assessments and develop a concrete case plan to guide the individuals programming during their time of incarceration.

The reentry phase begins 6 to 12 months prior to release and extends six months beyond release. This phase consists of completing the remaining programming indicated in the initial case plan (for high- and medium-risk clients) and addressing community stabilizing needs like obtaining identification and securing housing. During this phase, case planning is handed off to community supervision and would include re-assessment and referrals to community programming and services.

The final stage, community phase extends from six months after release through discharge from parole/probation supervisor to full integration into the community. During this phase, the focus would shift to long-term stabilization and extending pro-social support as formal supervision completes.

Throughout this plan, a Transitional Accountability Plan (TAP) underlies this entire process and is shared between all stakeholders involved in the process to ensure a coordinated and consistent plan for the client.

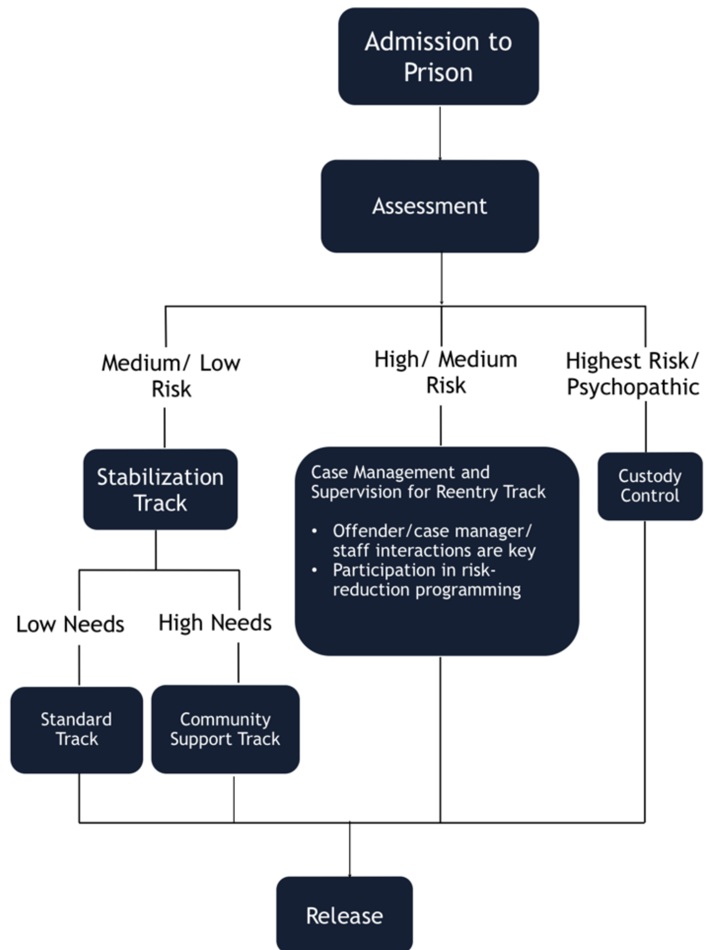


**Graphic Source: Technology Innovations in Corrections: https://slideplayer.com/slide/5725023/*

Based on interviews with stakeholders, research of the current state model and proven models like TJC/TPC, MWRS recommends the following system design to strengthen communication between agencies, streamline referral processes, increase linkages to SSI/SSP and social/health care services for older adults exiting the prison system with specific emphasis on addressing racial equity barriers.

Build Upon Pre-Release Programming & Planning

Similar to the TPC institutional phase, reentry should begin at admission to prison. While assessments are currently being conducted by CDCR at intake, the type of assessment needs to be revisited to reflect cultural and trauma needs for clients. Staff should also work with clients to create a release plan to help ensure that person is set up for success post-release. These plans currently are created closer to release dates and consist of CDCR TCMP staff recognizing a person's age and determining their likelihood of obtaining full-time work and/or the ability to care for themselves or be self-sufficient post-release. Referrals are then made to STOP programming for those who can work, or palliative care or hospice for those who cannot. TCMP staff also assist with beginning applications for benefits for those who may qualify. While this process is beneficial, in order to truly be effective, it needs to directly correlate and connect to external programming so a client can continue seamlessly post release.



Source: Modified from the Transition from Prison to Community (TPC) Implementation Handbook

Current pre-release programming in CDCR mainly focuses on general education and employment. While these types of workshops are helpful, older adults who may or may not have a disability, and/or who are unable to work, need to attend workshops that target their unique needs which include mental health programming related to stressors triggered by transitioning to living in the community after years and sometimes decades of incarceration, and utilizing modern technology like smart phones, phone applications, internet and computers to help people access resources and services once they are released. Ideally community-based service providers would have access to CDCR prisons to provide these types of programs pre-release, and then would have the ability to continue these services post-release. This not only gives the service provider time to form a relationship with the client, but the ability to be more aware of when the person is going to be released so as to coordinate transportation and services.

