Jails

Transitional Care Coordination

From Jail Intake to Community HIV Primary Care

DISSEMINATION OF

EVIDENCE-INFORMED

INTERVENTIONS

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TABLE OF CONTENTS

INTRODUCTION

PURPOSE AND BACKGROUND

The central aim of Transitional Care Coordination (TCC) is to facilitate the linkage of a client living with HIV to community-based HIV primary care and treatment services after incarceration in jail.

The jail offers an important window from which to conduct a public health intervention as it facilitates engagement with typically hard-to-reach people living with HIV (PLWH). Intervention activities include identifying PLWH as well as "right fit" community resources, developing a transitional care plan to address health and social service needs from jail intake through the critical first few months after incarceration, and coordinating activities needed to facilitate linkage to care after incarceration. Activities need to be initiated in the jail soon after an individual is incarcerated (ideally within 48 hours) because jail stays are often brief and the uncertainty around discharge dates and times presents a shorter window of opportunity to provide intervention services.

When designing a service model for transitioning clients from one system to another, in this case from jail to community health care, barriers need to be removed and relationships must be established.

This curriculum helps address the needs of organizations wanting to create a more unified health care and service delivery system between the community and the jail setting, including strategies to remove barriers for individuals and build relationships between programs and across systems. The curricula also walks trainers through important intervention topics and steps of TCC, as well as recommended training methodologies.

This curriculum is based on activities and trainings from the U.S. Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA), HIV/AIDS Bureau (HAB) "Dissemination of Evidence-Informed Interventions" Project.

TARGET AUDIENCES

The target audiences for this curriculum include AIDS service organizations, community-based organizations, Ryan White HIV/AIDS Program recipients and sub-recipients, and local health departments. The audience will ideally have a pre-existing relationship with their local jail(s) and buy-in for increasing service provision within the correctional facilities and beyond the walls. Jail health administrators may also find the information herein to be helpful in discussions around establishing or modifying a jail linkage program.

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 material for further learning.

ADDITIONAL RESOURCES

Care and Treatment Interventions (CATIs) are a series of evidence-informed interventions supported by HRSA/HAB to promote linkage, retention and viral suppression across Ryan White Programs. The CATIs replicate four previous HRSA/ HAB/SPNS initiatives. The CATI Manual provides the intervention protocol and implementation guidance; it will be linked throughout this curriculum. Additional TCC resources from this project include an intervention summary, sustainability report, evaluation protocol, and technical assistance (TA) agenda, all of which can be found at: *https://targethiv.org/deii/deii-transitional-care*

A NOTE ON LANGUAGE

Participant refers to someone in this training

Client refers to a person who is receiving services through the jails intervention

MATERIALS AND EQUIPMENT

Trainers will need the following items:

- A computer and projector that can play each of the PowerPoint presentations
- A screen, television, or blank wall on which to project each presentation
- A printer and/or copier to produce the training handouts. Alternatively, training materials can be sent to participants electronically, if they are able to review them in real-time on a laptop or tablet.
- Binders or folders to collate printed handouts, slides, and/or reference materials

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

Jails

MODULE 1:
Introduction to the Transitional Care Coordination model

Topics Covered: Overview of the Transitional Care Coordination (TCC) model including its key principles, professional tenets, and Core Concepts

OBJECTIVES

By the end of this module, participants will be able to:

- Describe the background and need for Transitional Care Coordination (TCC) and specify goals that may be achieved
- Understand the conceptual framework for the TCC Model
- Understand the key social work and public health guiding principles that serve as the foundation of the TCC model and learn the definitions of the Core Concepts:
  - engagement and termination
  - warm transition
  - linkages to care
  - continuity of care
- Define and describe implementation fundamentals: approaches, tools, techniques to remove barriers, and establishing relationships
- Demonstrate competency in applying the guiding principles to implement the Core Concepts at the client, program, and systems levels
- Describe measures/indicators used for tracking program implementation and outcomes
- Define methodologies toward successful program implementation
- Demonstrate how to use and understand the benefits of a "Wish List"

MATERIALS NEEDED

POWERPOINT

HANDOUTS

FLIP CHART SHEETS

- Flip chart sheets (sticky note variety preferred) or dry erase board(s) and eraser, with markers

REFERENCE MATERIALS

- Transitional Care Coordination Intervention Summary: *https://targethiv.org/deii/deii-transitional-care*
- Care and Treatment Interventions (CATIs) Manual: Transitional Care Coordination: From Jail Intake to Community HIV Primary Care: *https://targethiv.org/deii/deii-transitional-care*
- Cruzado-Quinones, J, Jordan, AO. et al. Tool + Tips for Providing Transitional Care Coordination Handbook (Chapters 1 & 2). *https://careacttarget.org/ihip/tools-tips-providing-transitional-care-coordination*
- Jordan AO, Cohen LR, Harriman G, Teixeira PA, Cruzado-Quinones J, Venters H. Transitional Care Coordination in New York City Jails: Facilitating Linkages to Care for People with HIV Returning Home from Rikers Island. AIDS and Behavior. 2013. (Suppl 2: S212-9).
- Teixeira, PA Jordan, AO et al. Health Outcomes for People living with HIV Released from the NYC Jail System with a Transitional Care-Coordination Plan. Am J Public Health. 2015; 105(2):351-57. *www.ncbi.nlm.nih.gov/pmc/articles/PMC4318285/*
- Jordan, AO. (2015) Linkages and Care Engagement: From NYC Jail to Community Provider. Health Disparities Collaborative Webinar: Addressing Health Disparities Among Incarcerated and Recently Incarcerated Populations. AIDS Education and Training Center / National Resource Center. *https://aidsetc.org/resource/health-disparities-collaborative-webinar-addressing-health-disparities-among-incarcerated*
- Jordan, AO (2018) The NYC Experience: SPNS Enhancing Linkages: The Finale.
- Lincoln T, Desabrais M, Simon D, Jordan A, Cruzado-Quinones J, Teixeira PA. (2013). Jail Linkages: Two Evidence-Based Approaches to Linkages to Care in the Community, Continuity of Care Models from Baystate MC and NYC Health. National Commission on Correctional Health Care National Conference.

Key Words and Phrases

- *Warm Transition*
- *Remove Barriers*
- *Establish Relationships*
- *Outreach*
- *Engagement*
- *Termination*
- *Linkages To Care*
- *Continuity Of Care*
- *Access To Care*
- *Wish List*
- *Warm Fuzzy*
- *Cold Prickly*
- *Maintenance In Care*

Method(s) of Instruction

Co-facilitated lecture using a **"tag team"** approach, facilitated discussion, and activities

PROCESS

In this activity you will:

- Welcome participants
- Introduce the training
- Discuss logistics and obtain mutual agreement around ground rules
- Review the background and need for TCC
  - Provide reference materials to participants and have them review prior to the training.
  - Training materials, including slides, handouts, and reference materials, can be provided electronically, if all participants will have access to a laptop or tablet. Alternatively, materials can be printed and collated in binders or folders by module. Participants should then keep printed materials with them for the duration of the training.
- Arrange chairs around multiple tables (ideally round) with natural homogeneous groups sitting together.
- Stick flip chart sheets to walls adjacent to each table/section with one for each group.

INTRODUCTIONS:

Presenters and participants introduce themselves, the organization they represent and their role on the project. Each participant is asked to share what they hope to learn from the training (the training participant's goals, see slide 1).

ENGAGE THE PARTICIPANTS:

Follow Instructions for each unit. Rather than reading examples shown on the slide, engage participants in providing their own "good questions" (slide 11) or past experience/expertise with applying social work or public health principles (slides 10 and 11).

FACILITATED DISCUSSION:

As part of the need for patience and persistent (slide 20) discuss client's "Wish List" and how to use motivational interviewing techniques, short and long-term goal setting, and other tools and techniques to guide the development of a client's "Wish List." Move from this facilitated discussion to the end of module "Wrap up," reviewing session participants' collective training goals. Trainers will review all goals to determine what lessons have been covered and what may be addressed at a later session.

HANDOUTS:

Have participants cross check/reference sections as you review relevant slides, and note how the TCC Intervention Summary, the CATI Manual, and Chapters 1 & 2 of the Handbook further detail and reinforce the Core Concepts and implementation strategies.

Collect all notes and materials after the session–if using white board rather than flip chart sheets, take a photo before erasing the board.

The approximate length of time the session will take.

Total: 90 minutes

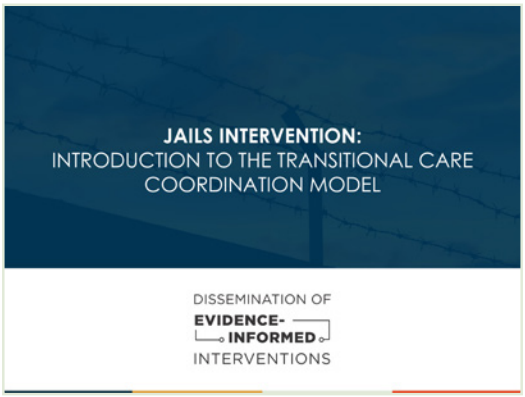
Ice breaker:
10 minutes

5 units/20 slides:
60 minutes

Facilitated discussion:
10 minutes

Wrap-up:
10 minutes

UNIT 1



SLIDE 1: Facilitator #1

Welcome participants

Introductions:

- Facilitators and participants introduce themselves, the organization they represent, and their role on the project.
- Explain the objectives of the training (from the Lesson Plan)
- Each participant is asked to share what they hope to learn from the training (the participant's training goals).

Facilitator #2

Activity: Conduct Ice Breaker activity

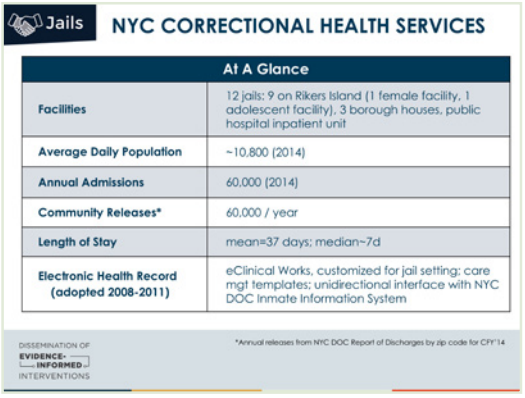
Ice Breaker: As part of introductory session, each participant's training goals are written on a blank flip chart sheet (ideally sticky note type) or dry erase board.

SLIDE 2: Facilitator #1

This is an aerial of view of Rikers Island and the other NYC Jails.

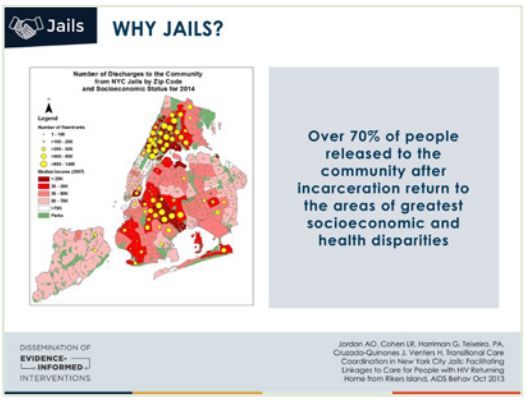
- The purpose of this is for you to have a visual sense of where the Transitional Care Coordination (TCC) intervention work began and the complex systems involved.
- The conceptual model for Transitional Care Coordination (TCC) intervention was created in New York City (NYC) as part of the "Enhancing Linkages to HIV Primary Care and Services in Jail Settings" (EnhanceLink) project, funded by HHS, HRSA, HAB, SPNS. Examples used throughout the curriculum are based on the experience of the NYC team

Citation: Jordan, AO. (2015) Linkages and Care Engagement: From NYC Jail to Community Provider. Health Disparities Collaborative Webinar: Addressing Health Disparities Among Incarcerated and Recently Incarcerated Populations AIDS Education and Training Center / National Resource Center. *https://aidsetc.org/resource/health-disparities-collaborative-webinar-addressing-health-disparities-among-incarcerated.*



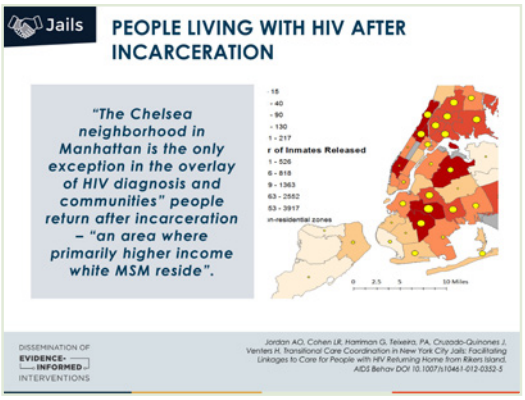
SLIDE 3: Facilitator #1

- As you can see from the last slide, there were 12 jails in NYC–9 on Rikers Island and 3 in community locations.
- When you look at the average length of stay keep in mind that NYC has a bi-modal system–think of a graph that depicts a camel with 2 humps–meaning that no single one is average.
- More than half of the population will be released in a week or less.
- Having an electronic health record has facilitated information sharing and providing care in as seamless a way as possible, despite frequent transfer of clients among and between jails facilities.



