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Implementing an Enhanced Care Management Program Serving Post-Incarcerated Individuals

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Abstract

The post-incarcerated population has poor health and social outcomes in San Benito and Santa Clara counties. Youth Recovery Connections is a nonprofit organization serving individuals with substance use disorders, gang, and justice involved individuals. The Enhanced Care Management program was implemented in the organization with the addition of serving post-incarcerated individuals. Contributing factors that lead to negative health outcomes include lack of case managers with lived experience, lack of self management skills, and instability of care transitions. Consequences that can arise from these factors include increased healthcare costs, recidivism, and lack of stable housing. The identified consequences cause negative health outcomes in individuals who have a history of incarceration.

The program offers case management, care planning, assessments, and self management skills by using a whole person approach. The project consisted of applications to health plans, electronic health record development, training staff, and thirty days to implement the workflows and services. Assessment of expected outcomes included staff surveys, application approval, an interview, and enrollment data. The application was approved and a contract was provided to the organization and 13% of participants were enrolled. Recommendations include analysis of enrollment data four months from implementing the program, a longer implementation time to assess outcomes, and improved software training to staff once finalized.

Keywords: Enhanced Care Management, Post-Incarcerated Individuals, Case Management, CalAIM, Whole-Person Care Model.

Agency & Communities Served

Agency Description

Youth Recovery Connections (YRC) is a nonprofit organization based in Hollister, CA. YRC was founded in 2022 to bridge the gap between youth and substance use disorder by prevention, education, and intervention services within San Benito County. The organization is fairly new and is still starting up. YRC has established clientele within the community and provides outreach to the community to spread awareness of services offered. In January 2024, YRC officially opened up their physical office location in Hollister. YRC's vision is,

> to help those with opioid and other substance use disorders by providing intervention and prevention services. We provide a secure and supportive atmosphere for young people who are struggling with substance abuse-related problems. Our primary goal is to help youth recover and regain their independence and well-being by implementing a healthy and productive lifestyle by treating them as the whole person (Youth Recovery Connections, n.d., para. 1).

YRC's mission statement is,

> Youth Recovery Connections (YRC) is a non-profit organization…offering intervention and prevention services for those suffering from opioid and other substance use disorders. Using a meet them where they are at approach, YRC offers an individualized and evidenced based approach focusing on the characteristics of the child or adolescent. (YRC, n.d., para. 2).

Not only does YRC serve youth and adults with substance use disorders but also serves individuals at risk for incarceration, individuals transitioning out of incarceration, and individuals involved with gangs. The nonprofit organization offers mentoring services with

youth and young adults and outreach to the community through education seminars, and community events.. Intervention efforts are provided through substance use counseling and referral to secondary services and by providing a safe space for youth to be at and hang out with peers (A. Bravo, personal communication, 2023).

Community Description

YRC provides substance use intervention and prevention services within San Benito County (SBC). Education and outreach to community events and schools in Monterey and Santa Cruz County are also provided. The total population in San Benito County is 63,329 people. Over half the population, 38,544 (60.9%), identifies as Hispanic/Latino. (U.S. Census Bureau, 2021). Other ethnicities include 32.3% White alone, 3% Asian/ Pacific Islander, 0.9% Black/African American, 0.3% Alaskan Native/American Indian, and 0.1% other races. The clientele YRC serves is primarily Hispanic/Latino (90% of clients and families) which is expected to be the majority of clients due to the ethnicity compilation in the county (A. Bravo, personal communication, 2023). Although Hispanic/Latinos comprise the majority of the population, they experience major socioeconomic and health inequities compared to other races in the SBC population.

Problem Model Background and Literature Review

Problem Statement

The post-incarcerated population has poor health and social outcomes in San Benito and Santa Clara counties. The post-incarcerated population in San Benito and Santa Clara Counties faces a critical health crisis, marked by the patterns of negative health outcomes. The transition from incarceration back to community reintegration poses significant challenges, contributing to physical and mental health disparities within this demographic group (Kinner & Young, 2018).

Factors such as limited access and/or lack of knowledge of healthcare services, social stigmatization, and a lack of targeted support to address social determinants of health (SDoH) exacerbate the already vulnerable health status of post-incarcerated individuals. Studies have found individuals with a history of incarceration have worse physical and mental health outcomes compared to the general population (Office of Disease Prevention and Health Promotion, n.d.). The California Health Care Foundation reports that 25% of the prison population have mental health problems, 60% have physical health ailments, and/or physical health disorders (2023). Addressing this issue is imperative to enhance the overall well-being of this population and foster successful reintegration process into society.

Figure 1: Problem Model

Contributing Factors	**Problem**	**Consequences**
Lack of case managers with lived experience	The post-incarcerated population has negative health outcomes compared to the non-justice involved population.	Increased healthcare costs
Lack of self management skills		Recidivism
Instability of care transitions		Lack of stable housing

Contributing Factors

Lack of Case Managers with Lived Experience

In order for successful re-entry into the general public after incarceration to occur there must be a support network which includes individuals with lived experience with incarceration and experience with the challenges that most individuals face after incarceration. This includes the use of a case manager who has lived experience. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), individuals with lived experience can help provide coping strategies, positive reinforcement, personal connection and shared understanding

of the members experiences, use a strengths based perspective, and provide resources to them (SAMHSA, 2023). The lack of case managers with lived experience working with this particular population is very common due to the stigmatization that happens after incarceration. Anthem Blue Cross' Enhanced Care Management program in California requires organizations to hire care managers with lived experience (Department of Healthcare Services, 2023). There has been a push, especially within California, for community based organizations to focus on hiring staff with lived experience for the populations they serve. For case managers with lack of lived experience it can be difficult to "build rapport, ensure accessibility and equity in processes and interactions, actively listen and engage empathetically" (Mackay, 2023, p. 1836), which are the foundations of case management. The case manager-client relationship is an important consideration to make when assessing clients' success with their goals. When a client can relate to the experiences of their case manager it provides an opportunity for clients to feel empowered to succeed in their goals and improve health outcomes.

Lack of Self Management Skills

Self Management skills may include maintaining activities of daily living, housing, food security, transportation, managing health appointments, social supports, and many more factors that pose challenges for individuals' management of their life and health (SAMHSA, 2023). A study performed with 52 individuals experiencing re-entry into the community found the majority of the participants shared increased burdens of everyday life. A quarter of those who shared this theme indicated it was not possible to fulfill the demands of re-entry into the community due to the stress and overwhelming nature of everyday burdens (Williams & Rumpf, 2020). The development of self management skills is crucial in order to manage an individual's health needs, personal affairs, basic needs, and legal obligations upon re-entry into the

community. By case managers aiding in the development of self-management skills, clients will be able to manage the everyday burdens of life which lead to improved health outcomes.

Instability of Care Transitions

Efficient and proactive transitions of care are essential for a warm handoff to be performed with vulnerable populations experiencing negative health outcomes. The transition of care begins in the institutions where one is held or cared for. The International Journal of Environmental Research and Public Health reports "Patients leave incarceration with limited or no supply of medications and medical supplies, rendering linkage to community care time sensitive" (Divakaran et al., 2023, para. 4). The Substance Abuse and Mental Health Services Administration (SAMHSA) reports in their *Best Practices for Successful Reentry From Criminal Justice Settings for People Living With Mental Health Conditions and/or Substance Use Disorders* guidebook that the prison systems may lack appropriate resources such as funding, infrastructure, and quality control to follow through on continuity of care for incarcerated individuals (SAMHSA, 2023). With proper care transitions, incarcerated individuals are more likely to have timely follow-up on medical care, establishment of primary care providers, and reduced stress for the individual during the re-entry process (Divakaran et al., 2023). Care transition preparation helps to coordinate necessary services the incarcerated individual may need when being released, which includes connecting with a case manager prior to discharge to streamline and develop a care plan aligned with the individual needs. Smooth transitions of care between organizations ensure that the continuum of client care is followed leading to improved health outcomes.

Consequences

Increased Healthcare Costs

Increased costs from healthcare expenses result from high acute care utilizers which includes the post-incarcerated population's use of emergency and urgent care services. The utilization of acute care services are caused by unmanaged health problems that the post-incarcerated population face. The American Journal of Public Health published a study which found even after the Affordable Care Act was expanded to include individuals with a history of incarceration, post-incarcerated individuals more frequently utilize acute care services compared to individuals with no history of incarceration who primarily utilize primary care providers whom they regularly follow-up with regarding health concerns (Winkelman et al., 2017). The average costs for emergency department (ED) visits among the justice involved population within one year of release is $4,000 compared to $1,000 for those who have no history of incarceration (Hwang, 2023). A study performed on individuals who had recent involvement with the justice system found that 27.2% had higher utilization of the ED, 26.6% were at risk for a ED visit, and 52.8% had history of behavioral health conditions compared to individuals with no justice involvement (McConville et al., 2018). This study highlights the consequence of higher utilizations of acute care visits which results in higher healthcare costs for the individual and the institutions that provide those services. Some of the factors that exacerbate under utilization of primary care providers for the justice involved populations include lapse in insurance, lack of transportation to appointments, and lack of knowledge on where to seek care (Walsh-Felz et al., 2019). The factors stated previously increase the likelihood of post-incarcerated individuals seeking acute care due to unmanaged health conditions which result in increased costs of healthcare.

Recidivism

Recidivism “refers to a person's relapse into criminal behavior, often after the person receives sanctions or undergoes intervention for a previous crime” (National Institute of Justice, n.d., para. 1). The consequence of recidivism increases when individuals post-incarceration do not receive the necessary support to re-enter in communities, address their personal and criminogenic needs, and receive supportive rehabilitative services (Latessa et al., 2020). Supportive re-entry into communities post-incarceration involves the use of case managers, reintegration programs, counseling services, food and housing assistance, social support programs, health management programs, and vocational or education resources. A re-entry program study performed with individuals who were newly released from correctional facilities indicated arrest rates were 14% lower for males and 48% lower for females who participated in the these program compared to those who did not (Gill & Wilson, 2016). Additionally the study found non-crimeonologic services mental health and substance use services were more beneficial to the participants reduced recidivism (Gill & Wilson, 2016). It is essential for individuals transitioning from incarceration to receive mental health, physical health, substance use, and social support in order to reduce recidivism caused by lack of care coordination and facility transitions.

Lack of Stable Housing

Stable housing has been a challenge for those re-entering into the community from incarceration. It is reported by the Reentry Coordination Council (RCC) that those formerly incarcerated are ten times more likely to experience homelessness compared to the general population (U.S. Department of Justice, 2022). What is more alarming is that individuals with a multi-incarcerated record are thirteen times more likely to experience homelessness than the general population (U.S. Department of Justice, 2022). The consequence of stable housing is

impacted by health as those who do not have health concerns addressed such as mental health and substance use disorders may impact their ability to secure appropriate housing (SAMHSA, 2023). Without proper case management to address all personal health needs, individuals may not be able to integrate back into society which impacts their ability to handle the stressors of daily living. Housing is an essential area when assessing social determinants of health (SDoH) of an individual. Housing stability, safety, and experience are directly correlated with health outcomes and well-being of individuals (Rolfe et al., 2020).

Project Description and Implementation Process

Project Description

The Enhanced Care Management Program with the Justice Population is a process that I implemented into my community based organization, Youth Recovery Connections, through the Department of Healthcare Services (DHCS) CalAIM initiative for Medicaid. I submitted an application to Anthem Blue Cross for my organization to contract with them through the Enhanced Care Management (ECM) program with a focus on the justice involved population for adults and minors. In conjunction with the application I composed ECM organizational policies and workflows for case managers, clinical consultants, supervising case managers, data entry specialist, and data management roles. During the planning phase I customized an ECM focused software with Aztute for staff to use for tasks required of the program. During this process I worked closely with software developers to perfect the platform to the needs of YRC and requirements of Anthem Blue Cross and Central Coast Alliance for Health (CCAH). Additionally, I made training materials for the software and informed all staff hired to work at the ECM program in use of the system and responsibilities. The implementation phase consisted of me leading the ECM team at YRC through the go-live date to initiate ECM services in San

Benito County for our contract that was signed with CCAH in January 2024. The final step in this process was to receive the Pre-Approval Contract from Anthem Blue Cross.

Project Justification & Benefits

The project is addressing the contributing factor of lack of case managers with lived experience in Santa Clara and San Benito counties. The project is addressing the factor through the implementation of an ECM program in San Benito county and extension of services to Santa Clara county. The ECM program at YRC has brought on case managers with lived experience that have already been working with the justice population and other vulnerable populations within Santa Clara and San Benito counties. Case managers (CM) with lived experience provide insights when working with the Justice Involved populations. As a result there is a degree of mutual understanding and trust that develops between the ECM member and case manager. Case management provides a whole person approach to addressing SDoH with vulnerable populations. The whole person approach is defined as, "...helping and empowering individuals, families, communities, and populations to improve their health in multiple interconnected biological, behavioral, social, and environmental areas. Instead of just treating a specific disease, whole person health focuses on restoring health, promoting resilience, and preventing diseases across a lifespan." (National Center for Complementary and Integrative Health, 2021, para. 1).

The ECM program uses a whole person approach to addressing SDoH needs within the Justice Involved population. This approach has been proposed by the Department of Healthcare Services (DHCS) as the center of their CalAIM initiative as a best practice when serving vulnerable populations and improving overall health outcomes in communities (2023). The whole person approach addresses clinical and non-clinical health and social needs of Medi-Cal members who qualify for the program. DHCS reports the use of community based organizations

to implement these programs provides a person-centered, interdisciplinary, high touch set of tools for comprehensive care (2023). CM's work closely with members to provide assessments, develop a mutually agreed upon care plan with attainable goals, assists with additional referrals for health and social needs, and follow-up with the member to ensure they are making progress to reach their care plan goals. As a result CM's will be addressing poor health outcomes that are commonly seen in the Justice Involved population post-incarceration in order to successfully re-enter into the community. The goal of the ECM program is to provide members with tools and strategies to self-manage their own social and health needs through the completion of the program goals.

Expected Outcomes & Assessment Plan

Since this project is composed of multiple elements, there are a few expected outcomes based on the deliverables. The first expected outcome is that a contract was successfully signed with Anthem Blue Cross. The second outcome consists of all ECM staff feeling confident and supported to use the Aztute software and perform case management activities. Finally, the third outcome is that the ECM program is able to successfully enroll 20% of eligible members within 30 days of going live with the services. I will use a survey to assess the second outcome and will be administered two weeks after the go-live date on March 5, 2024. Part of the assessment process will consist of using the data management component of the Aztute software to analyze the quantity of declined, not reachable, and enrolled ECM members. Additionally, the assessment plan will consist of a post-survey administered to all ECM staff regarding the quality of training. Furthermore an interview to determine if the process and outcomes of the project were successful will be conducted with Michael Salinas, the program director who supervised the project implementation. The interview will consist of the application process, quality of work

produced for the ECM program, success of go-live date, and contentment of program results thus far. Since this program will only be launched for a total of 30 days before obtaining results, the extent of how successful the program is cannot be fully determined. An additional five months is required to understand the success of the program fully.

Implementation Process

The Enhanced Care Management program is a project that required a multidisciplinary approach to implementing all the steps necessary for successful outcomes (see Appendix A). I began the project by reviewing and compiling all the necessary documents required for the Anthem Blue Cross application. This consisted of a small amount of research, creating compliant policies and procedures, constructing organizational charts, and forming mock charts and care plans. Next, I consulted and reviewed the application deliverables with the organizations director for approval. Once approval was obtained I submitted the application to the Anthem review team. While the application was being reviewed, I reviewed and modified the Aztute software with the software engineers. The software houses all ECM member information and helps to facilitate case manager workflow. Training videos were then created by myself to facilitate staff learning of the software and is provided as a reference tool for current and future staff. I provided additional in-person training to all staff members using the software which includes the use of test members to demonstrate all workflows and outcomes of the members' progression in the program. To provide staff with a better visualization of workflow, I formulated an interactive digital workflow chart which housed all training videos, references to policies, and additional resources. This workflow serves as a quick reference for all ECM staff to use. Once the Anthem Review Team had indicated they had completed the application review, the program director and I scheduled a follow-up meeting. During the meeting outstanding items and amendments that

needed to be made to the application deliverables were discussed. Once the final approval was made, the program director and I scheduled a meeting to review and design an implementation plan for the Anthem program. In the meantime I facilitated the go-live for a different health plan by the name of Central Coast Alliance for Health. This go-live was scheduled for March 10, 2024. I led and facilitated the go-live date to ensure a smooth and successful launch of the program with all roles involved in service delivery.

Project Results

The outcome of my project was measured through quantitative and qualitative methods. Firstly, the outcome of the Anthem Blue Cross contract was successful. I was able to gain acceptance of our application and received the "Pre-Approval Contract" on April 10, 2024. However, Youth Recovery Connections was not able to sign the contract before my capstone deadline. A survey was provided to all ECM staff (4). The survey received a 100% response rate. I was able to assess the staff's confidence using the software and knowledge in ECM after training was administered. The amount of staff who felt they received adequate training for basic usage such as administering and documenting assessments, care plans, and progress notes was 75%. The results for staff who indicated they would benefit from additional training about the software was 100%. On average it took staff three weeks to become fully comfortable with basic layout and functions of the software. These results were to be expected due to the evolving nature of the software. Throughout the training, some workflows were changed to improve efficiency. Additionally, the software experienced multiple bugs such as login issues, loading errors, and difficulty saving documentation. All of these complications hindered staff's experience when learning the software.

An additional component to assess the successfulness of the program consisted of analyzing the software data to identify what individuals declined services, were not reachable, or enrolled in the program. The goal for total individuals who enrolled in the program the first 30 days was 20%. The outcome of the total enrollment was 13% enrolled, 27% declined, and 47% not reachable (unable to make contact). The goal to reach 20% enrollment rate was not achieved by the project deadline.

To determine the overall satisfaction, benefit, and success of the program, the organization's director, Michael Salinas was interviewed. The interview revealed overall satisfaction with the program. He highlighted that the program opens doors for the community to access resources to their health and social needs. He reported this is a perfect fit for the organization as individuals transitioning from incarceration need this additional support to have successful outcomes. Mr. Salinas also mentioned this program is self-sustaining through the payments received for performing ECM services by the health plans. Youth Recovery Connections had yet to establish a method to become financially sustainable outside of awarded grants and donations prior to the program beginning. Mr. Salinas feels in order to determine the success of the program there needs to be more data which is gathered with more time. Before concluding the interview, Mr. Salinas stated he has no doubt that the program will be successful for YRC as there have been many milestones reached, positive reactions from the community and other local organizations, and dedication of the ECM team demonstrated at YRC in the short period of time the program has been live.

Conclusion & Recommendations

The ECM program addresses lack of case managers with lived experience, lack of self management skills in individuals of vulnerable populations, and the instability of care transitions

seen between community institutions. The implemented ECM program has addressed the lack of case managers with lived experience by bringing in personnel who have a history of being justice involved, substance use, and who have experienced mental health problems. These staff have been able to connect with their clients on a deeper level to support them in their health and social needs. The program aims to address self management skills by the time they have graduated out. Although the agency is not able to assess the outcome of this currently, the ECM program has adopted a strong emphasis on client involvement in their own care plan goals and interventions. This emphasis uses a strengths based perspective, motivational interviewing, and empowering interactions. Care transitions are addressed through the relationships established with community partners such as the probation departments, jail systems, medical offices, and other local organizations. A collaborative approach to addressing clients needs provides the program with a holistic support which keeps communication channels open. With open communication in clients care, the progress made toward clients goals and positive health outcomes improves.

I recommend the agency continues to develop their training and workflows to better improve efficiency, staff, and client experience. A more defined training provided to staff once the software customization has been completed will address any barriers experienced by staff when learning Aztute. Analysis of the program's goals to reach 20% enrollment at two months would be beneficial to see what can be improved upon in terms of outreach methods, approaches used to enroll, and services offered. Finally, analyzing the data for clients' improved health outcomes based on completion of care plan goals is recommended to assess the success of the program.

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Appendix A

Project Implementation Plan

Tasks	Timeline/ Deadlines	Parties Involved	Materials/ Services Needed	Deliverables
Create policies and documents for ECM application	12/17/2023	Brianna Tome and Michael Salinas	Library, Laptop, Google Drive, Canva	ECM policies, Staff List, Organizational Chart, Attestations, Mock Care Plan and Assessments
Review documents for application with mentor	12/31/2023	Brianna Tome and Michael, Salinas	Laptop	Approval on All Documents of Application.
Submit Application to Anthem	01/01/2024	Brianna Tome	Laptop	Email Confirmation Documents Received
Review and Modify Aztute Software	02/28/2024	Brianna Tome, Aztute Software Team	Laptop, Video Conference Platform, Basecamp Software, Aztute Software	Customized Software for Program
Perform Trainings with ECM Staff on Aztute	02/28/2024	Brianna Tome, ECM Staff	Laptop, Aztute Software, Designated Workspace	Staff Demonstrate Ability to Use Software
Create Training Videos on Aztute Workflow	02/14/2024	Brianna Tome	Laptop, Aztute Software, Video Editing Software, Google Drive	Training Videos
Develop Workflow Chart for ECM Program Activities	02/14/2024	Brianna Tome	Laptop, Canva Account, Google Drive	Interactive Digital Workflow Chart

Meet with Anthem to discuss application	01/29/2024	Brianna Tome, Anthem Blue Cross Review Team, Michael Salinas	Laptop, Video Conferencing Platform	Completed Meeting
Sign contract with Anthem to become ECM provider.	04/01/2024	Brianna Tome, Michael Salinas, Anthem Contracting Department	Laptop, Printer, Email	Signed Contract
Facilitate and Lead Go-Live Date for ECM Services with CCAH	03/05/2024	Brianna Tome, Michael Salinas, Aztute Team, ECM Staff	Office Space, Telephones, Computers, Aztute Software	Completed Outreach and Potential Enrollments for ECM Members