For pre-release planning to truly be effective, people being released need to connect with community-based providers and services months prior to their release. Specific to applying for SSI/SSDI benefits, simply providing a client with paperwork and/or status updates for applications that were started prior to their release and expecting them to be able to follow up and see through their application after release is not realistic. Having a program like CBEST who can provide pre-release support to begin applications and start

locating necessary documents prior to someone's release will cut down on the time post-release spent getting linked to services, waiting for intake, identifying missing documents and then applying for benefits. This should be an automatic process for all individuals who potentially qualify for benefits, and not just for those who request it. A prerelease agreement needs to be established between CDCR and CBEST or the Los Angeles Office of the Social Security Administration (SSA) so that either agency can provide application support and begin the process pre-release.

If CBEST or other providers are not able to access the prisons due to proximity, staffing, or other barriers, the applications that are began while in custody with TCMP staff need to be uploaded into an accessible electronic system so that the forms are not lost, forgotten about or discarded by the individual upon release, and providers on the outside are able to pick up where the process was left off. Most people exiting are primarily concerned about where they are going to live and how they are going to support themselves; so, having an established relationship with a provider, having basic knowledge of how to access services, and already having a start on their benefit applications will provide them with a more streamlined transition to the community.

Create Smooth Transitions from Prison to Community

Throughout the project, no stakeholders were identified as a service provider specific to the target population (older adults 50+ with incarceration history, who may or may not have a disability and who are experiencing homelessness). Stakeholders interviewed tended to provide services to more general populations of which the target population sometimes falls within. This results in few referrals or intakes specific to this population and highlights the great need for services tailored to their unique needs.

By creating a program, like STOP, but specific to the older reentry population and their individual needs will ensure individuals are 1) being transported home or to post-release programming safely, and 2) are connected directly with services specific to their needs (i.e., transitional or bridge housing, benefit enrollment, health and wellness, SUD etc.). The program should consist of transitional or bridge housing with wraparound support expanding on the programming and workshops offered while in custody. Additionally, individuals should be immediately provided with a cell phone or smart device so that providers are able to have reliable contact information for the person upon release. While there are concerns regarding the client losing or selling the device, or it being stolen, by directly connecting them with services and housing upon exit, the person will hopefully encounter less of a chance of this occurring.

Further Develop Post-Release Programming

Once placed into programming post-release, continued assistance with benefits applications and obtaining relevant documents (e.g., benefits related documents, identification, birth certificates, etc.) should be provided. The program should extend for at least six months so that clients have time to receive a response from their benefit application while still enrolled in the program. For those who have not received a response on their application, or the process is taking longer, an extension should be considered.

Creating a new (or expanding on the existing) Coordinated Entry System (CES) to include reentry service providers would ensure a truly "no wrong door" approach for this population. By streamlining intake

assessments, forms and processes, individuals entering the system would be able to access services quicker, bypass intake waiting times and having to repeat their information from provider to provider. Assessments and forms also need to be trauma informed and culturally relevant to not further stigmatize or underrepresent populations who are of the highest need. Prioritization processes for services needs to be revisited to factor in prior incarceration as an indicator of possible homelessness and vulnerability. As it is now, clients tend to have needs in only one area (e.g., mental health) and when entered into the current homeless system, their incarceration history is not considered and puts them at a lower priority for services.

Make Applying for Benefits Accessible for Clients

Expanding programs like SSA's "Second Tenant Program" where clients can meet virtually with providers will improve accessibility for those who lack transportation, mobility or who have mental health challenges that limit them from accessing services in person. Additionally, continuing onsite case management similar to the Project Roomkey programs where program staff meet directly with clients in the field at locations convenient to them will reduce disconnect and transportation barriers. Ideally clients will be linked with benefits prior to release, but for those who either are not able to complete application process while in custody, need to re-apply or have other needs, having immediate access to services and being met "where they are at" will create greater opportunities for benefit linkage.

SSA's "People Facing Barriers" program has a liaison component where agencies submitting applications have a direct line of contact with SSA who assists with submitting claims and following up on incomplete claims. Expanding this program to create liaisons dedicated to the target population would increase efficiency in the application process for asking questions about disability claims, understanding what forms or documentation may be needed or missing, and for status updates. Currently the onus on follow-up rests with the client, and for clients who have mental or physical health challenges, unstable or unsafe living environments, or may not have the ability to use or access to the technology needed to follow up, applying for benefits can be an impossible task. Through release of information agreements, community providers can have a direct line of communication with the agencies or departments making decisions on applications or disability diagnoses, which will help to speed up the process for contact, questions, and benefit procurement.

