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Medications-in-Hand

Early Learnings from Medicaid Reentry Waiver Implementation in California

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We are equally grateful to the community-based organization representatives and individuals with lived experience who participated in our focus groups. We deeply appreciate their openness in sharing their experiences, insights, and recommendations. Their perspectives remind us that successful implementation is measured not only by operational workflows, but by whether people leaving custody are able to successfully navigate the transition to care in the community. Their voices helped ensure that this report reflects not only how systems function, but how those systems are experienced by the people they are intended to serve.

We also thank the California Health Care Foundation for its generous support of this project and for its ongoing commitment to advancing equitable, person-centered reentry systems across California. Finally, we recognize the many counties, community organizations, and state partners that continue to innovate, collaborate, and share lessons learned with one another. Their willingness to learn from one another is accelerating implementation across California and helping strengthen systems of care for people returning to their communities.

Executive Summary

Under California's CalAIM Justice-Involved (JI) Initiative, counties are required to provide individuals leaving jail with 30 days of necessary medications at release ("medications-in-hand"), but implementation has proven complex, particularly in jail settings where release dates are often unpredictable and operational conditions vary widely.

With funding from the California Health Care Foundation, Justice System Partners (JSP) conducted a qualitative study to identify barriers, emerging best practices, and implementation lessons from counties that have already begun implementing the medications-in-hand requirement. The study draws on interviews with eleven counties, two focus groups, and an ongoing statewide survey.

Several key findings emerged.

- **Release unpredictability drives implementation.** Counties consistently identified unplanned and last-minute releases—which account for 75% or more of people leaving jail—as the primary operational challenge. Successful implementation depends on multiple workflows rather than a single release-planning process. Planned-release workflows support advance medication preparation, while rapid-response workflows and fallback strategies help ensure that people experiencing unexpected releases still receive medications.
- **Pharmacy operations are central to implementation success.** Counties are using a variety of approaches—including patient-specific medication models, advance preparation, clinical storage, and enhanced coordination between pharmacy, healthcare, custody, and release staff—to improve their ability to provide medications at release. Successful implementation depends on pharmacy resources, workflow design, and cross-system coordination.
- **Different medications require different approaches.** Routine chronic medications can often be managed through standardized workflows. In contrast, HIV and hepatitis C medications require a "zero-gap" continuity strategy, insulin requires coordination around refrigeration and supplies, medications for opioid use disorder require specialized clinical and community partnerships, and long-acting injectable medications require careful timing and administration planning.
- **Continuity of care extends beyond medication distribution.** Focus group participants emphasized that medications at release are necessary but not sufficient. Individuals leaving custody frequently face challenges with insurance activation, provider access, transportation, housing, communication, and navigating complex healthcare systems. The transition from an initial medication supply to ongoing treatment was consistently identified as the most vulnerable point in the reentry process.

Despite these challenges, counties are demonstrating that medications-in-hand implementation is achievable. Interview participants described significant progress in developing new workflows, strengthening partnerships, redesigning pharmacy operations, and improving coordination across systems. Although implementation remains a work in progress, these experiences demonstrate that continuity of medication access at release can be achieved through strong communication and multi-disciplinary collaboration.

Based on these findings, counties preparing to launch medications-at-release programs should design workflows around the realities of jail release patterns, invest early in pharmacy operations and workflow design, develop medication-specific continuity pathways, establish formal fallback strategies for unplanned releases, strengthen multidisciplinary coordination, and view medications-at-release as one component of a broader continuity-of-care strategy.

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Introduction

Access to prescribed medications during the critical transition from custody to community can help save people's lives as they transition from jail back to their community. Under the CalAIM Justice-Involved (JI) Initiative, counties are required to provide individuals leaving jail with 30 days of necessary medications—commonly referred to as "medications-in-hand." While the policy is straightforward, implementation has proven complex, uneven, and resource intensive.

With funding from the California Health Care Foundation, Justice System Partners (JSP) conducted qualitative study to identify barriers, promising practices, and actionable strategies for implementing the "medications-in-hand" component of CalAIM JI. The intended result is to support counties, the California Department of Health Care Services (DHCS), and partners in improving continuity of care, advancing health equity, and reducing preventable harms during reentry.

Justice System Partners (JSP) is a national nonprofit committed to helping justice and community partners transform their systems to be more equitable, effective, and humane. JSP has supported California counties since April 2023 in implementing the Medicaid reentry waiver through multi-county learning networks, technical assistance, and peer-to-peer collaboration. JSP brings a unique combination of subject-matter expertise in reentry, health and justice system coordination, qualitative research, and facilitation of peer learning.

Background and Need

In January 2023, California's Medicaid 1115 Reentry Waiver was approved, launching a statewide effort to improve care transitions for people leaving custody. As of May 2026, 14 counties and the California Department of Corrections and Rehabilitation (CDCR) had gone live with CalAIM JI; all counties are required to go live by October 2026.

A core element of this initiative is the medications-in-hand requirement—ensuring that people receive 30 days of prescribed medications at release. This practice is expected to reduce overdose, relapse, hospitalization, and treatment disruption.

Before CalAIM JI, counties often provided only limited supplies of medication at release (typically 7–30 days), often inconsistently. Scaling to universal, reliable provision of 30-day supplies presents several categories of challenges:

- **Operational:** Packaging and distributing medications in very short timeframes due to unpredictable release dates.
- **Clinical:** Ensuring appropriate dosing, patient safety, and safe storage during and after release.
- **Logistical:** Maintaining sufficient medication inventory and coordinating across custody, health care, and community providers.
- **Scale:** Providing medications at release to significantly larger number of people than in the past.

Addressing these barriers is essential to realizing the promise of CalAIM JI.

Project Goals and Activities

Launched in January 2026, the goals of this project are to:

- Identify operational, clinical, and logistical barriers to implementing the medications-in-hand requirement in early go-live counties.
- Surface and document promising practices and solutions emerging from counties that are successfully implementing the policy or components of the policy.
- Elevate the perspectives of people with lived experience to ensure solutions are informed by real-world reentry challenges.
- Produce actionable guidance to inform state and county implementation strategies, supporting more equitable and effective health transitions.

The project is not designed as a compliance review, but rather to learn from and share the experiences of those counties at the forefront of implementation with those that are still in the planning phase.

In support of those goals, the project design includes the following activities.

- Interviewing key leaders in eleven counties regarding their current medications-in-hand practices, including successes and ongoing challenges (April-May 2026).
- Conducting two focus groups, including:
    - One with people with lived experience to capture experiences, barriers, and suggestions for improving access and safety (May 2026).
    - One with leaders of community-based organizations that support people during reentry to capture experiences, barriers, and suggestions for improving access and service connections (May 2026).
- Inviting all California counties to participate in a survey regarding current practices with providing medications-in-hand at release (May 2026). A follow-up survey is scheduled to be conducted in late 2026.

This report summarizes the findings from activities completed through May 2026 and will form the framework for several virtual presentations to be delivered this summer[1].

Project Findings

Deep Dive into Early Implementation: Interviews with Counties

In April and May 2026, JSP conducted structured interviews via Zoom with eleven counties: eight that have gone live with CalAIM JI implementation for adults, one county that has gone live for youth, and two counties that are preparing to go live but are under federal consent decrees that require them to provide certain medications in hand prior to release. Interviewers asked about eligible populations, known and unknown release dates, routine medications, HIV medications, insulin and special-handling medications, medication-assisted treatment (MAT), antipsychotics, operational workflows, coordination structures, and implementation lessons.

This section draws on those interviews to identify common patterns and variations in county approaches, practical strategies, and specific examples to illustrate key themes. The following findings

[1] Methodological note: All interviews and focus groups were conducted live. AI was used to analyze transcripts and suggest key themes. This paper was fully edited by the JSP team and reviewed by clinical consultants for accuracy and clarity.

reflect a point-in-time view of early implementation, recognizing that counties are continuing to refine workflows and practices are evolving quickly.

1. Eligible Populations and Targeting Strategies

Across counties, implementation has generally been phased, beginning with people who have known or reasonably predictable release dates. This targeting is driven by operational feasibility, not a lack of commitment to broader access. Medication preparation requires a sequence of steps: identifying the eligible person, reconciling current medications, ordering or preparing the discharge supply, coordinating with the pharmacy, and ensuring the medication reaches the person at release. Those steps are much more reliable when the release date is known in advance.

> *"We are serving all the ones we can catch" —county implementation lead*

Counties repeatedly described the tension between the CalAIM goal of providing medications at release and the jail reality that many releases—more than 75%—are unplanned, court-driven, or occur outside normal business hours. In practice, most counties are building phased strategies: people with scheduled releases are prioritized first; and people released unexpectedly are handled through backup workflows such as on-hand medications, partial supplies, or e-prescriptions.

Key Highlights

- Known or anticipated release dates remain the primary pathway for full medications-in-hand workflows.
- Unplanned releases make universal medication delivery difficult, especially early in implementation.
- Counties use pragmatic language such as "serving all the people they can identify in time."
- The ability to serve more people depends on better release intelligence and more flexible pharmacy workflows.

Emerging Best Practices

> *"It's not a flip-a-switch kind of project . . . you start with what you can do" —behavioral health representative*

- Use a tiered strategy for known, likely, and unexpected releases.
- Work towards "zero gap" continuity for people with high-risk medical and behavioral health conditions.
- Build release intelligence through court monitoring, custody coordination, daily release lists, and alerts from jail records staff.
- Start with populations for whom the workflow is more feasible, then expand as release-notification and pharmacy systems mature.
- Track which populations are missed and why, so expansion priorities are based on evidence rather than anecdote.

2. Release Timing and Workflow Design

Release timing is the dominant operational variable across counties. Some counties described a preferred planning window of several days, while others identified 24 hours as a reasonable minimum. At the same time, several counties reported providing medications in hand for last-minute releases, sometimes with only 30 to 60 minutes of notice. This creates two very different operational workflows: a planned-release workflow and a rapid-response workflow. In addition, one county indicated they had implemented a third workflow for people who were missed during release.

The most developed approaches do not rely on a single ideal process. They use dual workflows. The planned workflow allows pharmacists and clinicians to reconcile and prepare medications in advance. The rapid-response workflow relies on real-time communication between jail records staff, charge nurses, prescribers, pharmacy, and release staff. In some models, the records team alerts a clinical point person, who activates a secure chat or shared communication channel so prescribers and pharmacists can act within minutes.

> *"We built a specific workflow for people already released"*
> *—pharmacist*

Counties that are further along have also adjusted staffing and hours to match actual release patterns. For example, one county reviewed discharge timing and extended pharmacy hours after identifying a late-evening release pattern. This illustrates a broader best practice: workflow design should be based on observed release data, not assumptions about when releases occur.

Key Highlights

- Release notice varies from several days to only minutes.
- Last-minute releases are routine and must be designed for, not treated as exceptions.
- Minimum viable notice differs by county and depends on pharmacy hours, staffing, transportation, and medication type.
- The strongest systems combine planned release workflows with rapid-response workflows.

> *"We probably do about six or seven patients a day through this last-minute process"*
> *—clinical operations lead*

Emerging Best Practices

- Develop separate workflows for planned releases and last-minute releases.
- Use real-time communication tools such as secure chat, shared lists, or release alerts.
- Analyze actual release timing and adjust pharmacy and prescriber coverage accordingly.
- Designate clear points of contact for records, nursing, prescribing, pharmacy, and release handoff.

3. Pharmacy Operations and Medication Preparation

Pharmacy operations play a central role in successful medications-in-hand implementation. Counties described pharmacy as both a critical clinical and operational function and a system bottleneck. Medication preparation must align with clinical need, jail workflow, pharmacy staffing, packaging requirements, billing rules, and release timing.

Several county jail pharmacies described their process of shifting from primarily using stock inventory to incorporating more patient-specific inventory medication models. Stock inventory refers to an aggregate supply of pharmaceuticals, (i.e., emergency drugs, over-the-counter medications, or starter doses) kept on hand for dispensing to patients.[4] Patient-specific (unit dosing) inventory models refer to medications that have already been dispensed by the pharmacy for specific patients and are often stored in blister packs or bottles and may be given directly to the patient at release.[5] While medications at release can be provided from either stock or patient-specific sources, several counties noted that patient-specific medications can be helpful for unexpected releases, as patient-specific medications already on site can be sent out with the person more quickly.

Another emerging strategy is preparing medications in advance and storing them with clinical staff. This approach recognizes that pharmacy staff may not be available 24/7, but clinical staff often are available 24/7. Preparing medications before release and storing them in a monitored clinical location bridges the gap between limited pharmacy hours and unpredictable release timing.

Interviewees also identified billing and packaging as significant technical issues. In some facilities, the medication package used in custody may not be the same package that can be billed or dispensed for release. This requires pharmacy teams to understand formularies, package sizes, and billing requirements, not merely clinical prescribing.

Key Highlights

- Pharmacy capacity and hours are frequent bottlenecks to meeting CalAIM JI expectations.
- Patient-specific medication models may improve responsiveness for unexpected releases.
- Pre-packaging medications and leaning on clinical staff can extend the practical reach of pharmacy beyond pharmacy hours.

> *"The majority of the medications we have are patient-specific . . . makes it easy for unexpected releases" —pharmacist*

Emerging Best Practices

- Treat pharmacy as a core reentry partner, not simply a dispensing function.
- Move toward patient-specific medications for people nearing release.
- Prepare medications in advance for people within a release-planning window.
- Store prepared medications with clinical staff when the pharmacy is not available 24/7.
- Align pharmacy workflows with Medi-Cal billing requirements, including package size and formulary considerations.

4. Routine Chronic Medications: Hypertension, Asthma, and Similar Conditions

Routine chronic medications, such as hypertension or asthma medications, are generally the least complex medication category from a release perspective. Counties often use these medications as the baseline workflow: if the release is scheduled, medications can be reconciled, filled, and provided as a standard supply. The typical benchmark across interviews was a 30-day supply, although the process for getting the medication into the person's hands differed by county.

Key Highlights

- Routine chronic medications are often standardized around 30-day supplies.
- Post-release e-prescribing is used as a fallback when medications-in-hand is not feasible.

> *"Hypertension is one of those categories we flag as critical and essential" —pharmacist*

Emerging Best Practices

- Avoid relying solely on the patient to navigate pharmacy pickup when a direct handoff is possible.

5. HIV, Hepatitis C, and Similar Zero-Gap Medications

The consequence of missing doses of HIV medications, hepatitis C medications, and similar "continuity critical" therapies was consistently treated as a higher-priority continuity concern. Counties emphasized that missed doses can have significant clinical consequences, and several described a stronger zero-gap orientation for these medications than for more routine chronic medications.

In some counties, HIV medication workflows mirror the general chronic-medication workflow but with more attention and stronger outpatient connections. For example, counties described specialized clinics, jail-based providers with existing links to outpatient care, and stronger referral pathways for people with HIV. These clinical relationships can improve continuity after release, especially when release timing is unpredictable.

When these medications are also high cost, an additional operational challenge arises. Counties noted that long-acting injectables and other expensive medications require careful attention to timing, billing, and accuracy. If a medication is ordered or dispensed in custody and the person leaves before receiving it, the county may face both a care-continuity problem and a cost-recovery problem. As a result, counties are beginning to place greater emphasis on identifying these medications early and ensuring administration or follow-up before release, whenever possible.

Key Highlights

> *"We really want to make sure they are not missing any days of meds" —clinician*

- High-risk medications require a more intensive continuity strategy than routine medications.
- Specialized clinics and established outpatient relationships can improve post-release continuity.
- High-cost medications require additional monitoring because timing errors can have clinical and financial consequences.
- Counties are thinking about how to identify people on high-risk medications earlier in the release process.

Emerging Best Practices

- Adopt a zero-gap principle for HIV, hepatitis C, and other high-risk medications.
- Use specialized clinic relationships to support warm handoffs and medication continuity.
- Flag high-cost medications and long-acting therapies early in release planning.
- Build workflows to administer or confirm follow-up for time-sensitive medications before release.

6. Insulin, Diabetes Care, DME, and Special-Handling Medications

> *"This is super difficult with our population" —behavioral health lead*

Insulin and diabetes care illustrate how medications-in-hand is not always just a pharmacy issue. Insulin raises questions about refrigeration, supplies, durable medical equipment, patient education, housing status, transportation, and post-release support. Counties described insulin as especially complex for individuals who are unhoused or do not have secure storage for medication and supplies.

Discussion in interviews about insulin highlighted the challenges of providing diabetes care in a carceral environment. For example, security concerns prohibit the provision of equipment such as sharps for checking blood sugar to people in detention. Medical regimens may also be adjusted to address differences in sugar intake between the jail and community settings. As a result, recommended care plans for individual patients may differ between carceral and community.

Several counties described ordering insulin through a pharmacy and storing it in refrigeration until release. However, insulin continuity also requires glucose monitoring supplies, test strips, needles, and sometimes broader DME. Some counties order supplies through vendors or DME suppliers, while others

described gaps or changes in DME contracting that made this area less stable than medication dispensing itself.

Housing and community supports are central to this medication category. Counties described trying to connect people with shelters, tiny-house programs, or other settings where refrigeration and medication storage are possible. For people with diabetes who are not insulin-dependent, counties may consider oral medications when clinically appropriate, but this does not eliminate the challenge for those who truly require insulin.

The interviews also surfaced the limits of medication provision when broader social needs are unmet. For people living outside, medication theft, loss of supplies, and inability to refrigerate insulin can quickly undermine the best-designed discharge workflow.

Key Highlights

- Insulin requires coordination beyond the medication itself, including refrigeration and supplies.
- DME and ancillary supplies can be less developed than pharmacy workflows.
- Unhoused individuals face major barriers to safe medication storage and diabetes self-management.
- Community supports such as ECM, shelters, immediate care clinics, and medically tailored meals are important continuity tools.

Emerging Best Practices

- Bundle insulin with glucose monitoring supplies, strips, needles, and related DME as needed.
- Identify refrigeration and storage needs before release.
- Coordinate with ECM, shelters, housing resources, or clinics that can support insulin storage and diabetes care.
- Use multidisciplinary meetings to identify insulin-dependent individuals before release.
- Consider medically tailored meals and other community supports as part of diabetes continuity planning.

7. Medication-Assisted Treatment (MAT) for Substance Use Disorders

MAT is one of the most operationally and clinically nuanced medication categories. Counties described a range of models involving oral/sublingual buprenorphine, methadone, naltrexone, long-acting injectable buprenorphine and naltrexone products, and community opioid treatment program partnerships. The medication choice affects what can be provided in hand, what must be administered in the clinic, what requires a wet signature or controlled-substance process, and what must be bridged through community appointments.

Methadone typically requires a relationship with an opioid treatment program. Some counties bring methadone into the jail through a community OTP, with the medication locked and administered on-site. Counties generally do not release people with methadone in hand. Instead, they schedule next-day treatment-center appointments or otherwise bridge to the treatment provider.

Buprenorphine workflows vary more widely. Some counties provide a 30-day supply when the release date is known, while others use shorter supplies, such as 14 days, particularly when paired with a follow-up appointment within 7 days. Controlled-substance rules, prescriber comfort, pharmacy requirements, and patient-specific risk all shape the release plan. Several counties also described long-acting injectable

medications as promising but still developing, especially because timing injections around unknown release dates remains difficult.

A key theme across counties is that MAT continuity depends on more than the medication. It requires release planning at every contact, referrals to low-barrier clinics, walk-in options, reentry centers, and communication with managed care plans and community providers. Counties with more developed MAT systems often emphasized patient choice rather than a one-size-fits-all medication approach. This matters because people enter custody with different histories, tolerances, preferences, and prior experiences with treatment.

> *"Most of the people we treat for SUDs have not been in treatment for some time or have never had MAT"*
> *—behavioral health lead*

The interviews also underscore the difference between continuing existing treatment and initiating treatment in jail. Some counties reported that many patients receiving MOUD are new starts, meaning they were not actively prescribed treatment prior to entering custody. This makes the jail a critical intervention point, but it also heightens the importance of post-release continuity to prevent a treatment gap.

Key Highlights

- MAT includes multiple medications and delivery models, each with different release implications.
- Methadone usually requires OTP coordination and next-day community continuation rather than medications-in-hand.
- Buprenorphine may be provided in hand, but supply length varies based on policy, prescriber comfort, and follow-up access.
- Long-acting injectables are promising but require careful timing and planning.
- Rapid, low-barrier community follow-up and patient choice are central to effective MAT continuity.

Emerging Best Practices

- Map separate workflows for methadone, buprenorphine, naltrexone, and long-acting injectables.
- Schedule next-day or rapid follow-up appointments for methadone and other clinic-administered medications.
- Pair shorter buprenorphine supplies with timely appointments, or use longer supplies where clinically and operationally appropriate.
- Discuss release planning at every MAT contact because release dates are uncertain.
- Maximize walk-in or low-barrier referral options for people released unexpectedly.
- Adopt a patient-choice approach when clinically appropriate, rather than defaulting everyone to a single medication model.

8. Antipsychotics, Long-Acting Injectables, and Behavioral Health Continuity

Antipsychotic medications, particularly long-acting injectables, raise a different set of continuity questions. Oral medications may follow the general discharge-medication workflow, but long-acting injectables (LAIs) cannot simply be handed to a person at release. They must be administered by an appropriate clinician, and the injection timing may need to be adjusted if release is imminent.

Some counties described using an integrated discharge medication workflow, even when prescribing inside the jail, may be managed by multiple entities. For example, behavioral health clinicians may manage antipsychotics during custody while medical clinicians manage other medications. At discharge, however, time constraints can require one designated prescriber or team to review the full chart and order all appropriate medications so that the person leaves with a complete regimen.

Key Highlights

- Oral antipsychotics may follow standard discharge workflows, but LAIs require administration planning.
- Injection timing may need to be adjusted when release occurs near the next scheduled dose.
- Discharge workflows may consolidate prescribing responsibility to avoid delays.
- Behavioral health linkages and warm handoffs are essential for people at risk of decompensation.

> *"If someone is due for their long-acting injection and they are scheduled to get out a couple days before it is due, we will sometimes request that it be administered early." —clinician*

Emerging Best Practices

- Flag individuals on LAIs early and track next dose dates.
- Administer LAIs before release when clinically appropriate and timing supports it.
- Create a single discharge-medication review process that covers psychiatric and medical medications.
- Develop warm handoffs to behavioral health providers, MCPs, and bridge clinics.
- Include people with moderate needs who may not meet the highest acuity thresholds but remain at risk after release.

9. Unknown and Unplanned Releases: Fallback Pathways

> *"Unexpected releases post a challenge, but we do our best" —county implementation lead*

Unplanned releases cut across every medication category. Counties repeatedly described the reality that planned release workflows only solve part of the problem. Even with good lists and court monitoring, people may go to court and be released immediately, post bail unexpectedly, or leave outside pharmacy or social services hours.

The strongest responses use fallback hierarchies. If patient-specific medication is already on site, the person may receive the remaining supply. If the full 30-day supply cannot be prepared, a partial supply may still be provided. If medications cannot be physically provided, counties may send an e-prescription to a pharmacy of the person's choosing or to a known outpatient pharmacy.

These backup strategies are not equivalent to medications-in-hand, but they recognize that continuity of care is a continuum: full in-hand supply is best, but partial medication, rapid e-prescribing, and post-release follow-up may prevent a complete medication gap.

Key Highlights

- Unknown release dates are a system-wide challenge to continuity of care, not a medication-specific exception.
- Patient-specific on-site medications make rapid release response more feasible.
- E-prescriptions and post-release reconciliation are common backup tools, though counties that can analyze prescription pickup post-release find that the pickup rate is low.
- Backup strategies are essential to meet the medication needs of people released unexpectedly from jail.

Emerging Best Practices

- Create a formal fallback hierarchy and train staff on when to use each option.
- Maintain patient-specific medications for people likely to be released.
- Use partial supplies when a full supply cannot be prepared in time.
- Allow e-prescribing to a chosen or known community pharmacy as a backup.
- Assuring patients that medication provided post-release is paid for through Medi-Cal or by the county.
- Develop post-release reconciliation lists for people who leave before medications are completed.

10. Coordination, Staffing, and System Integration

Medications-in-hand implementation depends on coordination across systems that often have different priorities, hours, data systems, and legal responsibilities. Custody staff may know about the release before healthcare staff. The pharmacy may need orders before it can prepare medications. Prescribers may need current medication reconciliation. Reentry staff may need to connect the person to community care. Any gap in the chain can break continuity.

> *"Communication is really key between teams" —pharmacist*

Counties described several coordination tools: shared patient lists, secure chats, court monitoring, release facility charge nurse workflows, designated discharge medical unit clerks, and direct communication between pharmacy and release staff. Some counties clarified that release staff do not dispense medication in a clinical sense; they hand a labeled bag to the person as part of the release process, including phone numbers and pharmacy information.

Staffing decisions also matter. Some counties added evening clinician coverage to match extended pharmacy hours. Others shifted behavioral health linkage responsibilities to pre-release care managers to distribute workload and reduce multiple referral pathways. These decisions show that implementation is as much an organizational design challenge as a medication distribution challenge.

Key Highlights

- Successful workflows require custody, clinical, pharmacy, and reentry staff to function as one system.
- Shared lists and secure communication reduce delays and missed handoffs.
- Clear role delineation protects staff from being asked to perform duties outside their scope.
- Staffing models may need to change as release patterns and medication demands become clearer.

Emerging Best Practices

- Define who identifies release, who orders medications, who prepares them, who transports them, and who hands them off.
- Use shared systems to track reconciliation, preparation, readiness, and delivery.
- Align clinical coverage with pharmacy hours and release patterns.
- Create dedicated discharge coordination roles where possible.
- Simplify referral pathways so community providers, MCPs, and behavioral health teams are not receiving duplicative or conflicting requests.

11. What Is Working Well and Advice for Continued Implementation

> *"We're figuring it out as we go"*
> *—county implementation lead*

Counties identified relationship-building, practical problem-solving, and cross-county learning as major strengths of early implementation. Even counties with very different pharmacy models and release workflows described the value of learning from peers and adapting ideas to their local context.

A recurring lesson is that implementation takes longer than expected. Counties described CalAIM JI policies as complex, with some aspects better suited to prison release planning than jail release realities. The fact that jails are developing workable models is itself a major implementation finding. Counties are showing that medications-in-hand is possible, but only when supported by partnerships, staffing, pharmacy redesign, and continuous improvement.

Another important theme is pride in demonstrating what is possible. Counties that have moved from "this cannot be done" to functioning workflows emphasized that the work changes how jail health, pharmacy, custody, and community partners see their roles. Medication provision becomes part of a broader continuity-of-care mission rather than a narrow discharge task.

Key Highlights

- Counties are still building and refining workflows after go-live.
- Peer learning has accelerated problem-solving across jurisdictions.
- Implementation success depends on relationships as much as technical design.
- Counties are increasingly able to show that medications-in-hand is feasible in jail settings.

Emerging Best Practices

- Start with workable workflows and improve them over time rather than waiting for perfect systems.
- Use peer learning networks to troubleshoot pharmacy, billing, and release issues.
- Treat law enforcement, community providers, MCPs, and pharmacy as core partners.
- Build feedback loops to identify when a person did not receive medications as expected.
- Frame implementation as continuity-of-care work, not simply a compliance task.

Community Perspective: Themes from Focus Groups

To complement interviews with county implementation teams, the project conducted two focus groups: one with community-based organizations (CBOs) providing reentry services and one with people who had recently experienced release from custody. These discussions offered both a systems-level and lived-experience perspective on implementation of the medications-in-hand component of the CalAIM Justice-Involved Initiative.

- The focus group for CBOs was conducted via Zoom on 5/13/26 for 90 minutes. Eight people registered for the meeting; four people participated and one person responded to questions via email in lieu of meeting participation.
- The focus group for people with lived experience was conducted via Zoom on 5/26/26 for 90 minutes. JSP did extensive outreach to recruit participants: Eight people registered for the meeting; four people participated. Participants received gift cards of $100 each as stipends for their participation.

The county interviews focused primarily on operational implementation of the medications-at-release requirement, including pharmacy workflows, release planning, staffing, and logistics coordination. In contrast, focus group participants viewed medications at release through the broader lens of reentry and healthcare access. Their experiences highlight that while medications-in-hand is a critical component of successful reentry, continuity of care after release depends on a range of additional factors, including insurance activation, provider access, care navigation, housing stability, and community supports.

Medications at Release Are Necessary but Not Sufficient

Participants consistently emphasized that providing medications at release is an important first step, but that medications alone do not ensure continuity of care. Individuals leaving custody often face significant challenges navigating healthcare systems immediately after release.

Key Highlights

- Both CBOs and people with lived experience described the transition from a short-term medication supply (provided at release) to ongoing treatment as the most vulnerable point.
- People with lived experience described receiving medications, but some were released without referrals, clinic information, or assistance obtaining refills.
- CBOs reported dedicating substantial staff time to helping clients reconnect to care, locate providers, and resolve administrative barriers.
- Both groups highlighted the need for dedicated navigation support before and after release.

> *"I thought it was a pretty good idea for them to give me a week's supply... I figured it worked out pretty well, you know, there was no issues. I was able to find a clinic pretty quickly."*
> *—person with lived experience*

The presence of a warm handoff—including a scheduled appointment, connection to a provider, pharmacy information, and clear instructions—was viewed as the critical factor determining whether an individual successfully continues treatment after release.

Insurance Activation Is Foundational

Active, full-scope Medi-Cal coverage emerged as one of the most important factors influencing successful medication access.

Key Highlights

- CBOs described delays in eligibility verification, benefit activation, and inter-county transfers that frequently interrupted care.
- Participants with lived experience similarly noted that obtaining medications was relatively straightforward when full-scope Medi-Cal was active but considerably more difficult when coverage was delayed or uncertain.

Ensuring coverage is active at the time of release was viewed as a prerequisite for successful implementation.

Social and Practical Barriers Affect Medication Access

Housing instability, lack of transportation, limited access to phones, and challenges obtaining identification frequently interfered with individuals' ability to maintain treatment after release. Participants described these practical barriers as equally important as the medication supply itself. CBOs echoed this concern, noting that medication continuity is often undermined by broader reentry challenges rather than clinical issues alone.

> *"A member was released without medications. Got his medications from urgent care, but was still unhoused and was robbed... now, trying to get a new set of medications, it became a whole process, because now it's whether or not they believe him." —CBO representative*

Medication-Assisted Treatment Requires Particular Attention

Both groups identified medications for opioid use disorder, particularly buprenorphine (Suboxone), as an area requiring focused attention. Participants described receiving short-term supplies without clear referral pathways, while providers expressed concern that disruptions in treatment increase the risk of relapse and overdose. Ensuring rapid connection to ongoing MAT providers was viewed as especially important given the high stakes associated with treatment interruptions.

County-Level Variation Creates Unequal Experiences

Experiences varied considerably across counties. Participants reported receiving anywhere from no medication supply to a 30-day supply at release. Similarly, levels of care coordination, discharge planning, and community support differed significantly across jurisdictions. Both groups suggested that implementation outcomes are driven as much by local coordination and operational practices as by statewide policy requirements.

System Fragmentation Places Burdens on Individuals and Frontline Staff

> *"You have the jail, and you have probation, and you have parole, all these different systems touching the same individual, and then when we receive them, we would have to go to each one... to get the full picture." —CBO representative*

CBOs described significant effort coordinating across correctional facilities, healthcare providers, managed care plans, behavioral health systems, and community organizations. People with lived experience similarly described being responsible for navigating multiple disconnected systems immediately after release. Across both groups, participants observed that successful outcomes often depended on the persistence of individual clients and frontline staff rather than on seamless system coordination.

Vision for an Effective Medications-at-Release Model

Despite describing different experiences, both groups articulated a similar vision for improvement. Participants envisioned a coordinated release process in which individuals leave custody with:

- medications in hand,
- active full-scope Medi-Cal coverage,
- identification documents,
- communication tools,
- scheduled healthcare appointments, and
- clear connections to community-based providers.

> *"Definitely increasing stability and decreasing stress... having those medications handy and ready when the person is getting out, and knowing that they're going to be okay and able until they can be connected with the provider. It has been helpful." —CBO representative*

The shared goal was a system that reduces the burden on individuals to navigate fragmented services during the critical transition from custody to community.

