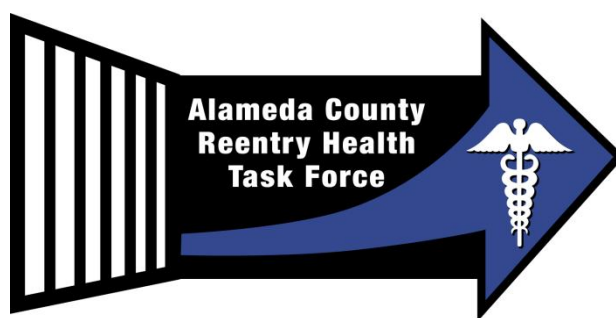


Reentry Health Care in Alameda County

Initial Assessment and Recommendations of the Alameda County Reentry Health Task Force

(A project of the Alameda County Reentry Network)



Arnold Perkins, Chair

Written by:
Bill Heiser
Junious Williams

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PREFACE

People being released from incarceration, whether from county jails or state and federal prisons, face an enormous set of challenges in reintegrating back into their families, communities and the broader society. They face challenges spanning from education to employment, from housing to social services, from family reunification to health. But the formerly incarcerated do not face these challenges alone—because every challenge they face is shared by their families and communities, many of which are already challenged by economic, educational, health and safety issues.

Given the large numbers of people who are and will be returning to our families and communities over the next few years, we must do a more effective job in understanding the challenges and barriers the formerly incarcerated, their families and communities face, and building effective policies and programs that will increase the likelihood that they can successfully reintegrate and become assets in rebuilding their families and communities.

The Reentry Health Task Force is the first in a series of Task Forces that the newly-formed Alameda County Reentry Network will convene to begin to systematically understand and address the challenges faced by those returning to our communities from incarceration (see www.acreentry.org for more information on the Reentry Network).

This inaugural Task Force would not have happened without the support of the Robert Wood Johnson Foundation which provided funds to cover cost of staffing the Task Force and preparing this report. Equally important, however, is the dedication and commitment of members of the Reentry Health Task Force, who regularly attended the Task Force meetings, participated in the discussions and contributed their thinking about how to improve the quantity and quality of health care services available to the formerly incarcerated. I would like to personally thank the members of the Task Force listed below, as well as their organizations that generously permitted them the time to participate. The commitment of the individuals and the organizations they represent is an example of the effort that all of us will have to make if we are to improve the health status of the formerly incarcerated and produce better results in reintegrating them back into the community and preventing them from returning to incarceration.

Arnold Perkins, Chair

Reentry Health Task Force Members

1. Kevin Ary, Sergeant, *Alameda County Sheriff's Office*
2. Robert Ayers, Warden, *California State Prison-San Quentin*
3. Mona Barra-Gibson, District Representative, *Office of State Senator Don Perata*
4. Laura Bowman, Community Partnership Manager, *California State Prison-San Quentin*
Rodney Brooks, Chief of Staff, Alameda County Supervisor Keith Carson
5. Jessica Buendia, Field Representative, *Office of Assembly Member Loni Hancock*
6. Doug Butler, Director, *Men of Valor Academy*
7. Josie Camacho, Director Constituent Services, *Office of the Mayor of Oakland*

8. Dean Chambers, Program Specialist, *Alameda County Behavior Health Care Services*
9. Arnold Chavez, Urban Male Health Initiative, *Alameda County Public Health Department*
10. Tony Crear, Community Network Coordinator, *Alameda County Probation Department*
11. Gloria Crowell, Co-Chair of the Allen Temple - AIDS Ministry, *Allen Temple Baptist Church*
12. Dennis DiBiase, Public Health Nurse, *California State Prison-San Quentin /Federal Receivers Office*
13. Fred Degree, Chaplaincy, *Regional Congregations and Neighborhood Organizations*
14. Nanette Dillard, Executive Director, *Associated Community Action Program (ACAP)*
15. Anna Dorman, Health Educator, *La Clinica De la Raza*
16. Mick Gardner, Measure Y Reentry Program Manager, *Oakland Human Services Department*
17. Carolyn Graham, Corrections and Reentry Program Director, *Volunteers of America*
18. Cherlita Gullem, Public Health Nurse, *California State Prison-San Quentin /Federal Receivers Office*
19. Dr. Tony Iton, Director, *Alameda County Public Health Department*
20. Rev. Raymond Lankford, Executive Director, *Healthy Oakland*
21. Rev. Jasper Lowery, Pastor, *Urojas Ministries*
22. Beth Newell, Project Analyst, *Alameda Health Consortium*
23. Dorsey Nunn, Director, *All of Us or None*
24. Shirley Poe, District Administrator, *California Parole Department*
25. Barbara Quintero, Operations Manager, *Women on the Way*
26. Vince Reyes, Assistant to the Director, *Alameda County Social Services*
27. Celsa Snead, Executive Director, *Mentoring Center*
28. Daniel Stevens, Pastor, *New Life COGIC*
29. Darryl Stewart, Oakland Constituent Liaison & Organizer, *Alameda County Supervisor Nate Miley*
30. Patricia Van Hook, Member, *Community Christian Church*

Reentry Health Task Force Planning Group

1. CHAIR: Arnold Perkins, former Director, *Alameda County Public Health Department*
2. Kenyatta Arnold, Research Assistant, *Urban Strategies Council*
3. Bill Heiser, Research and Program Associate, *Urban Strategies Council*
4. Rhody McCoy, Program Associate, *National Trust for the Development of African American Men*
5. Garry Mendez, Executive Director, *National Trust for the Development of African American Men*
6. Michael Shaw, Director, Urban Male Health Initiative, *Alameda County Public Health Department*
7. Rev. Lawrence Van Hook, Pastor, *Regional Congregations and Neighborhood Organizations*
8. Rev. Eugene Williams, Executive Director, *Regional Congregations and Neighborhood Organizations*
9. Junious Williams, CEO, *Urban Strategies Council*

The Alameda County Reentry Health Task Force would like to thank the Robert Wood Johnson Foundation for their generous support of this process through their funding of grant number 57323. All copyright interests in materials produced as a result of this grant are owned by Urban Strategies Council. The Robert Wood Johnson Foundation has a nonexclusive, irrevocable, perpetual, royalty-free license to reproduce, publish, summarize, excerpt or otherwise use or license others to use, in print or in electronic form any and all such materials produced in connection with this grant.



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REENTRY HEALTH CARE IN ALAMEDA COUNTY:

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EXECUTIVE SUMMARY

Prisoners and soon-to-be-released inmates in the U.S. are disproportionately afflicted with illnesses and tend to be sicker, on average, than the U.S. population. A Congressional report, *The Health Status of Soon-to-be Released Inmates—A Report to Congress*, documents significantly higher rates of communicable disease, mental illness, and chronic disease among releasees as compared to the general population. The health status of the formerly incarcerated is not only an issue for the reentry population, but a public health issue for the entire community. The Alameda County Reentry Health Task Force (Reentry Health Task Force) was designed to address these issues by identifying methods to improve the health status of the formerly incarcerated.

30% of people with hepatitis C and 40% of those with tuberculosis in the U.S. have served time in a prison or jail.

Overview of Task Force Process

The Reentry Health Task members included representatives of elected officials, county health agencies, law enforcement, the California Department of Corrections and Rehabilitation (corrections and parole), the federal court health receiver's office, organizations of formerly incarcerated people, service providers, and faith organizations, along with many others (for a full listing see the member list on p. iii). The Reentry Health Task Force received thirteen presentations addressing the Key Health Topics (general health; chronic diseases; communicable diseases; substance abuse; mental health; and oral, auditory and visual health). Presenters varied and included direct service providers, county agency directors, correctional medical staff, community-based medical providers and formerly incarcerated people.

The Reentry Health Task Force brought together these key stakeholders from across the county to identify and address the issues, problems and opportunities surrounding health care for the formerly incarcerated within the county. The Reentry Health Task Force was a seven-month process which included a series of briefings on Key Health Topics; a series of strategy, policy and program briefings; and a period of recommendation development. This process produced a set of recommendations which the Task Force believes will increase availability and improve the quality of health care for people after release from incarceration. The Reentry Health Task Force and its members will advocate for these recommendations across Alameda County, with the California Department of Corrections and Rehabilitation (CDCR) as well as with local, state and federal legislators. All documents and materials produced as part the Reentry Health Task Force are available on the website: <http://www.urbanstrategies.org/HealthTaskForce.html>

The Reentry Continuum and Health Care Needs flow chart on the following page gives a brief overview of the transition from incarceration to reentry and the general health care needs at each point along the way.

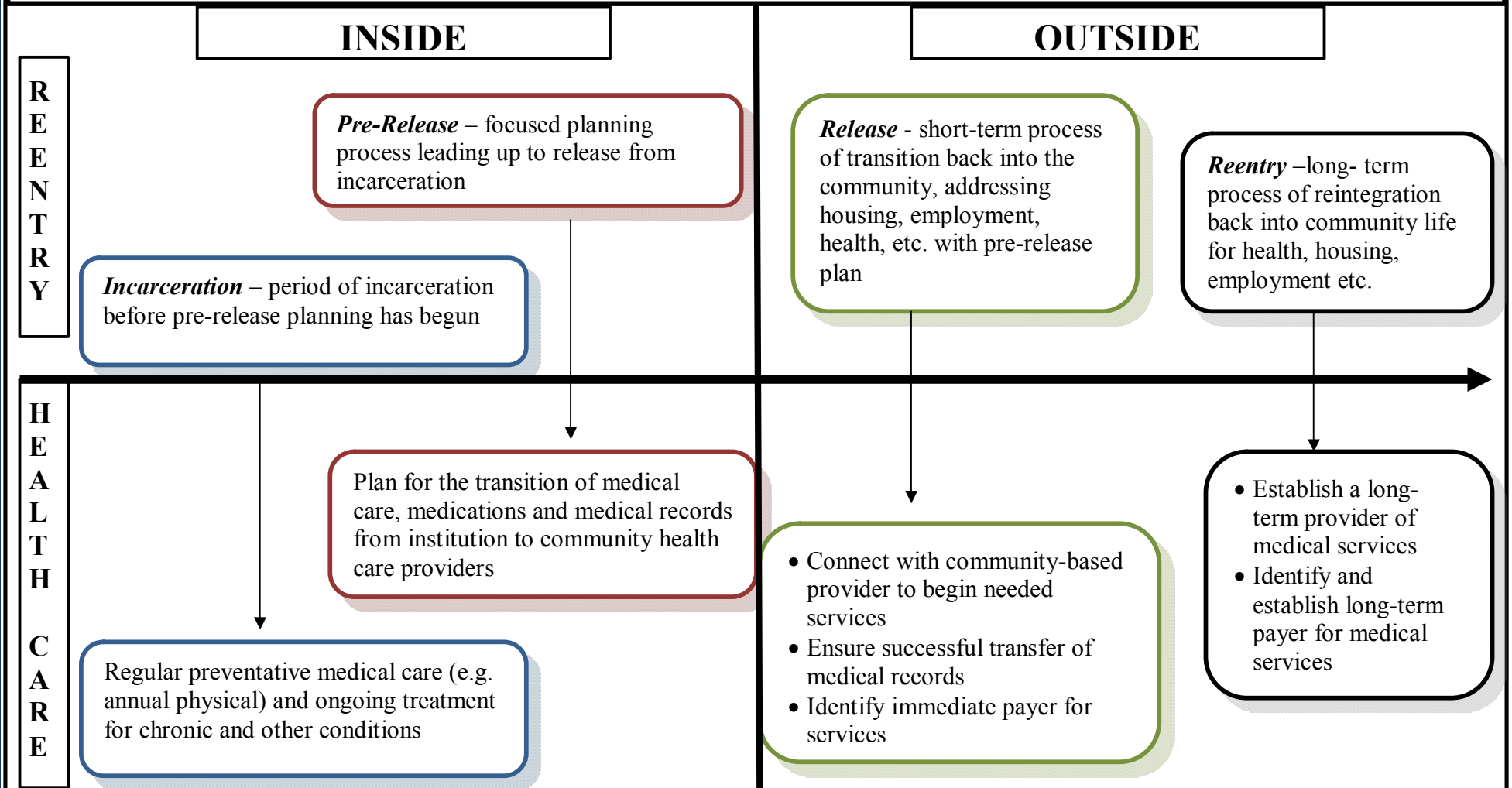


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Reentry Continuum and Health Care Needs





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Parole and Probation Population Data

In addition to the presentations on the Key Health Topics, the Reentry Health Task Force assembled data on the reentry population in Alameda County. We found that the population under criminal justice supervision (on probation or parole) as of June 2007 is conservatively estimated to be slightly over 20, 000 adults. This means that roughly 1 in 100 county residents is under criminal justice supervision. In Oakland, roughly 3 in 100 city residents are under criminal justice supervision.

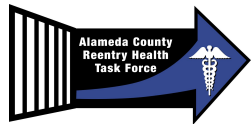
While we were unable to obtain address and city level data for the parolees and probationers for 2007, we do have these data for parolees from 2005. Based on this report from June 2005 we found that the parolee population in Alameda County was:

- Concentrated within Oakland (mainly West and East Oakland) and Hayward with 59% of all parolees residing in one of these two cities;
- Overwhelmingly male (91%);
- Under 50 years old (97%) with the largest proportion in the 30-40 age range; and
- Disproportionately people of color (84%) with African Americans comprising the largest ethnic group constituting 67% of the parolee population.

3 in every 100 Oakland residents and 1 in every 100 Alameda County residents are under criminal justice supervision.

In Map 1 on the next page we see geographic distribution of general or primary care providers across Alameda County overlaying the concentration of probationers and parolees. The shading of each city reflects the number of parolees and probationers within the city, with darker shading indicating a greater number of parolees and probationers. Each dot corresponds with a primary care provider that is a hospital, clinic or “other” (e.g. community organization that provides certain primary care services). The numbers located by each dot correspond with a table that provides the name and address of each primary care provider (to see the entire listing of general health care providers see the main report of the Reentry Health Task Force at <http://www.urbanstrategies.org/HealthTaskForce.html>).

Map 1 clearly shows that the largest share of the reentry population is located in Oakland as are the majority of primary care providers. However, Hayward lacks the comparable number of primary care providers considering the size of their reentry population.

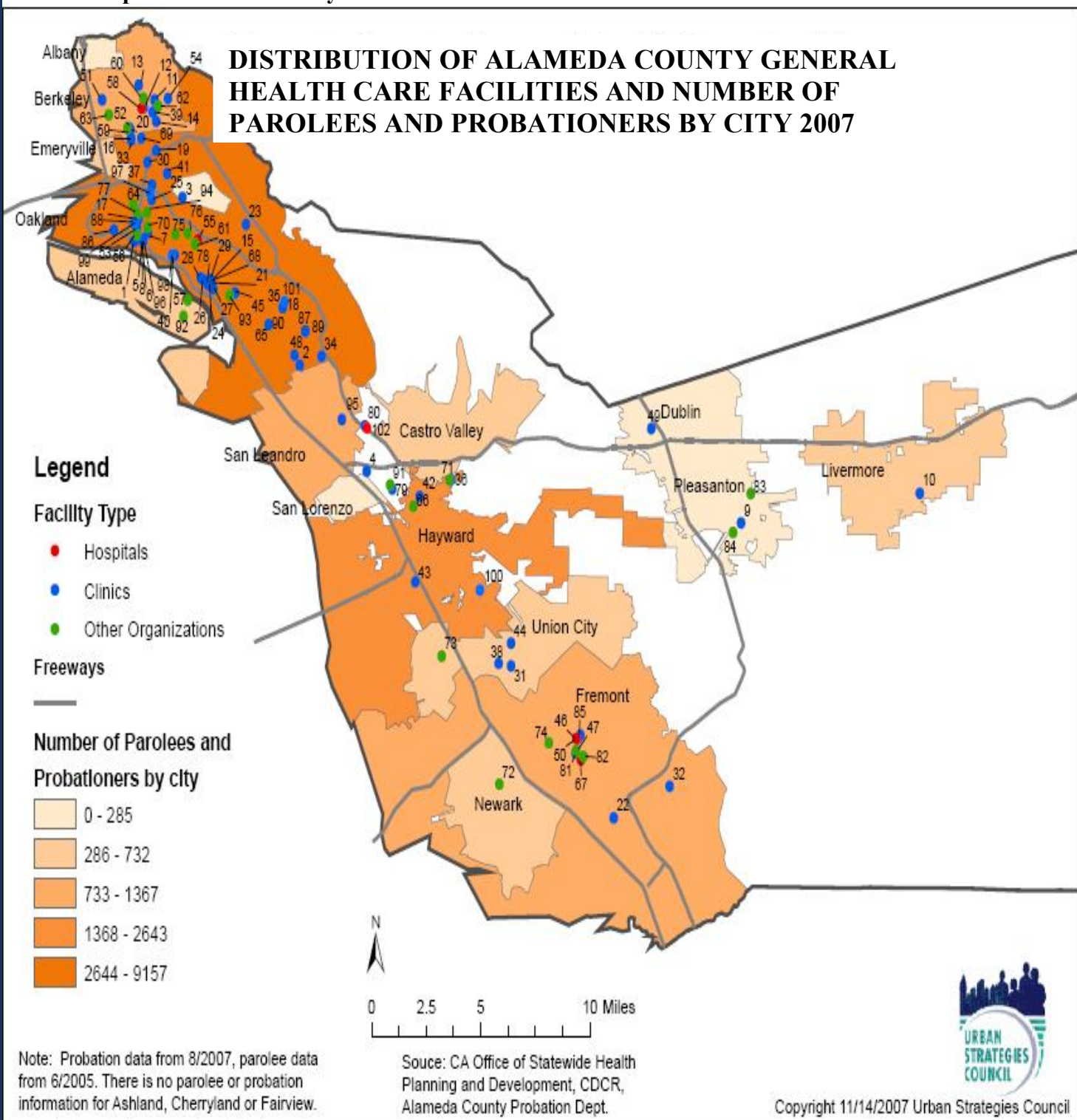


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Map 1: Alameda County General Health Care Facilities in 2007





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Health Status and Health Care for the Formerly Incarcerated of Alameda County

In addition to having a large number of parolees and probationers, Oakland and Hayward also have higher levels of coronary heart disease, mortality, diabetes, assault, homicide, teen births, tuberculosis, and AIDS.¹ The formerly incarcerated often enter these communities in very serious need of health care services, especially for substance abuse, communicable disease and mental health services. Consequently, the formerly incarcerated contribute to the communities' already high level of need for health care services.

We estimate that a minimum of 7% (11,452) of the 166,000 uninsured persons in Alameda County are currently under criminal justice supervision.

Unfortunately, meeting these needs is difficult since, in most cases, the formerly incarcerated return to the community uninsured and without a designated primary care provider. According to the California Health Interview Survey **there are currently 166,000 uninsured persons in Alameda County.** Determining how many of these people were currently under criminal justice supervision was difficult, especially considering data on uninsured formerly incarcerated persons do not exist. To begin addressing this situation, Urban Strategies Council and All of Us or None (www.allofusornone.org/) conducted a survey of 138 formerly incarcerated people within Alameda County. This survey found that among the formerly incarcerated:

- 57% had no health insurance;
- 20% had Medi-Cal or some other public health insurance; and
- 19.4% had insurance through their employer.²

Applying these results to the entire adult reentry population of 20,092, we estimate that **a minimum of 11,452 formerly incarcerated people in Alameda County are uninsured.** In other words, 7% of the 166,000 uninsured persons in Alameda County are currently under criminal justice supervision. The number of uninsured individuals who have ever been under criminal justice supervision is certain to be substantially higher; however, we were unable to obtain these data.

Like the other uninsured residents of Alameda County, these 11,452 uninsured formerly incarcerated people are

The formerly incarcerated seem to access public insurance at about the same level as other Alameda County residents (20% compared to 21% in the general population); however, they are five times more likely to be uninsured.

¹ Alameda County Health Status Report 2006, Alameda County Public Health Department.

² This survey was conducted by the Urban Strategies Council with assistance from All of Us or None, a summary report is available at [Reentry Health Survey Report - http://www.urbanstrategies.org/documents/HGSFinalReport_05.9.08BH.doc](http://www.urbanstrategies.org/documents/HGSFinalReport_05.9.08BH.doc) .



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likely go untreated or utilize Alameda County’s indigent care system. The Alameda County indigent care system currently provides free or low cost health care services to around 90,000 of the estimated 166,000 uninsured persons in Alameda County. By all estimates the indigent care system is currently operating above capacity with the Alameda County Medical Center currently serving 103% of their contracted patients and the community- based providers serving 106% of their contracted visits. Consequently, the formerly incarcerated must find ways of gaining access to a health care system that simply does not have space for them. While the indigent care system is available to everyone in Alameda County, gaining this access and utilizing the indigent care system and public health coverage can be a complicated process. It can be especially difficult to access these benefits when a person has been removed from society for extended periods of time and may or may not have their medical records, identification and other necessary documentation.

In Alameda County indigent care and public health coverage is structured to offer a general, base supply of services and, then, to meet the demands of specifically defined populations. Broadly speaking, the supply of indigent care services and public health coverage in Alameda County is available through one or a mix of the following sources, all of which are paid for by the county or state (with more and more responsibility being shifted to the counties):

1. Indigent care visits and/or patient “slots” at the Alameda County Medical Center or the Community-Based Organizations;
2. Programs that will cover and provide treatment for people with specific conditions (County Medical Services Program –Alameda County Excellence program); and/or
3. Being a member of specific populations that has been deemed eligible for certain types of coverage and care (e.g. parents with children).

Each of these three sources of accessing indigent health care creates a supply of services by either offering them generally to the entire indigent population or by limiting and/or defining a specific demand the supply is intended to meet (e.g. treatment is limited to people with diabetes or parents with children defined as eligible). Because the formerly incarcerated access health care services alongside other indigent populations, it is virtually impossible to find a suitable source of data that permits us to make a comprehensive health care services supply estimate specifically for the formerly incarcerated.

Knowing how to access these services/programs and negotiating the complicated qualification process are daunting tasks for anyone and are especially challenging for the formerly incarcerated already dealing with serious health conditions. Without realistic pre-release planning and/or a well-defined, easy to navigate system for accessing continuing or acute medical care, the formerly incarcerated are likely to go untreated. Without treatment they pose a threat to their own health as well as the health of the communities to which they return.

We could not find a suitable source of data to make an estimate of health care services supply for the formerly incarcerated.



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In addition, without medical care the formerly incarcerated will be hindered in their ability to find employment, housing and other needed services and, as a result, are more likely to be a financial burden on both their families and their communities.

Issues, Problems and Opportunities

In an effort to address these concerns, the Reentry Health Task Force sought to identify various issues, problems and opportunities that were most significantly affecting the health status of the formerly incarcerated. We found that the “system of care” for the formerly incarcerated suffers from a lack of continuity and is often fragmented and duplicative. The issues and problems begin during incarceration where medical pre-release planning is often inadequate if not completely absent. When pre-release planning is conducted, it is likely to be disconnected from the community-based services the incarcerated person is likely to utilize upon release. At release, the formerly incarcerated are not provided with the tools to access services (e.g. state ID, birth certificate, public benefits). Moreover, neither CDCR nor county jails routinely conduct medical screening incident to release (only at entrance) and, therefore, do not always report communicable disease patients to county public health departments, or mental and substance abuse patients to county Behavioral Health Care, etc. Once in the community, the formerly incarcerated struggle to establish a medical home. They are hindered in doing so by the difficulty in transferring medical records from CDCR and county jails and the lack of culturally or linguistically appropriate services.

One issue that was particularly prevalent was the lack of providers that understand and are sensitive to the experience of incarceration and the particular issues, needs and socio-cultural factors that are unique to this population as a result of incarceration. The effect and impact of incarceration can be seen in how the formerly incarcerated interpret and approach medical services and how health care providers approach the formerly incarcerated. For example, in her presentation about establishing the Transitions Clinic for the formerly incarcerated, Dr. Emily Wang noted that they were having difficulty getting formerly incarcerated people to come to the clinic until they hired a community outreach worker whose job is to bring the formerly incarcerated into the clinic. The community outreach worker had experience working with the formerly incarcerated and was very familiar with the population. After he began, the clinic was booked solid and has been since. The lesson is that a traditional approach to providing medical services may not be effective when working with the formerly incarcerated and methods that take into account the impact of incarceration are critical to successfully reaching the population.