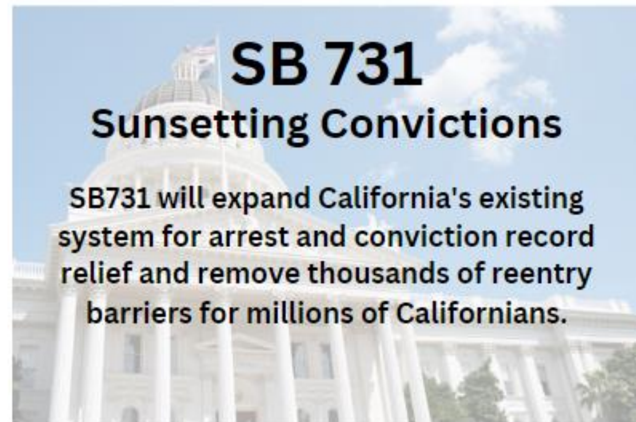
Additionally, having a dedicated website or central platform and automated phone system with current and accurate information on where and how to access or receive assistance with benefit applications and status updates would be beneficial to this population and the people who assist them in applying. Applicants and service providers alike need to know where they can access services and have linkages to liaisons who can answer questions regarding application status, missing or additional documentation requirements, and denials. While the current CBEST hotline provides tentative status updates, this system could be further developed to make it more efficient for clients.

Streamline Service Provision and Partnerships

Both CDCR and community-based organizations (CBO's) expressed the desire to collaborate with one another. By streamlining the process for developing memorandums of understanding (MOU's), contracts or general referral systems, both sides will be more aware of programs available for the target population and be able to better refer people within the systems. For providers who are able to provide in-reach services, they will be able to develop relationships with people exiting, which studies show create a greater chance of the person seeking and participating in services post-release.

DHS implemented medical workers to provide in-reach through the Whole Person Care model in the county jails. These individuals helped access medical records, apply for benefits, and connect individuals with SUD

or mental health needs to services post-release. By having skilled and experienced staff, it helped to cut down time accessing documents, streamlined processes, and created better connections with clients. Individuals with lived incarceration experience know the carceral system better than anyone and have been proven to better connect with and communicate with clients as well as know how to navigate services. The current system tends to screen these individuals out of employment or prohibits access to jails/prisons due to their past convictions. Recently passed senate bill 731 (SB731), effective July 1, 2023, will help with this in that convictions for most felonies will essentially "fall off" after a person has completed their terms, conditions, and supervision, and has not been convicted of any new felony offense for four years after this period. This will create opportunities for people to access jobs and provide services they historically have not been able to. Since COVID-19, staff burnout and turnover has been high, being able to hire a community of people who are skilled, ready to work and know the system would be invaluable to the program's success.



Creating a multidisciplinary task force or ad hoc committee to include providers from both the homeless and reentry communities, specific to the older adult population, can ensure communication between stakeholders, planning, evaluation, and implementation of new practices. This group should also seek opportunities to pool resources, apply for funding, and collaborate for advocacy and policy change. Meetings could provide a forum for agencies like SSA and LAHSA to provide training on processes and best practices for data sharing, referrals and services that benefit the target population.

Unify Information Sharing and Referral Systems

Currently, there are three (3) main databases used among providers (ARMS, HMIS, CHAMP), none of which "talk" to one another, share data or make effective referrals to all types of services. These systems are also unique to either homeless providers or to reentry providers but not to both. To cut down on data entry inefficiencies, staff time spent by locating and developing relationships with providers and making referrals that may be outdated or not conducive to the client's needs, a centralized database that is utilized for case notes, making referrals, tracking applications, updating client information, and that also connects with 211 would create for a more unified and seamless system.

An ideal system would have the ability to store documents (e.g., benefits applications, client income, personal and healthcare documentation, etc.) and make service referrals that all types of providers across the county could access. Providers would have different levels of access depending on the service they provide or position they hold within the organization so as to retain HIPAA compliance and to limit the types of data that is accessible where privacy may be of concern. Documentation storage would prove to be beneficial for clients who do not have space or ability to store and carry documents with them and would cut down on time spent by providers locating and tracking down documentation. Universal access would ensure that both "mom and pop" type organizations as well as governmental agencies like CDCR, CBEST, the Department of Motor Vehicles (DMV), DPSS and the Sheriff's Department could access the system to make/receive referrals, know what type(s) of services a client has accessed, completed, or if they have discontinued service or been rearrested – which is an element of the TJC model that was proven to be useful [having the ability to follow the client through the system from incarceration, through community and back if necessary]. This type of database, with ongoing required training on processes and data entry, would create a for a smoother continuum of care for clients and provide staff with the ability to pick up where someone else left off, cutting down on service time and relieving the client from having to remember/track who they spoke to, things they have done or

where they are at in the system.

This system should also have the ability to run demographic and service-related reports used to better serve clients, provide useful data and to support future system or programmatic enhancements. By having one centralized system, there will be a reduction in human inputting error which currently occurs from entering data into multiple systems. Whomever accesses the system can provide the most up-to-date contact information, case notes, or documents necessary to serve the client which can be accessed by the next provider. By being able to see who the last known trusted provider was, or if the person has a history of incarceration or homelessness, providers will be able to better tailor or deliver services for the client. Web based systems like 'Open Referral' or 'Unite Us' which are working to improve data quality, streamline processes, improve service delivery, and better connect providers, should be explored.