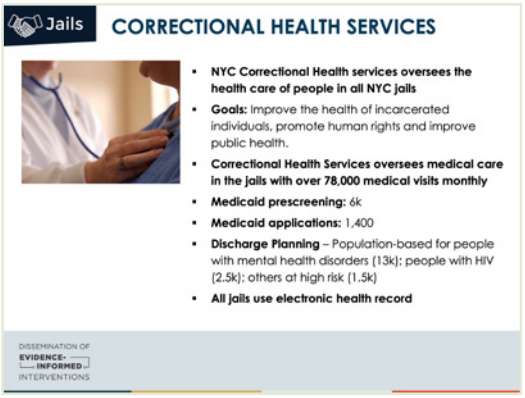
SLIDE 4: Facilitator #1

- Why jails? This illustrates why correctional health is public health.
- When Tom Frieden (former Commissioner of the New York City Department of Health and Mental Hygiene and former director of the CDC) presented the need for a solution to engaging people in primary care after incarceration, he said, as an epidemiologist, in order to address the public health needs of NYC, he would draw a big circle around Rikers Island.
- As the slide reads, over 70% of people in NYC released to the community after incarceration return to the areas of greatest socio-economic and health disparities. It is not that people in these communities commit more crimes, rather this is the depiction of a system where poor people in communities of color are more likely to be detained due to structural inequities and other socioeconomic and health disparities (aka structural racism).



SLIDE 5: Facilitator #1

- For people living with HIV (PLWH), the overlay described in the previous slide is the same, except for Chelsea where primarily white men who have sex with men (MSM) reside. These individuals are not frequently incarcerated–another indicator of systemic health inequities.



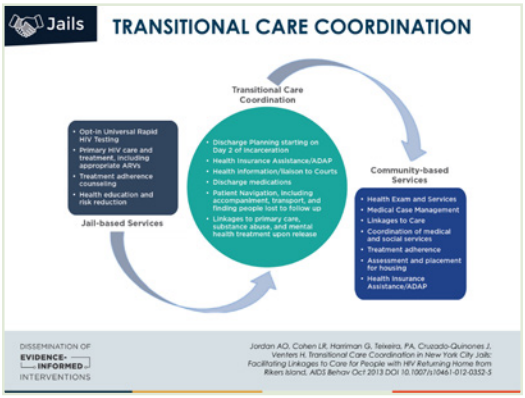
SLIDE 6: Facilitator #1

- Why correctional health? As part of the City's public health system, NYC Correctional Health Services oversees the health care in the jails and also responds to its larger public health and human rights mission—leading to innovations and integration between jail and community health agencies.
- Think about what entities are responsible in your jurisdictions. Are their missions aligned with public health and human rights as well as patient care? What might be the motivations when local jurisdictions hire for-profit correctional health businesses?

Facilitator #2

- Circulate among the participant tables. Guide participants with locating reference sections in material and identify questions for facilitated discussion.

UNIT 2



SLIDE 7: Facilitator #1

This is the conceptual model for Transitional Care Coordination. This model was created to address the HIV Care Continuum in response to the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), HIV/AIDS Bureau (HAB), Special Projects of National Significance (SPNS) "Enhancing Linkages to HIV Primary Care and Services in Jail Settings" (EnhanceLink) funding opportunity announcement and represents the outgrowth of the NYC proposal and how the final proposal was put into action.

When you look at this model, think of the box on the left as the jail health system and the box on the right as the community health care system. The model is designed as a way to link these two systems by creating a bridge between them. Think of the circle in the middle as a big hug which has implications for systems, programs, and individual interventions.

Consider what "cold, institutional" or "warm, friendly" systems look like. Generally correctional systems in the United States are cold and impersonal with concrete walls and razor wire. Some hospital institutions may also create barriers between individuals and care providers (e.g., the need for providing proof of insurance to someone behind a glass enclosure before saying, "Hello. How are you?") *[Solicit other examples from participants/ Co-Facilitator]*

These systems often work independently and without consideration of their impact on other systems. For example, consider what the impact of handcuffing a person to a row of attached seats waiting to see a provider in the jail might be when the person is told by a community clinic to have a seat. *[Solicit other examples from participants/Co-Facilitator]*

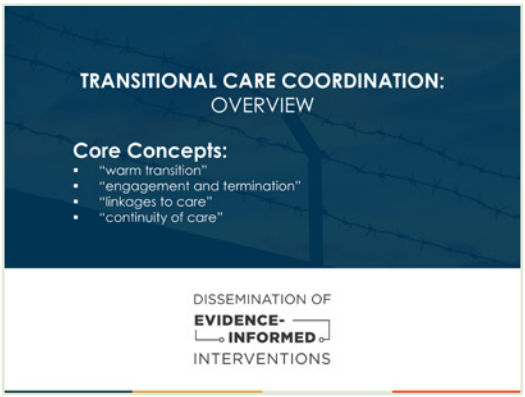
The TCC model facilitates coordination and collaboration among and between traditional systems to facilitate a "warm transition" at the systems, program, and individual levels.

Start thinking about your system in comparison to this model and consider how this model may help facilitate access to care (i.e., access to health insurance, housing, transportation assistance).

Facilitator #2:

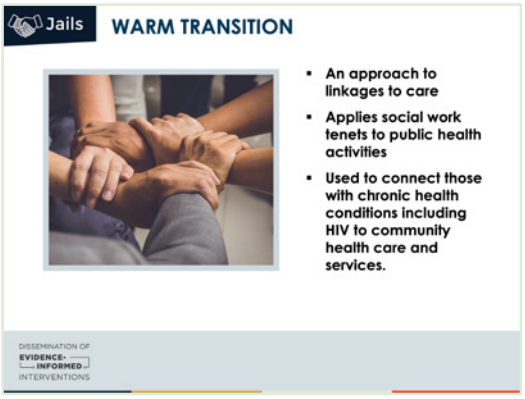
Circulate among the participant tables. Guide participants with locating reference sections in material and identify questions for facilitated discussion.

UNIT 3



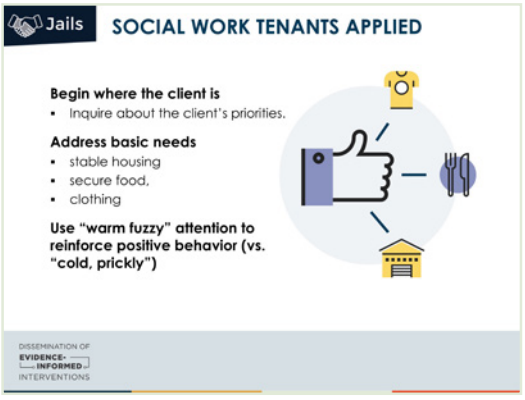
SLIDE 8: Facilitator #1

- These Core Concepts provide the principles that underpin the activities conducted as part of the Transitional Care Coordination intervention. These conceptual frameworks are rooted in social work tenets and public health principles.



SLIDE 9: Facitlator #1

- A Warm Transition applies social work tenets to public health practices. This approach creates a more effective engagement opportunity and results in increased retention in care of individuals with chronic conditions.

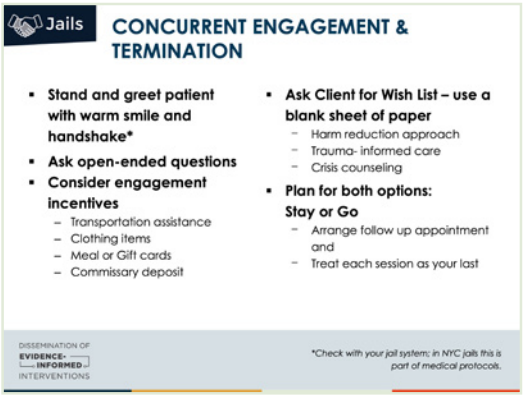


SLIDE 10: Facilitator #1

- Social work tenets applied to a warm transition include the fundamentals of beginning where the client is and addressing basic needs–Maslow was right–food, clothing, and shelter come first.
- It is a fundamental part of human behavior and the social environment to seek attention. If seeking attention in a positive way doesn't result in "warm, fuzzy" attention then people will seek negative ("cold, prickly") attention.
- Can you think of examples of warm fuzzies (e.g., tribbles) and cold pricklies (e.g., sea urchins)? *[Solicit other examples from participants/Co-Facilitator]*
- Note, if someone doesn't receive positive attention, as happens with many people who reside in institutions (think about those in the foster care to prison pipeline), they learn a pattern of seeking negative attention. However, a person seeking negative attention will respond (many even positively) to positive attention (e.g., smile, caring).

SLIDE 11: Facilitator #1

- If you ask a client residing in a jail facility "What's your address?" they may answer "3 upper" or ask if you mean the address corrections has or the one where they stay—or even give you the mailing address for the jail facility.
- Clients may be concerned that you are part of the system that is locking them up and think you might be asking for parole or probation reasons.
- Consider asking better questions that provide the information you need, such as, "How can I reach you to give you the information and resources you need after incarceration?"
- Another strategy to consider is asking about family support and if they call home regularly. One client said, "I always call my Mom on Sundays. If you call her and leave a message I'll call you back." *[Solicit other strategies from participants/Co-Facilitator]*
- Ask when and where you might meet up in the community rather than stating you will go visit their home address on a specified date/time. They may have personal reasons to meet elsewhere. [Skip as needed based on time remaining if participants provided other good examples]
- For people who are unstably housed, ask to meet at a program location they regularly go (e.g., soup kitchen, social club, or drop-in center). [*Skip as needed based on time remaining if participants provide other good examples]*
- Clients with health insurance may lose access to benefits when incarcerated. Continuity of benefits may be navigated during incarceration. For example, even though health care services provided in a correctional setting cannot be billed to Medicaid under Social Security law, Medicaid, Ryan White HIV/AIDS Program Part B, and AIDS Drug Assistance Program (ADAP) applications can be initiated in jail settings and the local social service district may "suspend" rather than "terminate" benefits, making it easier to arrange for community appointments after incarceration. Please note that Ryan White Part A funds can be used to facilitate TCC from jail to the community.
- Transportation assistance may mean transportation fare or a ride (e.g., car service, Uber and Lyft) as well as accompaniment on public transportation, in order to facilitate access to care and treatment. The availability of public transportation as well as the location and hours that a client is released to the community from jail may also impact their access to transportation.



SLIDE 12: Facilitator #1

- In social work school they teach you that it takes 6 weeks to terminate a therapeutic relationship; for people detained in local jails, length of stay is unpredictable. How do you reconcile this dilemma?
- Concurrent engagement and termination is the equivalent of the social work Olympics!
- **Plan for both possibilities:** 1) either the client will stay in the jail and see you at the next appointment (in a week or so) or 2) they will return to the community.
- At each session you will need two plans: one for if they stay and the other for if they go.
- Crisis intervention with motivational interviewing may be needed.
- Getting consent to contact the client's defense attorney may help. While most folks detained in jails are working to get their bail paid by a loved one, overburdened court systems may lead to multiple appearances before the case is resolved.

