Maricopa County Jail Project

Providing services to people with HIV who are justice-involved
Carmen Batista, Program Manager for the Phoenix EMA
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Disclaimer

Presenter, Carmen Batista

Carmen Batista is the Ryan White Part A Program Manager for the Phoenix EMA which includes Maricopa and Pinal Counties. She received her bachelors and master's degrees in Public Health from the University of Arizona.
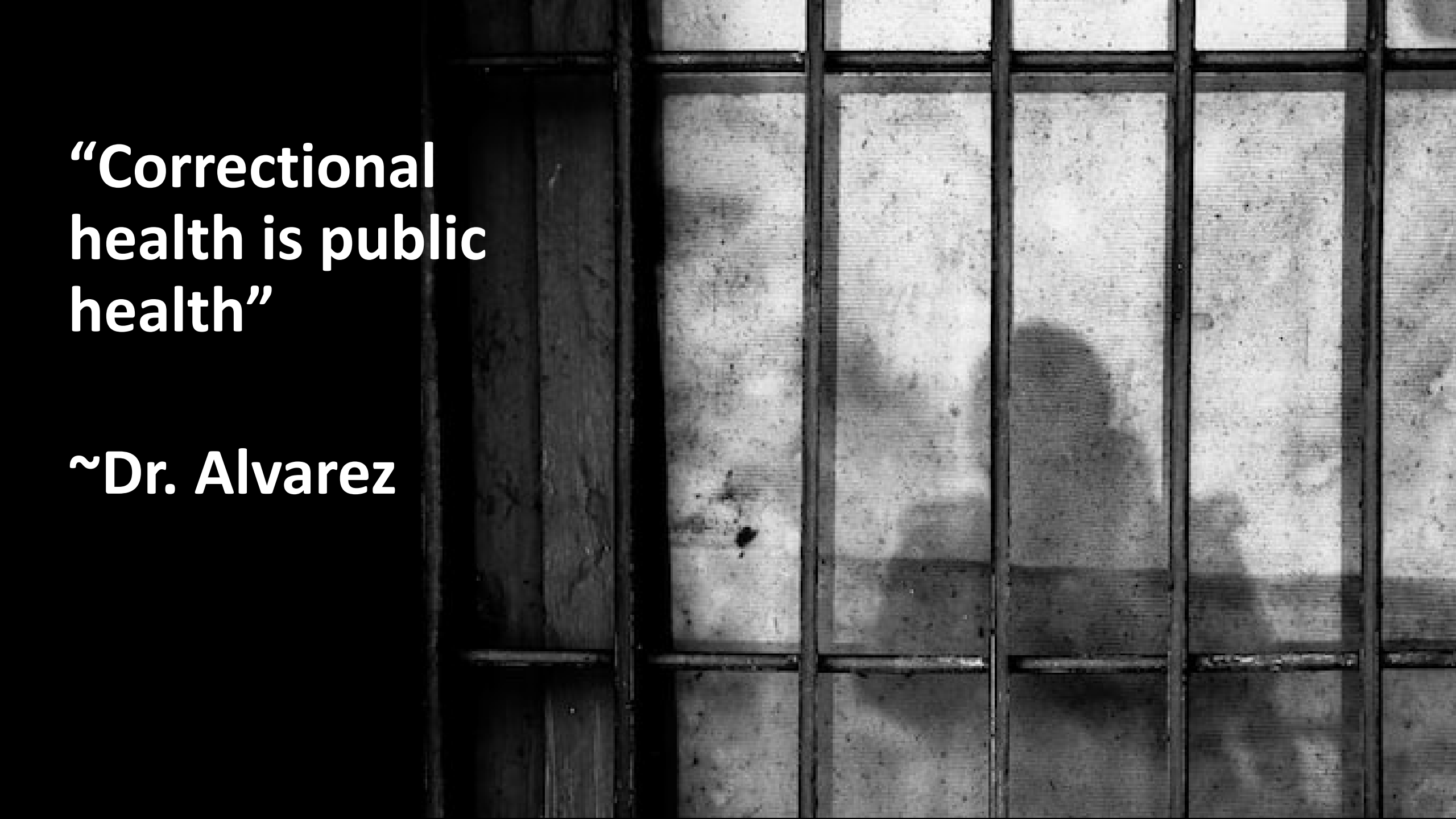
Carmen grew up in Ryan White, starting her public health career in 2007 as the Ryan White Part A Data Management Assistant responsible for all the consumer satisfaction surveys. She moved into various quality management positions and then Ryan White administration focused roles. She spent two and a half years as Arizona's Ryan White Part B and ADAP director. Carmen then took a break from HIV work to be Arizona's Office Chief of Chronic Disease and then returned home to Maricopa County to lead their Part A and Ending the HIV Epidemic programs.

Carmen is known for having hope in the capacity to end the HIV epidemic, client-centered approaches, innovative and integrated eligibility projects, and as a champion of lived experiences and inclusion.

Coordinated System of Care – Keys to Success

- Maricopa County is the 4th largest County in the country

- Maricopa County Department of Public Health is the Ryan White Part A recipient and an EHE Ryan White recipient

- Approximately 4,500 Ryan White clients annually

- Average between 70 and 100 PWH in the jails on a daily basis

- Offered HIV Opt-out testing initiative since 2013
  - Initially paired with case management and then medical services, after approval

"Correctional health is public health"

~Dr. Alvarez

Overview of Maricopa County Jail Project

- HRSA-funded Ryan White and EHE programs

- Addresses HIV health outcomes for justice involved populations

- Partnered with Correctional Health Services and Public Health prevention staff

- Created new data communication systems and bundled services for clients upon release

- Funding prescribing staff within correctional system has expedited linkage to care times and significantly improved viral suppression rates

Maricopa County Jail Project Purpose/Goals

- Implement opt-out HIV testing in a jail-based setting

- Decrease linkage to care time for people with HIV within a correctional environment

- Improve viral suppression rates among justice involved populations

- Improve linkage to care after release to the community

Reaching Our Goals

Maricopa Jail Project

STAKEHOLDER BUY IN

Correctional Health Medical Director, Public Health, County Board of Supervisors, HIV Prevention.

POLICIES AND PROCEDURES

Identify client service locations, medical supervision, develop and implement policies and procedures for care.

DEDICATED STAFF

Nurse Case Manager + Social Worker for linkages to care. Procure CHS staff training.

SERVE CLIENTS

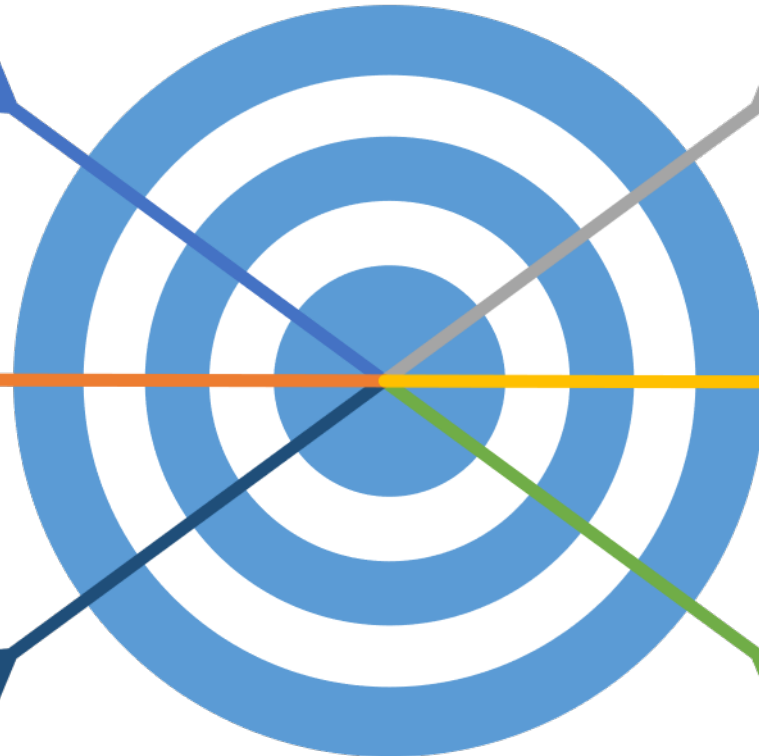Provide confidential, high-quality care to clients.

IDENTIFY CLIENTS

Implement Opt-out HIV testing. Establish reports and systems to count and track HIV+ clients within the jails.

TRACK METRICS

Monitor viral suppression and linkage to care timeframe.

Intervention Model - Stakeholders

Ryan White Part A/EHE

Funder & Providers

Pay for dedicated Nurse Practitioner and Social Worker staff. Do not duplicate services in alignment with PCN 18-02. Secure HRSA approval.

Correctional Health Services
Partner & Co-Funder

Pay Medical Assistant staff for blood-based HIV tests during assessments, provide medical supervision, staff training.

Public Health

Co-Founder

Process HIV tests, coordinate notifications of newly diagnosed individuals, partner services.

Clients

Co-Founders

Consent to treatment. Participate in partner services interviews. Provide information about needs and challenges.

Challenges and Solutions

CHALLENGES

- Challenging to get buy-in for jail-based HIV opt-out project. Concerns regarding treatment costs.
- Correctional Environments are physically intimidating and have unique safety requirements.
- New data systems can make it difficult to identify patients and track who's in jail.
- Released clients' 1st priority is often NOT connecting to medical care.

SOLUTIONS

- Send medical people to engage Medical Director as a champion before expanding to other stakeholders.
- Use existing Correctional Health training and hire strong, independent, solution focused staff.
- Dedicate staff time to identify clients and create systems for follow up.
- Address immediate needs such as emergency housing, food, and employment with external staff.

Challenges in *Depth*

Administrative:

- Ensuring that services are not duplicated, per PCN 18-02

- Understanding payor of last resort differences between jails and prisons

- Approval for Memorandum of Understanding

- Medication costs

- Defining metrics to track

Clinical/Programmatic:

- Needed new policies and protocols for providers

- Jail clients can be released at any time

- Clients can disappear after release

- Identifying housing after release

- Client confidentiality

Facilitators of Success *in Depth*

- Data systems and reports
- Coordinated system of care
- Right staff with the right training
- Strong stakeholder engagement
- Emergency gap lodging

Adding EHE Jump Start Program

Problem: Maricopa County struggled to link clients to care after release from jail

- Clients had other priorities besides accessing medical care
- Some patients were homeless
- Contact information didn't connect
- Jail-based staff didn't have time to meet clients outside of the jail
- And more…

Solution Step 1: Engaged Public Health Communicable Disease Investigations Leadership to identify opportunities to partner

Solution Step 2: Paperwork

✓ Developed interdepartmental agreement and budget to staff a Social Worker position within the Communicable Disease Investigation Unit

✓ Updated Memorandum of Understanding between the programs

Adding EHE Jump Start Program (con't)

Solution Step 3: **Developed policies and procedures about how the programs would work together**

- ✓ Shared electronic spreadsheet to communicate client status and who was currently in the jail or leaving

Solution Step 4: **Engaged all Stakeholders to address gaps**

- ✓ Additional communication and refinement of the initial HIV notification process

- ✓ Adapt to lower staffing levels related to COVID-19 pandemic

Solution Step 5: Care Coordination

- ✓ Joint visits brought the most success. Laptop for notes has also expedited services!

- ✓ Develop client release plan and potential resource bundles to engage in care

Solution Step 6: Sustainability
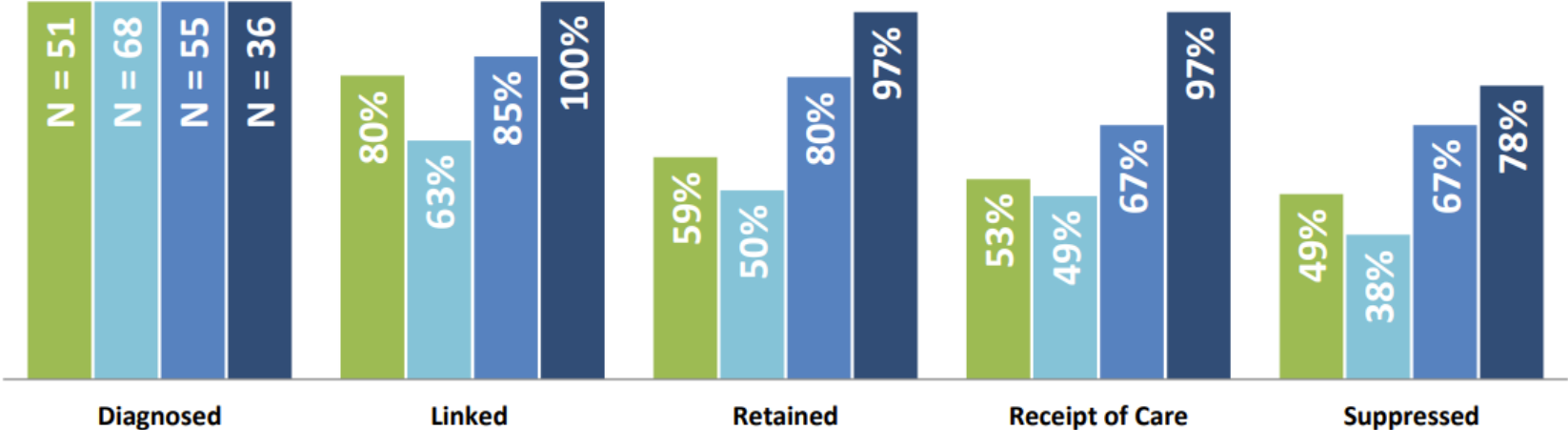
- ✓ Integrating into RWHAP and EHE funds

Outcomes

Maricopa County Public Health
WeArePublicHealth.org

Maricopa County Jail Project

2020 Continuum Data

Year to Year Continuum

■ 2017 ■ 2018 ■ 2019 ■ 2020

Category	2017	2018	2019	2020
Diagnosed	N = 51	N = 68	N = 55	N = 36
Linked	80%	63%	85%	100%
Retained	59%	50%	80%	97%
Receipt of Care	53%	49%	67%	97%
Suppressed	49%	38%	67%	78%

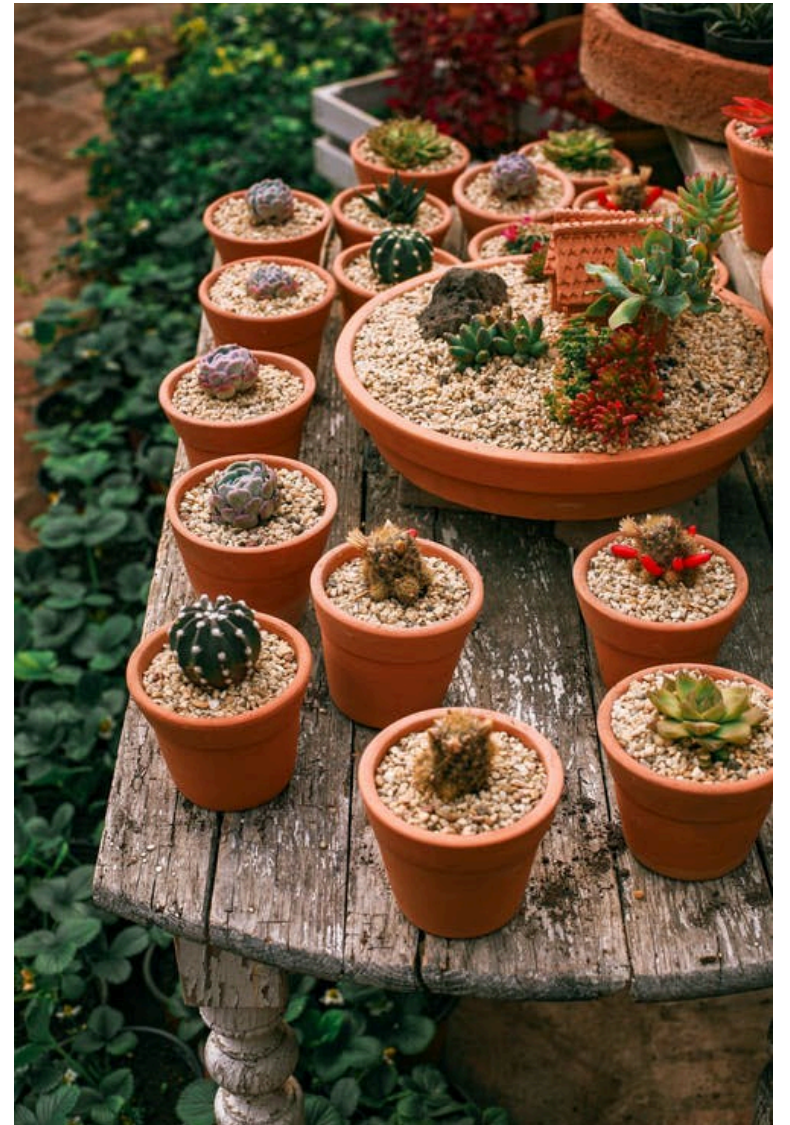**2020 Core Service Category Goal**

EIS Linkage

Goal: 88%
Actual: 100%

Client 1 Testimonial

" Thank you so much for listening to me about wanting to change my 2-pill regimen to 1 pill daily. I feel so much better on the new medication."

Client 2 Testimonial

" I never trusted anyone before, but you showed me kindness." So, I will start taking my medication."

Client 3 Testimonial

Letter received from a prior patient that is now incarcerated in Prison.

"Ms. Quinn , you were so helpful when I was at Maricopa County Jail, I am hoping you can give me information for resources when I am released from prison."

Sustaining the Gains

- Use grant funds to support ongoing continuing medical education
- Identify at least two staff – one with an internal medical focus, and one with an external focus
- Support succession planning by bringing on junior staff
- Monitor test numbers to identify when re-training HIV testing staff
- Maintain a data reporting system to be used in evaluating this process and sharing with other facilities
- Leverage EHE funding to add staff that is focused on securing linkage after release

Lessons Learned & Recommendations

1. Let clients help inform a bundle of client valued services (emergency housing, food voucher, clothing) to encourage connection after release

2. Established processes will need tending over time – retraining of staff for HIV test messaging

3. Budget for laptops to take notes

4. Figure out how to accept collect calls from jail

5. Build strong relationships and celebrate success so that stakeholders are open to addressing gaps and overcoming barriers

Resources

[HRSA HAB PCN 18-02](#)

On Target HIV:

[Beyond the Walls](#)

[Jail: Time for Testing](#)

[Navigator Case Management](#)

[Criminal Justice Initiative](#) - Addressing Continuum of Care for People with HIV and/or hepatitis C from Incarceration to Re-Entry

Contact Info

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Participant Feedback

Please use the following link to give your feedback

https://www.surveymonkey.com/r/8B8BYXT