Conduct Consistent Training & Employ Effective Outreach Efforts

Consistent training across the network for providers on processes for benefit applications (including what the benefit application process is, what is needed, who is eligible etc.) and available resources for clients, would ensure all stakeholders are providing clients with accurate and reliable information. Consistent training should also be conducted for the centralized database on data entry/management, quality assurance, and reporting to ensure that all stakeholders are employing similar methods for service delivery, tracking, and reporting.

While CBEST is relatively known across stakeholders within the homeless provider network, there is a lack of awareness and understanding of the services they provide within the reentry network. By employing effective outreach and marketing methods targeting the reentry community and smaller organizations within the homeless provider network, the entire network would have a clearer understanding of CBEST services, processes and how to utilize or access the resource.

Policy Recommendations for System Improvement

In January 2023, California became the first state permitted to provide benefits under Medicaid (i.e., Medi-Cal) to currently incarcerated individuals. These benefits will go into effect 90 days before discharge to ensure a smoother transition to the community. Eligible enrollees include those who are pregnant, have mental health challenges, SUD, or chronic physical conditions and disabilities, as well as youth in juvenile facilities. This was approved by the Department of Health and Human Services through a waiver of long-standing federal rules that prevented coverage of people who were in custody of the carceral system[26]. While this is a historic first, expanding this same policy to include SSI/SSDI benefits for the older adult reentry population could ensure that people exiting the system would transition more easily into programming or housing that will prevent them from living on the streets without basic needs and/or care.

Individuals with sex offenses and/or drug related convictions typically face the highest obstacles when obtaining housing. These barriers, by default, create a system of people living unhoused or who end up rearrested and back in the system due to supervision violations. In 2022, California Assembly Bill 2383 (AB 2383) was introduced to make it a discriminatory housing practice for rental housing owners to inquire about or require an applicant to disclose criminal convictions during the initial application process (unless required by state or federal law). Passing of this law would improve opportunities for individuals typically screened out to gain access to housing.

Service providers can also employ similar screening tactics, providing services based on criteria related to

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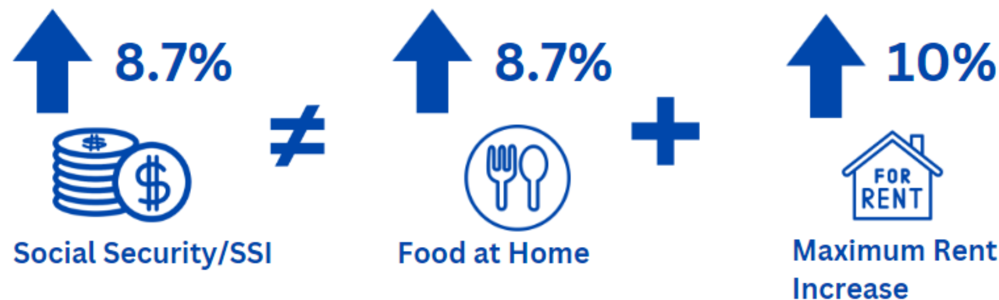
[26] Department of Healthcare Services (DHS) CalAIM
https://www.dhcs.ca.gov/CalAIM/Pages/Justice.aspx#:~:text=On%20January%2026%2C%202023%2C%20California,90%20days%20prior%20to%20release.

age or conviction type. Those with violent crimes, sex offenses or arson, who are above a certain age (e.g., older than what is considered to be Transitional Aged Youth (TAY) population) or who are unable to work often times have difficulties in accessing programs that will serve them. This leaves a large number of individuals without an avenue to access services or support. Providers should consider revisiting policies that may screen out the older reentry population or create new programs dedicated solely to the unique needs of this population.

The lack of housing inventory, coupled with rising rental costs, zoning issues, and the inflation of housing prices has priced most families – especially those with little-to-no income of their own – out of the housing market. This has led to an increase in unhoused populations throughout the state – particularly people 50+ and/or who are previously incarcerated. For seniors who rely on SSI/SSDI as their only source of income, the average 1-bedroom rental in LA County is not obtainable. A priority should be on developing affordable housing units and/or permanent supportive housing options for individuals who have mental illnesses, disabilities or who are otherwise unable to work.

Costs for basic needs are rising at rates incomes cannot keep up with. Since 2022, prices for food at home have increased 8.7%. Increases range from 2.6% for fruits and vegetables to 15.5% for cereals and bakery products[27]. Effective August 1, 2022, to July 31, 2023, the maximum allowable rental increase in LA County is 10%[28]. Social Security benefits and SSI payments increased by 8.7% in 2023[29]. With inflation affecting things like food and rental prices, older adults who rely on SSI/SSDI to survive will not be able to afford to live. Programs like SSP need to be increased to meet the need. SSP benefits increased in 2023 by 10.3% (roughly $21 for individuals and $52 for couples)[30] which does not make up for the drastic increase in food prices. In order for older adults with disabilities and/or who have the inability to work, supplemental programs need to be revisited so older people are not forced into food insecurity or homelessness.