Facilitator #2:

- Circulate among the participant tables. Guide participants with locating reference sections in material and identify questions for Facilitated Discussion.

UNIT 4

SLIDE 13: Facilitator #2

- **This model can be boiled down to two core principles:** 1) removing barriers and 2) establishing relationships. Barriers exist within every level: systematic, organizational, and individual.
- With the client, ask about basic needs (e.g., food, clothing, and housing) and linkage to primary care and continued treatment in the community at every session. Make sure that if the client returned to the community today, that they have a place to stay and a way to get medication today and to a provider within a week.
- Our clients often have many programs and systems to engage. Care management is often needed to coordinate care and help the client make a daily plan, including transportation and other steps to get through the first week after incarceration.
- Information sharing among and between systems can help remove barriers to continuity of care and treatment. Consider electronic health records and shared systems as ways to facilitate continuity of care.

SLIDE 14: Facilitator #2

- Establishing relationships—and then maintaining them—at each level helps facilitate transitions and access to care. See table in *Tools & Tips Handbook*, Chapter 2, Page 11.

Establish relationships at all levels.

Within the correctional setting:

- Greet with a warm smile and a handshake.
- Know the chain of command, including formal and informal roles.
- Listen first, then ask key questions such as:
  - How do things work now?
  - What do you need?
  - Can you help me?
- Identify a champion of this work within the jail administration.
- Be clear and set realistic, measurable, and achievable goals.
- Identify the benefit you're providing to the jail and to jail personnel (e.g., service gaps you may be filling, programs leading to reduced violence).
- Begin where you can.
- Acknowledge additional work for correctional staff (e.g. escort/transport, ensuring your staff's safety).
- Build trust by
  - Starting with winnable battles
  - Sharing at least five positive messages before any one negative one
  - Setting clients up to succeed
  - Setting clear expectations and delivering on them.
- Demonstrate your accessibility by
  - Visiting often and becoming a familiar face
  - Knowing who to approach for jail access, security training, and space in jail to interview clients.
- Align expectations with abilities.
- Recognize that you are a visitor in the jail and be respectful of the policies and procedures in place.
- Expect to give more than you receive.
- Invite input from jail administrators as a way of securing buy-in and opening lines of communication.

Facilitator #1:

- Circulate among the participant tables. Guide participants with locating reference sections in material and identify questions for Facilitated Discussion. Identify a volunteer from participants to read from Tools + Tips Handbook, Chapter 3, Program Planning, top of page 18.

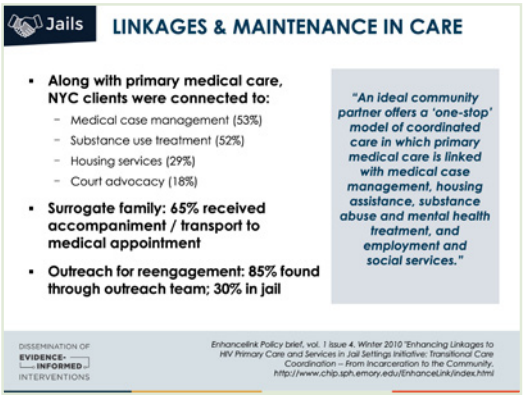
  Volunteer:

  "Introduce the program to the community: It is equally important to establish relationships with the community providers who will be receiving your clients. This can include ambulatory care clinics, hospitals, hospice, drug treatment programs, and nursing homes. Plan to visit them to introduce yourself and your continuum of care model. Offer site visits, arranging clearances through corrections leadership to allow community providers to become more familiar with your model, work flow, and staff. Give them an opportunity to present their program to your staff as well. This helps everyone get to know one another and familiarize themselves with the respective programs. This also helps you create a good resource list, which is highly valuable."

SLIDE 15: Facilitator #2

All of these services and processes help you facilitate a "warm transition" at the client, program, and systems levels. Some tools and tips include:

- EHRs help identify clients–or perhaps jail health has a log?
- Work with corrections on ways to greet and engage your client.
- Get together with community partners to streamline your workflow.
- Meet with health providers, defenders, and housing providers to create a network of care.
- Create processes and make arrangements so the client is supported throughout the journey.



SLIDE 16: Facilitator #2

- Reentry Service organizations, such as The Fortune Society, offers programs and services for client after incarceration that act as surrogate family. Patient navigation and accompaniment, non-judgment services, and treatment and people-first language are all part of culturally appropriate engagement.
- There is no health without housing.
- Whenever possible, make that first appointment at a place where all service needs can be met (i.e., a "one-stop" model of care). After the first appointment is kept, the community partner's system is then there to build from the right first step to the right next step.
- Conduct outreach for reengagement. It helps if you hire people with histories of incarceration or experience working with your client population.

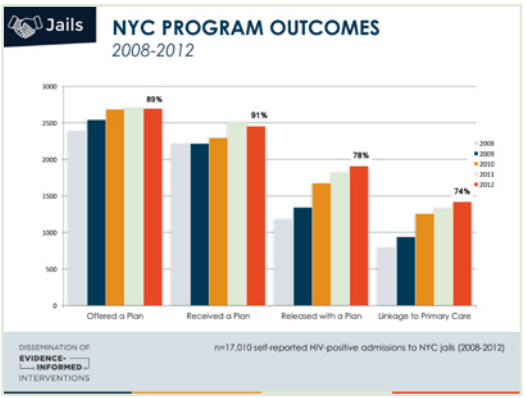
SLIDE 17: Facilitator #2

- **Client level:** Show you care; treat each session as if its your last.
- **Program level:** Hire staff who care–and build a team that includes those who are good at reporting and building relationships with partner organizations.
- **Systems level:** Work to remove barriers (like asking for a health insurance card before you say "Hello, how are you?").
- Patient navigation and accompaniment help introduce the client to the program—when you're together, you're visiting, which is very different from waiting for an appointment to begin.
- Walk-in hours, no wait services, and living room style areas as well as patient navigation and accompaniment all help create a warm transition. Like Disney's Haunted Mansion or Universal's Harry Potter attractions, where patrons are entertained before the main event (ride), so may clinics provide services (BMI check, health education group, testing) to clients in advance of an appointment with a primary care provider. [Solicit other examples as time allows]
- Implementation of the TCC model needs to occur at the individual (micro) level with clients, at the program (mezzo) level, and at the systems (macro) level–including cross systems, tracking population-level engagement in care, discharge planning during incarceration and community return, and linkages to care after incarceration.
- Given the many changes needed at varying levels of multiple systems, the ability to expect the unexpected and plan to work in a fluid way, within a framework, is needed. Set a good foundation and expect that you may need to adjust your action plan (i.e., crisis interventions) based on the opportunities and challenges presented on any given day.

Facilitator #1:

- Consolidate "Wish List" items
- Prepare for "Wrap-up"
- Circulate among and between the participant tables
- Guide participants with locating reference sections in material

UNIT 5



SLIDE 18: Facilitator #2

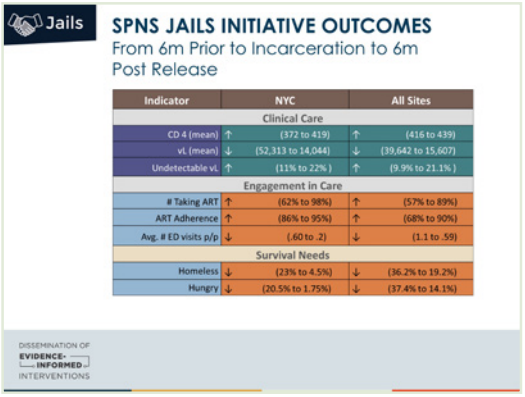
Keep a monthly tracking report of key indicators at each key step: Number of clients identified as eligible, offered intervention, accepted offer, returned to the community, and linked to care after incarceration. In the final year of the EnhanceLink project, NYC found that:

- Nearly 90% of those identified were offered a plan
- Over 90% of those offered received a plan
- Nearly 80% of those who received a plan were released to the community
- 74% released to the community were linked to care (over 1,400 people in 2012)

Using past rates helped to identify gaps and barriers as well as successes and facilitators:

- One month NYC saw a significant drop in offers accepted. After meeting with staff, leadership found that a "refusal" form had been implemented. The team eliminated the form and the acceptance rates returned to over 90%
- We hypothesize that court liaison services contributed to an increase in the jail release rate, which increased by 20%

Citation: Jordan, AO (2018) The NYC Experience: SPNS Enhancing Linkages: The Finale.



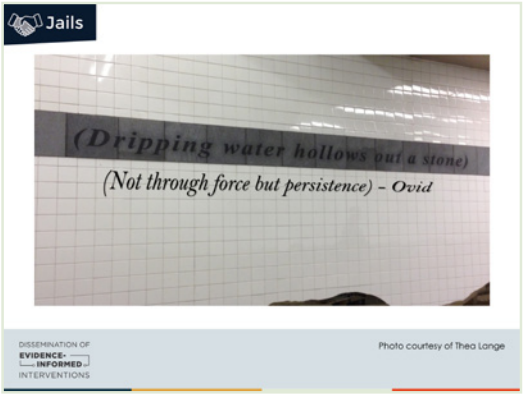
SLIDE 19: Facilitator #2

All sites participating in the EnhanceLink project found that clinical outcomes all went in the right direction.

What was also found was that in order to get to the doctor, folks' basic needs had to be met. After addressing basic needs for housing, food, and clothing, alongside long-term care, EnhanceLink sites also found reduced homelessness, hunger, and emergency department visits.

Clinical outcomes for participants who completed the baseline survey but not the 6-month follow up survey were also compared. With most studies, you don't know what you don't know. However, surveillance data was accessed and analyzed. This analysis found similar clinical improvements for those who did not complete the follow-up survey, compared with those who did complete the survey (Refer to Teixeira et al. cited on page 5).

Citation: Lincoln T, Desabrais M, Simon D, Jordan A, Cruzado-Quinones J, Teixeira PA. (2013). Jail Linkages: Two Evidence-Based Approaches to Linkages to Care in the Community, Continuity of Care Models from Baystate MC and NYC Health. National Commission on Correctional Health Care National Conference.



SLIDE 20: Facilitator #2

In 8AD, the Roman poet, Ovid, said: "Dripping water hallows out stone, not through force but through persistence".

Facilitate a discussion around methodologies for successful program implementation including the need for patience and persistent. Discuss process of developing client "Wish List" as a foundational tool to guide and develop a discharge plan/service plan.

When you first meet with a client in jail, to complete their intake assessment, consider putting your forms aside at first. Show the client a blank piece of paper and ask them to describe their wishes for themselves after release from jail. Once they have shared this with you, you can return to the intake forms that need to be completed. However, starting on this note can allow you to build trust with a client. It can also help ensure that goals included in the intake assessment and transitional care plan are responsive to clients' needs (rather than what a service provider may want for the client).

When you are completing an intake assessment with clients, ask yourself: Is this about completing a form on your computer? Do you listen first?

Facilitator #1

Facilitated Discussion:

Assess participant knowledge/need for training on motivational interviewing techniques, short and long-term goal setting, and other tools and techniques to guide and shape a transitional care plan based on the client's "Wish List."

Transition to review of participants' training goals from the Ice Breaker as part of session wrap-up. Reviewing participants' goals will include a recap of what has already been covered and what will be covered in future sessions.

CLOSING

"Next, we will demonstrate how to assess the functions of your system and compare/contrast your current and proposed systems approaches to the TCC model."