The Statewide Picture: Survey of Counties

To supplement the data collected via the interviews and focus groups, JSP developed a survey to gather information on how all California counties are implementing—or planning to implement—medications-in-hand at release. JSP conducted outreach to 58 California counties, targeting respondents primarily in pharmacy, medical services administration, and behavioral health, with limited exceptions for sworn staff where necessary.

On May 18, 2026 an invitation to participate in the survey was sent via email to contacts in 57 of the 58 California counties with at least one reminder to each county. Several counties responded that they do not have a jail, so could not answer the survey or referred JSP to other team members for response. The survey will remain open through June 30, 2026. Analysis of survey results and findings are forthcoming.

Insights and Recommendations

Interviews and focus groups pointed to consistent themes in early implementation of CalAIM JI's medications-in-hand policies. These include insights across all aspects of implementation as well as recommendations for counties that will be going live soon.

Cross-Cutting Insights

- **Release unpredictability drives system design.** Jail release timing is the root operational constraint. All major workflow decisions — pre-preparation, patient-specific medication, clinical storage, rapid-response communication, and fallback e-prescribing — are responses to this constraint.
- **Continuity of care is broader than medications-in-hand.** Medication provision is only one part of transition planning. Follow-up appointments, low-barrier clinics, ECM, managed care plan coordination, housing supports, behavioral health linkages, and patient education all determine whether the medication bridge holds.
- **Pharmacy infrastructure determines implementation capacity**. Counties with flexible pharmacy models, patient-specific medication systems, extended hours, or clinical storage pathways are better positioned to serve both planned and unplanned releases.
- **Medication categories require different workflows.** Routine chronic medications can often be standardized. HIV and hepatitis C medications require zero-gap continuity. Insulin requires supplies, refrigeration, and housing coordination. MAT requires controlled-substance workflows, clinic linkages, and patient choice. Antipsychotic LAIs require administration timing and behavioral health handoffs.
- **Relationships function as infrastructure.** Where formal systems are still developing, relationships between custody, health care, pharmacy, behavioral health, community providers, and peer counties make implementation possible.

Recommendations for Counties

Based on the experiences of early implementation counties, several recommendations emerge for jurisdictions preparing to launch or expand medications-in-hand.

- **Design workflows around the realities of jail release patterns.** Counties should develop both planned-release and rapid-response workflows from the outset, recognizing that most releases occur with little advance notice. Effective implementation requires systems that can accommodate both.

- **Establish formal fallback strategies for each workflow.** Counties should develop and communicate clear protocols for unexpected releases, including the use of patient-specific medications, partial medication supplies, e-prescribing, and post-release follow-up processes.
- **Invest early in pharmacy operations and medication preparation processes.** Pharmacy capacity is a critical determinant of implementation success. Counties should assess staffing, medication packaging, patient-specific inventory models, storage options, and after-hours coverage to ensure medications can be prepared and distributed within the timeframes required by jail operations.
- **Develop medication-specific continuity pathways.** Different medication categories require different approaches. Counties should establish tailored workflows for routine chronic medications, HIV and hepatitis C therapies, insulin and diabetes supplies, educations for opioid use disorder, antipsychotics and other special-handling medications.
- **Strengthen multi-disciplinary coordination and communication.** Successful implementation depends on effective collaboration among custody staff, healthcare providers, pharmacists, behavioral health teams, release staff, and community partners. Counties should establish clear roles, communication pathways, and accountability for each process step.
- **View medications-in-hand as part of a broader continuity-of-care strategy.** Providing medications at release is an important component, but reentry success depends on connecting individuals to ongoing care and support in the community. Counties should integrate medication workflows with discharge planning, healthcare navigation, and other reentry supports whenever possible.
- **Use implementation data to support continuous improvement.** Counties should monitor who receives medications at release, identify populations that are missed, analyze barriers to successful delivery, and use these findings to refine workflows and expand access over time.

Conclusion

Across counties, medications-in-hand implementation is emerging as both a practical operational strategy and a critical continuity-of-care intervention. Although counties continue to face significant challenges—including unpredictable release timing, pharmacy constraints, and the complexity of high-risk medications—the interviews demonstrate that workable models are being developed across diverse jail settings. Successful implementation depends less on any single policy or technology and more on flexible workflows, strong cross-system communication, and ongoing adaptation over time.

The findings also highlight that medications-in-hand cannot be treated as a one-size-fits-all process. Different medication categories require distinct operational approaches, and counties are increasingly designing systems around the realities of jail release rather than idealized discharge planning environments. Across interviews, relationships between custody, health care, pharmacy, behavioral health, managed care plans, and community providers consistently emerged as foundational to implementation success. Although implementation challenges remain, counties are demonstrating that medications can be successfully provided at release across a range of release scenarios and health conditions, creating new opportunities to support continuity of care and reduce gaps in treatment following incarceration.