Stakeholders interviewed mentioned the disconnect between the City of Los Angeles and the County of Los Angeles with regards to housing and shelter policies. It would be advantageous for these entities to align services and streamline processes to cut down on redundancies and inefficiencies in accessing beds for unhoused individuals. It was also suggested that CDCR have a direct connection with the city council districts, or the process be adjusted so that LAHSA/community providers have direct control instead of needing to coordinate with representatives from each council district.

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[27] US Bureau of Labor Statistics. https://www.bls.gov/regions/west/news-release/consumerpriceindex_losangeles.htm#:~:text=Over%20the%20year%2C%20food%20prices,from%20home%20advanced%206.7%20percent.

[28] Los Angeles Housing Department. https://housing.lacity.org/highlights/renter-protections#:~:text=Effective%20August%201%2C%202022%20to,10%25%20whichever%20is%20lower)

[29] Social Security FAQ. https://faq.ssa.gov/en-us/Topic/article/KA-01951#:~:text=Social%20Security%20benefits%20and%20Supplemental,beneficiaries%20receive%20in%20January%202023.

[30] https://lao.ca.gov/Publications/Report/4707#:~:text=Based%20on%20this%20calculation%2C%20SSP,individuals%20and%20%2452%20for%20couples)

Conclusion

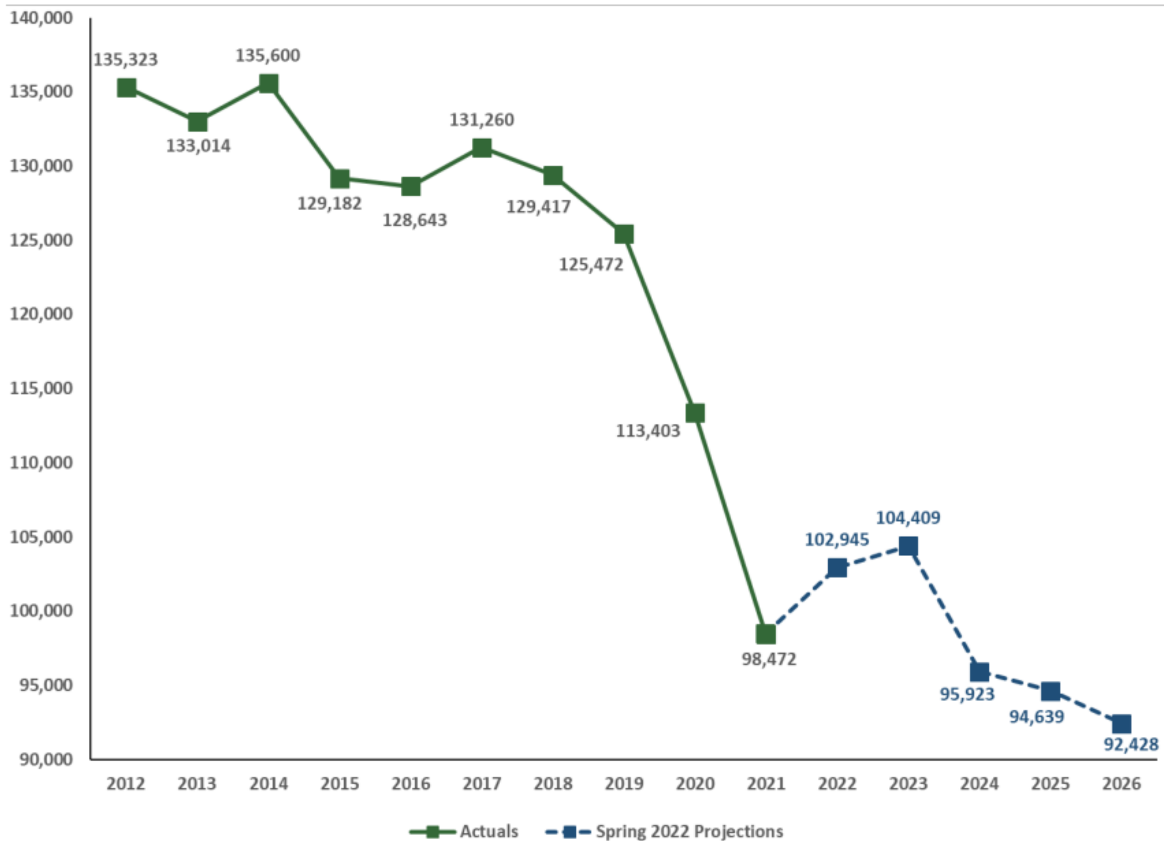
The older adult, reentry population returning home to Los Angeles County continues to grow, creating an ever-increasing need for services to accommodate their unique needs. Acquiring SSI/SSDI benefits upon exit from incarceration would impact this population's ability to obtain housing and secure basic needs needed to survive. Unfortunately, the process for accessing these benefits can be difficult to navigate, and systemic barriers related to a person's convictions (e.g., substance use or sexual offense) compound their ability to receive public benefits and in accessing housing.