MODULE 2 :
Functional Assessment Training: Mapping/Assessing the Flow

Topics Covered: Representations of the systems involved, TCC visual depiction, Core Elements of the TCC model, functional assessment and goal setting tools

OBJECTIVES

By the end of this module, participants will be able to:

- Understand the basics of the TCC model and the Core Elements of the intervention.
- Review how the intervention intersects across systems to facilitate a warm transition from jail to community HIV primary care.
- Learn how to use the Functional Assessment Tool. This is a prerequisite for initiating the intervention. The tool helps organizations/entities seeking to implement the TCC model determine if the intervention is a good fit for their local setting.

MATERIALS NEEDED

POWERPOINT

FLIP CHART SHEETS

HANDOUTS

- Functional Assessment Tool (slide 4), one per participant (electronic or printed)
- Goal Setting Tool (slide 5), one per participant (electronic or printed)

REFERENCE MATERIALS

- Care and Treatment Interventions (CATIs) Manual: Transitional Care Coordination: From Jail Intake to Community HIV Primary Care: *https://targethiv.org/deii/deii-transitional-care*
- Jordan AO, Cruzado, J et al, Transitional Care Coordination in NYC Jails: Facilitating Linkages to Care for People with HIV Returning Home from Rikers Island. AIDS and Behavior, 2012.

PROCESS

LECTURE:

Facilitator #1 will deliver a brief lecture on the TCC model, Core Elements, and the functional assessment and goal setting tools. These tools allow participants to review the Core Elements of the intervention and required activities that are related to each Core Element. Activities listed are necessary to ensure smooth implementation of the intervention and provision of high-quality services to clients, during and after incarceration. The functional assessment will not be completed during this module, but is rather introduced, so that participants can complete it once they have been trained on the intervention Core Elements. Participants should reflect on their system, using the tools as guides, throughout the training modules and during breaks in training so that they are well positioned to complete the functional assessment tool in Module 5.

HANDOUTS:

Slides 4 and 5 are intended to be used as worksheets. Have participants cross-check reference materials as you review relevant slide sections. Instruct participants to keep these worksheets handy as they will be completed later in Module 5.

Key Words and Phrases

- *Functional Assessment*
- *Goal Setting*
- *Needs Assessment*
- *Community Standard of Care*
- *Transitional Care Plan*
- *Warm Transition*
- *Transition to the Standard of Care*

The approximate length of time the session will take.

Total: 10 minutes

- 2 unit/5 slides: **10 minutes**

Method(s) of Instruction

This is a brief lecture.

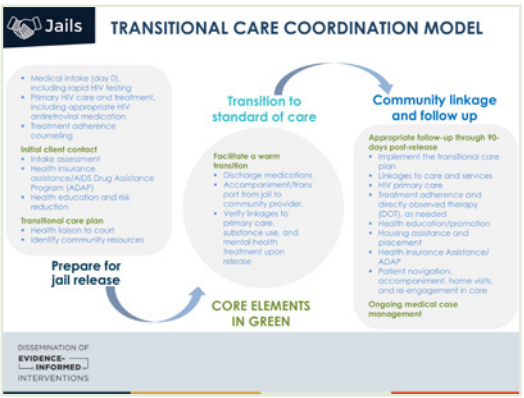
UNIT 1

SLIDE 1: Facilitator #1

This diagram represents the intervention model. On the left and right, you'll see representations of the large systems/institutions involved. This includes the correctional systems on the left and community health systems on the right. The circle in the middle is the TCC intervention model.

The overarching goals that occur in each system are typed inside the grey shapes: prepare for jail release while incarcerated, transition to standard of care as the outcome of the intervention, and community linkage and follow-up after transitioning to the standard of care in the community.

The arrows represent the methods used to support clients as they move from one large institutional system to the other.



SLIDE 2: Facilitator #1

This is a more detailed depiction of the TCC model with each of the **CORE ELEMENTS** of the intervention in **GREEN**. As you can see, there are actions that need to be taken to identify people living with HIV in jail prior to the **INITIAL CLIENT CONTACT.**

Prior to developing the **TRANSITIONAL CARE PLAN (TCP)** care coordinators should first complete an intake assessment in the jail setting. Then Ryan White HIV/AIDS Program, AIDS Drug Assistance Program (ADAP), or other health insurance applications should be completed and health education and risk reduction conversations should take place during the jail stay.

Then a transitional care plan can be developed. A transitional care plan addresses client-identified immediate needs and client-identified barriers to accessing care after incarceration. A sample format for a transitional care plan can be found in the CATI Manual. To implement the plan, you may need to use a court liaison; identify community resources, including those needed to address survival needs (such as housing, food, and clothing) and basic needs (such as income, purpose, and social support); as well as any anticipated crisis intervention needs (such as basic needs, intimate partner violence, overdose, and suicide prevention).

Continuity of HIV medication is critical to **FACILITATE A WARM TRANSITION** and achieve/maintain a suppressed viral load. A 7-day supply of medications, with up to a 30-day prescription is ideally provided after jail release. These medications would be ordered by the correctional health service. A medical appointment with a community provider to continue care and treatment should be scheduled as soon as possible after release from incarceration—ideally within 7 days but no later than 30 days after incarceration. Transportation assistance and patient navigation to the first HIV primary care appointment after incarceration are methods to achieve a warm transition, supporting clients as they move from the jail system to the community health system. (See CATI Manual for definitions.)

Continued on next page...

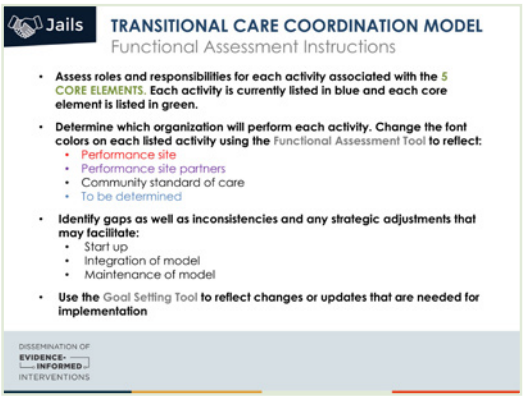
SLIDE 2: Continued

Care coordinators should document linkages to HIV primary care and verify connections to other service providers included in the **TRANSITIONAL CARE PLAN**.

Then, care coordinators should provide client-centered **FOLLOW-UP THROUGH 90 DAYS AFTER INCARCERATION**. This includes support services in the first critical days and weeks after incarceration (e.g., food, clothes, shelter, transportation assistance, treatment support, health education, housing, and employment assistance, patient navigation). Implement and document changes to the intake assessment and transitional care plan by conducting a re-assessment and/or updating the transitional care plan after incarceration and periodically thereafter. Begin the case termination process at least four weeks prior to the end of the 90-day post-incarceration period and conduct a case conference with the client and standard of care case manager/care team to facilitate the transition to the standard of care within 90 days after incarceration. The community standard of care includes **ONGOING MEDICAL CASE MANAGEMENT AFTER 90 DAYS POST-LINKAGE TO CARE**.

It is important to note that the transition to the community standard of care may be delayed due to arrest/incarceration or other criminal justice system involvement, as well as subsequent crises. Clinical supervision is needed to address the challenges to transferring a client to the community standard of care.

UNIT 2



SLIDE 3: Facilitator #1

Briefly review these instructions, so that participants are familiar and can refer back during Module 5: Use the **Functional Assessment Tool** (found on Slide 4) to change the font color on each function associated with the **CORE ELEMENTS.** (Leaving the **CORE ELEMENTS** in green font).

Either distribute electronic versions of slides 4-5 to participants using laptops OR distribute hardcopy printouts of slides 4-5 along with colored pens/pencils.

Participants should change (or highlight) the font color based on the following definitions:

Performance site: The organization with primary responsibility for implementing the TCC model.

Performance site partners: The organization(s) with secondary responsibilities related to implementing the TCC model (e.g., Department of Corrections officers to escort patients to jail health clinics, jail-based health team that provides HIV testing services, community reentry service program that provides patient navigation/case management after incarceration).

Community Standard of Care: Ryan White HIV/AIDS Program clinics, federally qualified health centers (FQHCs) working with Ryan White Part A case managers, and other service systems that provide HIV primary care and treatment with medical or non-medical case management.

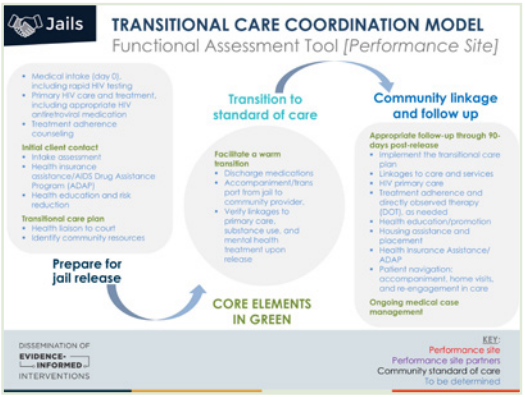
To be determined: Functions for which the listed service availability is undetermined, unknown, or unavailable.

Continued on next page...

SLIDE 3: Continued

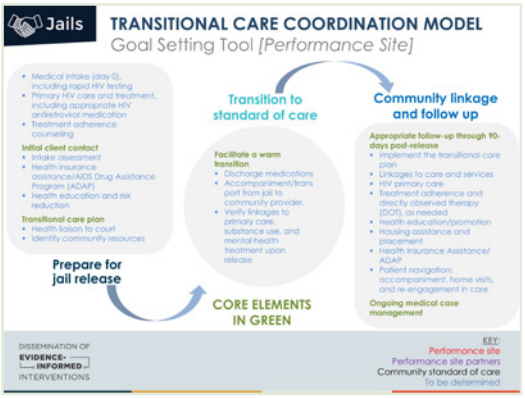
Use the Goal Setting Tool (found on slide 5) to reconfigure the current system (completed Functional Assessment Tool found on slide 4). Utilize the same instructions to change (or highlight) the font color of each function associated with the intervention's **CORE ELEMENTS**. In the Goal Setting Tool, an entity should be identified for all listed functions. This will help you determine negotiations that need to take place inside or outside of your organization to ensure that a responsible party can be identified to conduct all needed activities.

Note : In order to successfully implement the TCC model, all listed functions will be needed. Continue to identify sites, partners, and update/enhance community standard of care services to have the infrastructure needed to implement the TCC intervention.



SLIDE 4: Facilitator #1

Use this slide as your **"FUNCTIONAL ASSESSMENT TOOL",** using the directions on slide 3.



SLIDE 5: Facilitator #1

Use this slide as your **"GOAL SETTING TOOL",** using the directions on slide 3.

CLOSING

"Now that you have an understanding of the functional assessment tool, let's discuss the culture of corrections. Understanding the culture of corrections will allow you to anticipate challenges and strategies that may arise within your system. Once you have an understanding of the common principles and ideas of the TCC intervention and of working in correctional systems, we will revisit the functional assessment tool."

Jails

MODULE 3 :
Culture of Corrections: Transitional Care Coordination in a Non-Traditional Setting

Topics Covered: Building relationships and working in a correctional setting to implement the TCC intervention

OBJECTIVES

By the end of this module, participants will be able to:

- Understand the Chain of Command
- Develop communication strategies and critical skills to build relationships with corrections
- Identify the safety protocols and regulations in the jail, as well as strategies to be safe in a secure facility
- Negotiate with corrections

Key Words and Phrases

- *Establish Relationships*
- *Chain of Command*
- *Safety and Security*
- *Tactical Search Operations*
- *Count*
- *Re-count*
- *Contraband*
- *Lock-down*

MATERIALS NEEDED

POWERPOINT

FLIP CHART SHEETS

REFERENCE MATERIALS

- Cruzado-Quinones, J, Jordan, AO, et al. Tool + Tips for Providing Transitional Care Coordination Handbook (Page 11 & Appendix- Guidelines for Working in NYC Jails and Operations Order: Condom Distribution Policy). *https://targethiv.org/ihip/tools-tips-providing-transitional-care-coordination*
- Cruzado-Quinones, J. "Jail Linkages Initiative, NYC Demonstration Site" Presentation.
- Cruzado-Quinones, J, Jordan, AO, et al. Tool + Tips for Providing Transitional Care Coordination Handbook (Chapter 2, Page 11). *https://targethiv.org/ihip/tools-tips-providing-transitional-care-coordination*
- Cruzado-Quinones, J, Jordan, Alison O. et al. Tool + Tips for Providing Transitional Care Coordination Handbook (Chapter 7, Page 39). *https://targethiv.org/ihip/tools-tips-providing-transitional-care-coordination*

PROCESS

FACILITATED DISCUSSION:

Facilitators will review slides 1-7, focused on understanding the chain of command within a correctional facility. Given this structure, facilitators will also review concepts and strategies to build relationships with key staff.

Facilitators will then review slides 8-14, which provide an overview of security concerns inside a correctional facility. These slides provide tips for staff, regular security exercises, and guidance for conducting the intervention under increased security protocols.

Throughout the module, elicit participant engagement by asking for any past experience/expertise working within the correctional system.

ACTIVITIES:

Role Play: As part of slide 15, participants will be asked to act out scenarios focused on negotiation with a warden. Following each role play activity, the group will be asked to weigh in on the effectiveness of the communications and activities that were portrayed.

The approximate length of time the session will take.

Total: 30 minutes

- 3 units/16 slides: 30 minutes

Method(s) of Instruction

This is a Co-Facilitated Module:

Module uses a **"tag team"** approach, facilitated discussion, and activities.

UNIT 1

SLIDE 1: Facilitator #2

It is important that you understand the culture of corrections in order to begin; this module will focus on improving your awareness and knowledge of the correctional setting.

SLIDE 2: Facilitator #2

The learning objectives of this module are to: understand the Department of Corrections chain of command, which differs by the type of setting, how to negotiate when working with corrections and, most importantly, learning how to be safe in a secure environment.

SLIDE 3: Facilitator #2

Think about the various systems you are working with in order to implement the TCC model. Are you working inside a correctional facility?

If yes, what do you have? What is it that you want? What do you need in order to meet your goals?

If not, do you need access? And, if so, where do you start?

For example, do you plan to interview people? Will you need office space (desk, phone, computer)? Are you permitted to bring in office supplies (such as pens, spiral notebooks, cell phone)?

Do you have relationships in the correctional facility where you plan to implement the intervention?

Do you know anyone who works in the correctional setting? Have you found or identified a champion?

When you meet with corrections, have a plan but also make sure you ask for help to implement the model. You need to gain buy-in and they have the keys.

Be a familiar face. Smile and be available. Be sincere and professional.

SLIDE 4: Facilitator #2

Know your audience. This includes titles and ranks. Shirt color and emblems all have significance in corrections, which are like a para-military style organization.

The highest official in charge of the system may need to develop shared understanding with the leader of your organization before you can begin. Your homework includes learning the chain of command in your jail and knowing the formal and informal structures for getting things done.

In the example on the slide, the Commissioner may be in charge, but nothing happens in the facility unless the Chief of Department (highest ranking uniformed official) gives the order and designates people in the facility to work on the project.

SLIDE 5: Facilitator #2

You will always need to give more that you receive, and work harder to maintain the relationship. Expect to give more than you get—its part of the job.

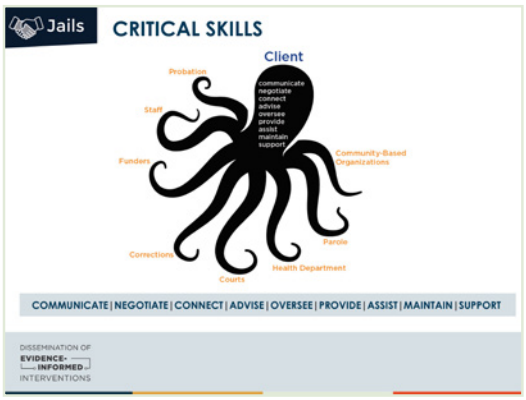
Linkage agreements, operational orders, and other documents will be needed to memorialize what you have agreed to. Change in leadership and staff shifts will otherwise derail the project. Operational/controlling orders solidify and legitimize the project and allow for continuity beyond the relationships.

At the same time, look at your community partners and see which organizations may also have relationships with corrections as a way to help identify champions.

Host a meeting or event with community and criminal justice system partners (e.g., jail, prison, parole, probation, defender groups, special courts, prosecutors).

Identify champions to cross-collaborate. Start the dialogue and build a strong foundation in order to establish relationships and build trust.

Remember that saying **"please and thank you"** takes you a long way.



SLIDE 6: Facilitator #2

Know your system and all the organizations that touch the lives of those you serve, both in correctional facilities and in the community.

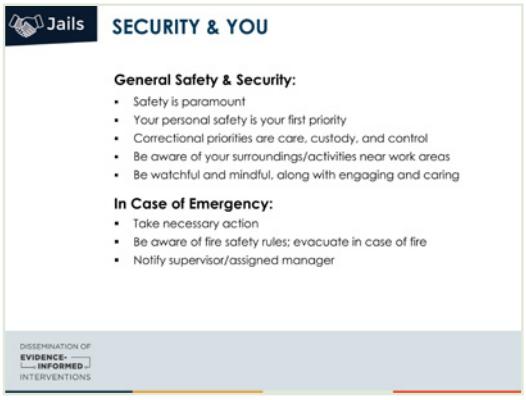
The "octopus" type diagram on the slide is a metaphor for understanding how many hands are touching the life of your client and how complex it is to navigate across all these systems. Your relationships among and between these systems will help you set your client up for success. For example, if you fail to recognize the competing priorities, you could well interfere with successful reintegration, making an appointment at the same time your client needs to check in with parole or go to a substance use program for drug-testing. If you have relationships, you can reach out to all parties to help navigate the systems and facilitate attendance at both the parole appointment and the substance use program, which would ideally be co-located or coordinated with HIV primary care.

SLIDE 7: Facilitator #2

Your relationships are gold. They must be treasured and polished.

Train the security staff, join in their activities and support them in ways that will help them see you as a valuable partner. For example, provide a mini-training/update at roll call, provide a mobile van at a wellness events, invite that special champion to join in your staff appreciation day event, and acknowledge the assistance staff provides (e.g., give certificates of appreciation or service awards).

UNIT 2



SLIDE 8: Facilitator #2

As part of negotiations, ask corrections to provide security training for all staff working in correctional facilities. Make sure that all staff receive security training as a part of the onboarding process. While your safety and security is of paramount importance, corrections staff are likely more focused on resolving the emergency situation.

Make sure the Department of Corrections training covers the procedures you need to follow in case of an emergency. If the training doesn't include this, find out from an official or your champion and train all staff on the protocols.

Be watchful of your surroundings and mindful of the setting and the issues of the day that may impact your personal safety and ability to see your clients. You may see and hear things in this setting that are a result of the criminal justice system. A cigarette, a plastic utensil, a pen, chewing gum, or even a toothbrush may be considered contraband. Sharp objects, like a pen knife, box cutter, or other tools you may have on your person could be seen as weapons you intend to pass on to an incarcerated person. Watch yourself.

Continued on next page...

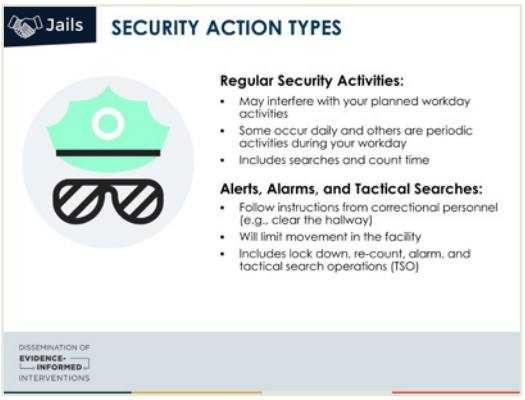
SLIDE 8: Continued

Maintain your professionalism, along with a caring attitude yet avoid conversations that would be looked upon as suspicious.

Tips:

If you provide a client with a pen to sign an official document, make sure you receive it back.

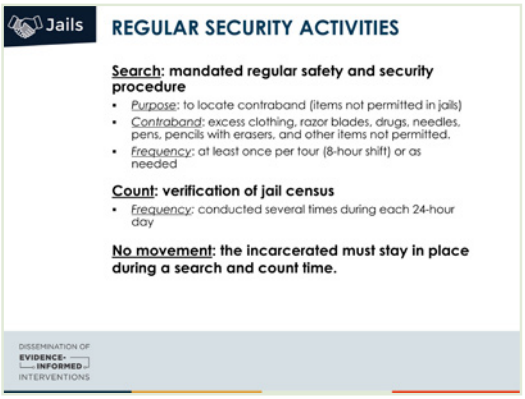
If you make a call to a family member while your client is present and they speak with them from your office telephone, make sure the conversation is brief and stays on topic.



SLIDE 9: Facilitator #2

There are various types of security actions and each facility may have a different approach. However, the general types of security actions that correctional facilities have are regular, predictable activities. Actions that are unpredictable are most often in response to rule violations. Regular daily activities include searches and count time.

Alerts, alarms, and technical searches are unpredictable and will limit movement in the facility.



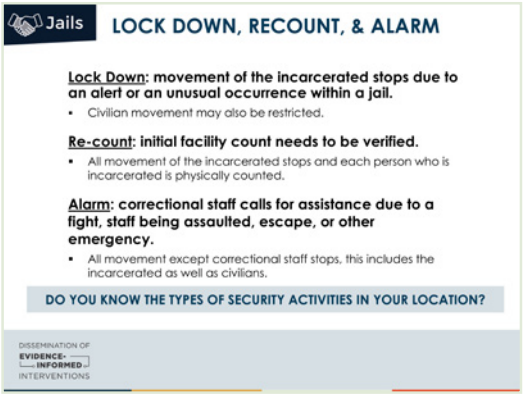
SLIDE 10: Facilitator #2

These are examples of Regular Security Activities:

Search: Mandated regular safety and security procedure.

Count: Several times each day, corrections will count the number of people in custody and check the totals against the known roster. There is no movement during count time and you need to be aware of the times of day that the count occurs in your facility.

If the count is off, an alert or alarm may result.



SLIDE 11: Facilitator #2

This a breakdown of some types of activities that are unpredictable and may be serious:

Lock down: Movement completely stops, including the incarcerated and civilians. Make sure you have snacks and reading materials as well as childcare arrangements in case you can't leave when you had planned.

Re-count: This takes some time and can prevent you from seeing clients.

Alarm: A serious security breach may have occurred and security staff may be running with tactical gear. Stay out of the way or you could get caught up and injured.

SLIDE 12: Facilitator #2

Tactical Search Operation (TSO): A major search where additional staff, such as officers and captains, are deployed to conduct a search when necessary to address a significant safety or security issue.

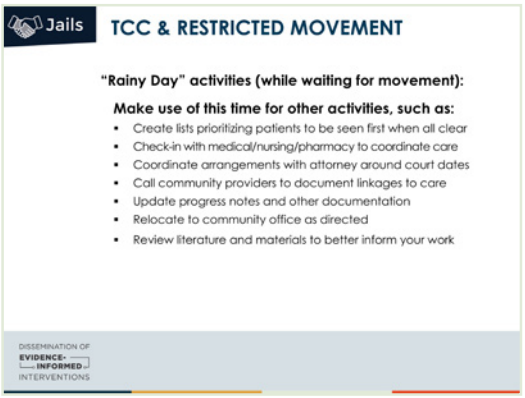
In NYC, for example, there are different levels of TSO:
Level 1: One Captain and 10 Officers from each facility.
Level 2: Two Captains and 20 Officers from each facility.
Level 3: Three Captains and 30 Officers from each facility.

What are the security actions that might happen in your facility? You need to know what will happen in the facility where you are located so you can be prepared for all scenarios.

SLIDE 13: Facilitator #2

Think about these activities when you are negotiating and implementing the program. If the count time is at 7am, maybe schedule staff to start at 8am after the count clears. Or should staff come in the evening when space may be more available with less movement issues and fewer programs being offered?

Are clients allowed to stay in the clinic or program area during the count or are clients returned to their housing unit for the count? You need to know this. It all depends on the Warden and the jail, and this will differ by facility and maybe even by shift.



SLIDE 14: Facilitator #2

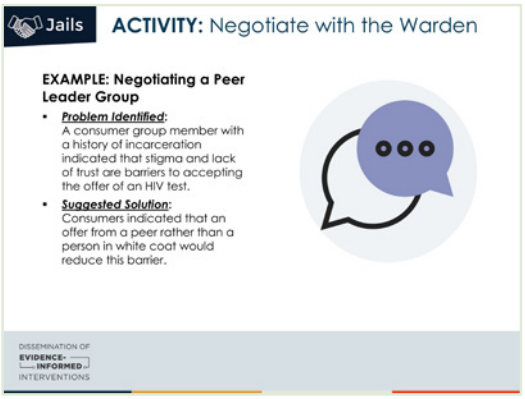
What if?

Plan for when there is down time and keep a list of specific things that you can do when you can't see clients.

What's on your list?

Facilitator will ask participants to share activities that are on their list and facilitate a discussion so that participants can learn from each other.

UNIT 3



SLIDE 15: Facilitator #2

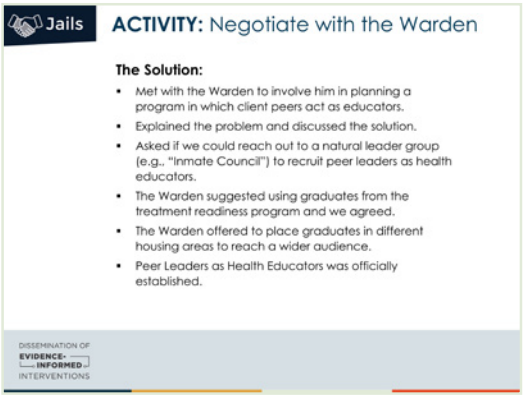
Activity: *"Now we're going to do a role-playing activity to see how well you negotiate with the Warden."*

Give the identified problem (from the slide) to the group. Then discuss potential solutions. Solicit volunteers to be the warden, program coordinator, and the coordinator's director.

Have volunteers act out this example scenario, including the suggested solution, in front of the class.

After the role playing has ended, facilitate a discussion with the class weighing in on the effectiveness of the role play and what works and what could have been done differently.

(ONLY ADVANCE to Slide 16 AFTER ROLE PLAY and DISCUSSION are complete.)



SLIDE 16: Facilitator #2

This is the actual solution.

At the end, the graduates were the natural leaders sought. The peer offers were successful and the program has been sustained to date.

Let's take a break now.

CLOSING

We will continue to discuss the culture of corrections, with a focus on the correctional health system.

MODULE 4 :
Policies & Practice: At the Nexus of Correctional Health and Public Health

Topics Covered: Policies and practice

OBJECTIVES

By the end of this module, participants will be able to:

- Understand the implications of policies for practice
- Identify key policy areas where health intersects with mass incarceration, including minority health inequities, human rights, and transitional care
- Discuss connections between community health, justice, and incarceration policies
- Discuss the impact of mass incarceration on public health and the need for community planning
- Demonstrate the impact of the intersection of minority health and incarceration on community needs
- Analyze programs to address the health disparities in communities impacted by mass incarceration
- Consider the intersectionality of roles, including health provider, public health service, and human rights
- Identify the manner in which correctional health services are provided
- Discuss the human rights concerns related to correctional health

MATERIALS NEEDED

POWERPOINT

- **Note:** Handouts and discussion questions are embedded into PowerPoint
- **Note:** Computer displaying PowerPoint should have ability to connect to Internet and play video link. (Check speaker volume in advance of launching module training.)

HANDOUTS

- Questions to Consider (Unit 1, slide 19)
- Scenarios (Unit 2, slides 27-33)
- Dual Loyalty survey questionnaire (with live polling software OR paper surveys). Note: Questions are embedded in slides and available in Glowa article (see "Reference Materials" below).

FLIP CHART SHEETS

REFERENCE MATERIALS

- Venters: A Three-Dimensional Action Plan to Raise the Quality of Care of US Correctional Health and Promote Alternative to Incarceration. AJPH. April 2016. *http://ajph.aphapublications.org/doi/pdf/10.2015/AJPH.2016.303076*
- Glowa-Kollisch: Human Rights Concerns & Correctional Health. *www.hhrjournal.org/2015/03/data-driven-human-rights-using-dual-loyalty-trainings-to-promote-the-care-of-vulnerable-patients-in-jail/*
- Jordan, A.O., Cruzado-Quinones, J., Sinnreich, R., Hane, L., MacDonald,R., Rosner, Z., Venters, H.D., Zack, B., Sterns, M., Siegle, A. Dansby, A., Paine-Thaler, C., Ptah-Riojas, A., & DiLonardo, S. (2015). At the Nexus of Correctional Health and Public Health: Policies and Practice. Presented at the American Public Health Association Annual Meeting. *https://apha.confex.com/apha/143am/webprogram/Session46024.html*
- Prison Policy Initiative, from Bureau of Justice Statistics, Correctional Populations in the U.S., 2010 & U.S. Census, 2010. Available at: *www.prisonpolicy.org/blog/2013/07/09/or-sb463/*
- *https://www.cdc.gov/nchhstp/newsroom/2017/HIV-Continuum-of-Care.html*
- Teixeira, P.A., Lloyd, K., & Jordan, A. O. (2013). HIV+ women incarcerated in New York City jails. Presented at the American Public Health Association Annual Meeting.

Key Words and Phrases

- *Dual Loyalty*
- *Mass Incarceration*
- *Health Disparities*
- *Human Rights*
- *Correctional Health*
- *Public Health*
- *Minority Health*
- *Structural Racism*
- *Criminal Justice*

Method(s) of Instruction

This is a co-facilitated module: Module uses a **"tag team"** approach, facilitated discussion, and activities.

PROCESS

ACTIVITIES:

- In advance of the training, facilitators will ask participants to review reference materials 1 and 2; facilitators will use these materials as reference to facilitate small group discussions.
- Facilitators will review the policies and practices that are the foundation of the principles at the core of transitional care coordination.
- Throughout the lecture, facilitators will engage participants in a discussion on policies and their impact on mass incarceration and community health.
- Then, if time allows, facilitators will show a video and lead a discussion, with a focus on programs that can address disparities.
- Then, all participants will engage in a small group discussion using the "Questions to Consider" handout.
- Next, facilitators will discuss how correctional health systems function and how it compares or contrasts with public health systems.
- Facilitators will describe dual loyalty and conduct a role play to illustrate dual loyalty in practice.
- Then, participants will complete a survey and discuss scenarios, specific to the jail setting, where dual loyalty may arise.
- Participants will then brainstorm both system and facility-level examples of dual loyalty, as well as solutions/strategies to mitigate these issues.
- Facilitators will request that participants review reference material 3 in detail after the conclusion of training.

The approximate length of time the session will take.

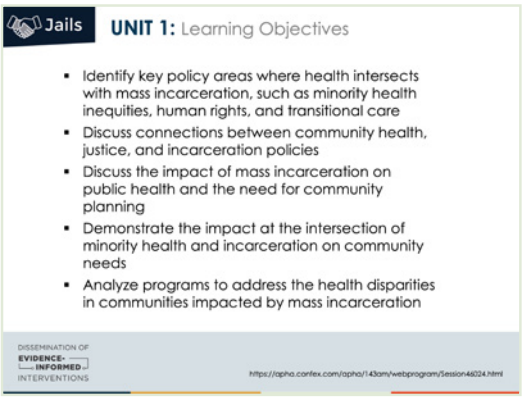
Total: 105 minutes

- Unit 1/slides 1-18: **50 minutes**
- Facilitated discussion: **10 minutes**
- Unit 2/slides 19-end: **15 minutes**
- Small group discussion: **20 minutes**

UNIT 1

SLIDE 1: Facilitator #1

This module will review the policies and practices that are the foundation of the principles at the core of Transitional Care Coordination.



SLIDE 2: Facilitators #1 & #2

Facilitator #1:

Summarize the key learning objectives.

Facilitator #2:

Circulate among the participant tables. Guide participants with locating reference sections in material and identify questions for facilitated discussion.

SLIDE 3: Facilitator #1

This session aims to provide an overview of key policies that are in play at the nexus of correctional health and public health.

We will review the minority health disparities and policies that demonstrate how mass incarceration in the U.S. is an outgrowth of racism. We will discuss human rights issues that intersect with incarceration and criminal justice policies and practices (e.g., there are some states that arrest people living with HIV for having consensual sex), as well as interventions, including Transitional Care Coordination, that can help to address disparities and practices. As we review these policies, consider how they inform program implementation, why we address socioeconomic disparities as well as health disparities, and how the tremendous growth in incarceration results from mental health treatment practices.

SLIDE 4: Facilitator #1

Reviews the slide and then leads a discussion.

Ask the class:

Can you identify policies that affect people of color at differing rates than Whites (e.g., police stop and frisk, bail requirements)?

Why are people of color affected more by bail requirements (e.g., people of color are more likely to be poor)?

What programs or interventions might address these disparities (see, for example, Siegler et al. study on naloxone distribution to visitors to NYC Rikers' Island)?

As time permits, watch NY1 video (2m)
https://spectrumlocalnews.com/nc/charlotte/criminal-justice/2016/06/24/volunteers-conduct-training-at-rikers-visitor-center-to-teach-people-how-to-use-heroin-overdose-antidote

SLIDE 5: Facilitator #1

Facilitator reviews the slide and then leads a discussion.

Ask the class:

How did de-institutionalization of mental health treatment affect the growth of mass incarceration?

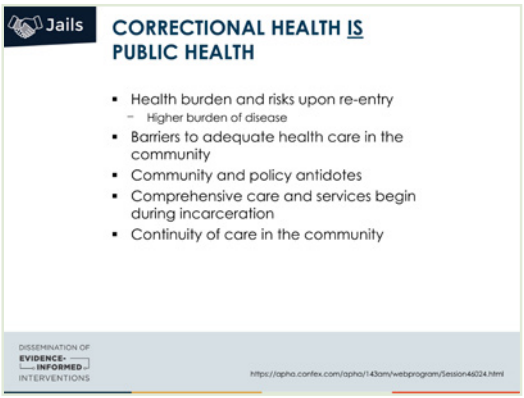
Why might you need to consider using a human rights framework to improve correctional health care? (e.g., ethical treatment, a constitutional right to health care while incarcerated, 8th amendment, Estelle v. Gamble.)

Why would it be important to think of housing as a human right? Meeting survival needs of all residents improves health for all. Does your state have case law that requires housing for its residents?

Resource: *www.ohchr.org/Documents/Publications/FS21_rev_1_Housing_en.pdf*

SLIDE 6: Facilitator #1

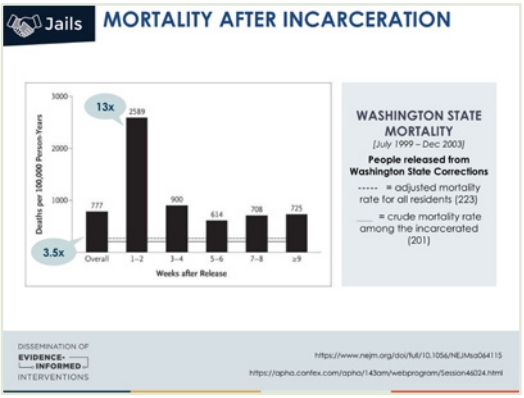
The TCC intervention is designed to include a health liasion to the courts and provides for linkages to care coordination and mental health treatment in the community. Consider why transitional care services may address some of the policy implications discussed earlier (e.g., racism, mass incarceration, and poverty).



SLIDE 7: Facilitator #1

Guided discussion

Why do we say "correctional health is public health?" (Engage participants and discuss bullet points on slide one-by-one.)



SLIDE 8: Facilitator #1

The U.S. population of people formerly incarcerated in prisons is large and growing. The period immediately after release may be challenging for formerly incarcerated people and may involve substantial health risks.

This chart is from a *New England Journal* of Medicine article based on a retrospective cohort study of all inmates released from the Washington State Department of Corrections from July 1999 through December 2003. The study assessed the risk of death among former inmates soon after their release from Washington State prisons.

Prison records were linked to the National Death Index. Data for comparison with Washington State residents were obtained from the Wide-ranging OnLine Data for Epidemiologic Research system of the Centers for Disease Control and Prevention. Mortality rates among former inmates were compared with those among other state residents with the use of indirect standardization and adjustment for age, sex, and race.

The figure shows mortality rates among former inmates of the Washington State Department of Corrections during the study follow-up (Overall) and according to 2-week periods after release from prison. The dashed line represents the adjusted mortality rate for residents of the State of Washington (223 deaths per 100,000 person-years), and the solid line represents the crude mortality rate among inmates of the state prison system during incarceration (201 deaths per 100,000 inmate person-years).

Results of the study were as follows: of 30,237 released inmates, 443 died during a mean follow-up period of 1.9 years. The overall mortality rate was 777 deaths per 100,000 person-years. The adjusted risk of death among former inmates was 3.5 times that among other state residents. During the first 2 weeks after release, the risk of death among former inmates was 12.7 times that among other state residents, with a markedly elevated relative risk of death from drug overdose. The leading causes of death among former inmates were drug overdose, cardiovascular disease, homicide, and suicide.

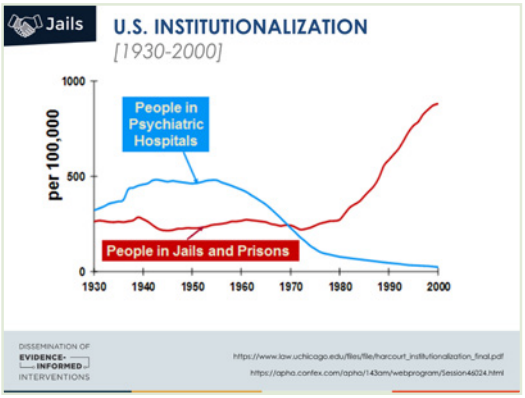
The study concluded that former prison inmates were at high risk for death after release from prison, particularly during the first 2 weeks post-release. As such, interventions are necessary to reduce the risk of death after release from prison. Other studies had similar findings - one in NYC jails and another ten year study also published by Binswanger, et al.

Continued on next page...

SLIDE 8: Continued

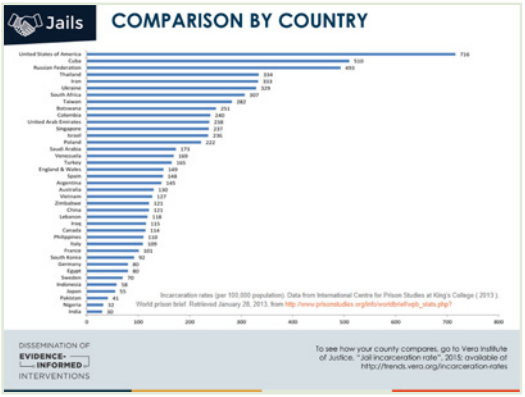
Resources: Binswanger, I. A., Stern, M. F., Deyo, R. A., Heagerty, P. J., Cheadle, A., Elmore, J. G., & Koepsell, T. D. (2007). Release from prison--a high risk of death for former inmates. The New England Journal of Medicine, 356(2), 157-65.

Note: Similar findings were found after incarceration in NYC Jails. See: Lim, S., Seligson, A. L., Parvez, F. M., Luther, C. W., Mavinkurve, M. P., Binswanger, I. A., & Kerker, B. D. (2012). Risks of drug-related death, suicide, and homicide during the immediate post-release period among people released from New York City jails, 2001–2005. American Journal of Epidemiology, 175(6), 519-526. *https://doi.org/10.1093/aje/kwr327*



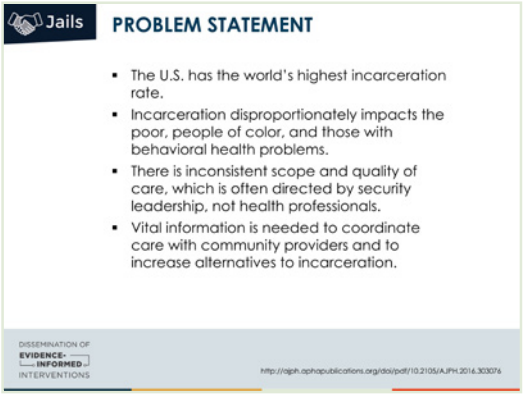
SLIDE 9: Facilitator #1

I asked earlier, "How did de-institutionalization of mental health treatment affect the growth of mass incarceration?" The graph on the slide clearly illustrates the major changes that have taken place since the 1970s, more growth since the 1990s where for-profit correctional health has led to the industrialization of mass incarceration.



SLIDE 10: Facilitator #1

The U.S. is by far the world's leading jailer with over 700 people per 100,000 incarcerated in jails and prisons.

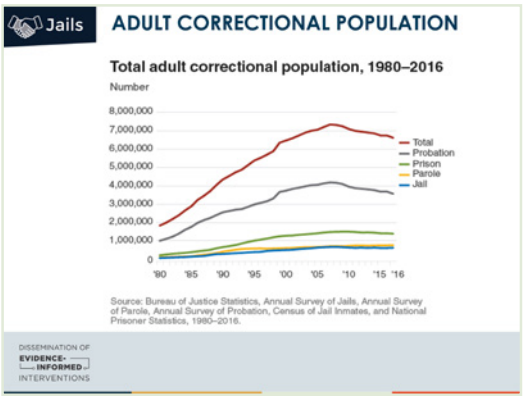


SLIDE 11: Facilitator #1

The people who are incarcerated are poorer minorities and people with mental health and substance use disorders.

Consider the impact on quality of care and human rights when correctional health providers are hired by and report to corrections (as contrasted with hospital or community health systems.).

Also consider potential impacts of correctional health services being incentivized to keep costs low—either through profit motive or by corrections leadership.

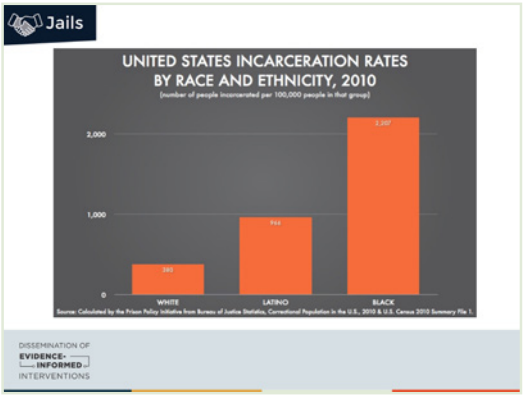


SLIDE 12: Facilitator #1

The growth of the total U.S. correctional population from 1980 to approximately 2008 is now seeing a slight downward trend in the number of people on probation while parole rates continue to climb and jail and prison rates appear level since 2010. However, the largest number of people affected by the corrections system are on probation, followed by prison and then parole and lastly jails.

The people incarcerated in jail are more likely affected by social determinants of health as people with resources are better able to pay bail as well as legal and court fees.

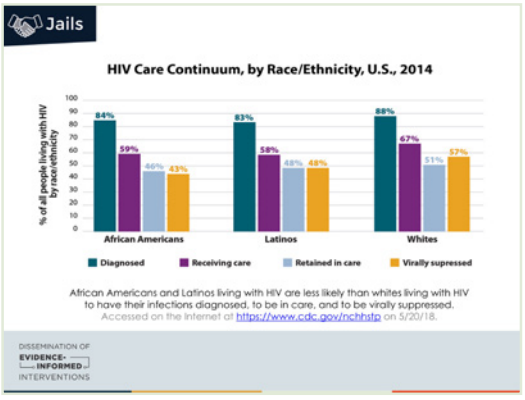
Furthermore, there is a cohort of people in jails that are homeless or unstably housed and are using jail, as well as emergency departments, as an alternative to homeless shelters.



SLIDE 13: Facilitator #1

The U.S. incarceration rates by race and ethnicity based on the Bureau of Justice Statistics from the last census is consistent with other data that points to the overrepresentation of minorities in jails and prisons along the same lines as socio-economic and health disparities.

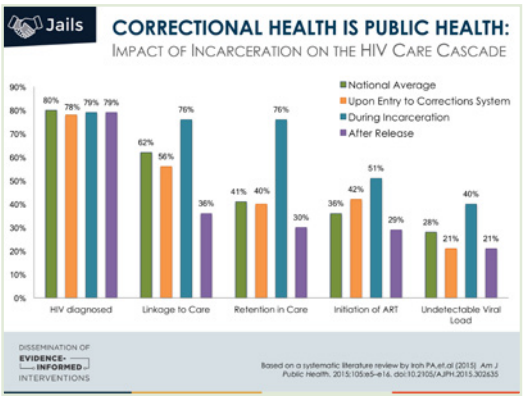
Source: Calculated by the Prison Policy Initiative, from Bureau of Justice Statistics, Correctional Populations in the U.S., 2010 & U.S. Census, 2010. Available at: *www.prisonpolicy.org/blog/2013/07/09/or-sb463/*



SLIDE 14: Facilitator #1

As stated by the CDC, African Americans and Latinos living with HIV are less likely than Whites living with HIV to have their infections diagnosed, to be in care, and to be virally suppressed.

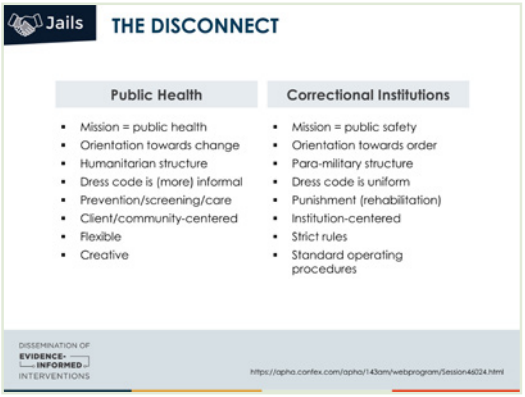
Note to Facilitators: Further information about incarceration and health disparities can be found on the CDC website: *https://www.cdc.gov/nchhstp/newsroom/2017/HIV-Continuum-of-Care.html*



SLIDE 15: Facilitator #1

Data based on a systematic literature review by Iroh PA, et al. (2015) (n=93 studies)

The reviewed articles suggested basic patterns: HIV care continuum outcomes were best among incarcerated individuals and worst after release.



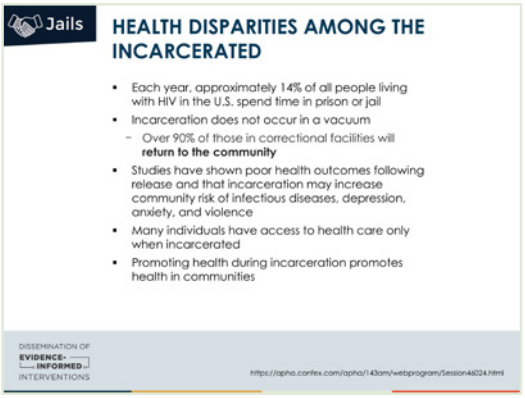
SLIDE 16: Facilitator #1

Providing health services using a public health approach in jails and prisons requires an understanding of the differing missions, orientations, cultural norms, as well as standard operating protocols between the two systems.

Consider also the differing approaches between health services that are operated by public health entities, non-profit health systems, for-profit health systems, and for-profit correctional health organizations.

Where on the continuum from public health to corrections/law enforcement might your entity fall?

