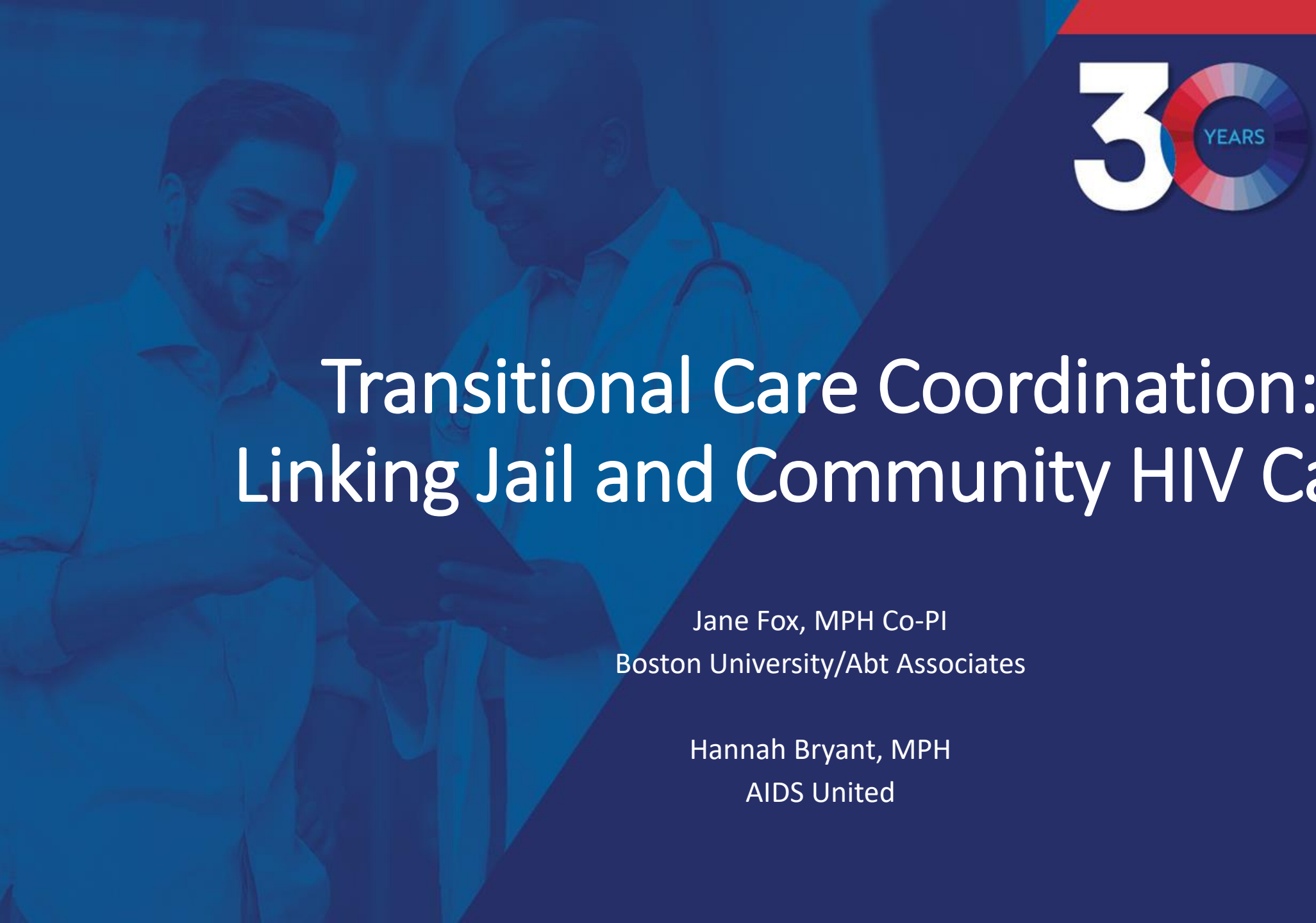

VIRTUAL 2020 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

Transitional Care Coordination: Linking Jail and Community HIV Care

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AIDS United

Disclosures

- The presenters have no relevant financial or non-financial interests to disclose.
- This continuing education activity is managed and accredited by AffinityCE in cooperation with HRSA and LRG. AffinityCE, HRSA, and LRG Staff, as well as planners and reviewers, have no relevant financial or non-financial interests to disclose. Conflict of interest, when present, was resolved through peer review of content by a non-conflicting reviewer.
- Commercial support was not received for this activity.