Los Angeles County has a robust system of providers within the reentry and homeless systems, but not a lot of cross collaboration between the two. Additionally, systems used to refer clients to services are disjointed and duplicative, and once referred, the processes to access services are often lengthy and cumbersome creating fallout when clients lose interest, lose touch or are re-arrested.

By creating a unified system of care and addressing key policy issues, this population will be able to access SSI/SSDI benefits and the support needed to keep them from becoming unhoused. Without these necessary changes, individuals will continue to live homeless in our streets, creating a strain on the health systems, our communities and the carceral system.

Appendices

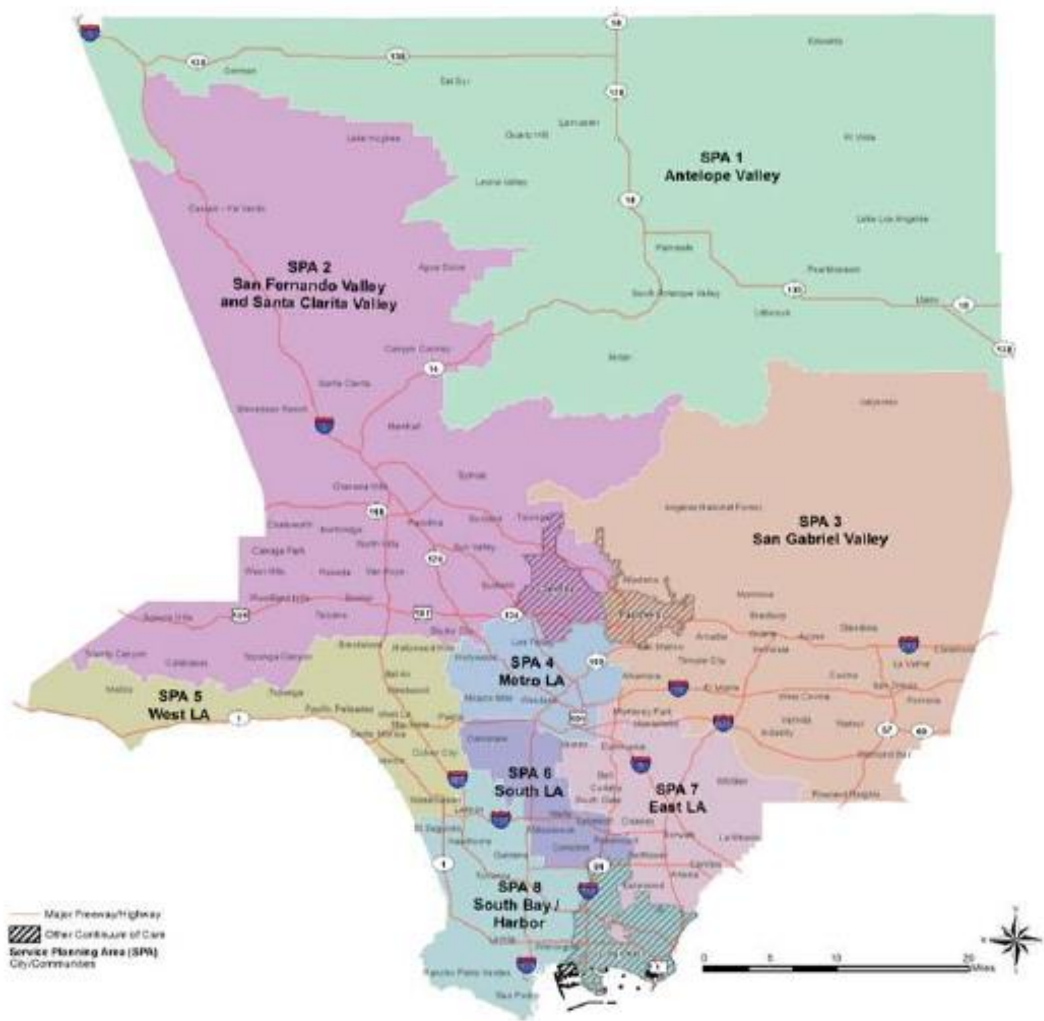
Appendix A. Prison Population Trends & Projections



Reference: https://www.cdcr.ca.gov/research/wp-content/uploads/sites/174/2022/05/Spring-2022-Population-Projections.pdf

Appendix B. Los Angeles Service Planning Areas (SPA's)

SERVICE PLANNING AREAS (SPAS)



SPA 1 - Antelope Valley
SPA 2 - San Fernando & Santa Clarita Valley
SPA 3 - San Gabriel Valley
SPA 4 - Metro Los Angeles
SPA 5 - West Los Angeles
SPA 6 - South Los Angeles
SPA 7 - East Los Angeles
SPA 8 - South Bay/Harbor City

Appendix C. What is CBEST?

WHO IS ELIGIBLE FOR SERVICES?

Individuals experiencing homelessness or at risk of homelessness who are:

- **Blind**
- **Disabled**
- **Elderly (65+)**
- **Veterans**

CBEST IS A PROGRAM OF:

Los Angeles County Department of Health Services (DHS)

- **Housing for Health (HFH)**

FUNDED BY:

The Los Angeles County Homeless Initiative and Measure H

WHAT IS CBEST?

