Addressing adversity in multiple forms can reduce rates of individuals who are returning from prison going back to prison.
CCRM returning health partnership
The project described was supported by Grant Number 1CMS331071-01-00 and 1C1CMS331300-01-00 from the Department of Health and Human Services, Centers for Medicare & Medicaid Services.

Disclaimer: The contents of this publication are solely the responsibility of the authors and do not necessarily represent the official views of the U.S. Department of Health and Human Services or any of its agencies.
PRESENTERS

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  CCCounty Health Svc Division Office of The Director Reducing Health Disparities Partnering With Center For Human Department

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- Medical Director, Health Care for the Homeless- Contra Costa County
- Physician Transitions Care Network and REMEDY program Contra Costa County

Michael Changaris, PsyD
- Health Psychologist – CCRMC Health Psychology Groups Program Lead
- Training Coordinator – Integrated Health Psychology Training Program Partnership Between CCRMC and Wright Institute
PRESENTATION GOALS

- Develop an understanding of key research findings on health and behavioral health factors impacting successful re-entry
- Recognize core components in integrated systems of care
- Understand the core road map for developing integrated health care partnerships for returning population
- Report on key outcomes and findings on pilot integrated medical home program
- Recognize signposts on the way to transition success
WORKSHOP OVERVIEW

5 Min  Panel Introductions and Introduction to TCN – REMEDY

5 Min  Addressing Health Disparities: Risk, Resilience, Returning Health

10 Min  Braking the Cycle Through Collaboration, Empowerment and Consumer Driven Interventions.

10 Min  Experiential Exercise: Developing a reentry health program in your clinic

5 Min  Provider Perspective – Relationships that change

5 Min  TCN – REMEDY Outcomes Data

5 Min  Question and Answer
INTRODUCTION - TCN AND REMEDY

REMEDY GROUP STATEMENT: The REMEDY group is a community home for people who are reentering from prison. We believe each of us has strength, wisdom and is worth full respect. Each member of the community is a vital strength. Each of us carry our struggles and together the struggles are lighter. Like iron that sharpens iron we support each other to build our personal health, community strength and group vitality. Through our connection and action we build healthy minds, healthy bodies and healthy spirits.
BUILDING A SYSTEM OF CARE HELPS OPEN DOORS TO BUILDING A LIFE OF MEANING AND PURPOSE
REENTRY SUCCESS

Healthy Mind
Healthy Body
Healthy Spirit
Healthy Community
Addressing health disparities can improve health, impact community health and reduce recidivism.
Even when controlling for access to care and insurance status formerly incarcerated individuals receive less care.

Perceived experiences of bias in medical system in other research has lead to less health care utilization.

In the first year Post-release there is an increased mortality rate (up to 3.5 fold increase) for formerly incarcerated individuals. Health related issues leading to mortality were HIV, Cancer and HTN.

The first year after release is highly vulnerable for mortality.

There are multiple barriers to receiving mental health and substance abuse treatment. These barriers impact access to care.
Those returning from prison often come back with a higher disease burden of health, mental health and substance abuse disorders. These three factors are a core part of what leads to recidivism.

If one considers the social determinants of health there are many other key social factors that become part of the story of why people are incarcerated to why people return to incarceration.

Many of our program participants have said at times to one of our team members ‘I don’t think I can do it. Maybe I will just go back (meaning prison).’

Some the factors that have triggered that statement were housing/work crisis, challenges with family, mental health/SUD and health/disease process.
America's New Mental Institutions

In the 1950's, about 500,000 people with serious mental illnesses were treated in publicly funded psychiatric hospitals.

Today, the numbers are quite different.

108,000 Receive Treatment
200,000 Are Left Homeless
356,000 End Up In Prison
34,000 Commit Suicide

Image from the web @ https://www.rehabcenterforwomen.org/recovery-blog/mental-disorder-highly-common-among-women-prison
Inmates and Mental Health

Prevalence of mental health issues among inmates

<table>
<thead>
<tr>
<th></th>
<th>State</th>
<th>Federal</th>
<th>Local</th>
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<tbody>
<tr>
<td>56%</td>
<td>45%</td>
<td>65%</td>
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</table>

Ever received mental health treatment 49.3%
Received treatment during the year before arrest 22.3%
Received treatment after admission 33.8%

Image pulled from web @ http://cdonohue.com/incarcerationinamerica/mental-health/
Jill a 54 year old Latina woman arrived to the REMEDY group 60 min late. She sat down and asked to meet with the health psychologist. When she and the health psychologist met she described intense feelings of pain in her feet, like she was walking on broken glass.

She explored her depression, housing insecurity and the need for pain medication. The health psychologist helped her identify the relationship between pain, depression stress and diabetes.

She reported that she had stopped taking her medication and due to housing insecurity was eating more poorly. She made a plan to secure her housing, improve her eating and was re-connected with her medical provider to have her metformin addressed. Her A1Cs were above 11.

In the next months her A1C levels normalized < 8, she found stable housing and began working a full time position.
BRAKING THE RECIDIVISM CYCLE

Developing Healthy Minds, Bodies, Spirits, family and community

“For what it’s worth: it’s never too late to be who you want to be. I hope you live a life you’re proud of, and if you find that you’re not, I hope you have the strength to start over.”

Eric Roth
RISKS OF RECIDIVISM

- There are two main classes of factors that lead to recidivism: Static factors that can not change (e.g. number of years incarcerated) and dynamic factors that can be effected (e.g. mental health, SUDs, Access to Housing, Health Care, Values, and Cognitions).

- Of the dynamic factors (factors that change) there are factors that are behaviorally influenced and factors that are more impacted by systems and environment. There are bidirectional relationships between environmental and behavioral factors.

- Environmental Factors: Problems with housing, lack of available work and economic challenges all increase risk.

- Behavioral/Internal Factors: Mental health, substance use disorders, stress, health behaviors.
ADVERSE CHILD EXPERIENCES AND INCARCERATION

- Adverse Childhood Events – Is a hidden epidemic leading to increase risk of health, mental health and social impacts.
- Adults with incarceration hx treated in San Diego Kaiser were 4X the rate of ACEs compared w/ Kaiser normative sample.
- Sex offenders treated in Kaiser system had higher rates of sexual abuse as children.
- Two main targets: Addressing late life impacts of childhood adversity and reducing risk of childhood adversity.


It is hard to get enough of something that almost works.  
Vince Felitti, MD
## FROM ADVERSITY TO COMMUNITY

### ADDRESSING ACES THROUGH TRANSITION HEALTH

<table>
<thead>
<tr>
<th>Adverse Childhood Experiences</th>
<th>REMEDY: Trauma Informed Tx and Group</th>
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</thead>
<tbody>
<tr>
<td>Adoption Health Risk Behaviors</td>
<td>REMEDY: CBT, Emotion Reg., Social Skill/Support</td>
</tr>
<tr>
<td>Social, Emotional and Cognitive Impairment</td>
<td>REMEDY: CBT, Emotion Reg., Social Skill/Support</td>
</tr>
<tr>
<td>Disease, Disability, and Soc. Prob.</td>
<td>REMEDY: Medical Care &amp; Health Conductors</td>
</tr>
</tbody>
</table>

**Prison to Life of Purpose Pipeline**
COMMUNITY IMPACTS OF INCARCERATION

Grandparents in parenting role and taking care of young children.

Increased family poverty and associated health and mental health risks.

Children w/ incarcerated parents have > risk of chronic illness, depression and beh problems.

Returning creates challenges with adjustment and impact family wealth.

Disrupts the family system and increases risk children in foster care and need for multiple health and mental health services.

Disrupted family relationships impacts a child’s ability to bond with returning family member.

Ripple Effects Impact Generations...
WHAT WORKS — EBP FOR REDUCING RECIDIVISM

- Education and Training: More than 30 years of data indicate that increased access to education and training reduce rates of recidivism.

- Mental Health Treatment: Studies have shown for individuals with significant mental health issues addressing those needs can reduce recidivism by >60%.

- CBT and Cognitive Interventions: Developing skills for self-regulation, challenging beliefs that lead to criminal actions and increasing positive coping all reduce relapse rates.

- Responsive Health Care: Poor health care, difficulty with attending treatments and health disparities all lead to increased risk of someone returning to prison. A provider trained on building relationships with formerly incarcerated individuals helps increase attendance and adherence.

- Substance Abuse Treatment: Access to solid SUD treatment can reduce significantly the likelihood someone will engage in criminal behaviors.
#1 Asking for help. People in our group report often having to go it alone. It takes trust to ask and confidence to accept support.

#2 Training People seeking training and getting support are more likely to succeed.

#3 Connection Being willing to open up and connect with others in the treatment team and the group.

#4 Visions Actions towards visions. Reconnecting to personal values and allowing oneself to take the risk of success.

#5 Giving Back Supporting other group members helps deepen learning and leads to empowering the REMEDY member.
Integrated health programs meet people where they are, reduce barriers to care and improve outcomes.
Health Disparities are common and being formerly incarcerated leads to multiple barriers to care. Those reentering come home with multiple health conditions and the first year is a high risk of mortality.
TCN REMEDY — ADDRESSING TRANSITIONS CARE

Pathway to Medical Home

- Trained health coordinators with returning experience
- Providers committed to returning health
- Access to support for training, education, jobs and housing
- Support from group tx and increased coping skills
- Mental health treatment and referrals
RETURNING PROGRAM THAT PROMOTES HEALTH

Trained Primary Care Provider
Providers who are committed to returning health and have training on some of the key barriers can improve health care attendance, medication adherence and patient health.

Health Conductors
Health conductors are trained professions who understand needs of a community and play a central role in health, mental health and care coordination.

Health Psychologist
Health psychologist/BHC provide warm handoffs for crisis & health education, referral SUD/MH services, group Tx and individual Tx.

REMEDY Group
The REMEDY group provides health education, CBT and emotion regulation skills, peer support, coordination with medical team and health conductor support.

Integrated Transitions Clinic
The integrated transitions clinic model has four components a. trained medical team, b. health conductor/consumer, c. REMEDY group, d. health psychologist.

Support Service
Reentry programs need a web of support services like day programs, job training/skills, education, SUD Tx, Housing, Transportation etc.
### Steps to Building Integrated Reentry System of Care for Reentry Medical Home

- **Assess services**
- **Build support**
- **Identify Medical Champion**
- **Enlist Admin Support**
- **Make list of reentry services list available**

- **Develop services**
  - Reentry clinic
  - REMEDY Group
  - Provider ed/tr.
  - Behavioral Health education
  - Reentry health conductors

- **Build on success**
  - Improve current programs
  - Develop new program(s)
  - Address care coordination need

- **Collaborative care teams**
- **Care team dev.**
- **Int. key services**
- **Challenging PTs QI for system dev**
- **Develop Standard Work**

- **Trained medical providers**
- **Trained mental health providers**
- **Standard work developed**
- **Regular QI with consumer input**

### Seed Team

- **Beginning Change**
  - Assess services
  - Build support
  - Identify Medical Champion
  - Enlist Admin Support
  - Make list of reentry services list available

- **Building on Success**
  - Develop services
  - Reentry clinic
  - REMEDY Group
  - Provider ed/tr.
  - Behavioral Health education
  - Reentry health conductors

- **Integrated System of Care**
  - Build on success
  - Improve current programs
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- **Reentry Medical Home**
  - Collaborative care teams
  - Care team dev.
  - Int. key services
  - Challenging PTs QI for system dev
  - Develop Standard Work

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**Seed Team**

- Assess services
- Build support
- Identify Medical Champion
- Enlist Admin Support
- Make list of reentry services list available

**Beginning Change**

- Develop services
  - Reentry clinic
  - REMEDY Group
  - Provider ed/tr.
  - Behavioral Health education
  - Reentry health conductors

**Building On Success**

- Build on success
  - Improve current programs
  - Develop new program(s)
  - Address care coordination need

**Integrated System of Care**

- Collaborative care teams
- Care team dev.
- Int. key services
- Challenging PTs QI for system dev
- Develop Standard Work

**Reentry Medical Home**

- Trained medical providers
- Trained mental health providers
- Standard work developed
- Regular QI with consumer input
<table>
<thead>
<tr>
<th>Level 1: Reentry Siloes</th>
<th>Signposts</th>
<th>Next Actions</th>
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<tbody>
<tr>
<td>Reentry programs are separate</td>
<td></td>
<td>Develop a seed team, build support with in program, identify medical champion, enlist administrative support, list community referrals</td>
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<tr>
<td>Mental health and PCP not reentry focused</td>
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<thead>
<tr>
<th>Level 2: Reentry Coordination</th>
<th>Signposts</th>
<th>Next Actions</th>
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</thead>
<tbody>
<tr>
<td>Periodic communication between programs</td>
<td></td>
<td>Develop change plan, start with core change, health conductors, re-entry group, collaborative clinic, provider education, mental health/BHC training. PDSA Cycles</td>
</tr>
<tr>
<td>Care coordination provider initiated</td>
<td></td>
<td></td>
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<tr>
<td>No regular access to trained care teams</td>
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<tr>
<th>Level 3: Co-located Re-entry Services</th>
<th>Signposts</th>
<th>Next Actions</th>
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</thead>
<tbody>
<tr>
<td>Regular reentry clinics</td>
<td></td>
<td>Take successes and build one them. Improve newly developed programs, develop additional program/services/trainings.</td>
</tr>
<tr>
<td>Trained Mental Health, SUD Tx &amp; PCPs</td>
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<td>Periodic case conferences</td>
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<tr>
<th>Level 4: Integrated Reentry Services</th>
<th>Signposts</th>
<th>Next Actions</th>
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<tbody>
<tr>
<td>Coordination/MOUs with housing, job sites and education/training programs</td>
<td></td>
<td>Develop clear referral pathways, trained primary care providers, specialized transitions clinics paired with REMEDY group, develop standard work and case collaboration.</td>
</tr>
<tr>
<td>Integrated Share the Care TCN and Mental Health Tx (Group, MH Warm Handoff, Psychiatry, SUD Tx, Indiv. Tx)</td>
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<tr>
<th>Level 5: Reentry Medical Home</th>
<th>Signposts</th>
<th>Next Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Returning health systems notified when people released.</td>
<td></td>
<td>Training medical team on referral pathways, Develop coordinated medical programs connecting from with in prison to reentry care, Dedicated quality improvement for reentry integration.</td>
</tr>
<tr>
<td>Pre-Release medical assessment and coordination with medical program</td>
<td></td>
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<tr>
<td>Well trained reentry specialists and clinics focused on reentry care.</td>
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The REMEDY program first started with a collaboration between our African American Health conductor team and primary care. These conversations lead to pulling in behavioral health. The initial conversations sparked the creation of a group that supported clinical services.

Initially we had speedbumps. There were challenges with filling clinics. There were challenges with keeping PCP appointments saved. The group initially filled up but then became very slow.

Addressing these challenges lead to a program that works.

As it Grew the Patients we Serve Made a Medical Home
We developed clear referral pathways and had regular meetings with primary care team to address challenges.

The model for the group needed a higher level of collaboration from people with insight into the experience. The academic knowledge was not enough. But collaboration between the health conductors who were also returning and behavioral health provider allowed for the development of a solid group.

We moved the clinic near the group. The physical space matters. Having the clinic near the group space increased group attendance and increased collaboration for the team.