• • •
When working with the formerly incarcerated, service providers must take into account the impact of incarceration on the individual in order to successfully treat the population.
• • •



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FINAL RECOMMENDATIONS

Coordination and Collaboration

Throughout our exploration of the issues, problems and opportunities affecting the health status of the formerly incarcerated, there was one issue which seemed to impact all facets of reentry health care: **the lack of coordination and collaboration among and between the different components of Alameda County's system of care for the formerly incarcerated and CDCR's system of care.** Every Reentry Health Task Force presenter identified an aspect of reentry health care that could be improved through increased collaboration among relevant agencies, organizations and departments. These improvements spanned the informational, policy, planning, funding and programmatic aspects of providing health care for the formerly incarcerated. Below, we list the relationships that need to be improved and provide a summary statement concerning the types of improvements that were recommended through discussions:

- 1. Corrections/Community:** The CDCR and Alameda County Sheriff need to work with community-based providers and county agencies to ensure effective pre-release planning and continuity of care after release, and to ensure that community-based medical providers have access to the medical records of their patients.
- 2. County Agencies:** County agencies should work with one another to provide more comprehensive and coordinated services that avoid duplication, maximize resources and engage in collaborative strategic planning whenever possible.
- 3. County and Cities:** County and City agencies, and their respective elected bodies, should coordinate with one another to address policy issues, maximize funding sources, align law enforcement with county services and to generally ensure that there is an active exchange of information concerning reentry health care opportunities.
- 4. County/City and Community/Faith Organizations and Providers:** County and City agencies should improve their collaborations with community/faith-based organizations and service providers to increase available services and maximize funding opportunities, to ensure referrals between services are accessible, appropriate and complete (i.e. medical records, medication maintenance, etc.) and to promote the use of promising practices.
- 5. Community/Faith Organizations and Providers:** Community/Faith-based providers and organizations should collaborate and coordinate their efforts in order to improve professional development activities, to increase knowledge and awareness of promising practices and possible partnerships.

Clearly, the process from pre-release planning to reentry involves a wide range of agencies, organizations and departments; however, there is no mechanism for coordination and collaboration that provides them with a systems level perspective on the reentry process. Task Force members were almost uniformly interested in and willing to explore collaboration but felt that the means for doing so was lacking. The Alameda County Reentry Network is an attempt to address some of these concerns. The Task Force concludes that in order to improve the cooperation and collaboration within Alameda County's system of care, and between CDCR and county agencies, departments, agencies and organizations should participate fully in the Reentry Network process and use that Network as a means of collaborating. For more information on the Alameda County Reentry Network visit: www.acreentry.org



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Specific Recommendations

As the above discussion indicates, the medical needs of the formerly incarcerated are enormous while the system of care to treat these medical needs is fragmented. Moreover, the portion of the system covering pre-release planning for health care occurs in a system that has been judged constitutionally insufficient. While the instincts of those concerned with social justice and health is to “fix the whole system,” the Task Force has had to restrain its instincts and target its attention on what we can do during the period of transition from incarceration and upon return to the community that would substantially improve the health status of the formerly incarcerated. The Task Force identified four themes around which recommendations were organized: Continuity of Care, Payer of Health Services, Health Services Delivery and Selected Specific Issues. Within these four themes the recommendations address infrastructure, policy and funding concerns that affect reentry health care. In Table 1 we provide a summary description of the recommendations identifying both the short and long term goals. Below Table 1 the recommendations are listed in their entirety.

Table 1: Recommendations Matrix

Recommendations	Short-Term Objective	Long Term Goal
Coordination and collaboration among components of the health care system	Board of Supervisors (BOS) and Health Care Services allocate funding to support the Reentry Network in developing a specific plan for health coordination using the Reentry Network as a vehicle	Implementation of a County-wide strategic plan for improving Reentry Health Care and coordination among all stakeholders
Continuity of Care	<ul style="list-style-type: none"> • Health Care Services and/or Public Health will convene medical staff from CDCR (San Quentin), Alameda County Sheriff, community- based providers to develop a collaborative and realistic system for pre-release planning • CDCR will meet with state legislators to discuss dedicating funding for pre-release planning 	State/County legislation to implement new and effective methods for medical and other pre-release planning from Santa Rita and San Quentin



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Recommendations	Short-Term Objective	Long Term Goal
Payer of Health Care Services	Health Care Services and/or Public Health and Social Services will convene medical staff from CDCR (San Quentin) and Alameda County Sheriff, to develop a collaborative and realistic plan for conducting public benefits eligibility screening prior to release and a “health care passport” upon release	<ul style="list-style-type: none"> • State legislators will adopt legislation for a program that suspends public benefits during incarceration rather than terminating them • BOS, County Sheriff and/or Public Health Department will allocate funding to initiate a program that conducts public benefit eligibility screening prior to release from Santa Rita
Health Services Delivery	<ul style="list-style-type: none"> • Public Health Department and BOS will convene a group to plan for creating or designating a specialty clinic for the formerly incarcerated • BOS will allocate funding to support the Reentry Network in developing a reentry resource database that will include service providers’ cultural and linguistic competencies as well as competence in working with the formerly incarcerated 	BOS and Health Care Services will create or designate a specialty clinic for the formerly incarcerated that has community outreach workers on staff and will serve as the initial medical home for formerly incarcerated
Selected Specific issues	<ul style="list-style-type: none"> • Public Health, CDCR and County Sheriff will meet to develop and then implement a system for pre-release communicable disease screening and reporting of positive cases to Public Health upon release • BOS will direct Health Care Services to convene CDCR, County Sheriff and community-based service providers to develop a system for making data more available on the supply of and demand for health care services 	<ul style="list-style-type: none"> • County Sheriff will implement a system for conducting communicable disease screening and reporting to public health department • State legislators will adopt a policy and allocate funding for communicable disease screening and reporting at San Quentin



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The Reentry Health Task Force recommendations are organized by theme and listed below:

Recommendation #1: Continuity of Care

CDCR, CSP-San Quentin, Alameda County Sheriff, Alameda County Agencies and community-based health services providers should make continuity of care during the period leading up to and immediately after release a reality by ensuring that those released have a pre-release medical plan which includes physical examination, their medical records, prescriptions and a supply of medications, and a temporary medical home at the time of release. Specifically, these groups should work to develop:

- 1a. Structured pre-release planning collaborations through formal agreements among agencies and with CBOs, designated agency liaisons, and broad community networks to allow for comprehensive referrals;
- 1b. Develop realistic, assessment-based pre-release plans for parolees that specifically address their medical needs, account for their ongoing health care and are flexible enough to prevent recidivism for mental health and substance abuse related incidents; and
- 1c. Provide inmates with a copy of their medical records upon release.

The formerly incarcerated utilize public insurance at about the same level as other Alameda County residents but they are five times more likely to be uninsured.

Recommendation #2: Payer of Health Care Services

CDCR, CDCR-Parole, Alameda County Probation, County Agencies and community-based service providers should work together to document and further develop a system that ensures that all persons released from incarceration are screened for eligibility for public benefits programs, enrolled in all public health insurance programs for which they qualify, and are informed of where they can go to receive free or low cost health care services immediately upon release. Specifically, these groups should:

- 2a. Implement a pre-release planning process with a clear strategy for payment of ongoing treatment;
- 2b. The Alameda County Public Health Department should work with CDCR and Santa Rita Jail to develop an electronic “continuity of care record” that would serve as an electronic “health passport” for inmates upon release (*recommendation comes from California Conference of Local Health Officers proposal to CDCR*);
- 2c. CDCR and Alameda County Sheriff should implement a program for public benefit eligibility screening and enrollment prior to release. The program should include service providers that work with the formerly incarcerated to use benefits eligibility screening and application software such as “Nets to Ladders”;
- 2d. Establish a program to suspend public benefits to the currently allowable period for persons incarcerated in county jail or state prison and work with the state to obtain



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federal waivers to extend the period of suspension of benefits to 24 months to cover the period during which many parole violators are re-incarcerated;

- 2e. Connect all recently released persons with diabetes, hypertension and congestive heart failure to the CMSP-ACE program; and
- 2f. Create tools and literature that can be used by case managers and the formerly incarcerated to identify possible sources of health care insurance and services and ensure that each inmate receives this information incident to pre-release planning and upon release.

• • •
**Funding for medical services
should reflect the prevalence
of conditions within the
incarcerated and formerly
incarcerated communities.**
• • •

Recommendation #3: Health Services Delivery

CDCR-Parole, Alameda County Sheriff, Alameda County Probation, County Agencies and service providers should work together to ensure that the formerly incarcerated are aware of and utilizing needed medical services by offering services that address the unique medical needs and reentry challenges of the formerly incarcerated. They should actively seek to engage the formerly incarcerated in planning and outreach for medical care and ensure that the formerly incarcerated and correctional and community-based medical service providers have access to current information on service providers and the reentry population. Specifically they should:

- 3a. Create or designate a direct services clinic as a specialty clinic for the formerly incarcerated within Alameda County that will serve as the initial “medical home” for those being released;
- 3b. Establish protocol to expedite transfer of medical records to the specialty clinic for use by medical staff there or for transfer to medical personnel identified by the individual who is the subject of those records;
- 3c. Create and maintain a county-wide reentry resource database with up-to-date information on health-related services as well as other services including housing, employment, etc.;
- 3d. Make substance abuse and/or mental health treatment a requirement of parole or probation;
- 3e. Implement a system of incentives to encourage Alameda County Sheriff to conduct more medical screening for communicable and chronic diseases as well as mental health and substance abuse disorders with the Alameda County Jail;
- 3f. Funding should be allocated to help the clinic designated to serve formerly incarcerated persons hire community health workers to conduct targeted outreach to the formerly incarcerated community; preference should be given to hiring the formerly incarcerated for these positions; and
- 3g. Identify a set of preferred health care providers that have a proven track record of providing quality and culturally competent services to the formerly incarcerated.

Recommendation #4: Selected Specific Issues

CDCR, County Agencies, service providers, community organizations and county and city elected officials should work to address the policy, funding and infrastructural challenges that are impacting the reentry of persons released from incarceration. They should ensure that those



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released understand the system of care that they are entering and their responsibilities within it and that the service providers, corrections and county agency staff have the necessary supports to effectively work with the reentry population. Specifically they should:

- 4a. Establish a system for making data more available on the supply of and demand for health care services so that program, funding and policy decisions can more accurately reflect the health care needs of the formerly incarcerated;
- 4b. Implement mandatory screening for communicable diseases prior or incident to release;
- 4c. Require CDCR or County Jail to report all positive communicable disease cases to the county of release's Public Health Department prior to release;
- 4d. Allow for substance abuse relapse without re-incarceration;
- 4e. Ensure that additional allocations are targeted to communities over-represented by recently released inmates;
- 4f. Dedicate funding for pre-release planning and post-release follow-up;
- 4g. Re-structure CPOs and probation officers training/professional development practices so they stay informed of trends in the population's medical needs and are capable of identifying issues in need of professional medical attention, especially mental illness; and
- 4h. Provide education and intervention funding for community-based and faith organizations that are collaborative partners.

As a particularly vulnerable and sick population, the formerly incarcerated are among those that exhibit the greatest need for medical care, but also face the greatest number of barriers to accessing medical care.

Next Steps and Sustainability

The recommendations and all the supporting data have been placed into this final report and the complimentary PowerPoint presentation. Both the report and the PowerPoint will be presented to various elected bodies and county agencies. Dr. Tony Iton, Alameda County Public Health Director, has agreed to present these recommendations to the Alameda County Board of Supervisors on behalf of the Reentry Health Task Force. Furthermore, Dr. Iton has agreed to have the Alameda County Public Health Department continue convening the Reentry Health Task Force on an "as needed basis" in an effort to build off of the momentum that this process generated.

The Alameda County Reentry Network will take responsibility for working with local stakeholders and service providers to implement the recommendations and to address the data and informational needs that have been identified by the Reentry Health Task Force. In addition, the Reentry Network will work with members of the Reentry Health Task Force to implement the communications plan so that the information generated through the Reentry Health Task Force will reach the widest possible audience



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I. INTRODUCTION

Virtually every incarcerated person in jail – and 97% of those incarcerated in prison – will eventually be released. Prisoners and soon-to-be-released inmates are disproportionately afflicted with illnesses and tend to be “sicker”, on average, than the U.S. population. The Congressional report, *The Health Status of Soon-to-be Released Inmates—A Report to Congress*, documents significantly higher rates of communicable disease, mental illness, and chronic disease among releasees as compared to the general population. Consequently, the successful re-integration of formerly incarcerated people into the community is a vitally important public health issue for both the newly-released and the communities to which they return.

In 1997 nearly 1 in 3 people with hepatitis C, and more than 1 in 3 of those with tuberculosis in the US were released from a prison or jail that year

In 2001 Alameda County had the ninth largest amount of people released from prisons in the US and the 6th most among California counties with 6,453 people returning to the community.³ These numbers reflect the massive expansion in California prisons between 1984 and 2000. Since 1984, California has added 21 correctional facilities, raising the total operated by the California Department of Corrections Rehabilitation (CDCR) to 33. In that same time, the inmate population has swelled from 24,000 to around 160,000.⁴ As a result the State of California now operates the second largest prison system in the US, making the raw number of people released from jail or prison into California communities exceptionally high.⁵ Upon release the formerly incarcerated are concentrated in a few core urban counties within California, and a few neighborhoods within those counties. Not surprisingly, these are the same neighborhoods that most of the formerly incarcerated resided in prior to their incarceration. Consequently, reentry is a national and state wide issue but the county and city become the governmental agencies that face the most immediate need to develop systems for addressing community reentry.

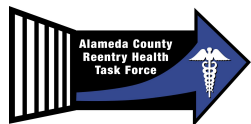
When the formerly incarcerated return they bring with them an array of health conditions and challenges. For example, in 1997, nearly 25% of all people living with HIV or AIDS, nearly 33% of people with hepatitis C, and more than 33% of those with tuberculosis were released from a prison or jail that year.⁶ Prisons also house more 3 times as many people with mental

³ U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, Releases by county of jurisdiction for participating National Correctional Reporting Program States, 2001, Revised April 2004

⁴ California Department of Corrections Population Reports

⁵ “One in 100: Behind Bars in America 2008”, report of the PEW Center on the States retrieved on 03.04.08 from: <http://www.pewcenteronthestates.org/uploadedFiles/One%20in%20100.pdf>

⁶ Outside the Walls: A National Snapshot of Community-Based Prisoner Reentry Programs, Amy L. Solomon, Michelle Waul, Ashley Van Ness, Jeremy Travis, January 2004.



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illnesses than mental health hospitals.⁷ An estimated 8 to 16% of the prison population has at least one serious mental disorder and is in need of treatment.⁸

The health profile of the prisoner population is quite possibly a reflection of both the inadequate health care available in the sending and receiving neighborhoods and the inadequate health care system within the CDCR. The situation within CDCR has reached critical levels and the medical system within all of California's 33 adult prisons is now under federal receivership.⁹ Any pre-existing health problems a person faces before incarceration are almost certainly exacerbated during incarceration. Unfortunately, if discharge planning takes place it rarely adheres to, and almost never includes, re-enrollment in public benefits programs (e.g. Medi-Cal, food stamps). As a result, the formerly incarcerated struggle to continue medical care that may have begun during incarceration putting both themselves and their communities at risk.

In light of the size, severity and cost of these health issues, concerns about the effects of incarceration, and the success or failure of prisoners reentering the community, can no longer be considered solely a criminal justice policy issue. While criminal justice issues have traditionally been articulated in terms of public safety, it is equally important to re-examine them in terms of the public health implications. As a large urban county that has a significant reentry population Alameda County has begun to recognize the public health challenge that this population presents. Through Measure A (a voter-approved transactions and use tax that provides funding for health services to low-income and indigent populations), the Alameda County Board of Supervisors and the Alameda County Health Care Services Agency approved \$250,000 per year for three years to provide expanded medical services to indigent adults in Oakland with focus on those with history of correctional system involvement, homelessness, and other risk factors. In addition, the Alameda County Public Health Director, Dr. Tony Iton, helped lead an effort by the California Conference of Local Health Officers to draft and submit a proposal that sought to improve public health systems within California State Prisons (CPS) and offered a series of recommendations to the federal receiver currently managing health care within CSPs.

However, even with these efforts, there is still a need to ensure that future, more ambitious efforts are informed by the current data and that the various stakeholders are invested in these efforts. The following report details the work of the Alameda County Reentry Health Task Force which sought to both inform county stakeholders and to capture their input around how best to address the health status of Alameda County's formerly incarcerated residents.

Figure 1 below outlines the general health care needs during transition from incarceration to reentry.

⁷ "Ill Equipped: US Prisons and Offenders with Mental Illness", Human Rights watch report, 2003.

⁸ Outside the Walls: A National Snapshot of Community-Based Prisoner Reentry Programs, Amy L. Solomon, Michelle Waul, Asheley Van Ness, Jeremy Travis, January 2004

⁹ For more information on the Federal Receivership see [History of CDCR and Transition to Receivership: http://www.urbanstrategies.org/documents/HistoryofCDCRHealthCareandReceivership_07.06.07_BH.doc](http://www.urbanstrategies.org/documents/HistoryofCDCRHealthCareandReceivership_07.06.07_BH.doc) and [General Information on State Receivers office: http://www.urbanstrategies.org/documents/Informationaboutthereceiver_07.06.07_bh.doc](http://www.urbanstrategies.org/documents/Informationaboutthereceiver_07.06.07_bh.doc) or visit the receiver's website at: <http://www.cprinc.org/>

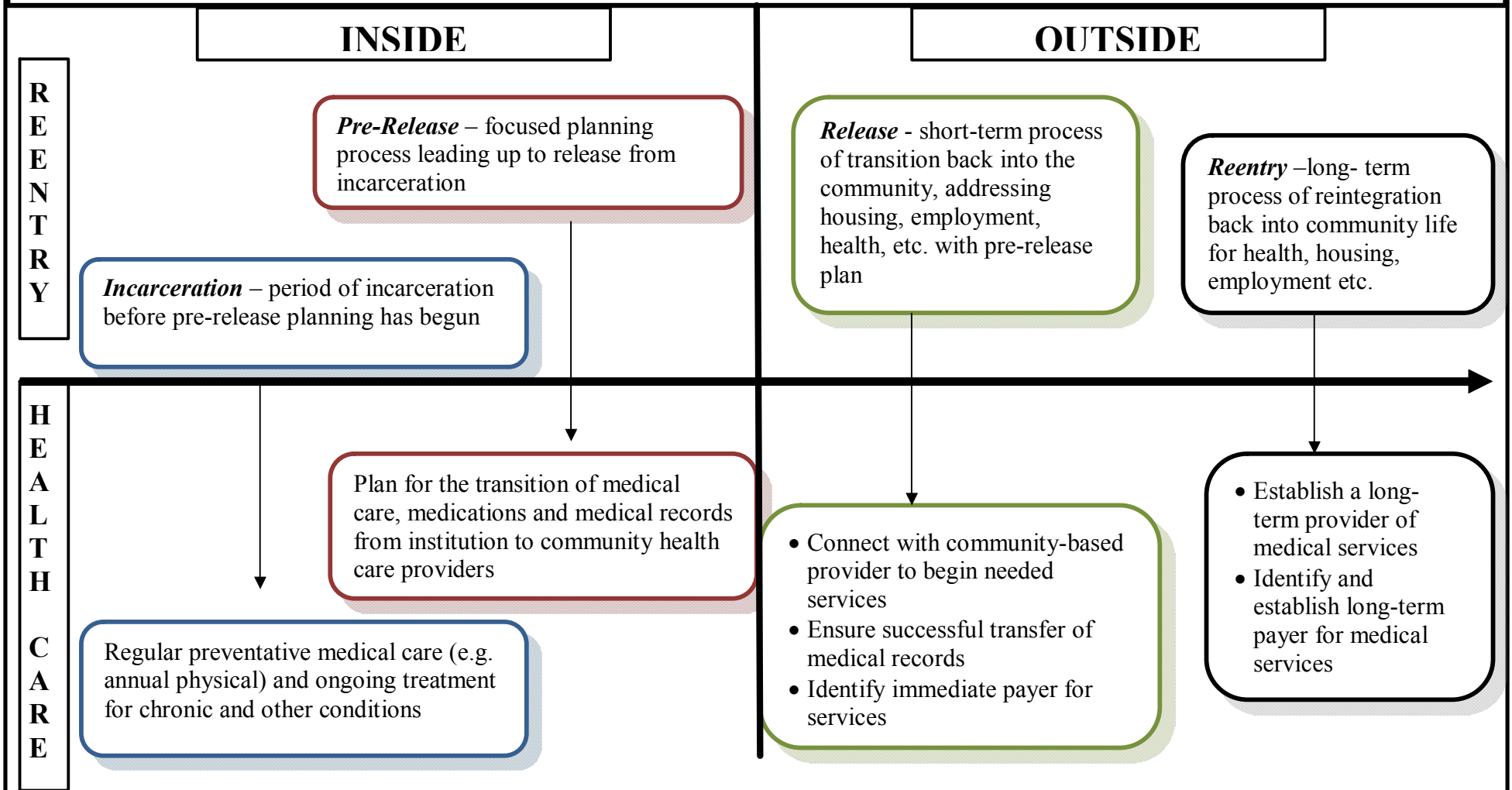


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Figure 1: Reentry Continuum and Health Care Needs





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II. Alameda County Reentry Health Task Force

Overview and Background

The Alameda County Reentry Health Task Force (Health Task Force) was designed to improve the health status of the formerly incarcerated. The Reentry Health Task Force brought together key stakeholders from across the county to identify and address the issues, problems and opportunities surrounding health care for the formerly incarcerated within the county. The Reentry Health Task Force was a seven-month process which included a series of briefings on Key Health Topics, a series of strategy, policy and program briefings, and a two-month period of recommendation development. The following report is the product of these efforts.

The Reentry Health Task Force was a pilot test for the task force process created under the newly-formed Alameda County Reentry Network (Reentry Network). The Reentry Network is an effort to organize the work around reentry that is currently taking place within Alameda County. The Reentry Network provides an infrastructure through which the various efforts of community organizations and state, county and city agencies working on community reentry can collectively assess, plan, and coordinate policies, resources and reentry services. Moreover, it establishes an efficient system by which the information about and the status of reentry work can be communicated to decision and policy makers across the county and at the state and federal levels. The Reentry Network will continue to convene Task Forces on topics that are relevant to the reentry population (e.g. employment, housing, etc) with the Reentry Health Task Force serving as a model for these subsequent Task Forces.¹⁰

Reentry Health Task Force Goal and Objective

- ▶ ***GOAL:*** The Alameda County Reentry Health Task Force is working to improve the health status of formerly incarcerated people in Alameda County.
- ▶ ***OBJECTIVE:*** The Alameda County Reentry Health Task Force created and will advocate for a set of recommendations which will increase availability and improve the quality of health care after release from incarceration.

Members, Presenters and Visitors

Member Roster

The Reentry Health Task Force was comprised of a broad cross-section of stakeholders from across Alameda County. The members represented elected officials, county health agencies, law enforcement, CDCR (correctional institutions and parole), the federal receiver's office, service

¹⁰ For more information on the Reentry Network go to: <http://acreentry.org/>



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providers and faith base providers, along with many others (for a full listing see the member list on p. iv). The members were selected to ensure that the final recommendations and the group process were as comprehensive and inclusive as possible. The members showed tremendous support for the Reentry Health Task Force with attendance remaining high throughout the process.

Reentry Health Task Force Presenters

The Reentry Health Task Force received a total of 13 topical presentations and 1 presentation from the Bay Area Consortium for Quality Health Care concerning a recent contract they had been awarded. The 13 topical presentations addressed each of the Key Health Topics around which the Reentry Health Task Force was organized (see Table 2 below). Presenters varied and included direct service providers, county agency directors, correctional medical staff and community-based medical services providers. The focus of these presentations was to provide the Reentry Health Task Force with a strong foundation in the systems of care available to the formerly incarcerated, the prevalence of the various health conditions and the strategies, policies and programs that are affecting the health status of the formerly incarcerated.

Reentry Health Task Force Visitors

The Health Task Force had a variety of visitors over its duration. These visitors varied as some came to hear a specific presentation and other were concerned with the process more generally. A list of the visitors appears in Appendix 2 below.

Key Health Topics

The Reentry Health Task Force’s work was organized around six **Key Health Topics** which were selected for their relevance to the formerly incarcerated population and as an attempt to be comprehensive in the health conditions addressed. The Key Health Topics provided a means for structuring the Reentry Health Task Force process and the final recommendations. The Key Health Topics (in bold) are summarized below:

Table 2: Key Health Topics		
<p>1. General Health Care</p> <ul style="list-style-type: none"> • Preventative care • Yearly physical examination • Relevant testing and procedures • Acute care for isolated incidents 	<p>2. Substance Abuse</p> <ul style="list-style-type: none"> • Alcoholism • Drug abuse • Tobacco 	<p>3. Mental Health</p> <ul style="list-style-type: none"> • Depression • Post-Traumatic Stress Disorder • Schizophrenia • Dual Diagnosis • Bi-polar disorder
<p>4. Chronic Diseases</p> <ul style="list-style-type: none"> • Hypertension • Diabetes • Kidney Disease • Cancer • Sickle Cell Anemia • Asthma 	<p>5. Communicable Disease</p> <ul style="list-style-type: none"> • STD • HIV/AIDS • Hepatitis B & C • TB 	<p>6. Oral, Auditory and Visual</p> <ul style="list-style-type: none"> • Check-ups • Oral Diseases and dentures • Vision diseases glasses • Hearing loss and aids • Oral surgery



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Task Force Process

1. Planning and Inauguration (April-September)

Planning and development of the Reentry Health Task Force began in April 2007 and continued through August. During this time period Arnold Perkins accepted an offer to serve as chair and potential members were identified. In August 2007 recruitment of potential members began. The first meeting of the Reentry Health Task Force was held in September 2007. The first meeting introduced the Reentry Health Task Force members and began the process of identifying the issues that the group considered most important to the health status of formerly incarcerated in Alameda County.

2. Key Health Topic Briefings (October and November)

Beginning in October 2007, the Reentry Health Task Force held a series of “Key Health Topic Briefings” provided by content experts (See Appendix 1: Reentry Health Task Force Presenters for a full listing of presenters). The Key Health Topic Briefings provided members with an understanding of the prevalence of various health conditions and information on the current health care system for each of the six Key Health Topics. These presentations focused on the most current and local data available and provided a foundation upon which the final recommendations could be developed. In addition, the Task Force was able to have Dr. Emily Wang present on the lessons from her experience in establishing the Transitions Clinic in San Francisco, a health clinic serving the formerly incarcerated. For more information on the Transitions Clinic see:

SFClinic Presentation: <http://www.urbanstrategies.org/documents/AlamedaCountyHealthTaskForce.ppt>

3. Strategy, Policy and Program Briefings (December 2007 and January 2008)

In December 2007 and January 2008 the Reentry Health Task Force began a series of briefings on the strategies, policies and programs affecting the health status of the formerly incarcerated in Alameda County. These briefings provided the Task Force members with an understanding of the health care systems in both Santa Rita Jail and in CSP-San Quentin. The Task Force also received a briefing from two psychologists who work primarily with youth and young adults concerning the mental health issues facing many of those involved with the criminal justice systems including a description of an innovative approach to understanding the underlying mental health causes of many of the behaviors which lead to contact with the criminal justice system.

4. Recommendation Development (February and March)

While we generated and recorded suggested recommendations throughout the process, in February and March 2008 the Reentry Health Task Force undertook the process of developing specific recommendations to deliver to a variety of audiences. See the Recommendations section below for more information on the product of these meetings.

5. Continuation and Sustainability



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While this initial stage of the Reentry Health Task Force concludes with this report, the Alameda County Public Health Department has agreed to continue assembling the group on an as needed basis in an effort to continue and update the work that was started.

For more information on the Reentry Health Task Force process see: [Schedule of Meetings: http://www.urbanstrategies.org/documents/HealthTaskForcemeetingoverview_08.31.07_BH_000.doc](http://www.urbanstrategies.org/documents/HealthTaskForcemeetingoverview_08.31.07_BH_000.doc)

III. Parole and Probation Population in Alameda County

Reentry Population

As the reader will note, we have decided to present data on “individuals under criminal justice supervision.” Specifically, we sought to determine the number of people on parole after a state prison term and under the supervision of the CDCR, the number of adults under supervision of the Alameda County Probation Department as well as those on juvenile probation. Unfortunately, we were not able to obtain information on juvenile parolees and federal probationers and parolees.

As reflected in Table 3, we estimate that as of June 30, 2007, there were approximately 3,300 residents of Alameda County on state parole and approximately 18,950 county residents on probation with Alameda County. This yields a conservative estimate of 22,250 individuals under criminal justice supervision in the county. This means that roughly 1 in 100 county residents is under criminal justice supervision. In Oakland, roughly 3 in 100 city residents are under criminal justice supervision. This population is primarily concentrated in East Oakland, West Oakland and Hayward.

Table 3: Probation and Parole Population in Alameda County	
(AS OF JUNE 30, 2007)	
Source of Supervision	Total
Adult Parole ¹¹	3,297
Adult Probation ¹²	16,795
Federal Probation and Parole	N/A
TOTAL ADULT POPULATION	20,092
Juvenile Probation ¹³ (Alameda County Juvenile Probation Caseload)	2,157
Juvenile Parole	N/A

¹¹ Parole Census Data June 30, 2007. CDCR. Retrieved on 10/17/07: http://www.cdcr.ca.gov/Reports_Research/Offender_Information_Services_Branch/Annual/PCensus1/PCENSUS1d0706.pdf

¹² June 2007 Monthly Statistical Report, Alameda County Probation Department. It is important to note that this number reflects all of the Adults on probation in Alameda County, not those that are actively supervised. The number of actively supervised individuals on probation in June 2007 was 2,369.

¹³ June 2007 Monthly Statistical Report, Alameda County Probation Department



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(DJJ parolees)	
TOTAL REENTRY POPULATION	22,249



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While we were unable to obtain address and city level data for the parolees and probationers from 2007 we do have this data from 2005. Based on a report from June 2005 data, the parole population is overwhelmingly male (91%), under 50 years old (97%) and people of color (84%) with African Americans comprising the largest ethnic group constituting 67% of the parolee population (to see more demographic data see Appendix 5).

We were able to collect data on the distribution of parolees and probationers in Alameda County for June 2005. Table 4 shows the distribution of Adult and Juvenile probationers by city. While Figure 2 on the following page shows the distribution of parolees across Alameda County.

Table 4: Probationers by City June 2005					
City	#	Adult		Juvenile	
		%	#	%	
Oakland	8,125	46%	821	46%	
Hayward	2,296	13%	232	13%	
Fremont	1,413	8%	107	6%	
San Leandro	1,060	6%	107	6%	
Berkeley	883	5%	71	4%	
Emeryville	883	5%	54	3%	
Union City	707	4%	89	5%	
Alameda	530	3%	71	4%	
Livermore	530	3%	54	3%	
Castro Valley	353	2%	36	2%	
Newark	353	2%	54	3%	
Pleasanton	177	1%	18	1%	
San Lorenzo	177	1%	36	2%	
Dublin	177	1%	18	1%	
Alameda County	17,663	100%	1,766	99%	

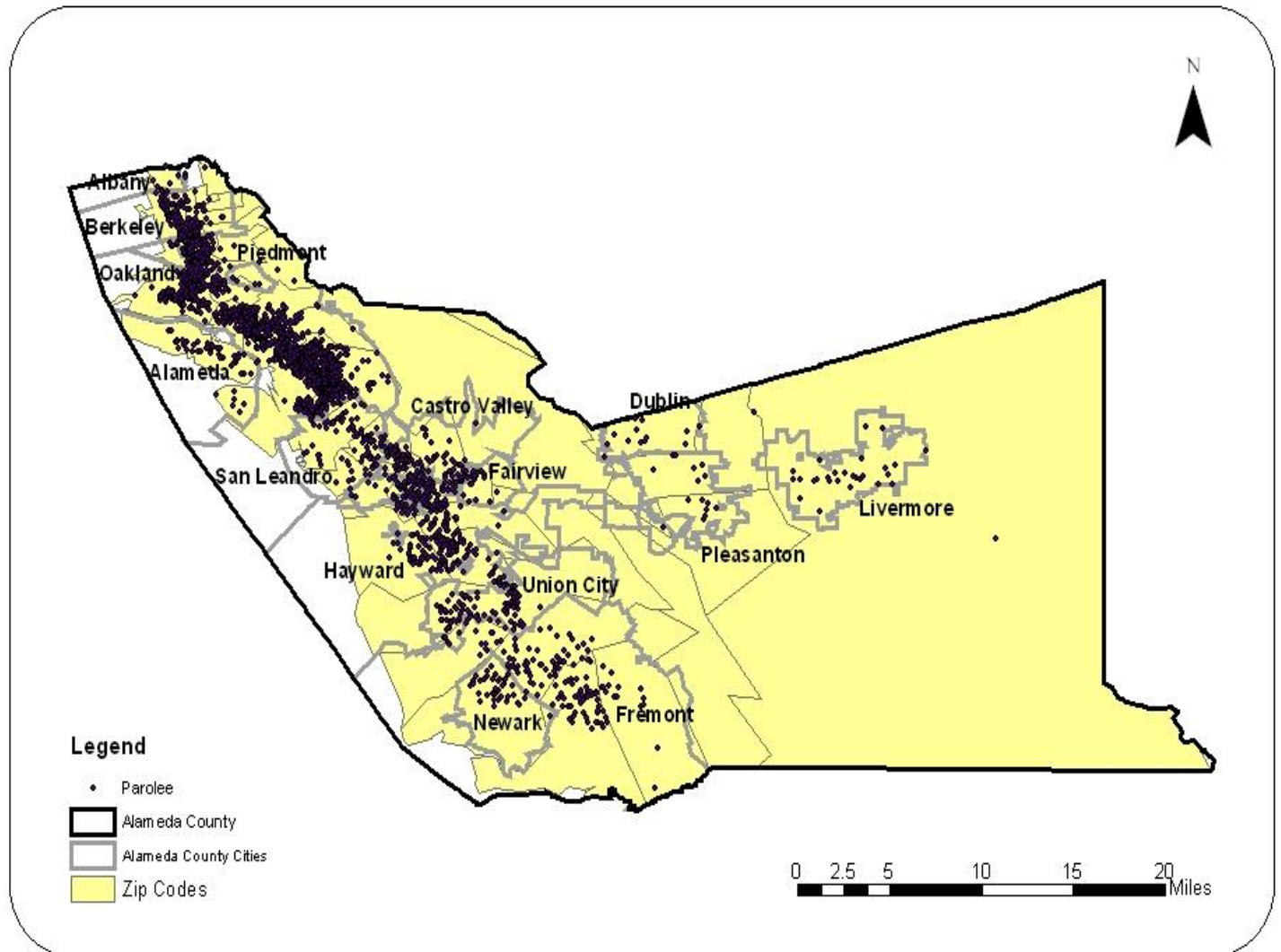


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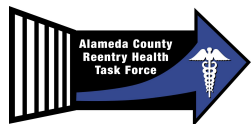
Figure 2: Distribution of Alameda County Parolees June 2005



Prepared for www.infoalamedacounty.org by Urban Strategies Council, November 21, 2005
Source: California Department of Corrections and Rehabilitation, June 1, 2005

For more detailed information on those under criminal justice supervision in Alameda County see:

1. [A Report on People Under Criminal Justice Supervision in Alameda County:](http://www.urbanstrategies.org/programs/csj/documents/ReportonPeopleunderCJSupervision_FIN_AL_020306.pdf)
http://www.urbanstrategies.org/programs/csj/documents/ReportonPeopleunderCJSupervision_FIN_AL_020306.pdf
2. [The Formerly Incarcerated in Alameda County:](http://www.urbanstrategies.org/documents/HealthStatusOverview_9.12.07.doc)
http://www.urbanstrategies.org/documents/HealthStatusOverview_9.12.07.doc



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IV. Health Status and Health Care for the Formerly Incarcerated of Alameda County

In this section we describe the systems of care or payers of medical services available the estimated 20,000 plus adults in Alameda County under criminal justice supervision.¹⁴ As was stated above, this population is largely, male, under 50 years of age, people of color and concentrated within a few specific areas of Alameda County-- mainly West Oakland, East Oakland and Hayward. The communities with high concentration of formerly incarcerated persons already exhibit high levels of coronary heart disease, mortality, diabetes, assault, homicide, teen births, tuberculosis, and AIDS.¹⁵ Based on our data we found that the formerly incarcerated showed an especially high need for substance abuse, communicable disease and mental health services and therefore contribute to the already serious need for health care services within these communities. This was shown to be especially true since the formerly incarcerated are likely to enter these communities uninsured and without a designated medical provider and are likely to go untreated or utilize the indigent care system along with the other uninsured and underinsured residents of Alameda County.

Using our own survey data and data from the Alameda County Health Care Services Agency this section provides a basic assessment of the level of access the formerly incarcerated might have to the indigent care system. We found that the indigent care system currently provides free or low cost health care services to around 90,000 of the 166,000 uninsured persons in Alameda County and, by virtually all estimates, is operating above capacity. The formerly incarcerated make up around 7% (11,452) of the 166,000 uninsured people in Alameda County. Like all indigent populations gaining access to health care in the United States and California is a complicated process that can be difficult to navigate. It can be especially challenging when a person has been removed from society for extended periods of time. In Alameda County indigent care and/or health coverage comes through one or a mix of the following sources: 1) indigent care visits that are paid for by the county or state; 2) programs that will cover specific conditions (CMSP-ACE program); and/or 3) being of a certain populations that has been deemed eligible for certain types of coverage and care (e.g. parents with children). Each of these three creates a supply by either offering them generally to the entire indigent population or by limiting and/or defining a specific demand the supply is intended to meet (e.g. treatment for people with diabetes or treatment for parents with children).

Finally, this section offers an initial analysis of the supply of health care services available to the formerly incarcerated and the level of need among the formerly incarcerated for these services. Based upon this analysis we come to the conclusion that without realistic pre-release planning and/or a well-defined, easy to navigate system for accessing continuing or acute medical care, the formerly incarcerated are likely to go untreated. Without treatment they pose a threat to their own health as well as the health of the communities to which they return. In addition, without medical care the formerly incarcerated will be hindered in their ability to find employment,

¹⁴ For the purposes of this analysis we have focused on the adult population only because the survey data used to make the demand estimates was only administered to adults

¹⁵ Parole Census Data June 30, 2007. CDCR. Retrieved on 10/17/07: HYPERLINK "<http://>



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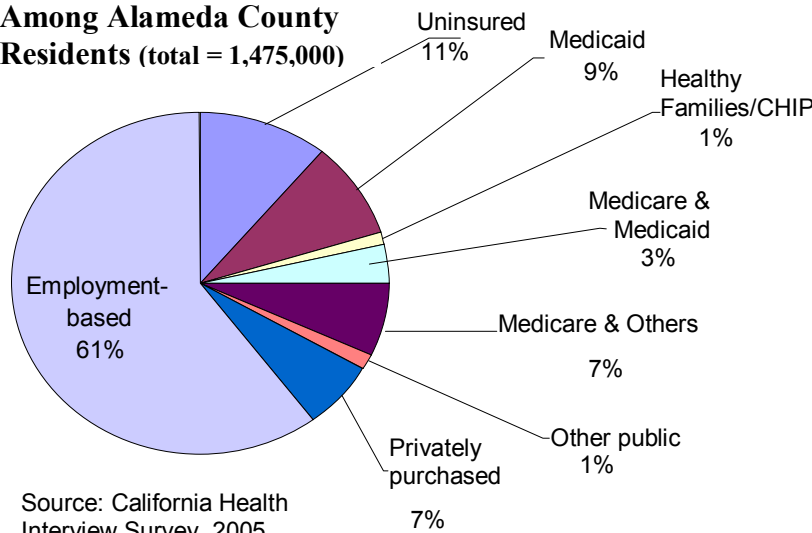
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housing and other needed services and as a result are more likely to be a financial burden on both their families and their communities. In the sections below we provide a more detail analysis of these findings.

Systems of Care or Payers for the Formerly Incarcerated of Alameda County

Developing a solid understanding of the systems of care and payers for medical care that are available to the formerly incarcerated of Alameda County was one focus of the Health Task Force. The Reentry Health Task Force received presentations from Dr. Tony Iton, Director of the Alameda County Public Health Department and Alex Briscoe, Assistant Director of Alameda County Health Care Services.

Figure 3: Health Coverage Among Alameda County Residents (total = 1,475,000)



Source: California Health Interview Survey, 2005

The medical “safety net” for the uninsured and the underinsured consists of two primary payers that will cover medical costs: Medi-Cal and County Medical Services Program (CMSP) which offers medical services to low income and indigent populations. The State of California, like

states across the country, is looking for ways to decrease spending on Medicaid and, thus, is passing more and more of the financial burden down to the counties. The CMSP serves the uninsured that are below 200% of the federal poverty level (federal poverty level for 2008 is \$10,400 for an individual and \$3,600 for each additional person in the household). It is comprised of Alameda County Medical Center (ACMC), which includes 3 hospitals and three outpatient clinics, 10 community-based clinics and Health Care for the Homeless. The Alameda County indigent care system includes these same hospitals and clinics; however, it also serves persons who are below 200% of the federal poverty level and are underinsured through Medi-Cal or private insurance. While this system of care is available to the formerly incarcerated they must access it along with the other uninsured and underinsured populations in need of free or low cost health care. Therefore, this service system should be viewed within the broader context of supply and demand for indigent care services across Alameda County.

In Figure 3 we provide a breakdown of health coverage for people in Alameda County. The 11% of uninsured persons equals roughly 166,000 people within Alameda County who do not qualify for health coverage and, therefore, use the County Medical Services Program (CMSP). Another 21% or 132,750 cannot afford adequate health coverage and are forced to use some form of



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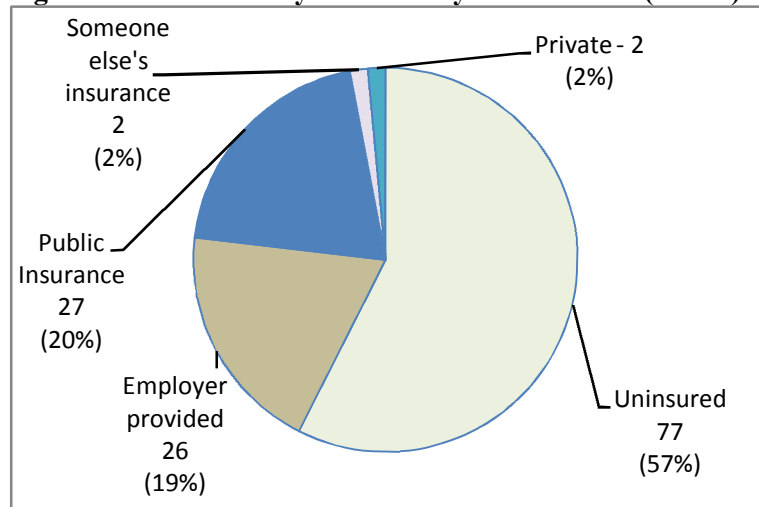
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public insurance.¹⁶ However, public insurance programs are often targeted at specific populations such as Healthy Families/CHIP which focuses on families with children. Medi-Cal targets those with disabilities and those who are categorically eligible (e.g. Women, Infants and Children or WIC). Thus, the uninsured population tends to be single adults without a disability who are not old enough to qualify for Medicare.

Because no data existed on health coverage among or the health status of the formerly incarcerated Urban Strategies Council and All of Us or none (www.allofusornone.org/) conducted a survey of 138 formerly incarcerated people within Alameda County. As Figure 4 shows, we found that 57% had no health insurance, 20% had Medi-Cal or some other public insurance and 19.4% had insurance through their employer.¹⁷ Thus, while the formerly incarcerated seem to utilize public insurance at about the same level as other Alameda county residents (20% compared to 21% in the general population), they are five times more likely to be uninsured.

Figure 4: Health Survey of Formerly Incarcerated (n=134)



As was stated earlier there are an estimated 20,092 adults under criminal justice supervision as of June 2007. The survey found that 57% of respondents were without health insurance which, when applied to the 20,092 produces an estimated 11,452 uninsured people who are under criminal justice supervision. Thus, our best estimate is that people under criminal justice supervision comprise almost 7% of the uninsured population in Alameda County.

1. For a concise description of the uninsured and the indigent care system in Alameda County see: [Dr. Tony Iton presentation:](http://www.urbanstrategies.org/documents/TopnyItonPresentationToRe-EntryTaskForce_000.ppt)
http://www.urbanstrategies.org/documents/TopnyItonPresentationToRe-EntryTaskForce_000.ppt

For additional information on health care service delivery systems, see

1. [Overview of Alameda County Health Care Services Initiatives and Programs:](http://www.urbanstrategies.org/documents/CityofOaklandInitiatives.doc)
<http://www.urbanstrategies.org/documents/CityofOaklandInitiatives.doc> ;
2. [Alameda County Emergency Room Map:](http://www.urbanstrategies.org/documents/AC_Emergency_Rooms_000.pdf)
http://www.urbanstrategies.org/documents/AC_Emergency_Rooms_000.pdf ;

[/www.cdcr.ca.gov/Reports_Research/Offender_Information_Services_Branch/Annual/PCensus1/PCENSUS1d0706.pdf](http://www.cdcr.ca.gov/Reports_Research/Offender_Information_Services_Branch/Annual/PCensus1/PCENSUS1d0706.pdf)
http://www.cdcr.ca.gov/Reports_Research/Offender_Information_Services_Branch/Annual/PCensus1/PCENSUS1d0706.pdf

¹⁷ June 2007 Monthly Statistical Rep



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3. [Alameda County Indigent Care Services Provider Network map:](http://www.urbanstrategies.org/documents/CmspNetwork.pdf)
<http://www.urbanstrategies.org/documents/CmspNetwork.pdf> ;
4. [Summary of Health Care Services Initiatives and Programs:](http://www.urbanstrategies.org/documents/CityofOaklandInitiatives_000.doc)
http://www.urbanstrategies.org/documents/CityofOaklandInitiatives_000.doc

Health Conditions and the Demand for Services

The Reentry Health Task Force attempted to develop estimates on the supply and demand of health care services for the formerly incarcerated. That is, what are our best estimates of the number of formerly incarcerated people who need various types of health related services (demand) and how many providers have “spaces” to provide those services.

As this section and the following sections reveal, the Task Force and the community lack the data needed to do this analysis with the precision we would like. However, as was the case for a number of issues the Task Force encountered, we decided to obtain the best available data and information, use it in the current process, and make recommendations regarding the need for and methods of obtaining better data or information in the future. Below we present the data we were able to collect to provide us with a sense of the supply and demand for health care services for the formerly incarcerated.

While the data on the population under criminal justice supervision in Alameda County was difficult to obtain, data on the health conditions and needs of the population and the availability of services were simply not available. In the absence of such data, we resorted to an examination of national and state studies of the health conditions and disease incidence among incarcerated and formerly incarcerated people. The data that we were able to gather is shown in Table 5 and indicates that there is a great demand for health care services, especially substance abuse, hypertension, hepatitis C and mental health care. During her presentation Dr. Emily Wang, indicate that 30% of people with hepatitis C and 40% of those with tuberculosis in the US have served time in a prison or jail. While a great deal of attention, and funding, has been dedicated to HIV/AIDS this data indicates that Hepatitis C is the far more prevalent communicable disease among the formerly incarcerated. The take away message is that treatment funding should accurately reflect the prevalence of conditions within the incarcerated and formerly incarcerated communities.

Funding for medical services should accurately reflect the prevalence of conditions within the incarcerated and formerly incarcerated communities



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Table 5: Estimated Need and Supply of Adult Health Services for the Formerly Incarcerated

HEALTH SERVICE	ESTIMATED PREVALENCE AMONG INCARCERATED POPULATION			ESTIMATED NEED ¹⁸	SUPPLY FOR THE FORMERLY INCARCERATED
	National ¹⁹	State ²⁰	County	County	County
General Health ²¹	100%	100%	100%	20,092	1,000 ²²
Mental Health		20%		4,019	
Substance Abuse		85%		17,078	2,158 ²³
Communicable Disease					
Hepatitis C	17.75%			3,556	
Hepatitis B ²⁴	2%	3.5%		703	
HIV	1.2%	1.8%		362	
TB	7.4%			1,487	
Chronic Disease					
Asthma	8.5%			1,708	
Diabetes	4.8%			964	
Hypertension	18.3%			3,677	
Oral, Auditory and Visual				N/A	

Supply of Health Care Services in Alameda County

ort, Alameda County Probation Department. It is important to note that this number reflects all of the Adults on probation in Alameda County, not those that are actively supervised. The number of actively supervised individuals on probation in June 2007 was 2,369.

¹⁹ June 2007 Monthly Statistical Report, Alameda County Probation Department

²⁰ Chicago: National Commission on Correctional Health Care

²¹ Prevalence of HIV Infection, Sexually Transmitted Diseases, Hepatitis, and Risk Behaviors Among Inmates Entering Prison at the California Department of Corrections, 1999

²² We assume that all persons released from incarceration are in need of General Health Care

²³ Refers to Healthy Oakland program which was the only program we could identify that specially served the formerly incarcerated

²⁴ This refers to the estimated number of clients that will be served during the Fiscal Year 2007-2008 by BASN, the number of clients served through Prop 36 in 2004-2005

²⁵ Refers only to current/chronic HBV infections, the same study found that 28.3% of inmates surveyed had a past HBV infection



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While we were able to gain some data on the prevalence of health conditions among the formerly incarcerated, we could not find a suitable source of data that would permit us to make comprehensive health care services supply estimates for the formerly incarcerated in particular. The challenge in obtaining these data is that medical providers do not collect data on a person's criminal background making it extremely difficult to retroactively identify the number of formerly incarcerated persons served. Nor were we able to obtain studies from CDCR or the County Jail reflecting the health status of persons under their care. Secondly, unlike some aspects of housing and employment, the formerly incarcerated are not categorically barred from receiving health services and, therefore, few programs identify them as a target population assuming that they have access to any services that they can afford or qualify for. For example, the formerly incarcerated are not categorically barred from receiving Medi-Cal, however, as noted above, Medi-Cal is only available to persons with disabilities or those that are deemed categorically eligible (e.g. women with children).

We could not find a suitable source of data to make an estimate of health care services supply for the formerly incarcerated

We were only able to identify four programs that are specifically designed or have specific funding streams to serve the formerly incarcerated: Bay Area Service Network (BASN), Prop 36, Healthy Oakland and a Public Health Department initiative to provide services to HIV positive people who are formerly incarcerated. BASN is the CDCR-funded substance abuse program for persons released from California State Prisons. In Alameda County the program is administered by Alameda County Behavioral Health Care Services. However, the only way to access BASN services is to be referred to them by a parole officer. In addition to BASN, there is Prop 36 which is a drug treatment diversion program. Persons are assigned to treatment instead of incarcerated and are required to complete the treatment or return to prison.