THE COUNTYWIDE BENEFITS ENTITLEMENTS SERVICES TEAM

is a Department of Health Services (DHS) program, comprised of a dedicated team of benefits advocates, clinicians, and legal partners that assist individuals to apply for the following disability programs:

- Supplemental Security Income (SSI)
- Social Security Disability Insurance (SSDI)
- Cash Assistance Program for Immigrants (CAPI)
- Veteran's Benefits

CBEST SCOPE OF SERVICES*

- Assess and provide linkages to case management & housing resources
- Gather and summarize current/historical medical evidence
- Submit full and complete disability benefits applications
- Full scope legal services for appeals and post-award suspensions and terminations
- Provide representative payee services

HOW DO WE SEND REFERRALS TO CBEST?

ELECTRONIC REFERRALS

Organizations can refer potential clients by submitting the CBEST referral form via email to cbestreferral@dhs.lacounty.gov or by fax at: 213-482-3395.

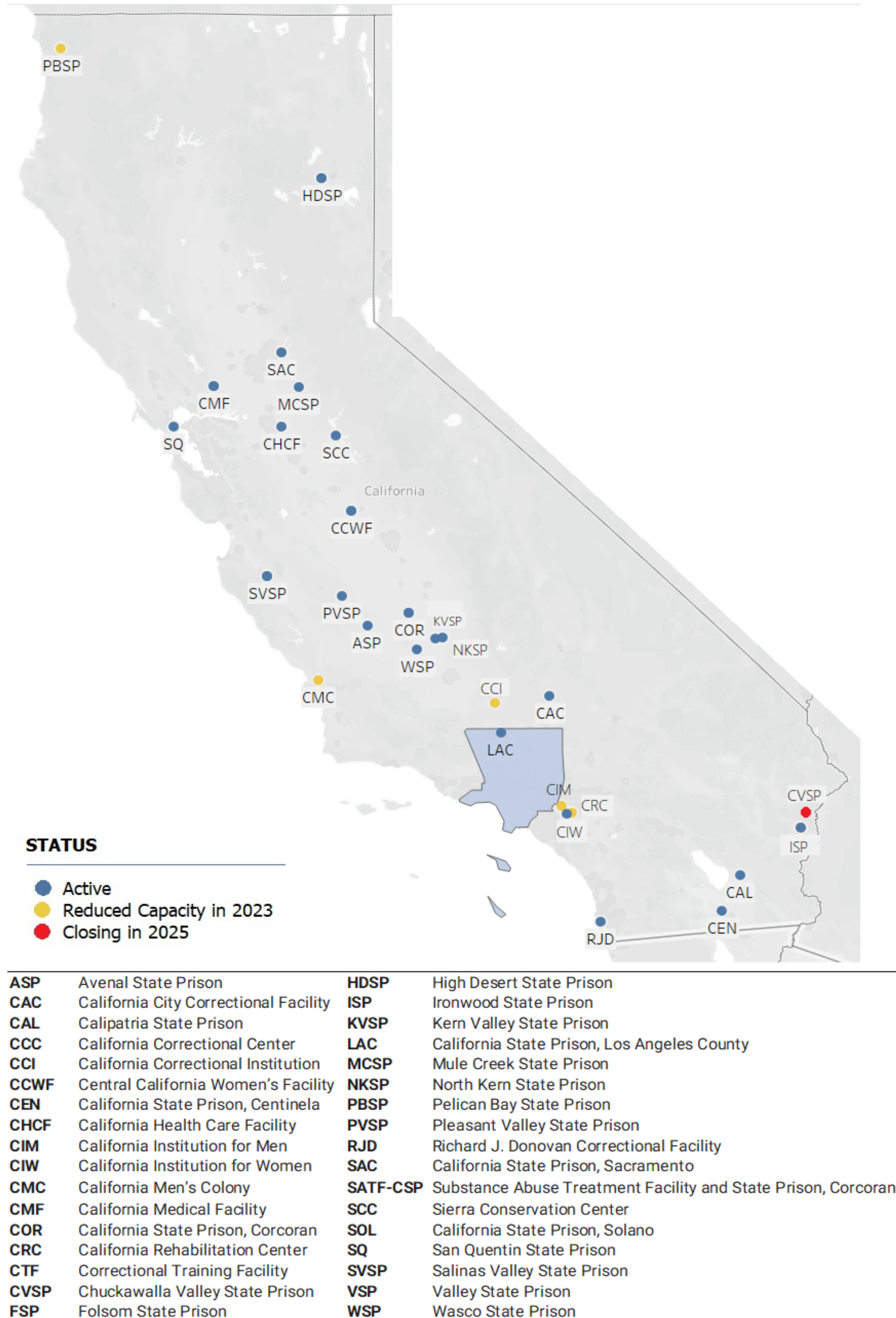
WALK- INS

Individuals who believe they may be eligible for CBEST can walk in to any of our partner community based organizations across the county and request a connection to CBEST (see back side of this sheet for locations across the county).