Human connection and person care are the heart of the group. Members feel cared for. They know someone, often multiple someone’s are tracking them and caring for them.
EXPERIENTIAL EXERCISE DEVELOPING A HEALTH REENTRY PROGRAM

Starting from where you are you can develop a responsive reentry health program.
EXERCISE FOR DEVELOPING REENTRY HEALTH PROGRAM IN YOUR COMMUNITY
REENTRY HEALTH PROGRAM
MEDICAL TEAM CARE

Relationship with providers matter. It increases rates of adherence and health outcomes.
MY HISTORY WITH TRANSITIONS CLINIC

Passion is essential (and palpable!)

Relationships matter
  ▪ Health conductors
  ▪ Patients
  ▪ Community connections – HCH, MDF, ED

You have to be informed, not just medically
Trust is essential
- Don’t make promises you can’t keep
- Be knowledgeable, be honest

No egos- this is your time to listen. You DON’T know what folks are going through

Trauma-Informed Care
No agenda in your first few visits
Recognize discrimination, barriers as real
Patient buy-in/understanding- evaluate health literacy and work within patient’s level

My philosophies:
- There is no last chance
- The buck stops here
- The door is always open
INITIAL VISIT

My initial intake visit discussion

I ask lots of questions, give lots of time, have no agenda; do a lot of listening.

EXPLAIN everything you are doing and why!

Be action-oriented; people are tired of waiting. Offer SOLUTIONS!

Move past criminal background- this is none of your business and better not to know!

Be aware of your population and their major issues/barriers.

- E.g yoga might not be the best option for LBP in someone with no job, sleeping in their car
- Building trust may require a carrot
REMEDY PROGRAM OUTCOMES DATA

Exploring the data related to health, mental health and treatment outcomes.
MAJOR ISSUES I’M SEEING

Chronic Pain - 41%

Strategies for addressing:
- Trigger point injections
- FB removals/GSWs; remove the bullet remove some reminder of the trauma
- PT
- Address trauma
- Flexibility with chronic pain management

Substance use disorders (35%) = coping. Ask what happened to you, not what’s wrong with you
- Alcohol
- Opioids
- Methamphetamines
  - Offer TREATMENTS

Mental Illness (32%) - remove barriers inherent in the siloed system
- Know your PTSD screening questions and how to treat (PCL5)
  - Prazosin, propranolol

Homelessness (54%) - especially with paroles with sex offender status
HEALTH OUTCOMES DATA 2014-2016

Report of all patients seen at least once in our “Transitions Clinic”
- N = 74

Metrics included:
- Number of scheduled visits
- No show rates
- Diabetes and A1c values
- GFR
- Lipids
- Hypertension
- Cancer screening
- ER Visits
- Recidivism
Transitions Clinic Visits Attended

Number of Clinic Visits

Patients
Transitions Patient No Show Rate
2014-2016

- **0**: (x = 2.5, m = 1; 1-21)
- **< 25%**: (x = 9.4, m = 5; 4-29)
- **26-50%**: (x = 4, m = 2; 2-13)
- **51-67%**: (x = 7, m = 4; 3-17)
Recidivism within Contra Costa County 2014-2016

# Patients

Number of re-incarcerations
Transition Clinic Health Metrics 2014-2016

- Diabetics A1C < 7 (N = 12)
- Total Pts A1C < 7 (N = 40)
- Average SBP < 140 (N= 74)
- LDL < 160 (N = 39)
- Total Chol < 240 (N = 32)
CANCER SCREENING

Breast Cancer Screening
- Eligible patients = 9
- Percentage of patients with up to date screening = 56%

Cervical Cancer Screening
- Eligible patients = 11
- Percentage with up to date screening = 64%

Colon Cancer Screening
- Eligible patients = 26
- Percentage with up to date screening = 54%
FUTURE VISIONS

Direct referrals from county detention/work together to develop treatment plans

Medi-cal waiver resources- expanded case management

Integrated psychiatry

Expand wrap-around services available

- Jobs
- Vocational training resources
- Peer support
Program development rooted in real human needs makes meaningful change in people’s lives.
QUESTION AND ANSWER PERIOD
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THANK YOU FROM OUR RETURNING HEALTH PARTNERSHIP