Learning Objectives

At the conclusion of this activity, participants will be able to:

- Describe the implementation evaluation outcomes – barriers and facilitators at pre-implementation and during implementation
- Discuss the client health outcomes and factors associated with linkage and viral suppression
- Share resources and tools to adapt and replicated the TCC intervention

Dissemination of Evidence-Informed Interventions (DEII)

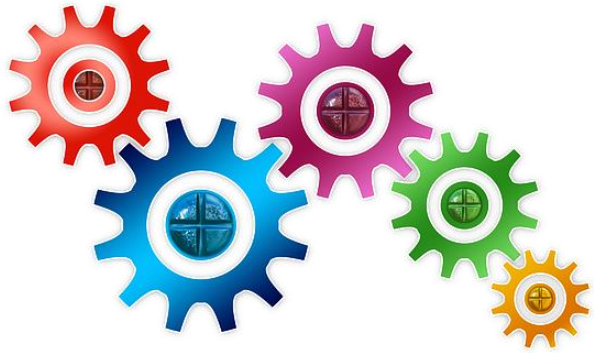
- Five-year Cooperative Agreement with HRSA HAB Special Projects of National Significance (SPNS)
- Two sites funded to work together
  - Implementation and Technical Assistance Center (ITAC) – AIDS United (2015-2019)
  - Dissemination and Evaluation Center (DEC) – Boston University (2015-2020)
- Replicates four adaptations of previously-implemented SPNS initiatives
- Conducts a multi-site evaluation of the implementation and patient outcomes

DISSEMINATION OF
EVIDENCE-INFORMED
INTERVENTIONS

Dissemination & Evaluation Center

Boston University

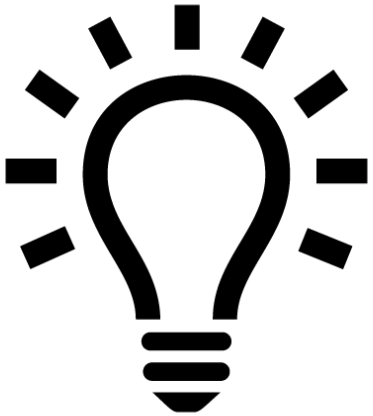
- Adapted and designed 4 intervention models for replication
- Designed and implemented multi-site evaluation
- Studied both patient outcomes (including retention in care and viral suppression) and implementation findings (what works in practice and what facilitates/hinders implementation)
- Publishing and disseminating final adapted interventions and study findings



Implementation & Technical Assistance Center

AIDS United

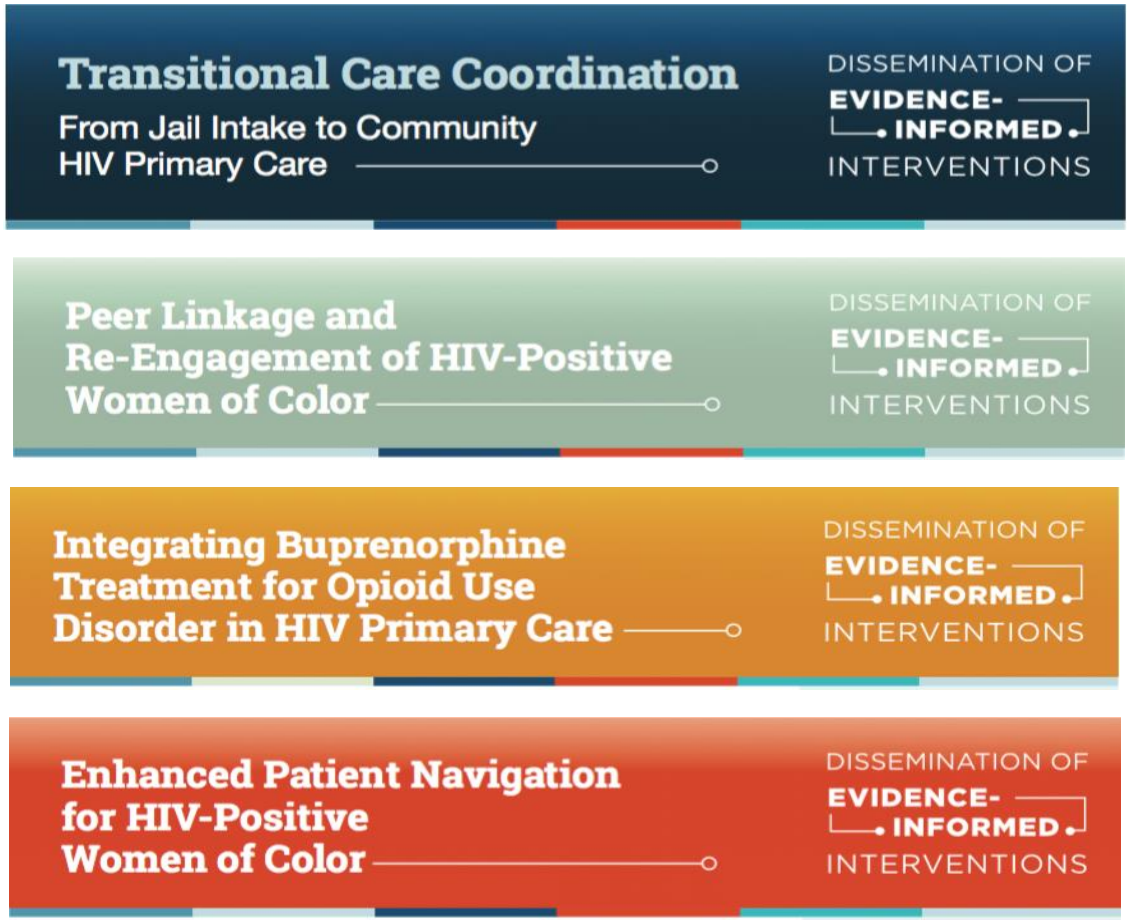
Select & Fund 12 Sites



Provide TA

Coordinate Experts

Interventions



Transitional Care Coordination

Transitional Care Coordination

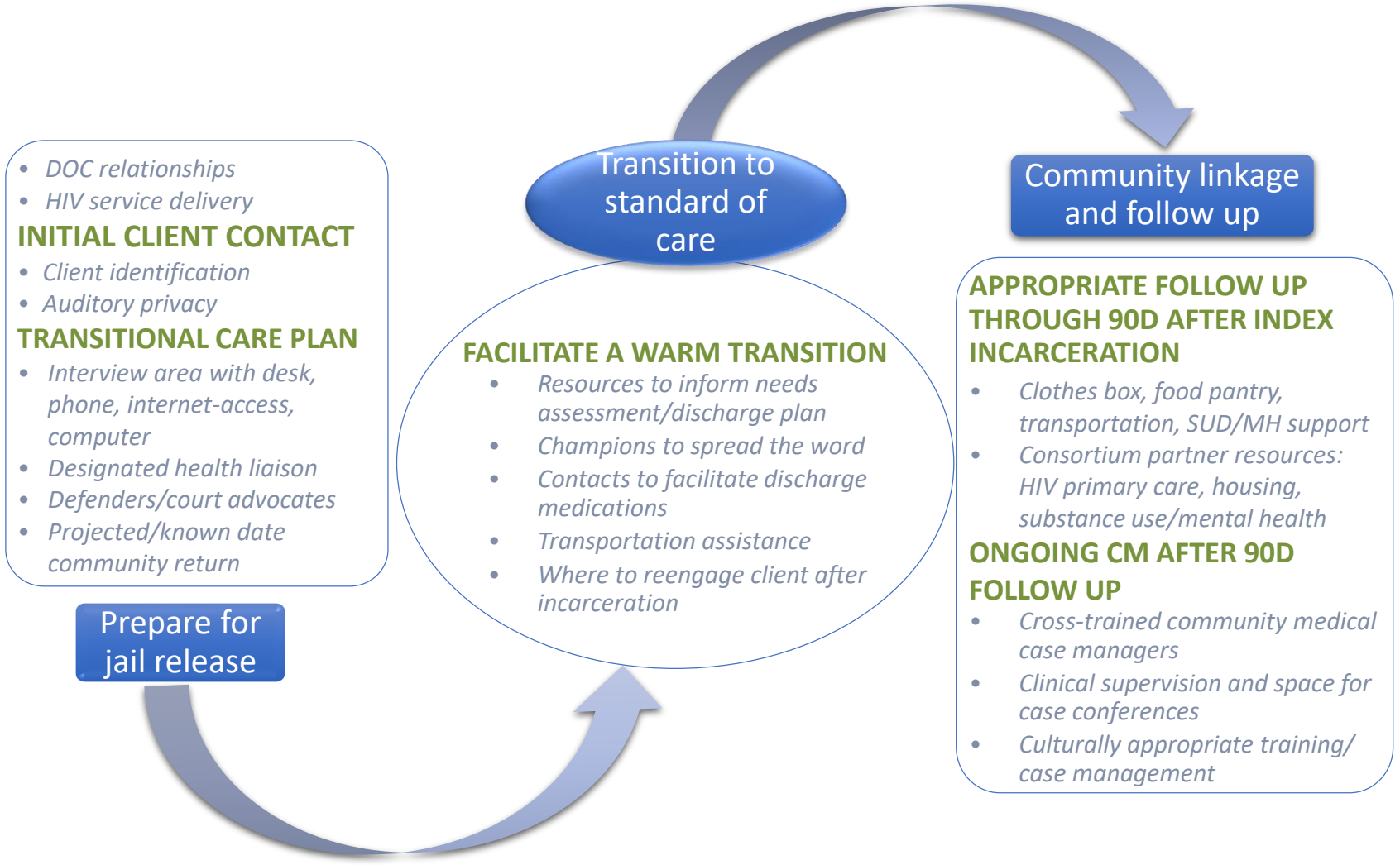
Intended for organizations and agencies considering strengthening connections between community and jail health care systems to improve continuity of care for HIV-positive individuals recently released from jails.

Designed to implement a new linkage program to for PLWH to support their care retention and engagement while incarcerated and post-incarceration and as they re-enter the community.

Overview

- Sites Funded: Cooper Health System in Camden, NJ; University of North Carolina in Raleigh, NC; and Southern Nevada Health District in Las Vegas, NV.
- Target population: HIV-positive individuals who are incarcerated in jail.
- Time frame of the intervention: From when a client completes an intake and assessment in the jail to 90 days post-release.
- Enrollment numbers: Across the 3 sites, 249 clients were enrolled into a multi-site evaluation study.

Core Model Components



Implementation Results

Pre-Implementation Lessons Learned

Supporting factors:

- Strong leadership from clinic administration and supervisors
- Existing collaborative relationships with the jails
- Proactive and engaged staff that have existing relationships with the jails

Challenging factors:

- Lack of leadership
- Policies specific to each jail setting (for example, people being released from the jail in the middle of the night & bail reform)

Implementation Lessons Learned

Jail Relationships

- Build a team that understands and fits-in with the culture among correctional officers and staff
- Promote connections between intervention team, correctional staff, correctional and community medical providers, and other community partners.
- Sites with strong implementation teams and strong leadership have been able to smoothly weather staff turnover/transitions.
- The intervention requires constant tending to the relationship with the jail (admin, medical, and officers). Staff turnover within the jail setting can impact intervention staff.

Implementation Lessons Learned

System and Community

- Adaptations have been necessary to “fit” the model into each setting.
- Partnerships between private/academic entities and state and county-level public health and correctional infrastructure promotes shared commitment to improving the health of persons living with HIV involved in the correctional system
    - Market the project to as many stakeholders as possible (within law enforcement, corrections, court system, community partners, etc.)
    - Relationships established offering housing and MAT were key

Staff

- Self-care is important
- Protect administrative time
- Provide supervision both individual and group

Implementation Lessons Learned

Clients

- Post release challenges are many and addressing them is key:
  - Homelessness/unstable housing
  - Mental health and substance use disorders
  - Transportation
  - Ongoing engagement with the criminal justice system
- Use harm reduction principles
  - Meet a client where they're at, not where you expect them to be and withhold judgements
  - MAT is an incentive to getting clients linked to care

Client Data Results

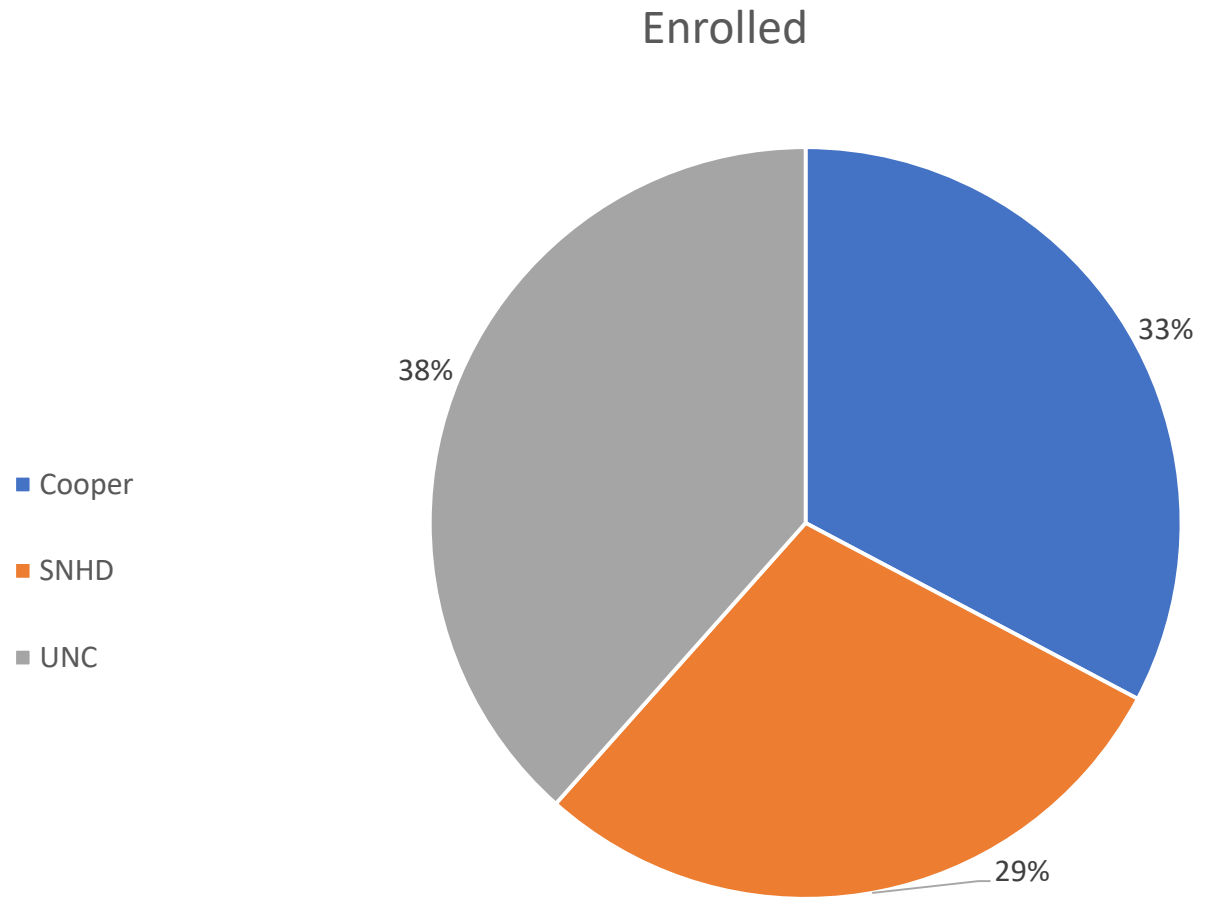
TCC Client Sample

268
- Total number of TCC clients enrolled across the three sites

264
- Excluded clients without a baseline interview within the window or had moved out of the service area

229
- Excluded clients who were not released or did not have 30 consecutive days post-release in the community

TCC Evaluation Sample(N=229)



Client Characteristics (N=229)

Demographics	N (%)
Gender	
Male	193 (84%)
Female	29 (13%)
Transgender	7 (3%)
Length of time HIV +	10.5 years (SD= 9.3) Range: 0 – 37.5 years
Age	40 years (SD= 10.8) Range: 19 – 64 years
≤ 30	51 (25%)
31 – 54 years	148 (65%)
≥ 55 years	24 (11%)

Client Characteristics (N=229)

Demographics	N (%)
Race	
Non-Hispanic Black	117 (51%)
Non-Hispanic White	61 (27 %)
Hispanic	22 (10%)
Other	29 (13%)

Demographics	N (%)
Education	
Less than high school	74 (33%)
High school	98 (43%)
More than high school	56 (25%)
Insurance	
Medicaid, Medicare, Private	155 (70%)
None	68 (30%)

Top Needs at Baseline

Reported Needs at Baseline	N (%)
Housing Assistance	134 (59%)
Transportation Assistance	119 (52%)
Assistance with Benefits	104 (45%)

Baseline interviews were conducted with clients while in jail. Questions related to needs were asked about the months prior to incarceration.

Top Reports Encounters

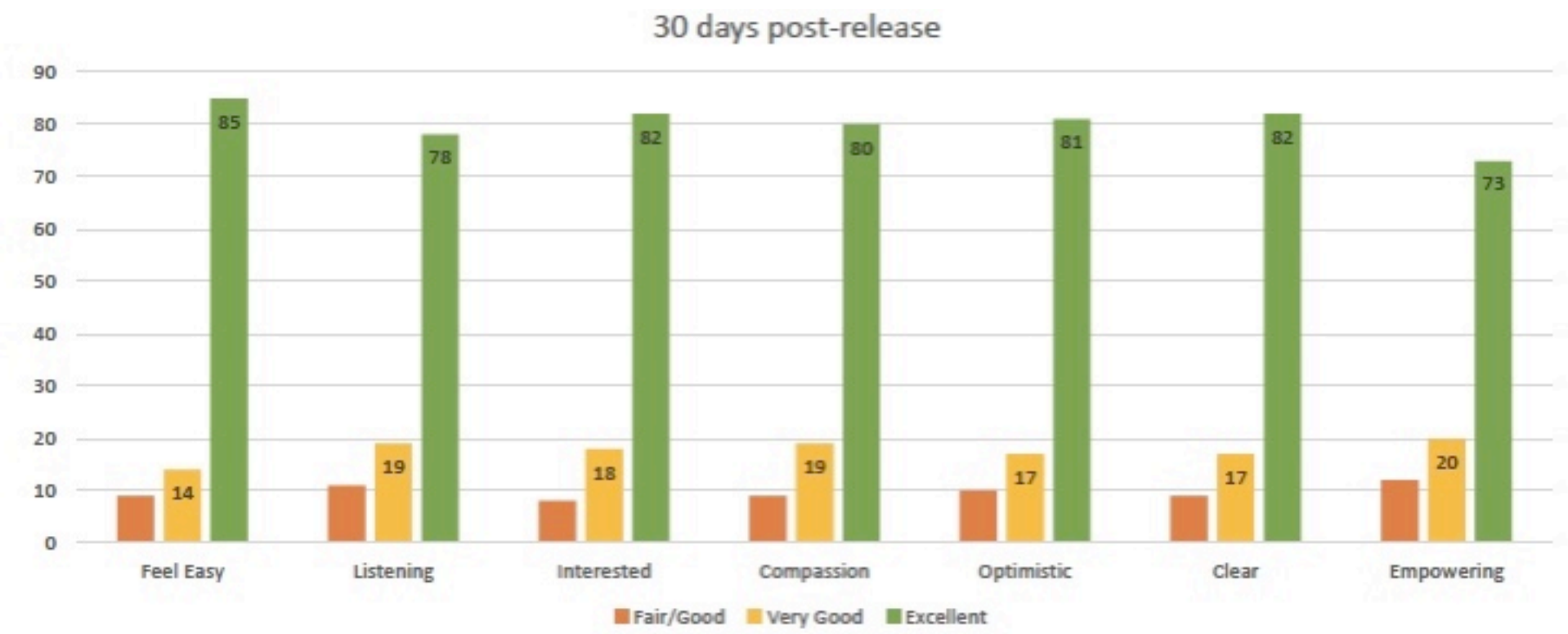
Pre-release

- Coaching on life skills
- Conduct client intake
- Provide appointment reminders
- Develop care plan
- Provide basic HIV treatment education

Post-release

- Coaching on life skills
- Provide appointment reminders
- Relationship building
- Discussions on disclosure
- Employment support

Client Satisfaction with TCC (N=113)



Client Outcomes

Linked to HIV Primary Care:

Time post-release	Number (%)
30 days	63 (28%)
90 days	102 (45%)
120 days	121 (53%)

Viral Suppression:

Viral suppression	Number (%)
Prior to enrollment	104 (58%)
90 days post	85 (77%)
120 days post	102 (80%)

Key findings:
Clients who had an encounter with their transitional care coordinator within one week post-release, were significantly more likely to link to HIV primary care within 30 days ($p < 0.001$)
Clients who had an encounter within 5 weeks post-release, were more likely to ever link to HIV primary care compared to those who did not have any post-release encounters ($p < 0.001$)

Client Outcomes

No difference depending on gender, length of time positive, or number of unmet needs.

We found a difference by race. Hispanic (OR 3.06) and Non-Hispanic Black (OR 3.54) clients were more likely to be linked to care within 30 days post-release than Non-Hispanic White clients and clients of other races

And a difference by age. Clients in the younger age group (30 years and under) were more likely to be linked to care within 30 days post-release in comparison to those clients in the 31 – 54 years age group (OR 2.3)

Clients who had one of the following services in jail: a social work visit, mental health visit, substance use disorder visit, or psych visit were more likely to link to care within 30 days post-release (OR 3.7)

Resources & Next Steps

Finding DEII Materials

https://targethiv.org/nextlevel

Tools for HRSA's Ryan White HIV/AIDS Program

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Dissemination of Evidence-Informed Interventions

DISSEMINATION OF EVIDENCE-INFORMED INTERVENTIONS

Project Goals and Resources

The end goal of the initiative is to produce and evaluate four evidence-informed Care And Treatment Interventions (CATIs) that are replicable; cost-effective; capable of producing optimal HIV care continuum outcomes; and easily adaptable to the changing health care environment. The multisite evaluation of this initiative will take a rigorous Implementation Science (IS) approach, which places greater emphasis on evaluation of the implementation process and cost analyses of the interventions, while seeking to improve the HIV care continuum outcomes of linkage, retention, re-engagement, and viral suppression among client participants.
Read the HRSA HAB Overview.

The four interventions are:

- Transitional Care Coordination: From Jail Intake to Community HIV Primary Care
- Integrating Buprenorphine Treatment for Opioid Use Disorder in HIV Primary Care
- Peer Linkage and Re-Engagement of HIV-Positive Women of Color
- Enhanced Patient Navigation for HIV-Positive Women of Color

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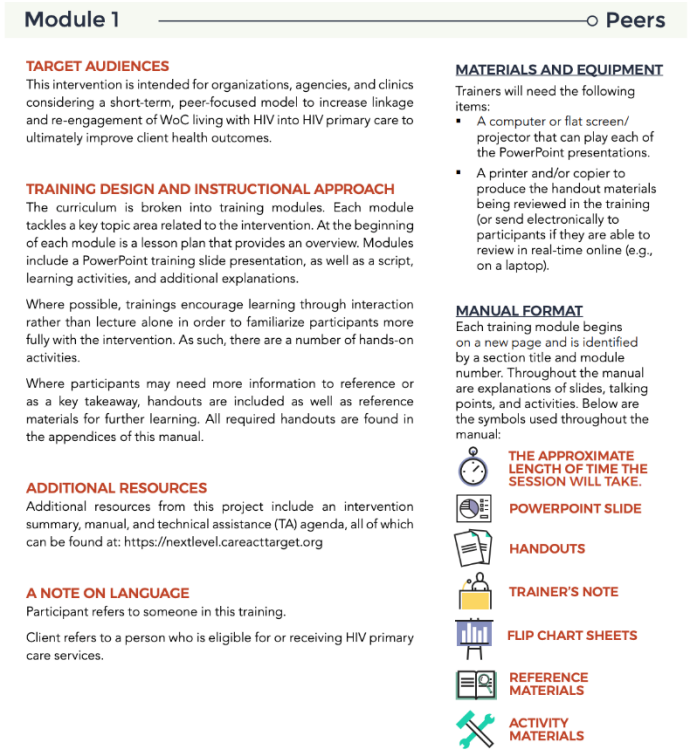
Funding:

Funding Mechanism: Cooperative Agreement

Training Materials

Training Manuals



Module 1 — Peers

TARGET AUDIENCES

This intervention is intended for organizations, agencies, and clinics considering a short-term, peer-focused model to increase linkage and re-engagement of WoC living with HIV into HIV primary care to ultimately improve client health outcomes.

TRAINING DESIGN AND INSTRUCTIONAL APPROACH

The curriculum is broken into training modules. Each module tackles a key topic area related to the intervention. At the beginning of each module is a lesson plan that provides an overview. Modules include a PowerPoint training slide presentation, as well as a script, learning activities, and additional explanations.

Where possible, trainings encourage learning through interaction rather than lecture alone in order to familiarize participants more fully with the intervention. As such, there are a number of hands-on activities.

Where participants may need more information to reference or as a key takeaway, handouts are included as well as reference materials for further learning. All required handouts are found in the appendices of this manual.