*The provision of CBEST services are contingent upon client need and CBEST recommendations.

Department of Health Services | Housing for Health Division | 238 E. 8th Street LA, CA 90014

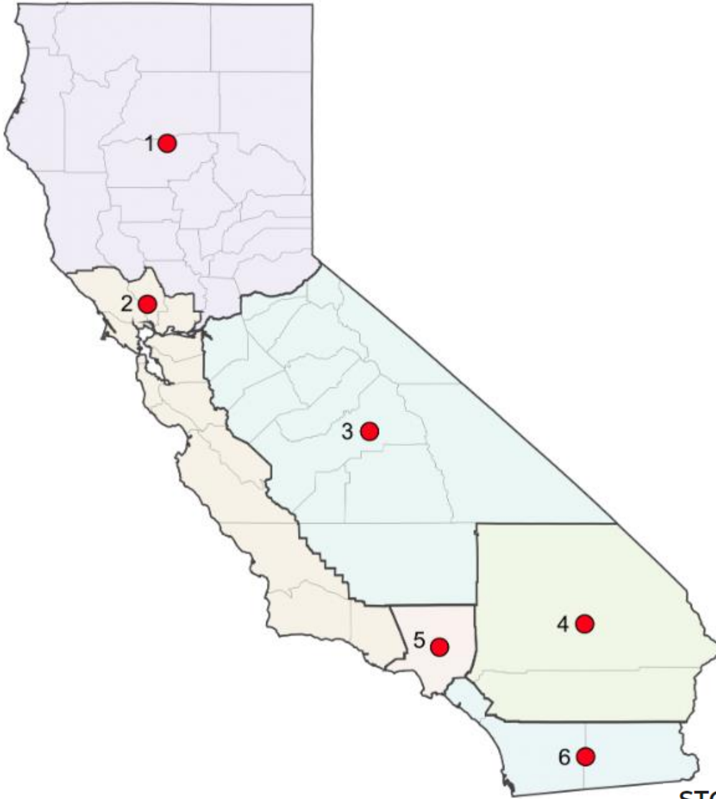
Appendix D. California State Adult Institutions Map



ASP	Avenal State Prison	**HDSP**	High Desert State Prison
CAC	California City Correctional Facility	**ISP**	Ironwood State Prison
CAL	Calipatria State Prison	**KVSP**	Kern Valley State Prison
CCC	California Correctional Center	**LAC**	California State Prison, Los Angeles County
CCI	California Correctional Institution	**MCSP**	Mule Creek State Prison
CCWF	Central California Women's Facility	**NKSP**	North Kern State Prison
CEN	California State Prison, Centinela	**PBSP**	Pelican Bay State Prison
CHCF	California Health Care Facility	**PVSP**	Pleasant Valley State Prison
CIM	California Institution for Men	**RJD**	Richard J. Donovan Correctional Facility
CIW	California Institution for Women	**SAC**	California State Prison, Sacramento
CMC	California Men's Colony	**SATF-CSP**	Substance Abuse Treatment Facility and State Prison, Corcoran
CMF	California Medical Facility	**SCC**	Sierra Conservation Center
COR	California State Prison, Corcoran	**SOL**	California State Prison, Solano
CRC	California Rehabilitation Center	**SQ**	San Quentin State Prison
CTF	Correctional Training Facility	**SVSP**	Salinas Valley State Prison
CVSP	Chuckawalla Valley State Prison	**VSP**	Valley State Prison
FSP	Folsom State Prison	**WSP**	Wasco State Prison

Appendix E. STOP Locations in California

Specialized Treatment for Optimized Programming (STOP) Program Map



STOP Program Areas / Contact Information:

To understand the above map, refer to each color block below. Detailed information is listed for each step.

1. **West Care**
   - Address: 1804 Tribute Road, Suite. K, Sacramento, CA, 95815
   - Tel: (916) 564-4400
2. **GEO**
   - Address: 100 East Hamilton Avenue, Campbell, CA, 95008
   - Tel: (408) 550-1679
3. **West Care**
   - Address: 2772 South Martin Luther King Boulevard, Fresno, CA, 93706
   - Tel: (559) 265-4800
4. **GEO**
   - Address: 1450 East Cooley Drive, Colton, CA, 91710
   - Tel: (909) 835-4606
5. **Amity Foundation**
   - Address: 3801 S Broadway, Los Angeles, CA, 90037
   - Tel: (213) 509-0330 or (323) 203-7228
6. **Health Right 360**
   - Address: 2515 Camino Del Rio South, Suite 204, San Diego, CA, 92018
   - Tel: (619) 326-9672

Appendix F. R-ICMS

Reentry Intensive Case Management Services

Reentry Intensive Case Management Services (RICMS) seeks to improve the health and well-being of justice-involved individuals by providing case management and service navigation. Community Health Workers with lived experience support individuals by determining their needs and making connections to relevant organizations and services including: