

CalAIM TRAINING SERIES

“Bridging Systems - Synthesizing Knowledge - Improving Outcomes”

Reentry and Transition Planning

September 15-18, 2026

Meet the Trainers



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Training Objectives



Understand the purpose of CalAIM reentry and transition planning

Discuss partner roles and shared responsibilities

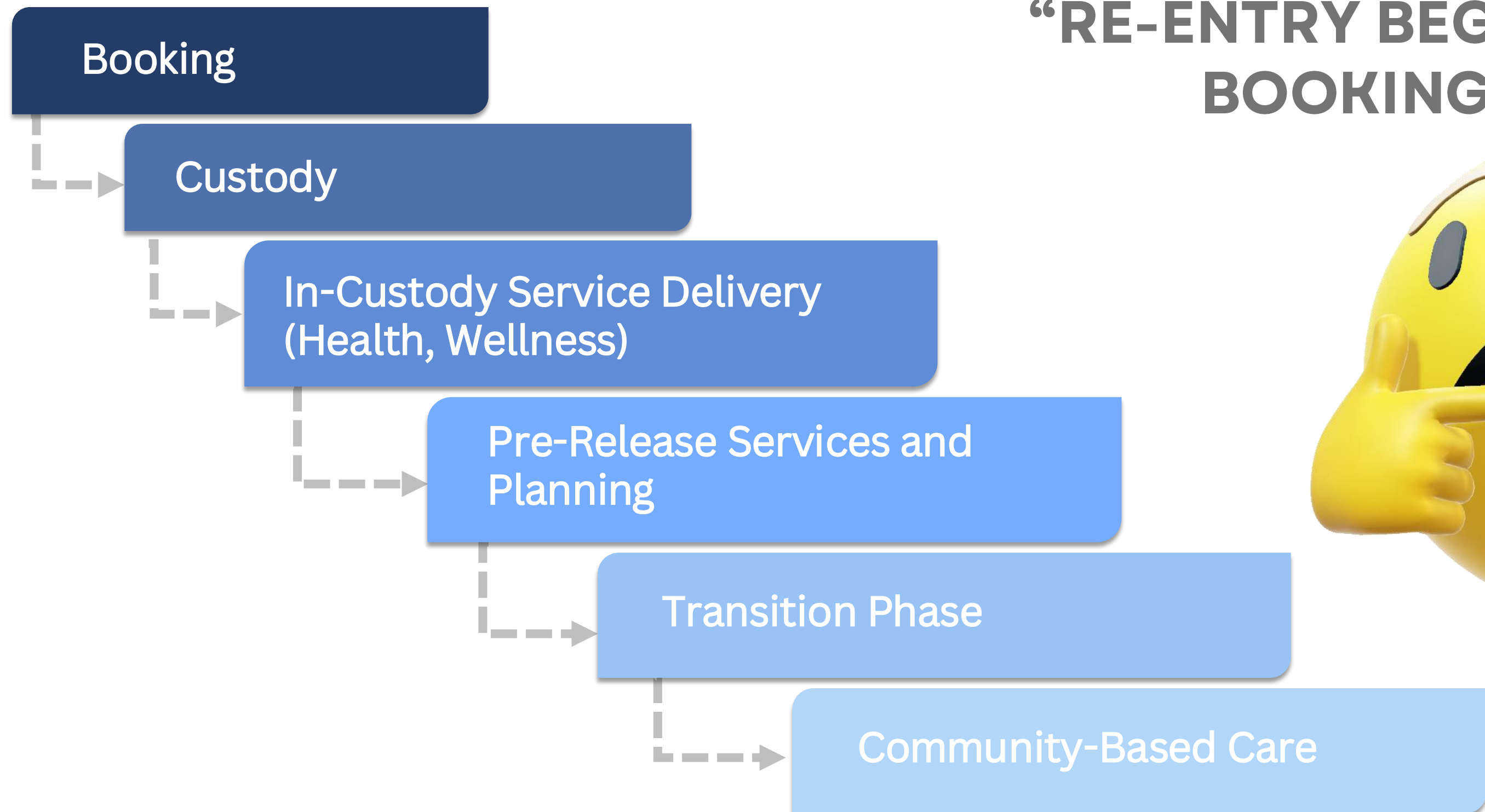
Identify the key components of pre-release care management and the Reentry Care Plan

Recognize key coordination points from pre-release through community transition

Explore practices that strengthen warm handoffs and continuity of care

Reflect on how reentry planning has evolved and lesson learned

The Reentry Continuum



**“RE-ENTRY BEGINS AT
BOOKING”**



The Reentry Continuum

- ❑ Multiple partners contribute to successful transitions
 - ❑ Corrections, Health, BH, ECM, MCP, CBO, Com. Supports
- ❑ Continuity depends on coordination and communication
- ❑ Community-based care begins before release through planning and partnerships
- ❑ Successful reentry requires a coordinated cross-system approach

- ❑ Community-based care begins before release through planning and partnerships

The goal is not simply to prepare someone to leave a facility.

It's to support continuity between pre-release care and community-based care.

Insights & Observations - Cohorts

- **24 sessions were facilitated by CPOC**
- **Adult and Juvenile ECM cohorts**
- **People shared their experiences and the lessons learned**
- **Some counties are live - most were not**

- ☐ **Leadership Support Matters**
- ☐ **Relationship between Probation and ECMs matters**
- ☐ **Families matter**
- ☐ **Our Systems are Not YET prepared**
- ☐ **We are ALL in a similar state of preparedness**
- ☐ **Engagement and relationships with the individual matter**
- ☐ **Local capacity and resources are critical**

C³

Collaborate

Coordinate

Communicate

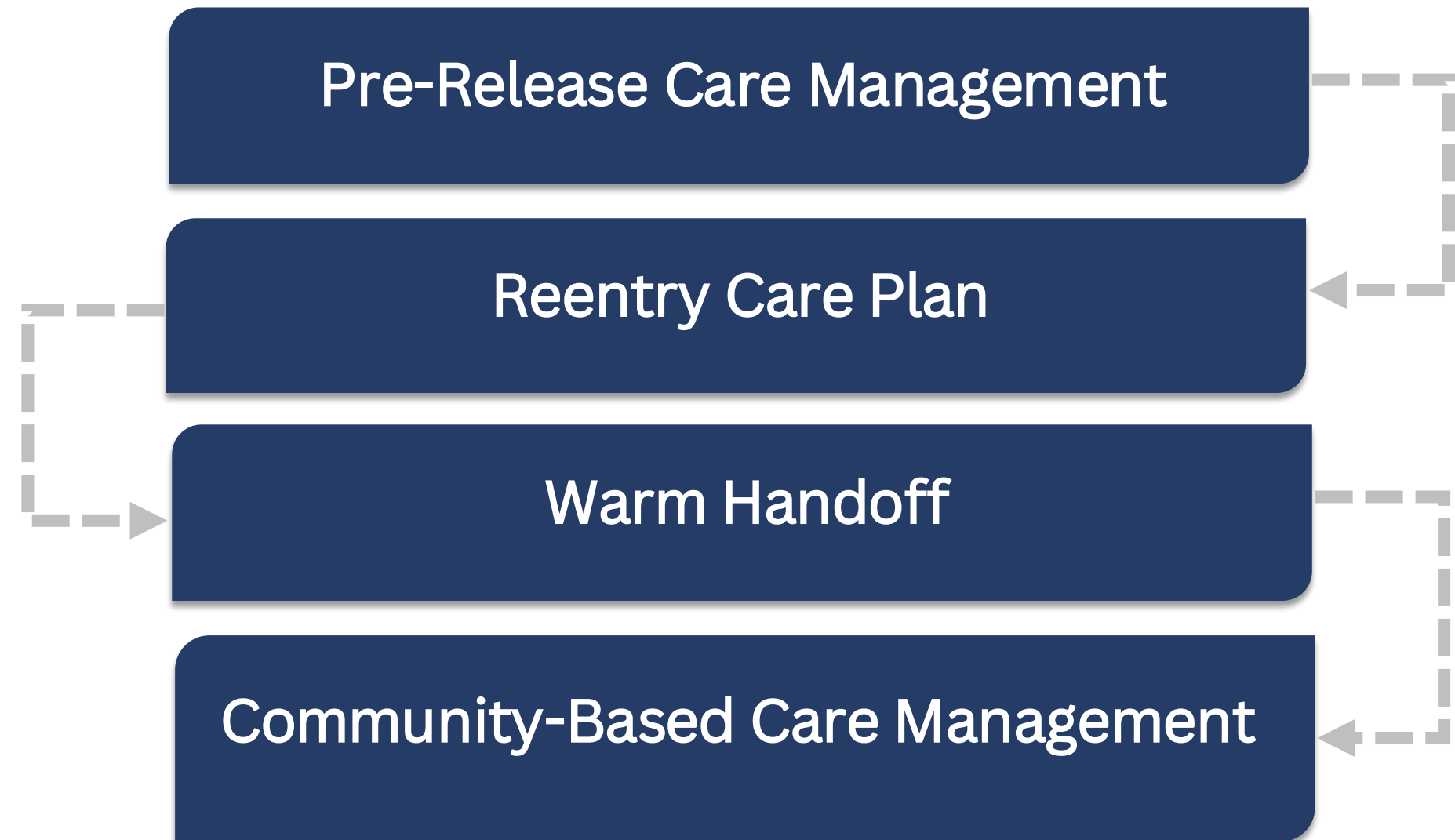
Relationship building is a key part of the reentry process

- Engagement begins before release
- Identifies priorities, strengths, and barriers
- Supports engagement and continued connection

Care Management : Connecting the Reentry Process

Care management supports continuity throughout the reentry and transition process by:

- Coordinating pre-release services and planning
- Connecting pre- and post-release care
- Supporting continuity through transition



The Reentry Process

Identify & Assess

- ☐ Medi-Cal Status
- ☐ Expected Release Date
- ☐ MCP Assignment
- ☐ Health Risk Assessment
- ☐ Health and Behavioral Health Needs
- ☐ Medication Needs
- ☐ Functional and Social Needs
- ☐ Strengths, Supports, and Barriers



Plan & Coordinate

- ☐ Develop Reentry Care Plan
- ☐ Identify Services and Supports
- ☐ Address Consent/Information Needs
- ☐ Arrange Appointments
- ☐ Physical and Behavioral Health Care
- ☐ Post-release Connection



Connect & Transition

- ☐ Identify Receiving Care Managers and Providers
- ☐ Complete Required Warm Handoffs
- ☐ Share the Reentry Care Plan
- ☐ Confirm Appointments and Service Connections
- ☐ Support the Individual's Understanding of Immediate Next Steps



Follow Through

- ☐ Confirm Engagement with Community Providers
- ☐ Follow Up with the Individual
- ☐ Address Barriers and Missed Connections
- ☐ Continue Care Management Following Release

What is a Reentry Care Plan?

- Patient-centered health care plan of action
- Created before release
- Developed collaboratively with the individual
- Informed by clinical consultation and the facility reentry planning team
- Extends beyond release
- Identifies available and appropriate resources

**The Reentry Care Plan is
not simply a discharge
document**



What Does the Reentry Care Plan Address?

COMPONENTS

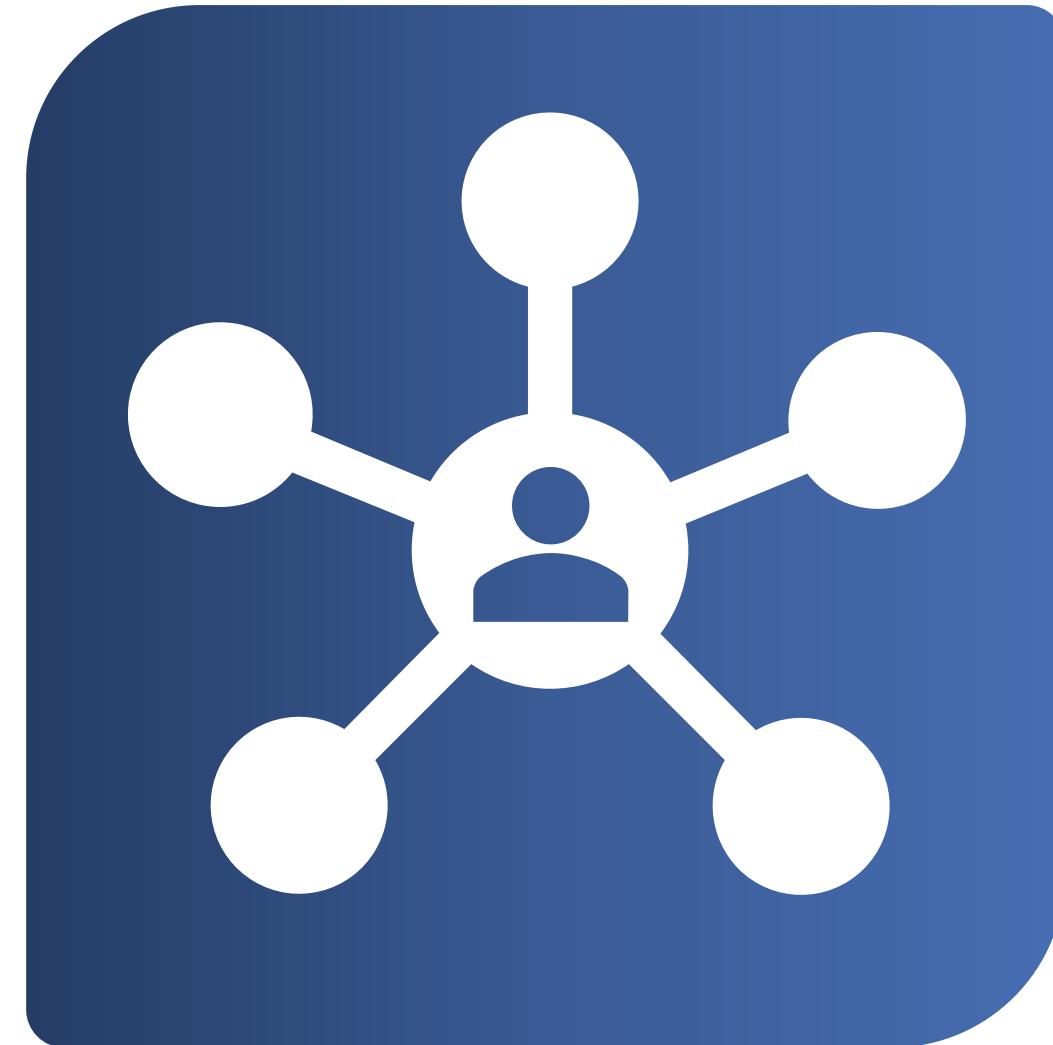
- **Physical health**
- **Mental health**
- **Substance use disorder needs**
- **Housing needs**
- **Other health-related social needs**
- **Functional needs**
- **Strengths and support resources**

SUPPORTS

- **Provider and service connections**
- **Necessary appointments**
- **Medication/DME continuity**
- **Post-release care management**
- **Outstanding transition needs**
- **Medi-Cal Coverage & MCP Connection**

Person-Centered Reentry Planning

- Reentry planning occurs in collaboration with the individual:
 - What matters to the individual?
 - What are their immediate priorities?
 - Where will they be living?
 - Who do they trust?
 - What has/has not worked in the past?
 - What barriers may affect follow-through?



Lessons Learned >> Reentry Care Plans

- ❑ **Develop a Reentry Care Plan "short-form" and "long-form"**
 - ❑ **Short-form** is for individuals booked into custody and released within 12, 24, or 48 hours. The reentry care plan is reduced to 1-2 pages to include the initial health screening information and referral to the ECM provider. Also works for short stays and quick releases.
 - ❑ **Long-form** is for the individuals in the detention facility for 5-10 days or longer depending on the circumstances. The reentry care plan is comprehensive and reaches 8-10 pages when populated.
- ❑ **Develop a Warm Handoff Form to track and managed the referrals to community-based providers and other reentry partners. This is a working form used by the Pre-release Care Manager and supports the development of the Reentry Care Plan.**

Reentry Planning Requires Information Across Systems



Information Sharing

- Information-sharing requirements vary based on:

- The type of information
- The entities sharing information
- The purpose of the information exchange
- Applicable federal and state requirements

- Obtain consent or authorization when required
- Identify information-sharing needs before the transition point
- ROI/data-sharing tools and local processes – to include Universal ROI and the ASCMI Form
 - Supports sharing of physical, behavioral, and social health information
 - Designed to support coordination across care partners

- Closed-loop communication facilitates continuity by:
 - Supporting communication between partners beyond the initial referral
 - Helping partners understand whether additional coordination is needed to support a successful transition



Roles and Responsibilities, Shared Transition

Partner	Examples of Responsibilities
Correctional Facility	○ Supports access to pre-release services/care management ○ Communicates release information and changes
Care Manager	○ Develops the Reentry Care Plan and coordinates pre-release services ○ Coordinates the warm handoff to community-based care
Managed Care Plan and ECM	○ Assign individual to ECM provider and connects members to services and supports ○ Coordinates with facilities and care management partners
Probation's Role	○ Shares relevant supervision and transition information when authorized ○ Supports and reinforces connections to identified services
Other Key Partners	Behavioral Health • Social Services • SUD Providers • CBO's • Housing & Transportation Workforce Development/Education • Family and Natural Supports

Up to 90 Days – Planning Must Fit the Actual Timeline

When *more time* is available:

- Relationship building
- Assessment
- Pre-release services
- Reentry Care Plan development
- Provider identification
- Appointment planning
- Warm handoff preparation

When *less time* is available:

- Prioritize immediate health needs
- Medication continuity
- Critical behavioral health connections
- Care management connection
- Available Reentry Care Plan information
- Rapid transition coordination

Release Dates Change: How the Workflow Will Respond

Local workflows should identify:

- Who receives release information?
- Who communicates a change?
- How quickly is the change communicated?
- Who updates transition planning activities?
- Who contacts the receiving care manager or provider?
- What occurs if the warm handoff cannot happen before release?



County Variation– Shared Coordination Functions

Local Models May Vary

- **County Size & Facility Structure**
- **Provider Capacity / ECM Network**
- **Service Delivery Model**
- **Data sharing and infrastructure to share information (i.e., reentry care plans, health risk assessments, warm handoffs)**

Core Functions Remain

- **Screen individuals for Medi-Cal and enroll based on the individual's qualifications**
- **Complete the initial health screening**
- **Activate in the JI Screening Portal**
- **Document the individual's condition & treatments thoroughly**
- **Initiate the coordination of warm handoffs and linkages with reentry partners**

The Care Manager - Navigator

Required when different individuals provide pre-release and post-release care management services

- Includes:
 - The individual
 - Pre-release care manager
 - Post-release ECM Lead Care Manager
- May occur:
 - In person
 - Via telehealth

- Warm handoff activities include:
 - Scheduling and conducting the meeting
 - Obtaining necessary consent or authorization
 - Sharing the Reentry Care Plan
 - Reviewing the plan and reentry services with the individual
 - Identifying outstanding service or support needs
 - Updating the plan based on new information
 - Beginning the relationship with the post-release care manager

The Plan Must Move with the Individual

- Reentry Care Plan is shared with appropriate partners
- Medication information follows the individual
- DME information follows the individual (as applicable)
- Appointment information is clear
- Contact information is available
- Individual understands immediate next steps



Pre-release to post-release transitions...

Transition Workflows should identify:

- Who is notified?
- Who assumes the next coordination activity?
- How does information move?
- How is the individual contacted?
- How do pre-release and post-release care management partners reconnect?
- What post-transition support is available?

Common reentry barriers:

- Medi-Cal is not activated or suspended
- Release date unknown or actual date not communicated to ECM provider
- Short stay, unexpected release
- Health plan unassigned and referrals to ECM providers
- Authorization issues unresolved
- Transportation vendor not confirmed for post-release appointments
- Timely access to care, medications, and other services is delayed
- Partially-completed reentry care plan and warm handoffs in motion

Key Takeaways

- Reentry is a process, and planning begins before release.
- Care management and relationships connect pre- and post-release care.
- Person-centered Reentry Care Plan supports continuity beyond release
- Partners have different but connected responsibilities
- Warm handoffs support successful connection to post-release care



Thank you! Join us next time:

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CPOC Statewide Conference

December 2-4, 2026 | Adult and Juvenile Workshop Sessions