ADDITIONAL RESOURCES

Additional resources from this project include an intervention summary, manual, and technical assistance (TA) agenda, all of which can be found at: https://nextlevel.careacttarget.org

A NOTE ON LANGUAGE

Participant refers to someone in this training.

Client refers to a person who is eligible for or receiving HIV primary care services.

MATERIALS AND EQUIPMENT

Trainers will need the following items:

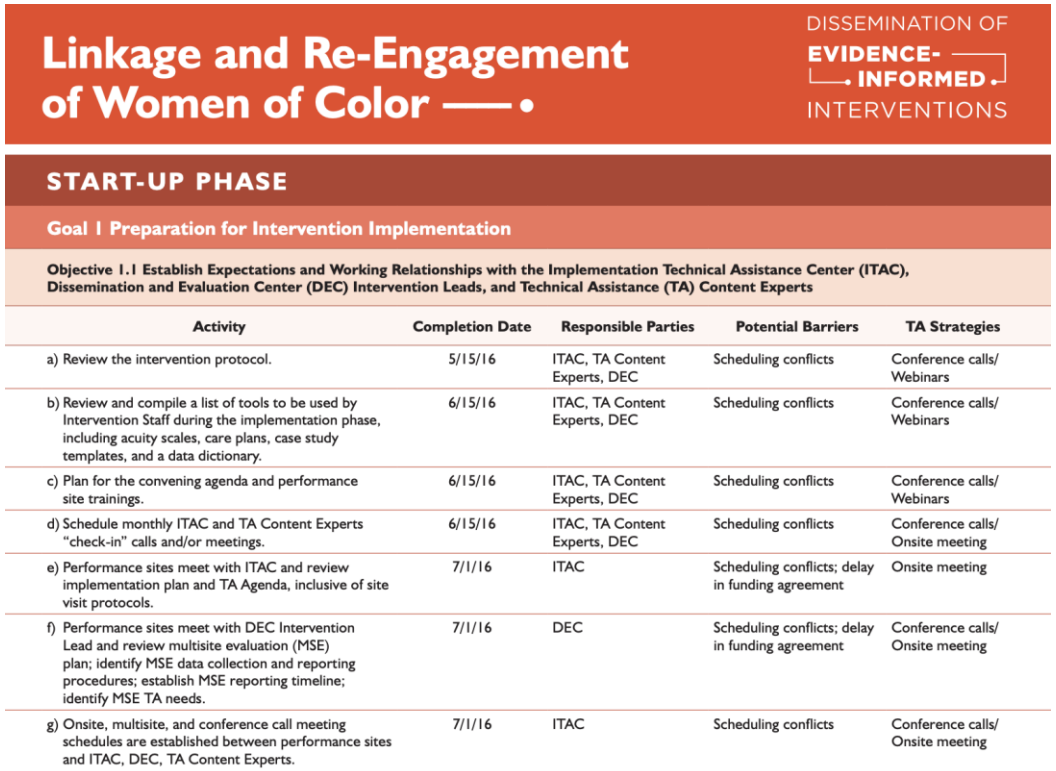
- A computer or flat screen/ projector that can play each of the PowerPoint presentations.
- A printer and/or copier to produce the handout materials being reviewed in the training (or send electronically to participants if they are able to review in real-time online (e.g., on a laptop).

MANUAL FORMAT

Each training module begins on a new page and is identified by a section title and module number. Throughout the manual are explanations of slides, talking points, and activities. Below are the symbols used throughout the manual:

- THE APPROXIMATE LENGTH OF TIME THE SESSION WILL TAKE.
- POWERPOINT SLIDE
- HANDOUTS
- TRAINER'S NOTE
- FLIP CHART SHEETS
- REFERENCE MATERIALS
- ACTIVITY MATERIALS

Technical Assistance Agendas



Linkage and Re-Engagement of Women of Color

DISSEMINATION OF EVIDENCE-INFORMED INTERVENTIONS

START-UP PHASE

Goal 1 Preparation for Intervention Implementation

Objective 1.1 Establish Expectations and Working Relationships with the Implementation Technical Assistance Center (ITAC), Dissemination and Evaluation Center (DEC) Intervention Leads, and Technical Assistance (TA) Content Experts

Activity	Completion Date	Responsible Parties	Potential Barriers	TA Strategies
a) Review the intervention protocol.	5/15/16	ITAC, TA Content Experts, DEC	Scheduling conflicts	Conference calls/ Webinars
b) Review and compile a list of tools to be used by Intervention Staff during the implementation phase, including acuity scales, care plans, case study templates, and a data dictionary.	6/15/16	ITAC, TA Content Experts, DEC	Scheduling conflicts	Conference calls/ Webinars
c) Plan for the convening agenda and performance site trainings.	6/15/16	ITAC, TA Content Experts, DEC	Scheduling conflicts	Conference calls/ Webinars
d) Schedule monthly ITAC and TA Content Experts "check-in" calls and/or meetings.	6/15/16	ITAC, TA Content Experts, DEC	Scheduling conflicts	Conference calls/ Onsite meeting
e) Performance sites meet with ITAC and review implementation plan and TA Agenda, inclusive of site visit protocols.	7/1/16	ITAC	Scheduling conflicts; delay in funding agreement	Onsite meeting
f) Performance sites meet with DEC Intervention Lead and review multisite evaluation (MSE) plan; identify MSE data collection and reporting procedures; establish MSE reporting timeline; identify MSE TA needs.	7/1/16	DEC	Scheduling conflicts; delay in funding agreement	Conference calls/ Onsite meeting
g) Onsite, multisite, and conference call meeting schedules are established between performance sites and ITAC, DEC, TA Content Experts.	7/1/16	ITAC	Scheduling conflicts	Conference calls/ Onsite meeting

Intervention Manuals

Contains step-by-step guidance on:

- Pre-implementation activities, including resources and infrastructure needed for successful implementation
- Intervention implementation
- Integrating and sustaining interventions

Contains resources to support replication such as:

- Logic models
- Job descriptions
- Client handouts
- Templates for care plans

Site Spotlights

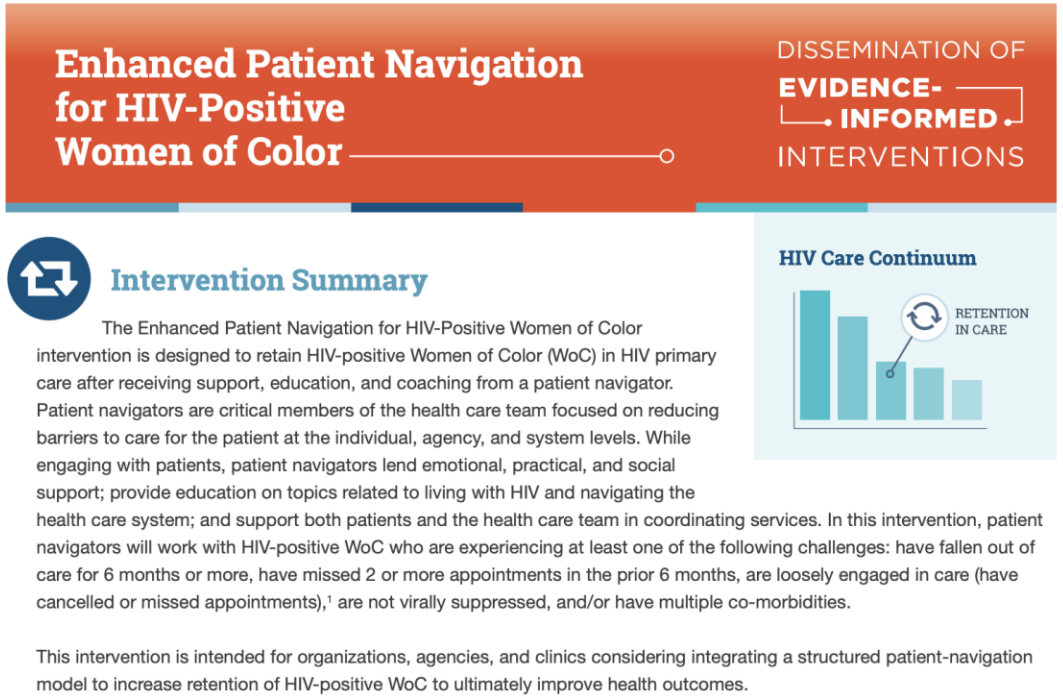
Site spotlights highlight the experience of implementation site-staff.

They provide practical, actionable tips that all Ryan White providers can use when working to support people with HIV.

Intervention Fact Sheets

Designed to provide an overview to the intervention, these fact sheets include:

- An intervention summary
- A review of the published literature related to the intervention
- The theoretical basis for the intervention
- Core intervention components and activities and programmatic requirements
- Staffing requirements
- Additional resources



Enhanced Patient Navigation for HIV-Positive Women of Color

DISSEMINATION OF EVIDENCE-INFORMED INTERVENTIONS

Intervention Summary

HIV Care Continuum

RETENTION IN CARE

The Enhanced Patient Navigation for HIV-Positive Women of Color intervention is designed to retain HIV-positive Women of Color (WoC) in HIV primary care after receiving support, education, and coaching from a patient navigator. Patient navigators are critical members of the health care team focused on reducing barriers to care for the patient at the individual, agency, and system levels. While engaging with patients, patient navigators lend emotional, practical, and social support; provide education on topics related to living with HIV and navigating the health care system; and support both patients and the health care team in coordinating services. In this intervention, patient navigators will work with HIV-positive WoC who are experiencing at least one of the following challenges: have fallen out of care for 6 months or more, have missed 2 or more appointments in the prior 6 months, are loosely engaged in care (have cancelled or missed appointments),[1] are not virally suppressed, and/or have multiple co-morbidities.

This intervention is intended for organizations, agencies, and clinics considering integrating a structured patient-navigation model to increase retention of HIV-positive WoC to ultimately improve health outcomes.

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DISSEMINATION OF
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