Healthy Oakland is the only provider that offers general health care specifically to the formerly incarcerated. Healthy Oakland has received support for this work through Alameda County Health Care Services Agency's Measure A funds. The numbers shown in the supply column Table 5: Estimated Need and Supply of Adult Health Services for the Formerly Incarcerated reflect the number of people served by BASN and Healthy Oakland. In addition, the Bay Area Consortium for Quality Health Care has recently received a contract from the Alameda County Public Health Department to provide services to HIV positive persons released from incarceration. However, this contract has just been executed and there was no indication in the RFP of a minimum number of persons that had to be served so we do not have any estimate on the number of people this program will eventually serve.

As a result of our inability to obtain data on the specific supply of services available to the formerly incarcerated we decided to provide data on the service utilization of the Alameda County Medical Center and the community clinics that are a part of Alameda County's indigent



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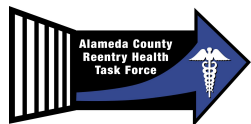
health care system. These data provide us with a baseline estimate of the supply of services that would be immediately accessible to the formerly incarcerated upon release, regardless of their health coverage. Currently, the Alameda County Medical Center (ACMC) and the associated community clinics serve around 90,000 of the 166,000 uninsured persons in Alameda County. Of this 90,000 served, 60,000 are paid for by the county through the CMSP while the other 30,000 are covered by the other programs (e.g. Medicare) or pay out of pocket for their services.²⁵ The county has also just introduced a new program (CMSP-ACE) that will focus on providing services to persons with diabetes and congestive heart failure outside of a hospital setting and, thus, reducing costs to the CMSP.

In Table 6 we have gathered data on the number of patients seen, the number of visits and the number of visits that were contracted by the county through the CMSP for FY2006-2007. Unfortunately, we could not locate supply data that could be accurately aligned with our Key Health Topics. Consequently, we had to use the categories of the Medically Indigent Care Reporting System (MICRS) which is centered on the type of service provider rather than the type of service. While the MICRS did have some data the type of services provided it was only for outpatient care and the categories did not align with our Key Health Topics either. Most notably, Table 6 does not include specific data on mental health and substance abuse as these services are either subsumed within the clinics and the hospital-based care figures or are funded separately through programs like the Mental Health Services Act (Prop 63). However, through the ACMC [website](#) we were able to determine that there were 3,100 admissions to John George Psychiatric hospital; unfortunately, the site does not indicate for what year this number refers.

Table 6 begins by comparing the number of patients or visits that a service provider served with the number that they were contracted to serve. For example, the Alameda County Medical Center (ACMC) was contracted to serve 35,000 patients in FY2006-2007 but actually served 36,084. The CBOs that the CMSP program contracts with were funded to provide 78,287 but actually provided 83,449 that they charged to the CMSP. The next two sections of Table 6 provide data on service utilization by service setting (e.g. inpatient, outpatient) and by service type (e.g. primary care). Table 6 clearly shows that both the ACMC and the CBOs were operating above capacity as of FY2006-2007. The formerly incarcerated must access these services along with the other 166,000 persons who are uninsured.

While we were unable to gauge the exact supply of services we were able to obtain data on the geographic distribution of services across Alameda County. In figure 5 is a map of all the indigent care providers across Alameda County. Figure 6 is a map of all emergency rooms within Alameda County. Between these two maps we can gain a spatial sense of where services are located and, in Figure 6, how these locations relate to the distribution of parolees and probationers in Alameda County. Moreover, these are locations that are available to anybody regardless of their health care coverage (the emergency rooms do not provide free care but they are required to treat all emergencies even if they charge the patients).

²⁵ Numbers based on data from the Medically Indigent Care Reporting System (MICRS) and independent research conducted by the Alameda Health Consortium and the Community Voices project.



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Table 6: Supply and Utilization of CMSP Funded Indigent Health Care Services				
HEALTH CARE UTILIZATION	SUPPLY OF INDIGENT HEALTH CARE SERVICES FY2006-2007			
	Unduplicated Patients	Contracted Patients	Visits	Contracted Visits
Utilization by Provider				
ACMC	36,084	35,000	112,407	N/A
Community Based Organizations	28,201	N/A	83,449	78,287
Utilization by Setting of Service Delivery				
Inpatient	1,829		7,553	
Outpatient	63,017		159,651	
Hospital based	21,396		44,053	
Free standing clinic	41,051		115,543	
M.D. office	36		36	
Other	534		19	
Emergency	11,879		26,953	
Outpatient Utilization by Service Types				
Primary Care ²⁶			104,403	
Specialty Care			29,704	
Home health			110	
Dental			20,631	
Visual			2997	
Podiatry			2408	
Ambulatory Surgery			1051	

²⁶ This includes the Key Health Topics pertaining to General Health, Communicable Diseases, and Chronic Diseases

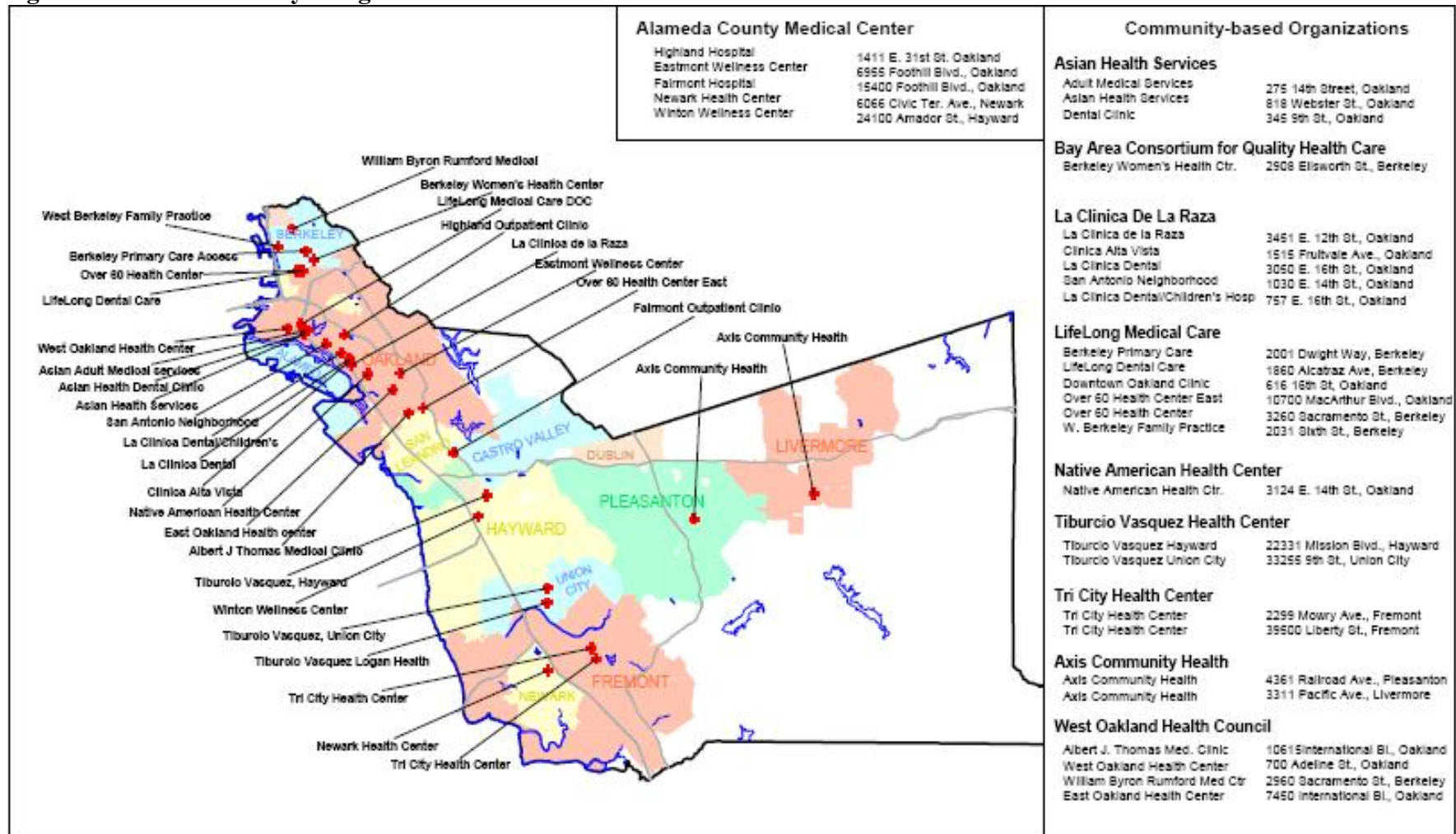


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Figure 5: Alameda County Indigent Care Providers



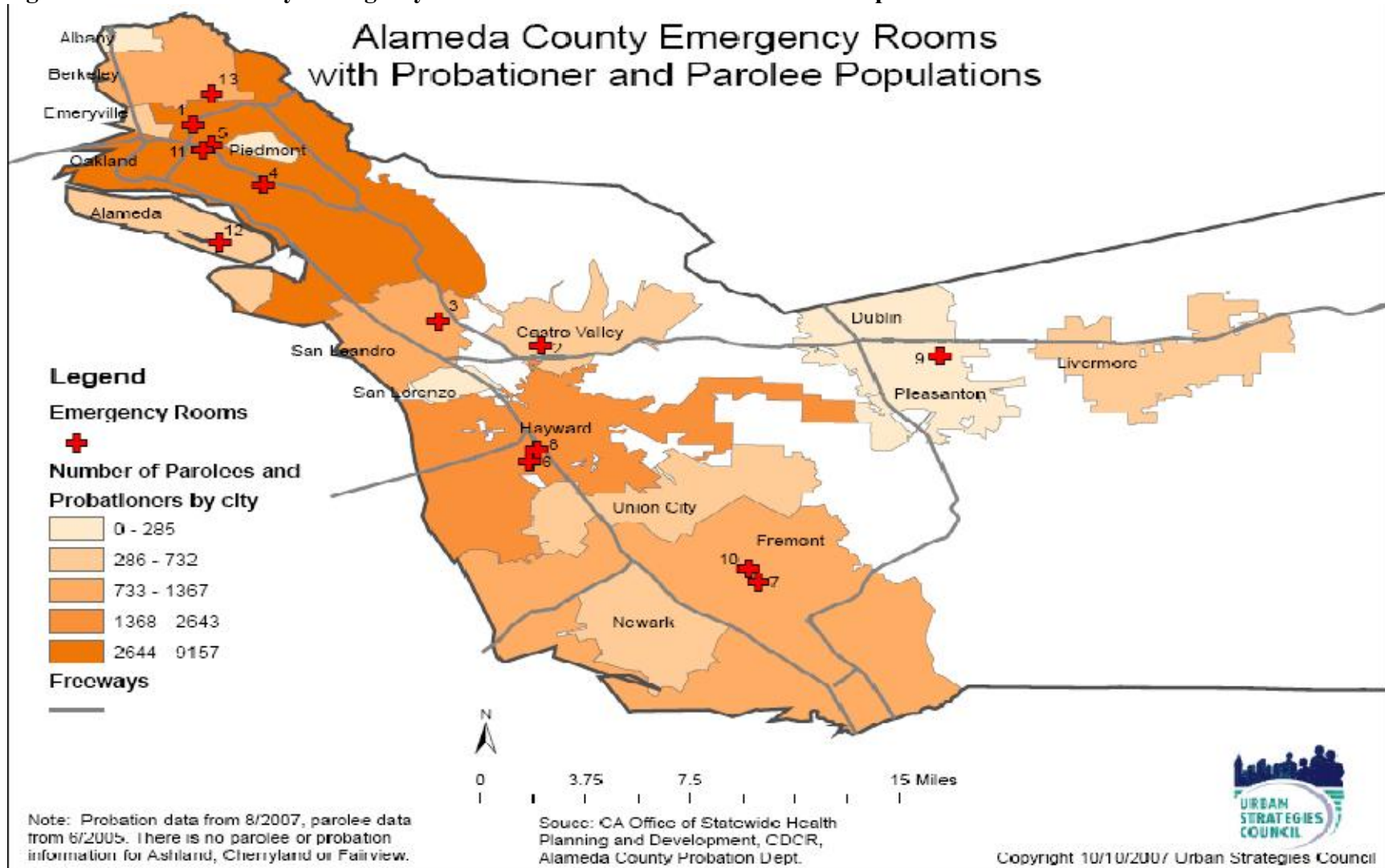


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Figure 6: Alameda County Emergency Rooms with Probationer and Parolee Populations





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Alameda County Reentry Resource Database Project

Not surprisingly, the data above indicates that the demand for medical services in Alameda County far outweighs their supply. The formerly incarcerated, as a particularly vulnerable and sick population are among those that exhibit the greatest need for medical care but also face the greatest amount of barriers to accessing it. While it is impossible to determine the exact size of this gap between the supply and demand for medical services what can be done is to develop tools that assist the formerly incarcerated and those that work with the formerly incarcerated in accessing existent medical services. With medical care being only one of a variety of services that are needed upon reentry these tools should be focused on the specific challenges that the formerly incarcerated face upon release. In conjunction with the Reentry Health Task Force process the Urban Strategies Council has been developing just such a tool: the Alameda County Reentry Resource Database which will be an online searchable database specifically geared towards the formerly incarcerated.

As part of the Reentry Health Task Force process the Urban Strategies Council has been focusing on gathering contact information on health care service providers in particular. Through this work we have developed a series of maps indicating where services are located across Alameda County and have rough counts on the number of sites that provide free or low cost health care services. In our next phase of data collection we will be administering a survey to the health care providers and gathering data on the number of people served by each site. This data will enable us to conduct a more refined analysis of the extent to which the supply of services is capable of meeting the demand. To see a discussion of the Reentry Resource Database and its results see Appendix 6 and to see the maps of the health care service providers see Appendix 10.

V. Issues, Problems and Opportunities for Healthy Reentry

Throughout the process, the Reentry Health Task Force sought to identify various issues, problems and opportunities that are affecting the health status of the formerly incarcerated. As the discussion below will indicate we found that the system of care for the formerly incarcerated suffers from a lack of continuity and is often fragmented.

From Pre-Release to Reentry

The issues and problems begin during the incarceration where pre-release planning is often inadequate or non-existent. When pre-release planning is conducted it is likely to be disconnected from the community-based services the inmate is meant to utilize upon release. At release the formerly incarcerated are not provided

About 60-70% of San Quentin's Health Care System is filled with parole violators
– (Paraphrased from comment by CSP- San Quentin Warden Robert Ayers)



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with the tools to access services (e.g. state ID, birth certificate, public benefits). Moreover, neither CDCR nor county jails routinely conduct medical screening incident to release (only at entrance) and, therefore, do not report communicable disease patients to county public health departments, or refer mental and substance abuse patients to county Behavioral Health Care, etc. Once in the community the formerly incarcerated struggle to establish a medical home. They are hindered in doing so by the difficulty in transferring medical records from CDCR and county jails to community based providers and the lack culturally or linguistically appropriate services.

The transition from incarceration to community-based health care is and must be understood as a process. Therefore, the issues, problems and opportunities that are affecting the health status of the formerly incarcerated can be usefully organized along the continuum from pre-release to reentry. We worked hard to maintain a community or reentry focus and not go too far “upstream” into the CDCR medical system. Therefore, while the issues, problems and opportunities that we have identified may involve the CDCR medical system, they only do so to the extent that they directly tied to the delivery of reentry health care and the health of the community. Below we have identified the primary issues problems and opportunities at each stage of the reentry process.

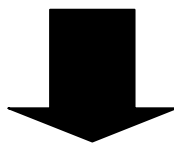
PRE-RELEASE

Issues, Problems and Opportunities:

1. Lack of and/or unrealistic pre-release planning
2. No set release date for undetermined sentences
3. Pre-release planning is often conducted with correctional staff rather than with community-based providers
4. Pre-release planning rarely makes direct referrals for medical services

Reentry Health Task Force Conclusions

1. Pre-release plans need to be formalized to ensure cooperation and collaboration between corrections and the county/community-based providers
2. Pre-release plans need to be realistic and account for eligibility requirements so individuals are not referred to services for which they are ineligible





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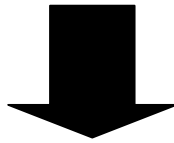
RELEASE

Issues, Problems and Opportunities

1. The formerly incarcerated are not released with a state identification
2. The formerly incarcerated are not enrolled and/or screened for public benefits
3. Lack of medical screening prior to release
4. Poor medication maintenance
5. No issuance of medical records upon release
6. No routine system for reporting communicable disease cases to the county of release
7. No clearly defined medical home

Reentry Health Task Force Conclusions

1. Release process needs to address systemic barriers (e.g. medical records, state identification, public benefit enrollment) prior to release
2. Formerly incarcerated who have serious conditions need to have a clearly defined medical home



REENTRY

Issues, Problems and Opportunities

1. The transition from correctional to community-based health care is fragmented and duplicative
2. CDCR and the county jail admit that they lack the infrastructure to transfer what medical records they do have to a county/community-based provider
3. Parole and probation have difficulty identifying the medical needs of their wards and, therefore, making appropriate referrals
4. Difficult to connect formerly incarcerated to providers with appropriate incarceration experience, cultural and linguistic competencies

Reentry Health Task Force Conclusions

1. Parole and probation should restrict their efforts to the public safety aspects of reentry and establish relationships with county and community-based agencies to provide medical services
2. Incarceration experience, culturally and linguistically appropriate outreach on the part of service providers is critical to reaching this population
3. Formalized system beginning with pre-release planning could dramatically improve service utilization by the formerly incarcerated



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One issue that was particularly prevalent was the lack of providers that understand and are sensitive to the experience of incarceration and the particular issues, needs and socio-cultural factors that are unique to this population as a result of incarceration. The effect and impact of incarceration can be seen in how the formerly incarcerated interpret and approach medical services and how health care providers approach the formerly incarcerated. For example, in her presentation about establishing the Transitions Clinic for the formerly incarcerated Dr. Emily Wang noted that they were having difficulty getting formerly incarcerated people to come to the clinic until they hired a community outreach worker whose job it was to recruit patients. As Dr. Wang noted, the community outreach worker had experience working with the formerly incarcerated and went into the communities they lived in to recruit patients. This was an issue that pervaded many of the presentations to the Reentry Health Task Force: when working with the formerly incarcerated a traditional approach to providing medical services may not be efficient and methods must take into account the impact of incarceration itself and the culture associated with incarceration in order to successfully reaching the population.

• • •
When working with the formerly incarcerated, service providers must take into account the impact of incarceration on the individual in order to successfully treat the population.
• • •

The Reentry Health Task Force concluded that there was a need to formalize and standardize the reentry process to ensure that the issues and problems affecting reentry health care were being addressed at each phase of the reentry process. The Reentry Health Task Force also concluded that there is an opportunity to improve the coordination and collaboration between the different components of Alameda County's system of care. Improving the relationships county jails, CDCR, county agencies, service providers and community-based organizations have with one another has the potential to improve every aspect of the reentry process, not just health care services. The Alameda County Reentry Network is an effort that is currently working to establish these types of collaborations and the Reentry Health Task Force voiced its support for this process and the potential impact it may have on reentry health care in Alameda County.

To see the complete set issues, problems or opportunities identified by the Reentry Health Task Force and possible barriers, current or possible strategies, policies or programs and any possible recommendations see the series of charts located in Appendix 7. For a more thorough description of the medical services see the following:

1. **San Quentin Health Care:** <http://www.urbanstrategies.org/ReceptionCenter.ppt.ppt>
2. **Santa Rita Health Care:** <http://www.urbanstrategies.org/CorrectionalMedicine-HaroldOrrMD.ppt.ppt>
3. **Health Care Matrix:** http://www.urbanstrategies.org/documents/MicrosoftWord-HealthCareMatrix_11.06.07_BH.pdf



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VI. Recommendations

As the above discussion indicates, the medical needs of the formerly incarcerated are great while the system of care to treat these medical needs is fragmented and, in the case of the California state Prison portion of the continuum, constitutionally insufficient. While the instincts of those concerned with social justice and health is to attempt to “fix the whole system,” the Task Force has had to restrain its instincts and target its attention on what we can do during the period of transition from incarceration and upon return to the community that would substantially improve the health status of the formerly incarcerated. The Task Force identified one issue that hindered reentry at virtually every point of the process: the lack of coordination and collaboration within the system of care. In addition to this cross-cutting issue we identified four themes around which the more specific recommendations were organized: Continuity of Care, Payer of Health Services, Health Service Delivery and Selected Specific Issues. Within these four themes the recommendations address infrastructure, policy and funding concerns that are all affecting reentry health care.

Coordination and Collaboration

Throughout our exploration of the issues, problems and opportunities affecting the health status of the formerly incarcerated, there was one issue which seemed to impact all facets of reentry health care: **the lack of coordination and collaboration among and between the different components of Alameda County’s system of care for the formerly incarcerated and CDCR’s system of care.** Every Reentry Health Task Force presenter identified an aspect of reentry health care that could be improved through increased collaboration among relevant agencies, organizations and departments. These improvements spanned the informational, policy, planning, funding and programmatic aspects of providing health care for the formerly incarcerated. Below, we list the relationships that we feel need to be improved and provide a summary statement concerning the types of improvements that were suggested by our presenters and through discussions:

6. **Corrections/Community:** The CDCR and Alameda County Jail need to work with community-based providers and county agencies to ensure effective pre-release planning and continuity of care after release, to better leverage health care dollars and to ensure that community-based medical providers have access to the medical records of their patients.
7. **County Agencies:** County agencies should work with one another to provide more comprehensive and coordinated services that avoid duplication, maximize resources and engage in collaborative strategic planning whenever possible.
8. **County and Cities:** County and City agencies and their respective elected bodies should coordinate with one another to address policy issues, maximize funding sources, align law enforcement with county services and to generally ensure that there is an active exchange of information concerning reentry health care opportunities
9. **County/City and Community/Faith Organizations and Providers:** County and City agencies should improve their collaborations with community-based organizations and service providers to maximize funding opportunities, to ensure referrals between services



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are accessible, appropriate and complete (i.e. medical records, medication maintenance, etc) and to promote the use of promising practices.

- 10. Community/Faith Organizations and Providers:** Community/Faith-based organizations and providers should collaborate and coordinate their efforts in order to improve professional development activities, to increase knowledge and awareness of promising practices and possible partnerships, to avoid duplication and redundancy and to best leverage resources.

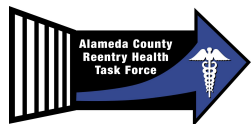
Clearly, the process from pre-release to reentry involves a wide range of agencies, organizations and departments; however, there is no mechanism for coordination and collaboration that provides them with a systems level perspective on the reentry process. Task Force members were almost uniformly interested and willing to explore collaboration but felt that the means for doing so was lacking. The Alameda County Reentry Network is an attempt to address some of these concerns. The Task Force feels that in order to improve the cooperation and collaboration within Alameda County's system of care, departments, agencies and organizations should participate fully in the Reentry Network process and use that Network as a means of collaborating. For more information on the Alameda County Reentry Network visit: www.acreentry.org

Specifically, the Reentry Health Task Force concluded that there needs to be a more formalized and standardized system of providing reentry health care such that pre-release planning and community-based services have a clear and tangible connection to one another. Identification of a payer for medical services and the necessary tools (e.g. state ID, birth certificate) should be identified and provided at the earliest possible point in the reentry process. Where a payer of medical services cannot be identified the formerly incarcerated individual should be made aware of this and be provided with information on how to best access the indigent care system. As a particularly vulnerable and difficult to reach population, community outreach is essential to getting medical services to the formerly incarcerated. When services are delivered they should address the incarceration experience, cultural and linguistic needs of this population. Finally, the necessary medical and service information should be readily available to service providers, county agencies (e.g. positive communicable disease cases) and to the formerly incarcerated, especially in the case of persons with serious medical conditions.

Specific Recommendations

As noted above, we have organized our recommendations in several ways which we hope aid in understanding and setting the path for action. First, we have chosen to organize the recommendations around a series of themes that emerged from our analysis of issues, problems and opportunities. These broad themes include:

1. Continuity of Care (e.g. pre-release planning, records transfer, medication supply/refill, etc.)



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2. Payer of medical care (e.g. public benefits eligibility screening, identify payer prior to release, health passport)
3. Service Delivery (e.g. specialized clinic, identified “medical home”, resource and referral system)
4. Specific Issues (e.g. data issues, funding issues, infrastructure issues, etc.)

In addition to organizing the recommendations around our broad themes, we have also organized the recommendations according to target group—that is, what group do we think is especially positioned to take action to implement the recommendation. These target groups include the Board of Supervisors; County Agency Directors; local, state and federal legislators; local, state and federal public agencies; services providers; and the community in general. The tables detailing the recommendations by target audience can be found in Appendix 9.

The recommendations have also been organized in terms of primary and secondary. It is the intent of the Task Force to identify a limited number of critical recommendations on which stakeholders can focus and which, if effectively implemented, will produce demonstrable results in terms of the health status of the formerly incarcerated. Under each of the 4 themes the primary recommendations are listed first. To see tables with the primary and secondary recommendations as well as the target audience see Appendix 8.

Finally, in Table 7 we have also tried to address the time dimension of the recommendations by labeling them as short-term objectives and long-term goals. Below Table 7 we present the recommendations in narrative summary form. Table 7 also condenses the narrative version of the recommendations listed below into more definitive action steps. While we have included long-term “goals” in Table 7 we have only done so because of the action oriented nature of these goals. In the tables of primary and secondary recommendations located in Appendix 8 we refrain from using “long-term” and opt to describe these goals as mid-term because it is our belief that the long-term solutions to quality health care for the formerly incarcerated are embedded in the broader public debates about universal health care and the federal court receiver’s efforts to improve the quality of health care provided during incarceration. How these issues are resolved will set the framework for how local communities structure their services to respond to the long-term system for meeting the needs of the formerly incarcerated.

Table 7: Recommendation Matrix

Recommendations	Short-Term Objective	Long Term Goal
Coordination and collaboration among components of the health care system	Board of Supervisors (BOS) and Health Care Services allocate funding to support the Reentry Network in developing a specific plan for health coordination using the Reentry Network as a vehicle	Implementation of a County-wide strategic plan for improving Reentry Health Care and coordination among all stakeholders
Continuity of Care	• Health Care Services and/or Public	State/County legislation to

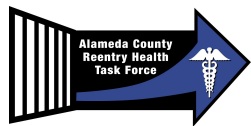


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Recommendations	Short-Term Objective	Long Term Goal
	<p>Health will convene medical staff from CDCR (San Quentin), Alameda County Sheriff, community- based providers to develop a collaborative and realistic system for pre-release planning</p> <ul style="list-style-type: none"> • CDCR will meet with state legislators to discuss dedicating funding for pre-release planning 	<p>implement new and effective methods for medical and other pre-release planning from Santa Rita and San Quentin</p>
Payer of Health Care Services	<p>Health Care Services and/or Public Health and Social Services will convene medical staff from CDCR (San Quentin) and Alameda County Sheriff, to develop a collaborative and realistic plan for conducting public benefits eligibility screening prior to release and a “health care passport” upon release</p>	<ul style="list-style-type: none"> • State legislators will adopt legislation for a program that suspends public benefits during incarceration rather than terminating them • BOS, County Sheriff and/or Public Health Department will allocate funding to initiate a program that conducts public benefit eligibility screening prior to release from Santa Rita
Health Services Delivery	<ul style="list-style-type: none"> • Public Health Department and BOS will convene a group to plan for creating or designating a specialty clinic for the formerly incarcerated • BOS will allocate funding to support the Reentry Network in developing a reentry resource database that will include service providers’ cultural and linguistic competencies as well as competence in working with the formerly incarcerated 	<p>BOS and Health Care Services will create or designate a specialty clinic for the formerly incarcerated that has community outreach workers on staff and will serve as the initial medical home for formerly incarcerated</p>
Selected Specific issues	<ul style="list-style-type: none"> • Public Health, CDCR and County Sheriff will meet to develop and then implement a system for pre-release communicable disease screening and reporting of positive cases to Public Health upon release 	<ul style="list-style-type: none"> • County Sheriff will implement a system for conducting communicable disease screening and reporting to public health department



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Recommendations	Short-Term Objective	Long Term Goal
	<ul style="list-style-type: none"> • BOS will direct Health Care Services to convene CDCR, County Sheriff and community-based service providers to develop a system for making data more available on the supply of and demand for health care services 	<ul style="list-style-type: none"> • State legislators will adopt a policy and allocate funding for communicable disease screening and reporting at San Quentin

Recommendation #1: Continuity of Care

CDCR, CSP-San Quentin, Alameda County Jail, Alameda County Agencies and community-based health services providers should make continuity of care during the period leading up to and immediately after release a reality by ensuring that those released have a pre-release medical plan which includes physical examination, their medical records, prescriptions and a supply of medications and a temporary medical home at the time of release. Specifically, these groups should work to develop:

- 1a. Structured discharge planning collaborations through formal agreements among agencies and with CBOs, designated agency liaisons, and broad community networks to allow for comprehensive referrals.
- 1b. Develop realistic, assessment-based discharge plans for parolees that specifically address their medical needs, account for their on-going health care and are flexible enough to prevent recidivism for mental health and substance abuse related
- 1c. Provide prisoners with a copy of their medical records upon release

Recommendation #2: Payer of Health Care Services

CDCR, CDCR-Parole, Alameda County Probation, County Agencies and community-based service providers should work together to document and further develop a system that ensures that all persons released from incarceration are screened for eligibility for public benefits programs, enrolled in all public health insurance programs for which they qualify and are informed of where they can go to receive free or low cost health care services. Specifically these groups should work to:

- 2a. Pre-release plan should have a clear plan for payment of ongoing treatment
- 2b. The Alameda County Public Health Department should work with CDCR and Santa Rita Jail to develop an electronic “continuity of care record” that would serve as an electronic “health passport” for prisoners upon release (*recommendation comes from California Conference of Local Health Officers proposal to CDCR*)
- 2c. CDCR and Santa Rita Jail should implement a program for mandatory public benefit eligibility screening and enrollment prior to release. The program should include service providers that work with the formerly incarcerated to use benefits eligibility screening and application software such as “Nets to Ladders”



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- 2d. Establish a program to suspend public benefits for persons incarcerated in county jail and work with the state to obtain federal waivers to extend the period of suspension of benefits to 24 months to cover the period when many technical violators are re-incarcerated.
- 2e. Connect all recently released persons to with diabetes, hypertension and congestive heart failure to the CMSP-ACE program
- 2f. Create tools and literature that can be used by case managers and the formerly incarcerated to identify possible sources of health care insurance and services and ensure that each inmate receives this information incident to pre-release planning and upon release

Recommendation #3: Health Services Delivery

CDCR-Parole, Alameda County Jail, Alameda County Probation, County Agencies and service providers should work together to ensure that the formerly incarcerated are aware of and utilizing needed medical services by offering services that address the unique medical needs and reentry challenges of the formerly incarcerated, that actively seek to engage the formerly incarcerated in medical care and that ensure that the formerly incarcerated and correctional and community-based medical service providers have access to current information on service providers and the reentry population.

Specifically they should:

- 3a. Create or designate a direct services clinic as a specialty clinic for the formerly incarcerated within Alameda County that would serve as the initial “medical home” for those being released.
- 3b. Establish expedited protocol to transfer records to specialty clinic for use by medical staff there or for transfer to medical personnel identified by the individual who is the subject of those records
- 3c. Create and maintain a county-wide reentry resource database with up to date information on health-related services as well as other services including housing, employment, etc.
- 3d. Make substance abuse and/or mental health treatment a requirement of parole or probation
- 3e. Alameda County Board of Supervisors should work with the county jails to implement a system of incentives to encourage County Jails to conduct more medical screening
- 3f. Funding should be allocated to help Community-Based Service providers hire community health workers to conduct targeted outreach to the formerly incarcerated community and preference should be given to hiring the formerly incarcerated for these positions
- 3g. Identify a set of preferred health care providers that have a proven track record of providing quality and culturally competent services to the formerly incarcerated

Recommendation #4: Selected Specific Issues

County Agencies, service providers, community organizations and county and city elected officials should work to address the policy, funding and infrastructural challenges that are



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impacting the reentry of persons released from incarceration by ensuring that those released understand the system of care that they are entering and their responsibilities within it and that the service providers, corrections and county agency staff have the necessary supports to effectively work with the reentry population. Specifically they should:

- 4a. Establish a system for making supply and demand data accessible so that program, funding and policy decisions can be more effectively
- 4b. Implement Mandatory screening for all communicable diseases prior or incident to release
- 4c. Implement Mandatory reporting of positive communicable disease cases to the county of release's Public Health Department by CDCR or County Jail medical staff
- 4d. Allow for substance abuse relapse without recidivating
- 4e. Ensure that additional allocations are targeted to communities over-represented by recently released inmates
- 4f. Dedicate funding for discharge planning and post-release follow-up
- 4g. Restructure CPOs and probation officers training/professional development practices so they stay informed of trends in populations medical needs and are capable of identify issues in need of professional medical attention, especially mental illness
- 4h. Provide education and intervention funding for faith & community-based organizations that are collaborative partners

VII. Next Steps

The recommendations, and all the supporting data, have been placed into this final report and the complimentary PowerPoint presentation. Both the report and the PowerPoint will be presented to various elected bodies and county agencies. Dr. Tony Iton, Alameda County Public Health Director, has agreed to present these recommendations to the Alameda County Board of Supervisors on behalf of the Reentry Health Task Force. Furthermore, Dr. Iton has agreed to have the Alameda County Public Health Department continue convening the Reentry Health Task Force on an as needed basis in an effort to build off of the momentum that this process generated.

The Alameda County Reentry Network will take responsibility for working with local stakeholders and service providers to implement the recommendations and to address the data and informational needs that have been identified by the Reentry Health Task Force. In addition, the Reentry Network will work with members of the Reentry Health Task Force to implement the communications plan so that the information generated through the Reentry Health Task Force will reach the widest possible audience.



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VIII. Appendices

Appendix 1: Reentry Health Task Force Presenters

The following persons presented to the Reentry Health Task Force and on specific health conditions, current programs, the system of care within the county and other relevant topics that pertain to the health status of the formerly incarcerated within alameda county.

Meeting 2 - 10.11.07				
TOPIC	FIRST	LAST	TITLE	ORGANIZATION
<i>General Health Care</i>	Dr. Tony	Iton	Director	Alameda County Public Health Department
<i>General Health Care</i>	Alex	Briscoe	Deputy Director,	Alameda County Health Care Services
<i>Mental Health</i>	Dean	Chambers	Program Specialist	Alameda County Behavioral Health Care
<i>Substance Abuse</i>	Lee	Boone	Substance Abuse Specialist	Haight-Ashbury African American Family Healing Center
<i>Formerly Incarcerated</i>	Ron	Owens		
Meeting 3 - 11.08.07				
TOPIC	FIRST	LAST	TITLE	ORGANIZATION
<i>Chronic Care</i>	Dr. Tony	Iton	Director,	Alameda County Public Health Department
<i>Communicable Diseases</i>	Dr. Rosilyn	Ryals	Director of Division of Communicable Disease Control	Alameda County Public Health Department
<i>Dental Health</i>	Dr. Jared	Fine	Dental Health officer	Alameda County Public Health Department
<i>Transitions Clinic</i>	Dr. Emily	Wang	Clinician	Transitions Clinic
Meeting 4 - 12.08.07				
TOPIC	FIRST	LAST	TITLE	ORGANIZATION
<i>Jail Health Care</i>	Dr. Harold	Orr	Medical Director	Alameda County Jails
<i>Prison Health Care</i>	Cherlita	Gullem	Head Nurse	Federal Receiver's office
Meeting 5 - 01.10.07				
TOPIC	FIRST	LAST	TITLE	ORGANIZATION
<i>Mental Health</i>	Dr. Sean	Frugé	Clinician	Frugé Psychological Associates, Inc.
<i>Mental Health</i>	Dr. Alexis	Green-Frugé	Clinician	Frugé Psychological Associates, Inc.



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Appendix 2: Reentry Health Task Force Visitors

FIRST	LAST	ORGANIZATION
Lamurson	Cross	
Rasheed	Salaam	
Alvan	Quamina	<i>AIDS Project of the East Bay</i>
Mosby	Roosevelt	<i>SMAAC Youth Center</i>
Dennis	DeBiase	<i>CSP-San Quentin State Prison</i>
LaMicha	Williams	<i>Regional Congregations and Neighborhood Organizations</i>
Gloria	Lockett	<i>California Prevention and Education Project</i>
Andrea	Girton	<i>California Prevention and Education Project</i>
Karie	Gaska	<i>Alameda County Public Health Department</i>
Lorie	Hill	<i>Providing Alternatives to Violence</i>
Lawhnel	Eoddaenal	
Dr. Harold	Orr	<i>Prison Health Services - Santa Rita Jail</i>
Elliot	Frey	<i>New Beginning Church</i>
Jarrell	Booker	<i>Berkeley Health Center</i>
Dedoceo	Hasi	<i>Mindworks Net</i>
LaTonya	Winsey	<i>Bay Area Consortium for Quality Health Care</i>
Jacqueline	Escudero	<i>Bay Area Consortium for Quality Health Care</i>
Margaret	Richardson	<i>East Bay Community Law Center</i>
Lloyd	Farr	



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Appendix 3: Probation and Parole Population of Alameda County by Gender

TABLE 2
PROBATION AND PAROLE POPULATION IN ALAMEDA COUNTY: GENDER
(AS OF JUNE 2007)

Source of Supervision	MALE	FEMALE
Adult Parole ²⁷	3,015	282
Adult Probation ²⁸	N/A	N/A
Federal Probation and Parole	N/A	N/A
TOTAL ADULT REENTRY POPULATION IN ALAMEDA COUNTY	N/A	N/A
Juvenile Probation ²⁹ (Alameda County Juvenile Probation Caseload)	N/A	N/A
Juvenile Parole (DJJ parolees)	N/A	N/A
TOTAL REENTRY POPULATION IN ALAMEDA COUNTY	N/A	N/A

Appendix 4: Probation and Parole Population of Alameda County by Level of Supervision

TABLE 3
PROBATION AND PAROLE POPULATION IN ALAMEDA COUNTY: LEVEL OF SUPERVISION
(AS OF JUNE 2007)

	Population	Percent
CDCR Adult Parolees		
High Control	N/A	N/A
High Services	N/A	N/A
Control Services	N/A	N/A
Minimum Services	N/A	N/A
Unknown Disposition	N/A	N/A
Total Adult Parolees	3,297	100%

²⁷ Parole Census Data June 30, 2007. CDCR. Retrieved on 10/17/07:
http://www.cdc.ca.gov/Reports_Research/Offender_Information_Services_Branch/Annual/PCensus1/PCENSUS1d0706.pdf

²⁸ June 2007 Monthly Statistical Report, Alameda County Probation Department. It is important to note that this number reflects all of the Adults on probation in Alameda County, not those that are actively supervised. The number of actively supervised individuals on probation in June 2007 was 2,369.

²⁹ June 2007 Monthly Statistical Report, Alameda County Probation Department.



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TABLE 3
PROBATION AND PAROLE POPULATION IN ALAMEDA COUNTY: LEVEL OF
SUPERVISION
 (AS OF JUNE 2007)

	Population	Percent
DJJ (CYA) Parolees	N/A	100%
TOTAL CDCR PAROLEES	N/A	
AC Probation Dept. Adult Probationers		
Maximum Supervision	2,283	14%
Active Supervision	2,369	14%
Prop. 36	2,022	12%
Minimum/Medium Supervision	10,121	60%
Total AC Probation Dept. Adult Probationers	16,795	100%
AC Court Probationers	N/A	N/A
TOTAL ALAMEDA COUNTY PROBATIONERS	16,795	
Federal Bureau of Prisons		
Federal Probationers	N/A	N/A
Federal Supervised Release		
Federal Parolees	N/A	N/A
TOTAL FBI PAROLEES AND PROBATIONERS	N/A	N/A
Total Reentry Population in Alameda County	22,249	100%
Alameda Co. Juvenile Probationers	N/A	N/A



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Appendix 5: Age Distribution by Ethnicity and Gender of Alameda County Parolees June 2005

Ethnicity/Gender	Age																Total	
	20-29		30-39		40-49		50-59		60-69		70-79		80+		Missing/		#	%
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%		
African Americans	624	26.7%	745	31.9%	659	28.2%	272	11.6%	33	1.4%	3	0.1%	0	0%	1	0%	2,337	100%
Males	598	27.9%	665	31.1%	595	27.8%	247	11.5%	32	1.5%	3	0.1%	0	0%	1	0%	2,141	100%
Females	26	13.3%	80	40.8%	64	32.7%	25	12.8%	1	0.5%	0	0%	0	0%	0	0%	196	100%
Mexicans	151	33.9%	152	34.1%	108	24.2%	30	6.7%	5	1.1%	0	0%	0	0%	0	0%	446	100%
Males	145	36.0%	139	34.5%	86	21.3%	28	6.9%	5	1.2%	0	0%	0	0%	0	0%	403	100%
Females	6	14.0%	13	30.2%	22	51.2%	2	4.7%	0	0%	0	0%	0	0%	0	0%	43	100%
Whites	99	17.9%	180	32.5%	199	35.9%	62	11.2%	11	2.0%	2	0.4%	1	0.2%	0	0%	554	100%
Males	82	17.0%	163	33.8%	172	35.7%	53	11.0%	9	1.9%	2	0.4%	1	0.2%	0	0%	482	100%
Females	17	23.6%	17	23.6%	27	37.5%	9	12.5%	2	2.8%	0	0%	0	0%	0	0%	72	100%
Other	40	47.1%	30	35.3%	10	11.8%	5	5.9%	0	0%	0	0%	0	0%	0	0%	85	100%
Males	39	48.8%	28	35.0%	8	10.0%	5	6.3%	0	0%	0	0%	0	0%	0	0%	80	100%
Females	1	20.0%	2	40.0%	2	40.0%	0	0%	0	0%	0	0%	0	0%	0	0%	5	100%
Chinese, Japanese, Hawaiian and Pilipino*	7	25.9%	8	29.6%	8	29.6%	3	11.1%	1	3.7%	0	0%	0	0%	0	0%	27	100%
Males	7	26.9%	7	26.9%	8	30.8%	3	11.5%	1	3.8%	0	0%	0	0%	0	0%	26	100%
Females	0	0%	1	100.0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	1	100%
Native Americans	2	18.2%	4	36.4%	4	36.4%	1	9.1%	0	0%	0	0%	0	0%	0	0%	11	100%
Males	2	18.2%	4	36.4%	4	36.4%	1	9.1%	0	0%	0	0%	0	0%	0	0%	11	100%
Females	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	100%
Missing Ethnicity	2	100%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	2	100%
Males	2	100%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	2	100%
Females	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	-
Total for Alameda Co.	925	26.7%	1118	32.3%	989	28.6%	376	10.9%	50	1.4%	5	0.1%	1	0%	1	0%	3,462	100%
Males	873	27.8%	1006	32.0%	873	27.8%	337	10.7%	47	1.5%	5	0.2%	1	0%	1	0%	3,143	100%
Females	50	15.8%	113	35.6%	115	36.3%	36	11.4%	3	0.9%	0	0%	0	0%	0	0%	317	100%



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Appendix 6: Alameda County Reentry Resource Database

Table 8: Reentry Health Resources in Alameda County	
General Health	141
Mental Health	124
Substance Abuse	123
Dental	23
Vision	4
Reproductive Health	17
TOTAL	432

Thus far we have collected a list of 432 sites that provide health related services in Alameda County, presumably to the formerly incarcerated.³⁰ This number includes all indigent care related services, providers who accept Medi-Cal or some other public insurance and low cost medical providers and organizations conducting referrals and health education. Table 8 provides a breakdown of all health services available to the formerly incarcerated according to the type of service.

For example, this means that there are 123 different sites, meetings or organizations that are providing referrals, direct service or prevention related to substance abuse within Alameda County. Treatment for chronic and communicable diseases falls under the “General Health” resources category as treatment for these conditions is often administered through a primary care provider. We have attempted to be more inclusive than exclusive, meaning that if a program was potentially available to the formerly incarcerated we included it in the database. Consequently, as we refine and solidify these data the numbers are likely to go down but to be more specific and more targeted to the formerly incarcerated.

Table 9: Private Health Facilities in Alameda County	
Hospital	3
Clinic	47
Other	125
Emergency Room	3
TOTAL	178

In Table 9 we provide some more detailed data on the types of facilities that are providing services within Alameda County. “Hospitals” and “Clinics” refer to organizations that licensed to provide direct health care services while the “Other” group refers to organizations that make referrals to health care services, provide health educations, but do not offer direct medical services. The data in Table 9 excludes all indigent care services and is comprised entirely of private hospitals, clinics and community based organizations. These services may still accept Medi-Cal or provide low-cost health care they are just outside of the Alameda County indigent care system. The “Other” category in Table 9 comprises 70% of total private health care providers in Alameda County. This means that only 30% of the private health care providers are actually offering services. This means that while it may be relatively easy for a formerly incarcerated person to receive health education or get a referral to a health care provider, it is much more competitive to actually access direct services.

³⁰ The word “sites” is used to indicate that each site of a multiple site provider, such as La Clinica de la Raza, is counted separately. This was done because each site functions as an independent resource to the community it serves.



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Table 10: Alameda County Indigent Care Providers	
Hospital	3
Community Based Providers sites	26
County Based Health Centers	4
TOTAL	33

In Figure 5 we have listed the Indigent Medical Care Services Provider Network. These are all direct services and are limited to organizations that are included by the Alameda County Health Care Services Agency as part of the Indigent Medical Care Services Provider Network. These are services that are specifically geared towards indigent populations. The formerly incarcerated must compete with the other 166,000 uninsured persons across Alameda County. The community-based organizations and the community health centers comprise the bulk of the indigent care providers. The community based organizations and the community health centers operate on a first- come-first served appointment basis, meaning once they hit their limit for the number of appointments that they can cover

in a given month that center has reached capacity.



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Appendix 7: Issues, Problems and Opportunities working charts

CROSS-CUTTING CONCERNS			
<i>Issues, Problems and Opportunities</i>	<i>Barriers and Challenges</i>	<i>Strategies, Policies, & Programs</i>	<i>Possible Recommendations</i>
Parolees and Probationers are not enrolled in all the public benefits programs for which they qualify	<ol style="list-style-type: none"> 1. Lack of infrastructure and coordination/collaboration to connect community based providers with prisoners before fore release to conduct eligibility determinations and begin enrollment process 2. Current federal regulations enable but do not require states to provide reenrollment in Medi-Cal. (The Public Health Dimensions of Prisoner Reentry: p.8 Community Health Care Services) 3. 	<ol style="list-style-type: none"> 1. Mandatory eligibility screening and enrollment prior to release for all public benefits programs. Including: <ul style="list-style-type: none"> o Medi-Cal o Food Stamps o SSI o General Assistance 2. Where applicable, suspend public benefits upon entry into system rather than terminate 	<ol style="list-style-type: none"> 1. Mandatory eligibility screening and enrollment prior to release 2. Automatic reactivation of public benefits upon release 3. Automatic enrollment in public benefits programs prior to release for all qualified persons
Lack of standardized screening for all health conditions		<ol style="list-style-type: none"> 1. Mandatory screening for all health conditions. 	Develop a standardized medical screening for both intake and release



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CROSS-CUTTING CONCERNS			
<i>Issues, Problems and Opportunities</i>	<i>Barriers and Challenges</i>	<i>Strategies, Policies, & Programs</i>	<i>Possible Recommendations</i>
			Annual screening for communicable diseases and mental health problems
Prisoners access to medical care	<ol style="list-style-type: none"> 1. Prisoners are required to make \$5 Co-payment for health care certain health services within CDCR 2. COs are intermediary between prisoners and medical staff 	Repeal state law requiring co-payment during incarceration	<ol style="list-style-type: none"> 1. Eliminate co-payment for health care during incarceration 2. Ensure prisoners have direct access to medical staff
Coordination and cooperation between community based service providers		The Alameda County Reentry Network is attempting to address this lack of coordination by providing a single infrastructure to increase collaboration and cooperation between community based service providers, policy makers and other relevant stakeholders	<ol style="list-style-type: none"> 1. Provide education and intervention funding for faith & community-based organizations that are collaborative partners (LA and San Diego Health Task Forces) 2. Provide technical assistance funding to counties to foster collaboration w/ faith & community-based providers (LA and San Diego Health Task Forces)
Coordination and collaboration between		1. Establish managed care “special needs” programs for	1. Dedicate funding for discharge planning and post-release follow-up.



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CROSS-CUTTING CONCERNS			
<i>Issues, Problems and Opportunities</i>	<i>Barriers and Challenges</i>	<i>Strategies, Policies, & Programs</i>	<i>Possible Recommendations</i>
CDCR and community-based providers		<p>returning inmates that provide comprehensive and coordinated medical, mental health, and substance abuse services. (The Public Health Dimensions of Prisoner Reentry: p.8 Community Health Care Services)</p> <p>2. Develop a set of preferred health care providers (LA and San Diego Health Task Forces)</p>	<p>2. Assign dedicated staff to provide pre-release discharge planning services and designate a discharge planning coordinator at each facility and statewide.</p> <p>3. Collaborative team of corrections staff, parole agents, and CBOs staff meets with each inmate prior to release</p> <p>4. Assign case managers to work with released inmates; when possible the same provider should work with the client before and after release</p> <p>5. Institutionalize discharge planning collaborations through formal agreements among agencies and with CBOs, designated agency liaisons, and broad community networks to allow for comprehensive referrals.</p> <p>6. Develop a set of preferred health care providers (LA and San Diego Health Task Forces)</p>
Poor understanding the medical needs of	1. Lack of reliable data on formerly incarcerated	1. Regularly updated report on the health status of	1. Create a multi-service clinic for the formerly incarcerated



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CROSS-CUTTING CONCERNS			
<i>Issues, Problems and Opportunities</i>	<i>Barriers and Challenges</i>	<i>Strategies, Policies, & Programs</i>	<i>Possible Recommendations</i>
the formerly incarcerated		California's prison population 2. Improved data collection within CDCR, including maintenance of a single medical record 3. System for transferring medical records to relevant community based providers 4. Multi-service health clinic for the formerly incarcerated	2. Provide prisoners with a copy of their medical records upon release 3.
Lack of information on the supply of and demand for services	No centralized source for information on supply of services	Develop a resource and referral database that can be updated by service providers	County wide resource and referral database
Correctional and parole/probation staff professional development trainings are outdated		Restructure current training of CPOs and probation officer deals w/currents medical needs of the population	Restructure current training of CPOs and probation officer deals w/currents medical needs of the population
Distribution of public resources		1. Devote more resources into preventative care and community education 2. Identify any dollars that could be redirected to health care for the formerly incarcerated 3. Let the dollars follow the inmate into the community	1. Ensure that additional allocations are targeted to communities over-represented by recently released inmates (LA and San Diego Health Task Forces) 2. Let the dollars follow the person into the community



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CROSS-CUTTING CONCERNS			
<i>Issues, Problems and Opportunities</i>	<i>Barriers and Challenges</i>	<i>Strategies, Policies, & Programs</i>	<i>Possible Recommendations</i>
		(w/CBOs) while he/she is on parole. Parole time served is decreased, spent dollars in the community. 4.	

GENERAL HEALTH CARE			
<i>Issues, Problems and Opportunities</i>	<i>Barriers and Challenges</i>	<i>Strategies, Policies, & Programs</i>	<i>Possible Recommendations</i>
Lack knowledge of indigent care services	1. Lack of coordination and planning between CDCR and the county	1. County has program to treat people with Diabetes, hypertension and congestive heart failure it is the CMSP-ACE program 2. Distribute pamphlet of indigent care services	Connect all recently released persons to with Diabetes, hypertension and congestive heart failure to the CMSP-ACE program
Over use of emergency room for non-urgent medical care		1. Identify a primary care service provider prior to release 2. Community Health workers to reach out to the population	1. Multi-service health clinic for the formerly incarcerated 2. Hire community health workers to conduct outreach



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MENTAL HEALTH			
<i>Issues, Problems and Opportunities</i>	<i>Barriers and Challenges</i>	<i>Strategies, Policies, & Programs</i>	<i>Possible Recommendations</i>
Limited access to mental health services during incarceration (From Prison To Home:pg27 Physical and Mental Health)		Mandatory screening at least 120 days prior to release (LA and San Diego Health Task Forces)	1. Mandatory screening to identify medical problems at intake and prior to release, (ideally annual screening)
Limited identification of mental health problems during incarceration and after release	Prisoners can only access to medical staff through CPOs	Those health service providers on the inside and outside have to be educated and more capable of identifying persons in need of a mental health assessment	1. CPOs and/or medical staff need to be trained to identify person's in need of mental health assessment 2. Ensure prisoners have direct access to medical staff
Lack of follow-up care within community (From Prison To Home:pg27 Physical and Mental Health)	Lack of coordination between CDCR and community based providers Poor medication maintenance	1. Identify a mental health provider prior to release and have that provider meet the parolee at the gate 2. Transference of mental health cases to relevant county agency	1. Establish a pre-release plan which identifies a mental health care provider as well as a source for medication refills 2. Service providers hire community health workers to provide outreach
Parole agencies have been unable to effectively identify and	A national survey of parole administrators indicated that fewer than a quarter provide special programs for parolees with	1. Parole Department is willing to make psychiatric care a requirement of a person's	1. Make mental health care a requirement of a person's parole



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MENTAL HEALTH			
<i>Issues, Problems and Opportunities</i>	<i>Barriers and Challenges</i>	<i>Strategies, Policies, & Programs</i>	<i>Possible Recommendations</i>
address the needs of mentally ill parolees	mental illness.(From Prison To Home: pg29 Physical and Mental Health)	parole however they need to work with the county to identify service providers and establish relationships with those providers	2. Develop a specialized plan for parolees with mental illnesses that accounts for their on-going health care and is flexible enough to prevent recidivism for mental health related incidents

SUBSTANCE ABUSE			
<i>Issues, Problems and Opportunities</i>	<i>Barriers and Challenges</i>	<i>Strategies, Policies, & Programs</i>	<i>Possible Recommendations</i>
CDCR will not fund methadone maintenance programs, only detoxification programs	CDCR policy against funding methadone maintenance	County can apply for an exception and or develop a system with CDCR to pay for methadone maintenance	County and parole/probation work together to fund methadone maintenance programs



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SUBSTANCE ABUSE			
<i>Issues, Problems and Opportunities</i>	<i>Barriers and Challenges</i>	<i>Strategies, Policies, & Programs</i>	<i>Possible Recommendations</i>
Community based treatment can conflict with demands of parole	Lack of coordination between CDCR and community based providers	<ol style="list-style-type: none"> 1. Make treatment a requirement of parole 2. Don't recidivate for relapse 3. Ensure continued treatment during the critical first 30 days after release, if a long term provider cannot be identified 	<ol style="list-style-type: none"> 1. Make treatment a requirement of parole 2. Allow for relapse without recidivating

COMMUNICABLE DISEASES			
<i>Issues, Problems and Opportunities</i>	<i>Barriers and Challenges</i>	<i>Strategies, Policies, & Programs</i>	<i>Possible Recommendations</i>
Impact of communicable diseases within institution and community	Inadequate facilities within institutions	<ol style="list-style-type: none"> 1. Organize new intake and sick-call areas to be well ventilated 2. Reduce duration of infectiousness through timely diagnosis of disease; isolation; and prompt and effective treatment 	Mandatory screening for all communicable disease and especially Hip C, HIV/AIDS



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COMMUNICABLE DISEASES			
<i>Issues, Problems and Opportunities</i>	<i>Barriers and Challenges</i>	<i>Strategies, Policies, & Programs</i>	<i>Possible Recommendations</i>
Lack of consistent reporting of contagious clients to public health department	Lack of coordination between CDCR and county agencies		Mandated transference of positive communicable disease cases to relevant Public Health department
Need greater coordination of resources and institution staff in the prevention of communicable and infectious diseases		<ol style="list-style-type: none"> 1. Establish a Public Health Services Unit within CDCR 2. CDCR has begun to develop a set of internal recommendations and a proposed structure for the Public Health Services Unit within CDCR 	Establish a robust and competent public health infrastructure within CDCR
Screening for HIV/AIDS is voluntary		<ol style="list-style-type: none"> 1. Inmates should be screened upon entrance and release and re-screened annually and at least 120 days prior to release 2. In addition to regular screening inmates should be screened for HIV/AIDS prior to release and all positive cases should be reported to family members 	<ol style="list-style-type: none"> 1. Mandatory screening for all communicable diseases 2. Report positive HIV/AIDS cases to family members



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CHRONIC DISEASES			
<i>Issues, Problems and Opportunities</i>	<i>Barriers and Challenges</i>	<i>Strategies, Policies, & Programs</i>	<i>Possible Recommendations</i>
Plan for ongoing treatment	Lack of pre-release planning	All persons with Chronic Diseases should have a plan for ongoing treatment	Pre-release plan should have a clear plan for ongoing treatment including the transference of medical records
Little to no preventative care in the County system		Need to convert county system into more of a vertically oriented system that addresses prevention and identification	Increase preventative care and programs

ORAL, AUDITORY AND VISUAL HEALTH			
<i>Issues, Problems and Opportunities</i>	<i>Barriers and Challenges</i>	<i>Strategies, Policies, & Programs</i>	<i>Possible Recommendations</i>
“Meth Mouth”	Lack of identification within prisons	H.R. 3187	
Identifying community service providers	Medi-Cal will pay for services but there has been trouble identifying dentists who will accept Medi-Cal	Create a multi-service clinic for the formerly incarcerated	Create a multi-service clinic for the formerly incarcerated



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PRE-RELEASE³¹			
<i>Issues, Problems and Opportunities</i>	<i>Barriers and Challenges</i>	<i>Strategies, Policies, & Programs</i>	<i>Possible Recommendations</i>
Lack of coordinated pre-release process		1. Pre-release process should include: <ol style="list-style-type: none"> a. Pre-release health curriculum b. Community Health Directory c. Electronic transmission of health records to local public health department d. Vouchers for establishing health access CURRENT INITIATIVES 2. STAND-UP San Quentin	1. Establish a coordinated pre-release process which includes the dedication of at least one staff person whose job it would be to oversee pre-release and coordinate with the community based providers 2. Support STAND-UP San Quentin

³¹ *Pre-Release*– The period of time prior to release during which pre-release planning takes place. This may include meetings with Parole agents and community-based service providers.



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PRE-RELEASE³¹			
<i>Issues, Problems and Opportunities</i>	<i>Barriers and Challenges</i>	<i>Strategies, Policies, & Programs</i>	<i>Possible Recommendations</i>
		3. AB 900 requires that CDCR conduct assessments of all soon-to-be-released prisoners for substance abuse, medical and mental health concerns	
Lack of time for pre-release planning	Unless the individual has been given a determinate sentence it is often the case that they will be notified of their release and released within a matter of days, this is especially true in CDCR where more people have undetermined sentences but also applies to County Jail where there is significantly less programming in general and the brevity of sentences prevents pre-release planning.	4. Institute a system of pre-release planning that begins at least 180 days prior to release, even if the release date is pushed back	3.

RELEASE³²

³² **Release** – the week prior to release and the week after which the person is released from custody.



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<i>Issues, Problems and Opportunities</i>	<i>Barriers and Challenges</i>	<i>Strategies, Policies, & Programs</i>	<i>Possible Recommendations</i>
<p>Communicate medical history to parole and community based medical providers</p>		<ol style="list-style-type: none"> 1. Electronic medical records 2. Need to facilitate process for obtaining records in general, and especially to the parole department 3. Primary Care clinic devoted entirely to reentry population 	<p>Public Health Department would work with CDCR and Santa Rita Jail to develop an electronic “continuity of care record” that would serve as an electronic “health passport” for prisoners upon release</p>
<p>Lack of state identification upon release</p>		<ol style="list-style-type: none"> 1. Issue California ID and Social Security card prior to release. <p><u>CURRENT INTERVENTIONS</u></p> <ol style="list-style-type: none"> 1. Gov. Schwarzenegger has signed AB 639 to test a pilot program that will issue California IDs to qualifying persons prior to their release from CSP-San Quentin 	

REENTRY³³

³³ *Reentry* – The period of up to six months after release during which a person is re-establishing themselves within the family, neighborhood and community and accessing services called for in the pre-release plan.



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<i>Issues, Problems and Opportunities</i>	<i>Barriers and Challenges</i>	<i>Strategies, Policies, & Programs</i>	<i>Possible Recommendations</i>
Maintain Medication regimen after release		Multi-service clinic for the formerly incarcerated	Multi-service clinic for the formerly incarcerated
Difficulty connecting with community-based providers	<ol style="list-style-type: none"> 1. Recruit patients directly from the PACT meetings 2. Community Health Workers are essential to success of service providers (esp. clinics) 	Multi-service clinic for the formerly incarcerated	Multi-service clinic for the formerly incarcerated
Lack of culturally competent health care services	Cultural and linguistic differences between providers and formerly incarcerated	Identify culturally competent community based health care and treatment providers to services ex-offenders	Identify culturally competent community based health care and treatment providers that service the formerly incarcerated. (LA and San Diego Health Task Forces)



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Appendix 8: Primary and Secondary Recommendations

PRIMARY RECOMMENDATIONS*						KEY	
Recommendations	Time	Cross-Cutting	Incarceration	Pre-release/Transition	Reentry/community		Target Audience
Continuity of Care							
1a. Structure pre-release planning collaborations through formal agreements among agencies and with CBOs, designated agency liaisons, and broad community networks to allow for comprehensive referrals.	Mid-term			○ ☒ ▲ ◆ □	○ ☒ ▲ ◆ □	●	Alameda County Board of Supervisors
1b. Develop realistic, assessment based discharge plans for parolees that specifically address their medical needs, account for their on-going health care and is flexible enough to prevent recidivism for mental health and substance abuse related incidents	Mid-term			○	▲ ○	○	County Agencies
1c. Provide inmates with a copy of their medical records prior to release						■	City, State, Federal elected officials
						▲	City/State/Federal Agencies
						☒	CDCR
						◆	Providers (Health, Faith, CBO)
						□	Community
Payer							
2a. Implement a pre-release planning process with a clear strategy for payment of ongoing treatment	Mid-term			☒ ▲ ■ ○	○ ◆		
2b. Public Health Department should work with CDCR and Santa Rita Jail	Short-term	☒ ▲ ○					



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PRIMARY RECOMMENDATIONS*						KEY	
Recommendations	Time	Cross-Cutting	Incarceration	Pre-release/Transition	Reentry/community	Target Audience	
to develop an electronic “continuity of care record” that would serve as an electronic “health passport” for prisoners upon release						●	Alameda County Board of Supervisors
2c. CDCR and Alameda County Sheriff should implement a program for public benefit eligibility screening and enrollment prior to release. The program should include service providers that work with the formerly incarcerated to use benefits eligibility screening and application software such as “Nets to Ladders”	Short-term			☒ ■ ◆ ○		○	County Agencies
						■	City, State, Federal elected officials
						▲	City/State/Federal Agencies
						☒	CDCR
						◆	Providers (Health, Faith, CBO)
						■	Community
2d. Establish a program to suspend public benefits to the currently allowable period for persons incarcerated in county jail or state prison and work with the state to obtain federal waivers to extend the period of suspension of benefits to 24 months to cover the period during which many parole violators are re-incarcerated	Short-term	● ○					
Service Delivery							
3a. Create or designate a direct service	Mid-term					● ■ ▲ ◆ □	



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PRIMARY RECOMMENDATIONS*						KEY	
Recommendations	Time	Cross-Cutting	Incarceration	Pre-release/Transition	Reentry/community		
clinic for the formerly incarcerated within Alameda County that would serve as the initial “medical home” for those being released					○	●	Target Audience
						○	Alameda County Board of Supervisors
3b. Establish a protocol to expedite transfer of medical records to the specialty clinic for use by medical staff there or for transfer to medical personnel identified by the individual who is the subject of those records						○	County Agencies
						■	City, State, Federal elected officials
						▲	City/State/Federal Agencies
3c. Create and maintain a county wide reentry resource and referral database with up-to-date information on health related services as well as other services including housing, employment, etc.	Short-term				◆ ■ ▲ ○	☒	CDCR
						◆	Providers (Health, Faith, CBO)
						■	Community
3d. Make Substance Abuse and/or mental health treatment a requirement of parole	Mid-term				☒ ▲ ○		
3e. Implement a system of incentives to encourage Alameda County Sheriff to conduct more medical screening for communicable and chronic diseases as well as mental health and substance abuse disorders within the Alameda County Jail							



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PRIMARY RECOMMENDATIONS*						KEY	
Recommendations	Time	Cross-Cutting	Incarceration	Pre-release/Transition	Reentry/community	Target Audience	
Specific Issues							
4a. Establish a system for making data more available on the supply and demand data for health care services so that program, funding and policy decisions can more accurately reflect the health care needs of the formerly incarcerated	Mid-term				● ▲ ○ ☒	● Alameda County Board of Supervisors	
4b. Implement mandatory screening for communicable diseases prior or incident to release	Mid-term	☒ ○ ▲ ■				○ County Agencies	
4c. Require CDCR or County Jail to report all positive communicable disease cases to the county of release's Public Health Department prior to release	Mid-term	☒ ○ ▲ ■				■ City, State, Federal elected officials	
4d. Allow for substance abuse relapse without recidivating	Mid-term				▲ ☒	▲ City/State/Federal Agencies	
4e. Ensure that additional funding allocations are targeted to neighborhoods/communities over-represented by recently released inmates	Mid-term				● ■	☒ CDCR	
4f. Dedicate funding for pre-release planning and post-release follow-up	Mid-term			▲ ● ■		◆ Providers (Health, Faith, CBO)	
						■ Community	



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SECONDARY RECOMMENDATIONS*					
Recommendations	Time	Cross-Cutting	Incarceration	Pre-release/Transition	Reentry/community
Continuity of Care					
1c. Provide prisoners with a copy of their medical records upon release	Mid-term				▲ ■
Payer					
2e. Connect all recently released persons to with Diabetes, hypertension and congestive heart failure to the CMSP-ACE program	Short-term			○ ☒	▲ ○
2f. Create tools and literature that can be used by case managers and the formerly incarcerated to identify possible sources of health care insurance and services and ensure that each inmate receives this information incident to release planning and upon release	Mid-term				◆ ☒
Service Delivery					
3f. Funding should be allocated to help the clinic designated to serve the formerly incarcerated hire community health workers to conduct targeted outreach to the formerly incarcerated	Mid-term				◆ ○ ■

KEY	
Target Audience	
●	Alameda County Board of Supervisors
○	County Agencies
■	City State/Federal elected officials
▲	City/State/Federal Agencies
☒	CDCR
◆	Providers (Health, Faith, CBO)
◻	Community



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SECONDARY RECOMMENDATIONS*					
Recommendations	Time	Cross-Cutting	Incarceration	Pre-release/Transition	Reentry/community
community and preference should be given to hiring the formerly incarcerated for these positions					
3g. Identify a set of preferred health care providers that have a proven track record of providing quality and culturally competent services to the formerly incarcerated	Short-term				▲◆■○
Specific Issues					
4g. Restructure CPOs and probation officers training/professional development practices so they stay informed of trends in populations medical needs and are capable of identify issues in need of professional medical attention, especially mental illness	Mid-Term	☒			
4h. Provide education and intervention funding for faith & community-based organizations that are collaborative partners	Mid-term				●■

KEY	
	Target Audience
●	Alameda County Board of Supervisors
○	County Agencies
■	City State/Federal elected officials
▲	City/State/Federal Agencies
☒	CDCR
◆	Providers (Health, Faith, CBO)
◻	Community



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Appendix 9: Recommendations by Target Audience

Alameda County Board of Supervisors

ALAMEDA COUNTY BOARD OF SUPERVISORS										
Recommendations	Cross-Cutting	General Health	Mental Health	Substance Abuse	Communicable Diseases	Chronic Diseases	Oral, Auditory, Visual Health	Pre-Release	Release	Re-entry
3a Create or designate a direct service clinic for the formerly incarcerated within Alameda County that would serve as the initial “medical home” for those being released	X									X
3g Identify a set of preferred health care providers that have a proven track record of providing quality and culturally competent services to the formerly	X									X



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ALAMEDA COUNTY BOARD OF SUPERVISORS

Recommendations	Cross-Cutting	General Health	Mental Health	Substance Abuse	Communicable Diseases	Chronic Diseases	Oral, Auditory, Visual Health	Pre-Release	Release	Re-entry
incarcerated										
4a Establish a system for making data more available on the supply and demand data for health care services so that program, funding and policy decisions can more accurately reflect the health care needs of the formerly incarcerated	X									X
4e Ensure that additional funding allocations are targeted to neighborhoods/communities over-represented by recently released inmates	X									X
4f. Dedicate funding for pre-release planning and post release follow up	X									X
4h Provide education	X									X



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ALAMEDA COUNTY BOARD OF SUPERVISORS

Recommendations	Cross-Cutting	General Health	Mental Health	Substance Abuse	Communicable Diseases	Chronic Diseases	Oral, Auditory, Visual Health	Pre-Release	Release	Re-entry
and intervention funding for faith & community-based organizations that are collaborative partners										

County Agencies

COUNTY AGENCIES

Recommendations	Cross-Cutting	General Health	Mental Health	Substance Abuse	Communicable Diseases	Chronic Diseases	Oral, Auditory, Visual Health	Pre-Release	Release	Re-entry
1a Structure pre-release planning collaborations through formal agreements among agencies and with CBOs, designated agency liaisons, and broad community	X							X	X	



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COUNTY AGENCIES

Recommendations	Cross-Cutting	General Health	Mental Health	Substance Abuse	Communicable Diseases	Chronic Diseases	Oral, Auditory, Visual Health	Pre-Release	Release	Re-entry
networks to allow for comprehensive referrals.										
1b Develop realistic, assessment based discharge plans for parolees that specifically address their medical needs, account for their on-going health care and is flexible enough to prevent recidivism for mental health and substance abuse related incidents			X					X	X	
2a Implement a pre-release planning process with a clear strategy for payment of ongoing treatment	X							X		
2b Public Health Department should work with CDCR and Santa Rita Jail to develop an electronic “continuity of	X							X	X	X



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COUNTY AGENCIES

Recommendations	Cross-Cutting	General Health	Mental Health	Substance Abuse	Communicable Diseases	Chronic Diseases	Oral, Auditory, Visual Health	Pre-Release	Release	Re-entry
care record” that would serve as an electronic “health passport” for prisoners upon release										
2c CDCR and Alameda County Sheriff should implement a program for public benefit eligibility screening and enrollment prior to release. The program should include service providers that work with the formerly incarcerated to use benefits eligibility screening and application software such as “Nets to Ladders”	X							X		
2e Connect all recently released persons to with Diabetes, hypertension and congestive heart		X								



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COUNTY AGENCIES										
Recommendations	Cross-Cutting	General Health	Mental Health	Substance Abuse	Communicable Diseases	Chronic Diseases	Oral, Auditory, Visual Health	Pre-Release	Release	Re-entry
failure to the CMSP-ACE program										
3a Create or designate a direct service clinic for the formerly incarcerated within Alameda County that would serve as the initial “medical home” for those being released	X								X	X
3c Create and maintain a county wide reentry resource and referral database									X	X
3d Make Substance Abuse and/or mental health treatment a requirement of parole				X						
3e Funding should be allocated to help the clinic designated to serve the formerly incarcerated hire community health	X									X



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COUNTY AGENCIES

Recommendations	Cross-Cutting	General Health	Mental Health	Substance Abuse	Communicable Diseases	Chronic Diseases	Oral, Auditory, Visual Health	Pre-Release	Release	Re-entry
workers to conduct targeted outreach to the formerly incarcerated community and preference should be given to hiring the formerly incarcerated for these positions										
3f Identify a set of preferred health care providers that have a proven track record of providing quality and culturally competent services to the formerly incarcerated	X									X
4a Establish a system for making data more available on the supply and demand data for health care services so that program, funding and policy decisions can	X									X



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COUNTY AGENCIES

Recommendations	Cross-Cutting	General Health	Mental Health	Substance Abuse	Communicable Diseases	Chronic Diseases	Oral, Auditory, Visual Health	Pre-Release	Release	Re-entry
more accurately reflect the health care needs of the formerly incarcerated										
4c Require CDCR or County Jail to report all positive communicable disease cases to the county of release's Public Health Department					X					
4g Restructure CPOs and probation officers training/professional development practices so they stay informed of trends in populations medical needs and are capable of identify issues in need of professional medical attention, especially mental illness			X					X		



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City/State/Federal Elected Officials

CITY/STATE/FEDERAL ELECTED OFFICIALS										
Recommendations	Cross-Cutting	General Health	Mental Health	Substance Abuse	Communicable Diseases	Chronic Diseases	Oral, Auditory, Visual Health	Pre-Release	Release	Re-entry
1c Provide prisoners with a copy of their medical records upon release	X								X	
2a Implement a pre-release planning process with a clear strategy for payment of ongoing treatment	X							X	X	
2b Public Health Department should work with CDCR and Santa Rita Jail to develop an electronic “continuity of care record” that would serve as an electronic “health passport” for prisoners upon release	X							X		
2c CDCR and Alameda County Sheriff should	X							X	X	



Arnold Perkins, Chair

REENTRY HEALTH CARE IN ALAMEDA COUNTY:

Initial Assessment and Recommendations of the Alameda County Reentry Health Task Force

CITY/STATE/FEDERAL ELECTED OFFICIALS

Recommendations	Cross-Cutting	General Health	Mental Health	Substance Abuse	Communicable Diseases	Chronic Diseases	Oral, Auditory, Visual Health	Pre-Release	Release	Re-entry
implement a program for public benefit eligibility screening and enrollment prior to release. The program should include service providers that work with the formerly incarcerated to use benefits eligibility screening and application software such as “Nets to Ladders”										
2d Establish a program to suspend public benefits to the currently allowable period for persons incarcerated in county jail	X							X		
3a Create or designate a direct service clinic for the formerly	X									X



Arnold Perkins, Chair

REENTRY HEALTH CARE IN ALAMEDA COUNTY:

Initial Assessment and Recommendations of the Alameda County Reentry Health Task Force

CITY/STATE/FEDERAL ELECTED OFFICIALS

Recommendations	Cross-Cutting	General Health	Mental Health	Substance Abuse	Communicable Diseases	Chronic Diseases	Oral, Auditory, Visual Health	Pre-Release	Release	Re-entry
incarcerated within Alameda County that would serve as the initial “medical home” for those being released										
3e Funding should be allocated to help the clinic designated to serve the formerly incarcerated hire community health workers to conduct targeted outreach to the formerly incarcerated community and preference should be given to hiring the formerly incarcerated for these positions	X									X
4b Implement mandatory screening for communicable diseases prior or incident to release					X				X	



Arnold Perkins, Chair

REENTRY HEALTH CARE IN ALAMEDA COUNTY:

Initial Assessment and Recommendations of the Alameda County Reentry Health Task Force

CITY/STATE/FEDERAL ELECTED OFFICIALS

Recommendations	Cross-Cutting	General Health	Mental Health	Substance Abuse	Communicable Diseases	Chronic Diseases	Oral, Auditory, Visual Health	Pre-Release	Release	Re-entry
4c Require CDCR or County Jail to report all positive communicable disease cases to the county of release's Public Health Department					X					X
4e Ensure that additional funding allocations are targeted to neighborhoods/communities over-represented by recently released inmates	X									X
4f Dedicate funding for pre-release planning and post-release follow-up	X							X	X	
4h Provide education and intervention funding for faith & community-based organizations that are collaborative	X									X



Arnold Perkins, Chair

REENTRY HEALTH CARE IN ALAMEDA COUNTY:

Initial Assessment and Recommendations of the Alameda County Reentry Health Task Force

CITY/STATE/FEDERAL ELECTED OFFICIALS										
Recommendations	Cross-Cutting	General Health	Mental Health	Substance Abuse	Communicable Diseases	Chronic Diseases	Oral, Auditory, Visual Health	Pre-Release	Release	Re-entry
partners										

City/State/Federal Agencies

CITY/STATE/FEDERAL AGENCIES										
Recommendations	Cross-Cutting	General Health	Mental Health	Substance Abuse	Communicable Diseases	Chronic Diseases	Oral, Auditory, Visual Health	Pre-Release	Release	Re-entry
1a Structure pre-release planning collaborations through formal agreements among agencies and with CBOs, designated agency liaisons, and broad community networks to allow for comprehensive referrals.	X							X		
1b Develop realistic, assessment based			X							X



Arnold Perkins, Chair

REENTRY HEALTH CARE IN ALAMEDA COUNTY:

Initial Assessment and Recommendations of the Alameda County Reentry Health Task Force

CITY/STATE/FEDERAL AGENCIES										
Recommendations	Cross-Cutting	General Health	Mental Health	Substance Abuse	Communicable Diseases	Chronic Diseases	Oral, Auditory, Visual Health	Pre-Release	Release	Re-entry
discharge plans for parolees that specifically address their medical needs, account for their on-going health care and is flexible enough to prevent recidivism for mental health and substance abuse related incidents										
1c Provide prisoners with a copy of their medical records upon release	X								X	
2a Implement a pre-release planning process with a clear strategy for payment of ongoing treatment	X							X		
2b Public Health Department should work with CDCR and Santa Rita Jail to develop an electronic “continuity of	X								X	X



Arnold Perkins, Chair

REENTRY HEALTH CARE IN ALAMEDA COUNTY:

Initial Assessment and Recommendations of the Alameda County Reentry Health Task Force

CITY/STATE/FEDERAL AGENCIES										
Recommendations	Cross-Cutting	General Health	Mental Health	Substance Abuse	Communicable Diseases	Chronic Diseases	Oral, Auditory, Visual Health	Pre-Release	Release	Re-entry
care record” that would serve as an electronic “health passport” for prisoners upon release										
2e Connect all recently released persons to with Diabetes, hypertension and congestive heart failure to the CMSP-ACE program		X							X	X
3a Create or designate a direct service clinic for the formerly incarcerated within Alameda County that would serve as the initial “medical home” for those being released	X							X		
3b Create and maintain a county wide reentry resource and referral database	X									X
3c Make Substance Abuse and/or mental				X					X	X



Arnold Perkins, Chair

REENTRY HEALTH CARE IN ALAMEDA COUNTY:

Initial Assessment and Recommendations of the Alameda County Reentry Health Task Force

CITY/STATE/FEDERAL AGENCIES										
Recommendations	Cross-Cutting	General Health	Mental Health	Substance Abuse	Communicable Diseases	Chronic Diseases	Oral, Auditory, Visual Health	Pre-Release	Release	Re-entry
health treatment a requirement of parole										
3f Identify a set of preferred health care providers that have a proven track record of providing quality and culturally competent services to the formerly incarcerated	X									X
4a Establish a system for making data more available on the supply and demand data for health care services so that program, funding and policy decisions can more accurately reflect the health care needs of the formerly incarcerated	X									X
4c Require CDCR or County Jail to report all positive communicable					X					X



Arnold Perkins, Chair

REENTRY HEALTH CARE IN ALAMEDA COUNTY:

Initial Assessment and Recommendations of the Alameda County Reentry Health Task Force

CITY/STATE/FEDERAL AGENCIES

Recommendations	Cross-Cutting	General Health	Mental Health	Substance Abuse	Communicable Diseases	Chronic Diseases	Oral, Auditory, Visual Health	Pre-Release	Release	Re-entry
disease cases to the county of release's Public Health Department										
4d Allow for substance abuse relapse without recidivating				X						X

CDCR

CDCR

Recommendations	Cross-Cutting	General Health	Mental Health	Substance Abuse	Communicable Diseases	Chronic Diseases	Oral, Auditory, Visual Health	Pre-Release	Release	Re-entry
1a Structure pre-release planning collaborations through formal agreements among agencies and with CBOs, designated agency liaisons, and	X								X	X



Arnold Perkins, Chair

REENTRY HEALTH CARE IN ALAMEDA COUNTY:

Initial Assessment and Recommendations of the Alameda County Reentry Health Task Force

CDCR										
Recommendations	Cross-Cutting	General Health	Mental Health	Substance Abuse	Communicable Diseases	Chronic Diseases	Oral, Auditory, Visual Health	Pre-Release	Release	Re-entry
broad community networks to allow for comprehensive referrals.										
2a Implement a pre-release planning process with a clear strategy for payment of ongoing treatment	X								X	X
2b Public Health Department should work with CDCR and Santa Rita Jail to develop an electronic “continuity of care record” that would serve as an electronic “health passport” for prisoners upon release	X								X	X
2c CDCR and Alameda County Sheriff should implement a program for public benefit eligibility screening and enrollment prior to release. The program	X							X		



Arnold Perkins, Chair

REENTRY HEALTH CARE IN ALAMEDA COUNTY:

Initial Assessment and Recommendations of the Alameda County Reentry Health Task Force

CDCR										
Recommendations	Cross-Cutting	General Health	Mental Health	Substance Abuse	Communicable Diseases	Chronic Diseases	Oral, Auditory, Visual Health	Pre-Release	Release	Re-entry
should include service providers that work with the formerly incarcerated to use benefits eligibility screening and application software such as "Nets to Ladders"										
2d Establish a program to suspend public benefits to the currently allowable period for persons incarcerated in county jail	X							X		
2e Connect all recently released persons to with Diabetes, hypertension and congestive heart failure to the CMSP-ACE program		X							X	X
2f Create tools and literature that can be used by case managers	X							X	X	X



Arnold Perkins, Chair

REENTRY HEALTH CARE IN ALAMEDA COUNTY:

Initial Assessment and Recommendations of the Alameda County Reentry Health Task Force

CDCR										
Recommendations	Cross-Cutting	General Health	Mental Health	Substance Abuse	Communicable Diseases	Chronic Diseases	Oral, Auditory, Visual Health	Pre-Release	Release	Re-entry
and the formerly incarcerated to identify possible sources of health care insurance and services and ensure that each inmate receives this information incident to release planning and upon release										
3c Make Substance Abuse and/or mental health treatment a requirement of parole				X						X
4a Establish a system for making data more available on the supply and demand data for health care services so that program, funding and policy decisions can more accurately reflect the health care needs of the formerly	X									X



Arnold Perkins, Chair

REENTRY HEALTH CARE IN ALAMEDA COUNTY:

Initial Assessment and Recommendations of the Alameda County Reentry Health Task Force

CDCR										
Recommendations	Cross-Cutting	General Health	Mental Health	Substance Abuse	Communicable Diseases	Chronic Diseases	Oral, Auditory, Visual Health	Pre-Release	Release	Re-entry
incarcerated										
4b Implement mandatory screening for communicable diseases prior or incident to release					X			X		
4c Require CDCR or County Jail to report all positive communicable disease cases to the county of release's Public Health Department					X				X	X
4d Allow for substance abuse relapse without recidivating	X									X
4f Dedicate funding for pre-release planning and post-release follow up	X									X
4g Restructure CPOs and probation officers training/professional development practices			X					X		



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REENTRY HEALTH CARE IN ALAMEDA COUNTY:

Initial Assessment and Recommendations of the Alameda County Reentry Health Task Force

CDCR										
Recommendations	Cross-Cutting	General Health	Mental Health	Substance Abuse	Communicable Diseases	Chronic Diseases	Oral, Auditory, Visual Health	Pre-Release	Release	Re-entry
so they stay informed of trends in populations medical needs and are capable of identify issues in need of professional medical attention, especially mental illness										

Service Providers

SERVICE PROVIDERS										
Recommendations	Cross-Cutting	General Health	Mental Health	Substance Abuse	Communicable Diseases	Chronic Diseases	Oral, Auditory, Visual Health	Pre-Release	Release	Re-entry
2a Implement a pre-release planning process with a clear strategy for payment of ongoing treatment	X							X	X	X
2f Create tools and	X							X	X	X



Arnold Perkins, Chair

REENTRY HEALTH CARE IN ALAMEDA COUNTY:

Initial Assessment and Recommendations of the Alameda County Reentry Health Task Force

SERVICE PROVIDERS										
Recommendations	Cross-Cutting	General Health	Mental Health	Substance Abuse	Communicable Diseases	Chronic Diseases	Oral, Auditory, Visual Health	Pre-Release	Release	Re-entry
literature that can be used by case managers and the formerly incarcerated to identify possible sources of health care insurance and services and ensure that each inmate receives this information incident to release planning and upon release										
3a Create or designate a direct service clinic for the formerly incarcerated within Alameda County that would serve as the initial “medical home” for those being released	X									X
3e Funding should be allocated to help the clinic designated to serve the formerly	X									X



Arnold Perkins, Chair

REENTRY HEALTH CARE IN ALAMEDA COUNTY:

Initial Assessment and Recommendations of the Alameda County Reentry Health Task Force

SERVICE PROVIDERS										
Recommendations	Cross-Cutting	General Health	Mental Health	Substance Abuse	Communicable Diseases	Chronic Diseases	Oral, Auditory, Visual Health	Pre-Release	Release	Re-entry
incarcerated hire community health workers to conduct targeted outreach to the formerly incarcerated community and preference should be given to hiring the formerly incarcerated for these positions										
3f Identify a set of preferred health care providers that have a proven track record of providing quality and culturally competent services to the formerly incarcerated	X									X
4g Restructure CPOs and probation officers training/professional development practices so they stay informed of trends in populations	X							X		X



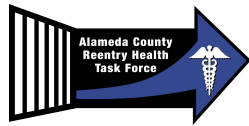
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REENTRY HEALTH CARE IN ALAMEDA COUNTY:

Initial Assessment and Recommendations of the Alameda County Reentry Health Task Force

SERVICE PROVIDERS

Recommendations	Cross-Cutting	General Health	Mental Health	Substance Abuse	Communicable Diseases	Chronic Diseases	Oral, Auditory, Visual Health	Pre-Release	Release	Re-entry
medical needs and are capable of identify issues in need of professional medical attention, especially mental illness										



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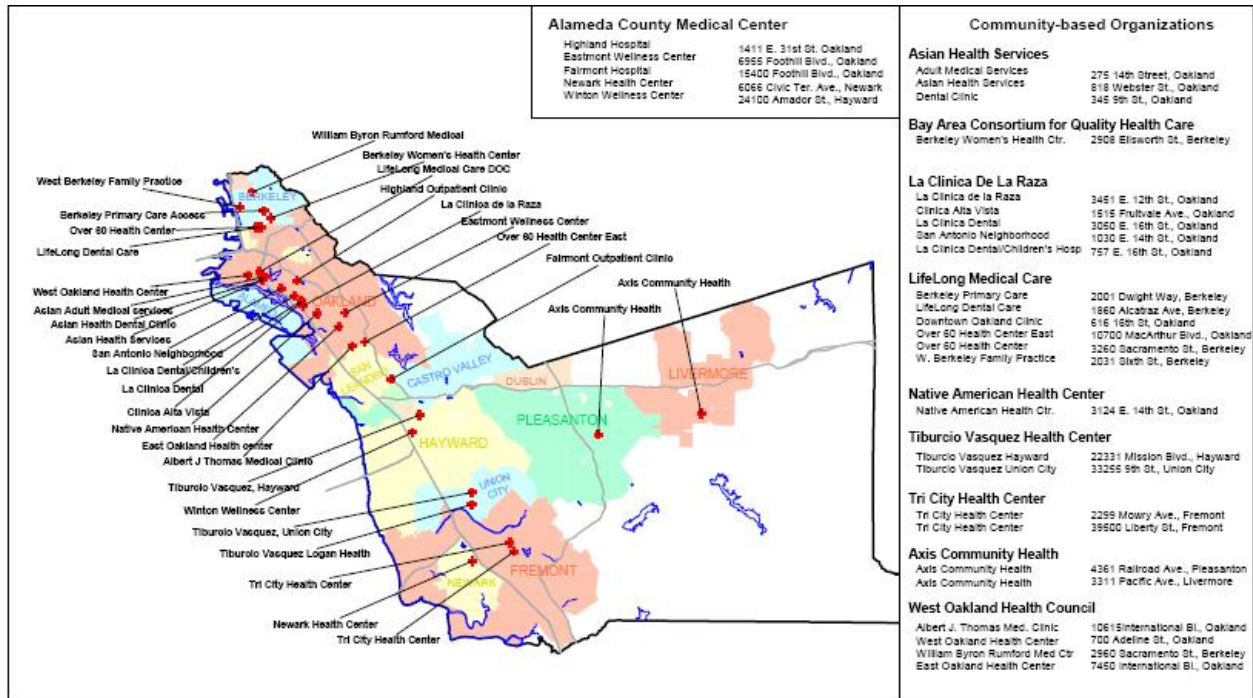
REENTRY HEALTH CARE IN ALAMEDA COUNTY:

Initial Assessment and Recommendations of the Alameda County Reentry Health Task Force

Appendix 10: Health Service Maps

(All the maps shown below are available under the “Maps” section of the Task Force website: <http://www.urbanstrategies.org/HealthTaskForce.html> or click on map to see it immediately)

CMSP Facilities

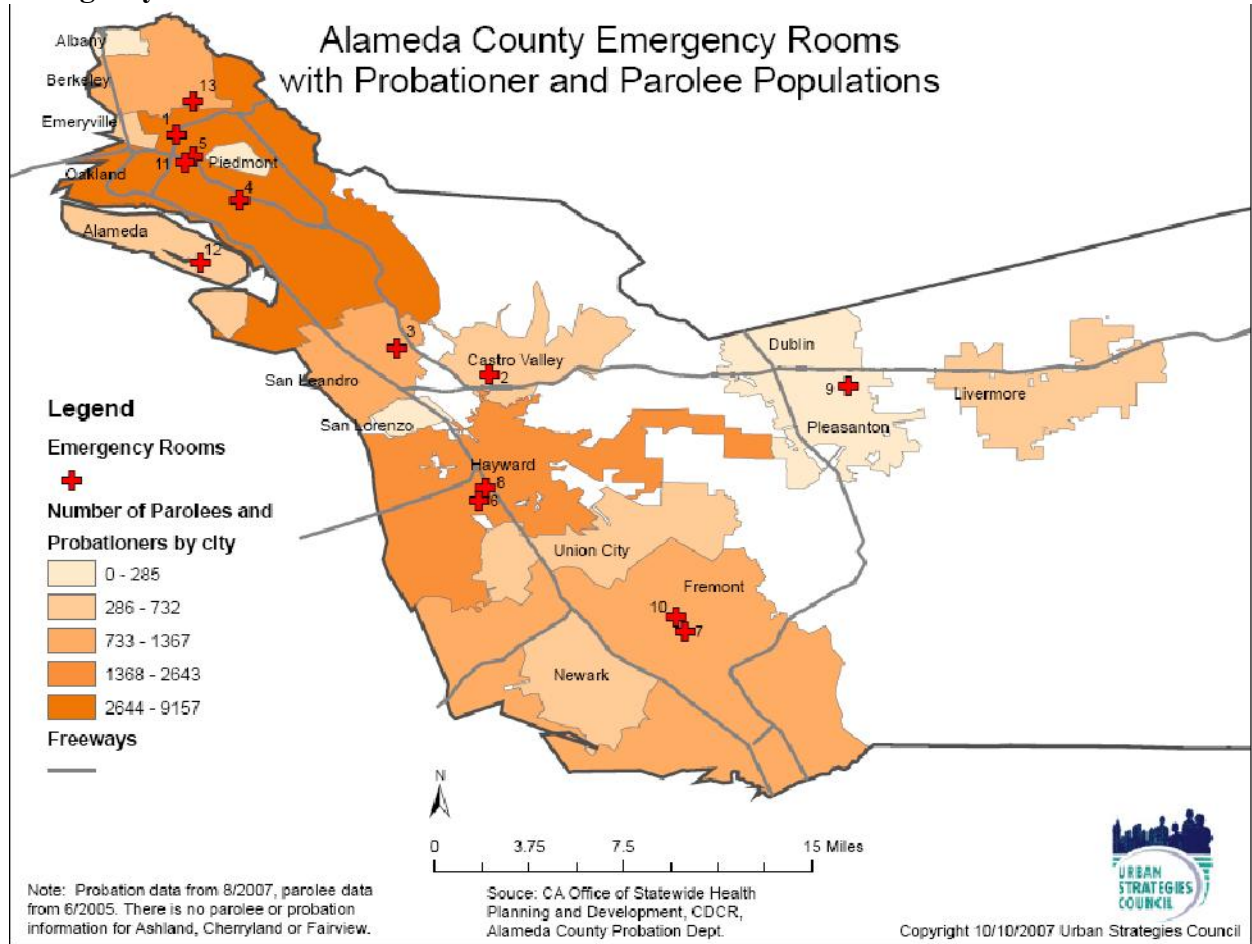




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REENTRY HEALTH CARE IN ALAMEDA COUNTY: Initial Assessment and Recommendations of the Alameda County Reentry Health Task Force

Emergency Rooms





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REENTRY HEALTH CARE IN ALAMEDA COUNTY:

Initial Assessment and Recommendations of the Alameda County Reentry Health Task Force

Facilities from Alameda County Emergency Rooms Map

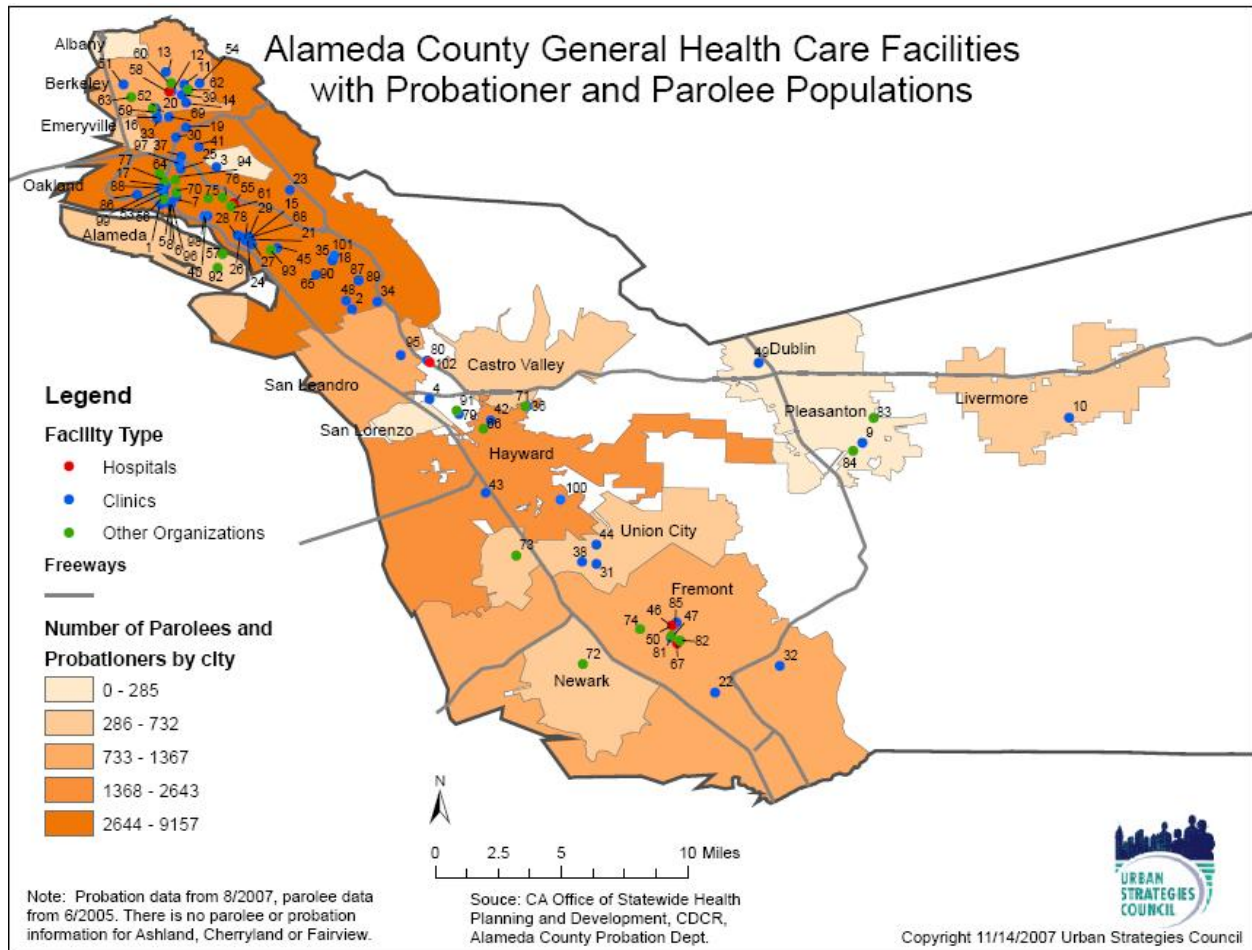
Label	FACILITY	ADDRESS	CITY	ZIP CODE
1	Children's Hosp & Research Ctr of Oakland	747 52Nd St	Oakland	94609
2	Eden Med Ctr	20103 Lake Chabot Rd	Castro Valley	94546
3	San Leandro Hosp	13855 E 14Th St	San Leandro	94578
4	Alameda Co Med Ctr, Highland	1411 E 31St St	Oakland	94602
5	Kaiser, Oakland	280 W Macarthur Blvd	Oakland	94611
6	Kaiser, Hayward	27400 Hesperian Blvd	Hayward	94545
7	Kaiser, Fremont	39400 Paseo Padre Pkwy	Fremont	94538
8	St Rose Hosp	27200 Calaroga Ave	Hayward	94545
9	Valleycare Med Ctr	5555 W Las Positas Blvd	Pleasanton	94588
10	Washington Hosp - Fremont Alta Bates Summit Med Ctr - Summit-	2000 Mowry Ave	Fremont	94538
11	Hawthorne	350 Hawthorne Ave	Oakland	94609
12	Alameda Hosp	2070 Clinton Ave	Alameda	94501
13	Alta Bates Summit Med Ctr	2450 Ashby Ave	Berkeley	94705



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REENTRY HEALTH CARE IN ALAMEDA COUNTY: Initial Assessment and Recommendations of the Alameda County Reentry Health Task Force

General Health Care Facilities





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REENTRY HEALTH CARE IN ALAMEDA COUNTY:
Initial Assessment and Recommendations of the Alameda County Reentry
Health Task Force

Facilities from Alameda County General Health Services Map

Label	FACILITY	ADDRESS	CITY	ZIP CODE	CATEGORY
1	Aids Project of The East Bay	499 5Th St	Oakland	94607	Community Clinic
2	Albert J. Thomas Med Clinic	10615 International Blvd	Oakland	94603	Community Clinic
3	Ann Martin Children's Ctr	1250 Grand Ave	Piedmont San	94610	Community Clinic
4	Ashland Free Med Clinic	50 E Lewelling Blvd	Lorenzo	94580	Free Clinic
5	Asian Cmty Mental Hlth Svcs	310 8Th St	Oakland	94607	Community Clinic
6	Asian Hlth Svc	818 Webster St	Oakland	94607	Community Clinic
7	Asian Hlth Svcs	275 14Th St	Oakland	94612	Community Clinic
8	Asian Hlth Svcs	345 9Th St	Oakland	94607	Community Clinic
9	Axis Cmty Hlth	4361 Railroad Ave	Pleasanton	94566	Community Clinic
10	Axis Cmty Hlth	3311 Pacific Ave	Livermore	94550	Community Clinic
11	Berkeley Cmty Hlth Project Berkeley Primary Care Access Clinic	2339 Durant Ave	Berkeley	94704	Free Clinic
12		2001 Dwight Way 1749 Martin Luther King Jr Way	Berkeley	94704	Community Clinic
13	Berkeley Therapy Inst		Berkeley	94709	Community Clinic
14	Berkeley Women's Hlth Ctr	2908 Ellsworth St	Berkeley	94705	Community Clinic
15	Casa Del Sol Ctr For Elders Independence - Berkeley	1501 Fruitvale Ave	Oakland	94601	Community Clinic
16		1497 Alcatraz Ave	Berkeley	94702	Community Clinic
17	Oakland Ctr For Elders Independence Charlotte Maxwell	1955 San Pablo Ave	Oakland	94612	Community Clinic
18		7200 Bancroft Ave	Oakland	94602	Community Clinic
19	Complementary Clinic	5691 Telegraph Ave	Oakland	94609	Community Clinic
20	City Help Cmty Svcs	1500 Ashby Ave	Berkeley	94703	Community Clinic
21	Clinica Alta Vista	1515 Fruitvale Ave	Oakland	94601	Community Clinic
22	East Bay Agcy For Children	42875 Gatewood St	Fremont	94538	Community Clinic
23	East Bay Agcy For Children East Bay Native American Hlth Ctr	2540 Charleston St	Oakland	94602	Community Clinic
24		3124 International Blvd	Oakland	94601	Community Clinic
25	First Resort Independent Living Skills Program Teen Hlth Ctr.	400 30Th St	Oakland	94609	Community Clinic
26		2647 International Blvd	Oakland	94601	Community Clinic
27	La Clinica De La Raza	3451 E 12Th St	Oakland	94601	Community Clinic
28	La Clinica De La Raza Hlth	1500 Fruitvale Ave	Oakland	94601	Community Clinic
29	La Clinica De La Raza Hlth La Clinica Dental at Children's Hosp	3050 E 16Th St	Oakland	94601	Community Clinic
30		747 52Nd St	Oakland	94609	Community Clinic
31	Logan Hlth Ctr	1800 H St	Union City	94587	Community Clinic
32	On Lok Senior Hlth Svcs	159 Washington Blvd	Fremont	94539	Community Clinic
33	Over 60 Hlth Ctr Over 60 Hlth Ctr at Foothill Square	3260 Sacramento St	Berkeley	94702	Community Clinic
34		10700 Macarthur Blvd	Oakland	94605	Community Clinic
35	Planned Parenthood Golden Gate	7200 Bancroft Ave	Oakland	94605	Community Clinic



Arnold Perkins, Chair

REENTRY HEALTH CARE IN ALAMEDA COUNTY:
Initial Assessment and Recommendations of the Alameda County Reentry Health Task Force

36	Planned Parenthood Golden Gate	1866 B St	Hayward	94541	Community Clinic
37	Planned Parenthood Golden Gate	482 W Macarthur Blvd	Oakland	94609	Community Clinic
38	Pregnancy Choices	33523 Western Ave	Union City	94587	Community Clinic
39	Psychotherapy Inst	2232 Carleton St	Berkeley	94704	Community Clinic
40	San Antonio Neighborhood Hlth Ctr	1030 International Blvd	Oakland	94606	Community Clinic
41	Techniclinic	4351 Broadway	Oakland	94611	Community Clinic
42	Tiburcio Vasquez Hlth Ctr	22331 Mission Blvd	Hayward	94587	Community Clinic
43	Miranda Clinic	27171 Calaroga Avenue	Hayward	94544	Community Clinic
44	Tiburcio Vasquez Hlth Ctr	33255 9Th St	Union City	94577	Community Clinic
45	Tiger Hlth Clinic	4610 Foothill Blvd	Oakland	94601	Community Clinic
46	Tri-City Hlth Ctr	2299 Mowry Ave Ste 3-B	Fremont	94538	Community Clinic
47	Tri-City Hlth Ctr	39184 State Street	Fremont	94538	Community Clinic
48	Ujima Holistic Family Hlth Ctr	9925 International Blvd	Oakland	94603	Community Clinic
49	Valley Pregnancy Ctr	7660 Amador Valley Blvd	Dublin	94568	Community Clinic
50	Washington On Wheels	2000 Mowry Ave	Fremont	94538	Community Clinic
51	West Berkeley Family Practice	2031 6Th St	Berkeley	94710	Community Clinic
52	W B Rumford Med Clinic	2960 Sacramento St	Berkeley	94703	Community Clinic
53	Womens Choice Clinic - Oakland	570 14Th St	Oakland	94612	Community Clinic
54	Wright Inst	2728 Durant Ave	Berkeley	94704	Community Clinic
55	Alameda County Medical Center Highland	1411 East 31St. Street	Oakland	94602	
56	Alameda County Public Health	1000 Broadway,Suite 500	Oakland	94607	
57	Alameda Family Services	2325 Clement Ave	Alameda	94501	
58	Alta Bates Medical Center	2001 Dwight Way	Berkeley	94704	
59	Berkeley Addiction Treatment Services (Berkeley Oakland Support Services, Inc.	2975 Sacramento Street	Berkeley	94703	
60	Bi-Bett- - Orchid	2065 Kittredge Street, #E	Berkeley	94701	
61	Center for Independent Living	1342 E 27Th Street	Oakland	94606	
62	Community Recovery Services	2539 Telegraph Avenue	Berkeley	94704	
63	East Bay Community Recovery Project	2512 Ninth Street #9	Berkeley	94745	
64	East Oakland Health Center	2551 San Pablo Avenue	Oakland	94612	
65	Eden I & R, Inc. (AHIP)	7450 14Th St.	Oakland	94601	
66	Fremont Phys. (Private) Hospital	570 B Street	Hayward	94541	
67	Native American Health Center	39001 Sundale Dr.	Fremont	94538	
68	Over 60's Clinic	3124 14Th St.	Oakland	94601	
69	S.T.R.I.D.E.S.	1860 Alcatraz Avenue	Berkeley	94703	
70	Second Chance Hayward	285 17Th Street	Oakland	94612	
71	Second Chance- Newark	1826 "B" Street;			
72	Second Chance, Inc.	107 Jackson St.	Hayward	0	
		6330 Thornton Avenue	Newark	94560	
		3195 Smith Street	Union City	94587	



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REENTRY HEALTH CARE IN ALAMEDA COUNTY:
 Initial Assessment and Recommendations of the Alameda County Reentry
 Health Task Force

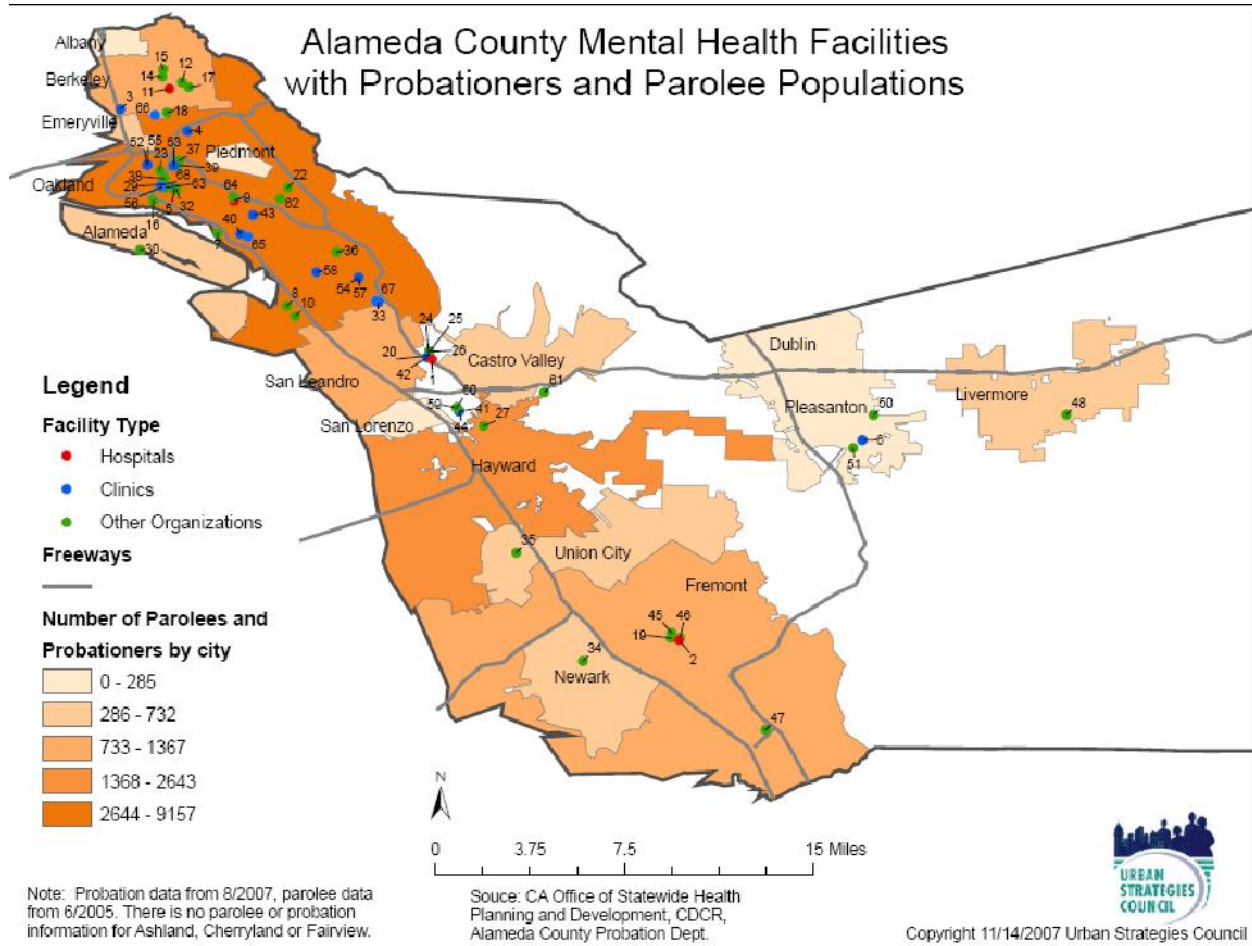
	Second Chance-Women's				
74	Phoenix Program	37957 Fremont Blvd.	Fremont	94536	
75	Solid Foundation - Keller	353 Athol Avenue	Oakland	94606	
76	Solid Foundation - Mandela	2825 Park Blvd.	Oakland	94610	
77	St. Mary's Center	635 22Nd Street	Oakland	94612	
78	Telecare - Garfield	1451 28Th Avenue	Oakland	94601	
79	Telecare - Morton Bakar Center	494 Blossom Way	Hayward	0	
80	Telecare - Villa Fairmont	15200 Foothill Blvd.		94579	
81	Tri-City Community Support Center	39155 Liberty Street, Ste. G-710	Fremont	94538	
82	Tri-City Health Center	39500 Liberty Street	Fremont	94538	
83	Valley Community Health Center	3922 Valley Avenue, Ste. A	Pleasanton	94566	
84	Valley Community Health Center	157 Main Street	Pleasanton	94566	
85	Washington Hospital	2000 Mowry Avenue	Fremont	94538	
86	West Oakland Health Center	700 Adeline Street	Oakland	94607	
87	West Oakland Health Center - East Oakland	90006 Macarthur Blvd.	Oakland	94605	
88	West Oakland Health Center - First Step	1531 Jefferson Street	Oakland	94545	
89	West Oakland Health Center - East Oakl	9006 Macarthur Blvd.	Oakland	94605	
90	West/East Oakland Health Center	7450 14Th St.		94621	
91	Women on The Way Recovery Center	20424 Haviland Avenue	Hayward	94541	
92	Xanthos	1335 Park Avenue	Alameda	94501	
93	Y.M.C.A.	1612 45Th Avenue	Oakland	94601	
94	Y.M.C.A. of the East Bay	2330 Broadway	Oakland	94612	
95	San Leandro Outpatient Rehab Svcs	14207 E 14Th St	San Leandro	94578	Rehabilitation Clinic
96	Asian Network Physical Therapy & Rehab	821 Harrison St	Oakland	94607	Rehabilitation Clinic



Arnold Perkins, Chair

REENTRY HEALTH CARE IN ALAMEDA COUNTY: Initial Assessment and Recommendations of the Alameda County Reentry Health Task Force

Mental Health Facilities





Arnold Perkins, Chair

REENTRY HEALTH CARE IN ALAMEDA COUNTY:

Initial Assessment and Recommendations of the Alameda County Reentry Health Task Force

Facilities from Alameda County Mental Health Services Map

Label	FACILITY	ADDRESS	CITY	ZIP CODE	CATEGORY
1	Alameda Co Med Ctr, John George Medical Pavilion	15400 Foothill Blvd	San Leandro	94578	General Acute Care Hospital
2	Fremont Hosp - Fremont	39001 Sundale Dr	Fremont	94538	Acute Psychiatric Hospital
3	La Cheim Behavioral Hlth Svcs	1 Bolivar Dr	Berkeley	94710	Psychology Clinic
4	La Cheim Adult Behavioral Hlth Svcs	5263 Claremont Ave	Oakland	94618	Psychology Clinic
5	Psychological Svcs Ctr	1730 Franklin St	Oakland	94612	Psychology Clinic
6	Axis Cmty Hlth	4361 Railroad Ave	Pleasanton	94566	Psychology Clinic
7	Access Program Alameda Co. Public	2000 Embarcadero 4Th Fl	Oakland	94606	
8	Guardian/Conservator Alameda County Medical Center	8000 Edgewater Dr.	Oakland	94621	
9	Highland Alameda County Voc.	1411 East 31St. Street 333 Hegenberger Road,	Oakland	94602	
10	Rehabilitation Prog	Suite 600	Oakland	94621	
11	Alta Bates Medical Center BACS Creative Living Centers,	2001 Dwight Way	Berkeley	94704	
12	Berkeley	2340 Durant Avenue	Berkeley	94704	
13	Bay Area Community Services	Po Box 2296	Oakland	94621	
14	Berkeley Place	1844 Addison Street	Berkeley	94701	
15	Berkeley Therapy Institute	1749 Mlk Jr. Way	Berkeley	94709	
16	Catholic Charities of the Diocese	433 Jefferson Street	Oakland	94607	
17	Center for Independent Living	2539 Telegraph Avenue	Berkeley	94704	
18	Coalition Alternative MH Community Counseling and	3234 Adeline Street 3775 Beacon Avenue, 2Nd	Berkeley	94703	
19	Education Cent	Floor	Fremont	94538	
20	Conditional Release Program	2060 Fairmont Dr.	San Leandro	94612	
21	Crisis Support Services	Po Box 9102	Bekeley	94709	
22	East Bay Activity/Oakland East Bay Community Recovery	2540 Charleston Street	Oakland	94602	
23	Project	2551 San Pablo Avenue	Oakland	94612	
24	Eden Adult Community Clinic	2060 Fairmont Dr.	San Leandro	94578	
25	Eden Childrens Clinic Eden Community Support Center	2045 Fairmont Dr.	San Leandro	94578	
26	(ACCESS P Eden I & R, Inc. Youth link vm	2045 Fairmont Dr.	San Leandro	94578	
27	(*Youth H Oakland Community Support	570 B Street	Hayward	94541	
28	Center	Bancroft Ave	Oakland	94605	
29	Oakland Homeless Project	1820 Jefferson Street 1150 Ballena Blvd., Suite	Oakland	94612	
30	Prison Health Services	200	Alameda	94501	
31	S.A.V.E.	Po Box 8283	Fremont	94537	
32	S.T.R.I.D.E.S.	285 17Th Street	Oakland	94612	
33	Schuman-Liles Psychiatric Clinic	10850 Macarthur Blvd.	Oakland	94605	



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34	Second Chance- Newark	6330 Thornton Avenue	Newark	94560
35	Second Chance, Inc.	3195 Smith Street	Union City	94587
36	Solid Foundation-Mandela I	6939 Mac Arthur Blvd.	Oakland	94621
37	Solid Foundation-Mandela II	3408 Andover Street	Oakland	94609
38	St. Mary's Center	635 22Nd Street	Oakland	94612
39	Summit Medical Center	3100 Summit	Oakland	94623
40	Telecare - Garfield	1451 28Th Avenue	Oakland	94601
41	Telecare - Morton Bakar Center	494 Blossom Way	Hayward	0
42	Telecare - Villa Fairmont	15200 Foothill Blvd.		94579
43	Telecare-Gladman	2622 E 27Th Street	Oakland	94601
44	Telecare-Monton Bakar Center	494 Blossom Way	Hayward	94541
45	Tri-City Community Support Center	39155 Liberty Street, Ste. G-710	Fremont	94538
46	Tri-City Health Center	39500 Liberty Street	Fremont	94538
47	Tri-City Homeless Coalition	588 Brown Rd.	Fremont	94539
48	Tri-Valley Haven	3663 Pacific Avenue	Livermore	94551
49	Tri-Valley Haven for Women & Children	Po Box 2190	Livermore	94541
50	Valley Community Health Center	3922 Valley Avenue, Ste. A	Pleasanton	94566
51	Valley Community Health Center	157 Main Street	Pleasanton	94566
52	West Oakland Health Center	2730 Adeline Street	Oakland	94607
53	West Oakland Health Center	3007 Telegraph Avenue	Oakland	94609
54	West Oakland Health Center East Oakland	90006 Macarthur Blvd.	Oakland	94605
55	West Oakland Health Center Mental Healt	2730 Adeline Street	Oakland	94607
56	West Oakland Health Center-First Step	1531 Jefferson Street	Oakland	94545
57	West Oakland Health Centrer - East Oakl	9006 Macarthur Blvd.	Oakland	94605
58	West/East Oakland Health Center	7450 14Th St.		94621
59	Woman Of Faith	20424 Haviland Avenue	Hayward	94541
60	Women on The Way Recovery Center	20424 Haviland Avenue	Hayward	94541
61	Woodroe Crisis Residential	22505 Woodroe Avenue	Hayward	94541

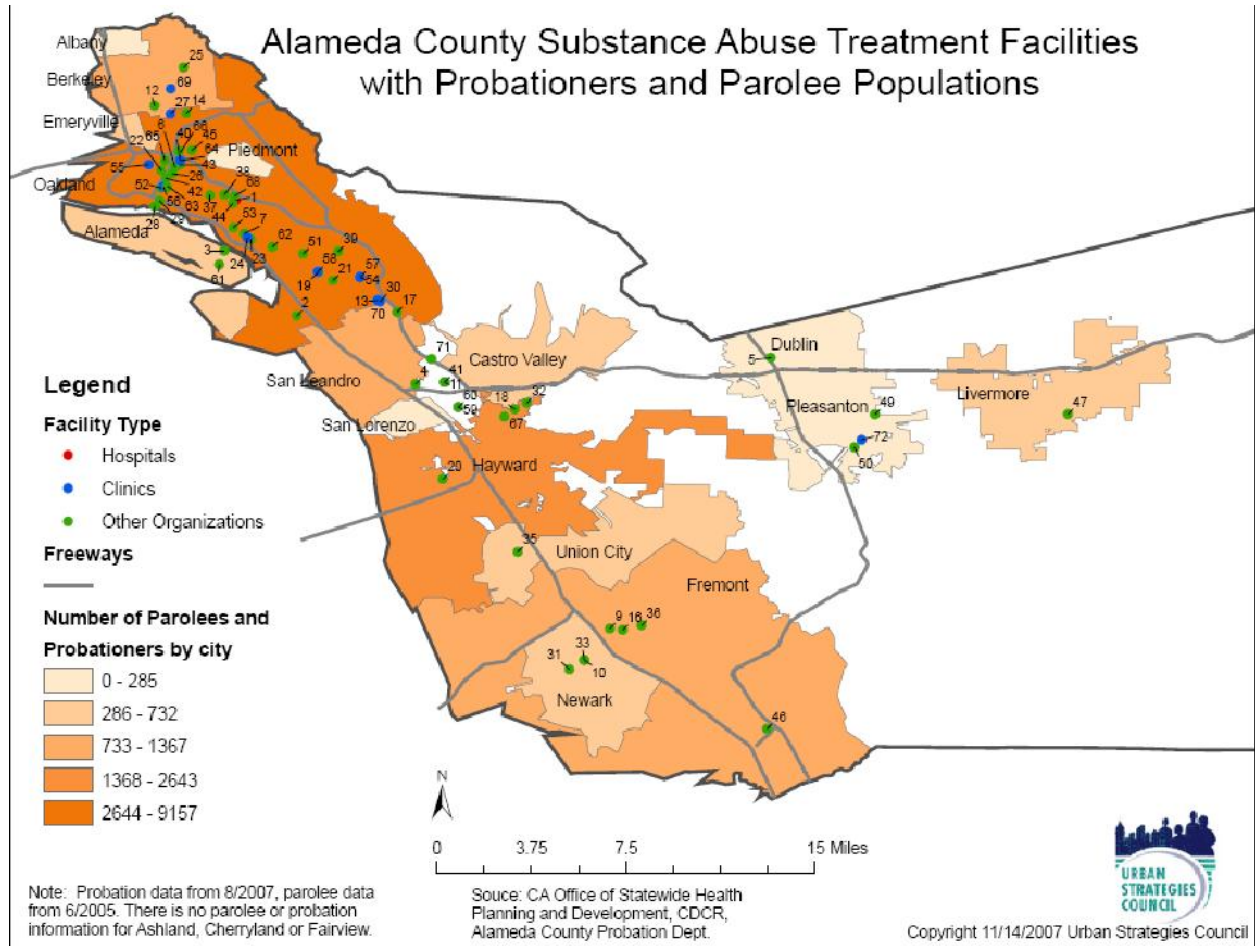
Substance Abuse Facilities



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Facilities from Alameda County Substance Abuse Treatment Facilities Map

Label	FACILITY	ADDRESS	CITY	ZIP CODE
1	Alameda County Medical Center Highland	1411 East 31st. Street	Oakland	94602
2	Alameda County Voc. Rehabilitation Prog	333 Hegenberger Road, Suite 600	Oakland	94621
3	Alameda Family Services	2325 Clement Ave	Alameda San	94501
4	Al-Anon	15287 Hesperian Blvd., Suite 5	Leandro	94578
5	Alcoholic Anonymous	7000 Village Parkway	Dublin	94568
6	Alcoholic Anonymous	2910 Telegraph Ave.	Oakland	94609
7	Allied Fellowship	1524 29th Avenue	Oakland	0
9	BASN	4673 Thorton/ Suite P	Fremont	94536
10	BASN	6330 Thorton Ave.	Newark San	94560
11	BASN	1403 164th Ave	leandro	94578
12	Berkeley Addiction Treatment Services	2975 Sacramento Street	Berkeley	94703
13	Bi Bett - East Oakland recovry Center	10700 Mac Aurther #12	Oakland	94605
14	Bonita House	6333 Telegraph Avenue	Oakland	94609
15	BuddhistPeace Fellowship Prison Program	PO Box 3470	Berkeley	94703
16	C.U.R.A.	4510 Perlta Blvd. #1	Fremont San	94536
17	Celebrate Recovery	951 MacArthur Blvd.	Leandro	94577
18	CommPre Community Recovery Center (Cocaine	1558 B st. 202	Hayward	94541
19	Reco	7501 14th St.	Oakland	94621
20	CroninHouse	2595 Depot Road	Hayward	94545
21	Dr. J Alfred Smith, Sr., Training Acade	8501 14th St.	Oakland	94612
22	East Bay Community Recovery Project	2551 San Pablo Avenue	Oakland	94612
23	Narcotics Education League-Si Se Puede/	3315 14th St.	Oakland	94601
24	Native American Health Center	3124 14th St.	Oakland	94601
25	New Bridge Foundation	1820 Scenic Avenue	Berkeley	94704
26	North Gate Transitional Housing	522 25th St	Oakland	94612
27	Over 60's Clinic	1860 Alcatraz Avenue	Berkeley	94703
28	Port of Oakland - Employment Resources	530 Water Street	Oakland	94607
29	Public Health Department	499 5th Street	Oakland	94607
30	Schuman-Liles Psychiatric Clinic	10850 MacArthur Blvd.	Oakland	94605
31	Second Chance- Fremont	7643 Thorton Ave Suite P	Newark	0
32	Second Chance Hayward	1826 "B" Street; 107 Jackson St.	Hayward	0
33	Second Chance- Newark	6330 Thornton Avenue	Newark	94560
35	Second Chance, Inc. Second Chance-Women's Phoenix	3195 Smith Street	Union City	94587
36	Program	37957 Fremont Blvd.	Fremont	94536
37	Solid Foundation - Keller	353 Athol Avenue	Oakland	94606
38	Solid Foundation - Mandela	2825 Park Blvd.	Oakland	94610
39	Solid Foundation-Mandela I	6939 Mac Arthur Blvd.	Oakland	94621



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40	Solid Foundation-Mandela II	3408 Andover Street	Oakland	94609
41	South county-quick referrals	403 "E" 164th Avenue	Ashland	0
42	St. Mary's Center	635 22nd Street	Oakland	94612
43	Summit Medical Center	3100 Summit	Oakland	94623
44	The Orchid Women's Recovery Center	1342 E. 27th Street	Oakland	94606
45	Thunder Road	340 40th Street	Oakland	94609
46	Tri-City Homeless Coalition	588 Brown Rd.	Fremont	94539
47	Tri-Valley Haven	3663 Pacific Avenue	Livermore	94551
48	Tri-Valley Haven for Women & Children	PO Box 2190	Livermore	94541
49	Valley Community Health Center	3922 Valley Avenue, Ste. A	Pleasanton	94566
50	Valley Community Health Center	157 Main Street	Pleasanton	94566
51	Volunteers of America	2139 Seminary Ave, #102	Oakland	94621
52	Volunteers of America	624 14th St	Oakland	94612
53	Volunteers of America	2344 E. 15th Street	Oakland	94601
54	West Oakland Health Center East Oakland	90006 MacArthur Blvd.	Oakland	94605
55	West Oakland Health Center Mental Health	2730 Adeline Street	Oakland	94607
56	West Oakland Health Center-First Step	1531 Jefferson Street	Oakland	94545
57	West Oakland Health Center - East Oakl	9006 MacArthur Blvd.	Oakland	94605
58	West/East Oakland Health Center	7450 14th St.		94621
59	Woman Of Faith	20424 Haviland Avenue	Hayward	94541
60	Women on The Way Recovery Center	20424 Haviland Avenue	Hayward	94541
61	Xanthos	1335 Park Avenue	Alameda	94501
62	Y.M.C.A.	1612 45th Avenue	Oakland	94601



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Dental Facilities