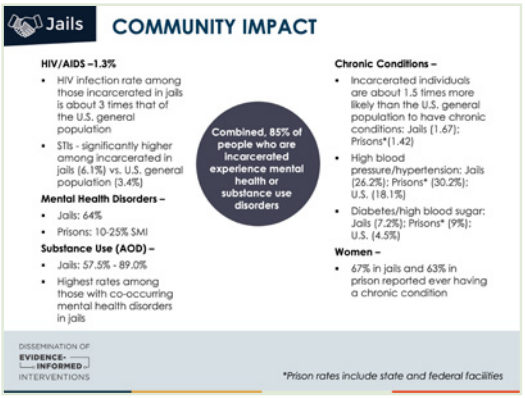
What does this mean for your practice?



SLIDE 17: Facilitator #1

Access to health care in jails and prisons varies. For example, only 11% of facilities have HIV testing. (See CDC Guidelines 2009, SPNS Jail Linkages "A time for Testing," and World Health Organization (WHO) guidelines for policies and practices regarding HIV testing in correctional settings.)

HIV rates in jail settings tend to mirror rates in the areas of greatest socio-economic disparities in the local community. This is one reason why HIV testing, care, and treatment in correctional settings is seen as public health practice.



SLIDE 18: Facilitator #1

Note: Average rates vary by jurisdiction. A good benchmark for considering HIV and other disease prevalence in local jails is to look at the rates in local areas with the lowest socioeconomic status because incarceration in jail is a symptom of low socioeconomic status.

Also, jail rates for HIV, mental health disorders, and substance use are higher than those reported in state and federal prisons while rates for chronic conditions are lower—likely due to short stays, under-reporting, and the aging of the prison population. In all cases, however, incarcerated individuals have greater health burden than the U.S. general population and incarcerated women have higher rates of cited diseases than men by every indicator.

Continued on next page...

SLIDE 18: Continued

What ways does incarceration impact communities, particularly communities with the greatest socioeconomic and health disparities? Some examples include: loss of wage earners and the creation of single parent families (which particularly impacts women); infectious diseases are screened, which can serve as a facilitator for community health; and most people with a history of incarceration first learn their HIV status in jail.

In what ways does incarceration reflect the health of communities and available resources? For example, incarceration of people with mental health or substance use disorders. Incarcerated individuals with mental health disorders also have higher rates of experiencing homelessness, foster care, and sexual abuse.

Sources:

Women:
Teixeira, P.A., Lloyd, K., & Jordan, A. O. (2013). HIV+ women incarcerated in New York City jails. Presented at the American Public Health Association Annual Meeting.

HIV infection rates:
https://journals.lww.com/co-infectiousdiseases/fulltext/2013/02000/HIV_among_persons_incarcerated_in_the_USA___a.3.aspx
(state and federal 3+ times)
www.cdc.gov/nchhstp/newsroom/2012/hivincidencegraphics.html
(State and federal 4x)
www.bjs.gov/content/pub/pdf/hivp10.pdf (state & federal - 4x)
https://tradingeconomics.com/united-states/population
www.gmhc.org/files/editor/file/a_pa_prison_report0511(1).pdf
(prisons and jails 5-7x)
www.bjs.gov/content/pub/pdf/mpsfpji1112.pdf State and federal p.3 (3.25x)

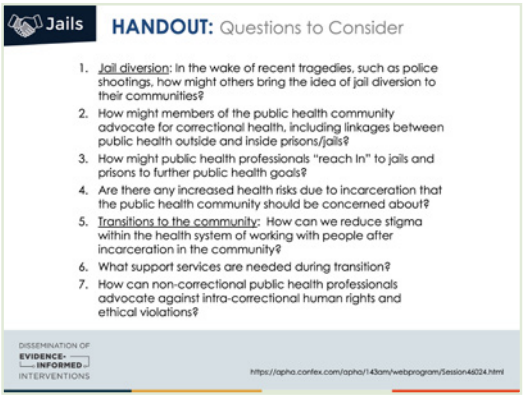
STD rates:
US DOJ Feb 2015 – Medical Problems of State and Federal Prisoners and Jail Inmates, 2011-12 *www.bjs.gov/content/pub/pdf/mpsfpji1112.pdf*

Mental Health Disorders:
www.bjs.gov/content/pub/pdf/mpsfpji1112.pdf
Table 2. 44.8% Federal prisons, 56.2% State prisons, 64.2% jails
SMI: APA Incarceration Nation 10.14 vol 45 no 9 print version p 56
www.apa.org/monitor/2014/10/incarceration.aspx; also

Substance Use:
National Academies Press, The Growth of Incarceration in the US p.204 Table 7-1 *www.nap.edu/catalog/18613/the-growth-of-incarceration-in-the-united-states-exploring-causes*
SMI: Ibid p.205; Jail SMI
http://thenationshealth.aphapublications.org/content/40/3/E11
"Released in February, the center's second report on the topic found that of the 2.3 million U.S. inmates, 1.5 million suffer from substance abuse addiction and another 458,000 inmates either had histories of substance abuse, were under the influence of alcohol or other drugs at the time of committing their crimes; committed their offenses to get money to buy drugs; were incarcerated for an alcohol or drug violation. Combined, the two groups make up 85 percent of the U.S. prison population, according to the report, 'Behind Bars II, Substance Abuse and America's Prison Population.'"

Chronic Conditions:
10-4-16 www.bjs.gov/content/pub/pdf/mpsfpji1112.pdf
Including rates among women

UNIT 2



SLIDE 19: Facilitators #1 & #2

Facilitator #1 hands out "Questions to Consider" worksheet (slide 19). Facilitator #2 conducts facilitated discussion of the questions while Facilitator #1 consolidates responses/suggestions to each question.

SLIDE 20: Facilitator #1

The second half of this module will review health disparities among incarcerated individuals, as well as key considerations when public health intersects with mass incarceration.

SLIDE 21: Facilitator #1

Facilitator will review objectives on slide.

SLIDE 22: Facilitators #1 & #2

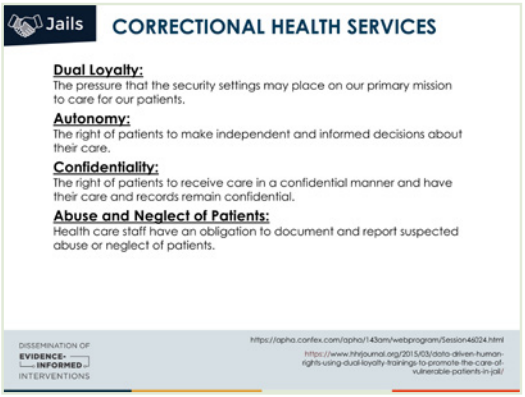
Facilitators will conduct a role play to present differing perspectives (public health vs. corrections). The purpose of this role play is to illustrate dual loyalty.

Facilitator #1 presents from public health/provider perspective and Facilitator #2 presents from the corrections/law enforcement perspective.

Facilitator #1: *"I need to continue to interview this client."*

Facilitator #2: *"We pay your salary and you need to follow our rules."*

Facilitator #1: *"I have an oath and responsibility as a health/social service professional to abide by the tenets of my profession."*



SLIDE 23: Facilitators #1 & #2

Facilitators will conduct a role play to present differing perspectives (public health vs. corrections). The purpose of this role play is to illustrate dual loyalty.

Facilitator #1 presents from public health/provider perspective and Facilitator #2 presents from the corrections/law enforcement perspective.

Facilitator #2: *"Count time is now—it's time to go back to the house."*

Facilitator #1: *"Patients have rights to make informed decisions about their care."*

Facilitator #2: *"They can make informed decisions some other time; my rules do not include free decision-making by inmates."*

Facilitator #1: *"I need time to explain this."*

Facilitator #2: *"Unless there is an emergency and I need to call for an ambulance, he's coming with me now."*

(As an aside, learning the department of corrections and correctional health services policies, rules, and guidelines will help when confronted with violence between correctional officer and an incarcerated person. Find ways to be comfortable saying no, not on my watch! Be known as someone who will speak up—while being charming.)

Facilitator #1: *"How about we check with the clinic captain to see if it would be possible for patient to be counted as part of the clinic census today?"*

SLIDE 24: Facilitator #1

As illustrated on the slide, dual loyalty is an omni-present challenge when working in a non-traditional setting like a correctional facility. Feeling the discomfort and pull? Can you compromise without compromising effective care and service delivery?

We will now conduct a series of activities focused on dual loyalty. The purpose of these activities is to:

1. Familiarize participants with the concept of dual loyalty.
2. Collectively reflect and share experiences with dual loyalty.
3. Encourage participants to prospectively gauge when they are confronted with dual loyalty.

Continued on next page...

SLIDE 24: Continued

4. Identify systems and facility-level examples of dual loyalty.
5. Brainstorm methods to mitigate systems and facility level issues that arise from dual loyalty.

Our first activity is a one-question survey. The survey question is:

Do you think we should spend time and energy identifying and addressing concerns that stem from dual loyalty?

Use a poll or a raise of hands to collect "Yes" or "No "responses. After the poll is taken, tally and show responses to the full group. Then show next slide.

Resource: *www.hhrjournal.org/2015/03/data-driven-human-rights-using-dual-loyalty-trainings-to-promote-the-care-of-vulnerable-patients-in-jail/*

SLIDE 25: Facilitator #1

Review results from Glowa study (cited on page 32) and compare to the class responses.

SLIDE 26: Facilitators #1 & #2

Activity - breakout session

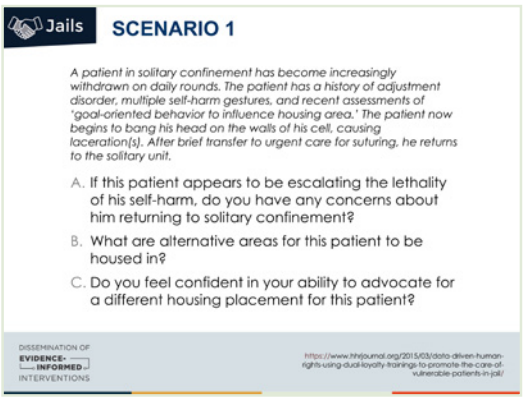
Break into 3 groups: count off around the room 1, 2, 3 to have mixed groups with people who didn't come together.

Facilitator #2:

On the flip chart sheets located by each table, groups should list both system and facility-level examples of dual loyalty. Upon completing the list of examples, please brainstorm a brief list of solutions to help your fellow participants mitigate/resolve these issues. *(Have each group select a recorder and presenter. The recorder writes examples and solutions on the flip chart paper. Presenters share examples and solutions with the larger group and facilitated discussion follows.)*

Return to large group and ask each group's presenter to describe the examples and solutions identified.

After the full group discussion, ask participants to return to their three small groups. Assign each of the three groups one of the three scenarios that follow. Ask the small groups to discuss the scenario. Both facilitators will circulate among the groups to facilitate discussion. When the small group discussion has ended, return to the large group. Each scenario will be reviewed individually in the following slides. Ask each group's presenter to report back on the discussion that occurred in the small group when their scenario is displayed.



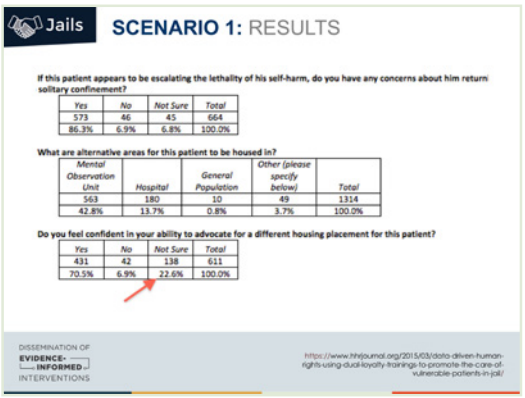
SLIDE 27: Facilitators #1 & #2

Facilitator #2:

Show Scenario 1 to the full group and ask participants to vote on a response to each of the three questions (A, B, and C), as listed on slide. After the votes are recorded, Facilitator #2 receives feedback from Group 1 and checks to see if any of the 3 groups raised similar concerns. Use problem-solving among the class to identify ways to improve confidence in patient advocacy.

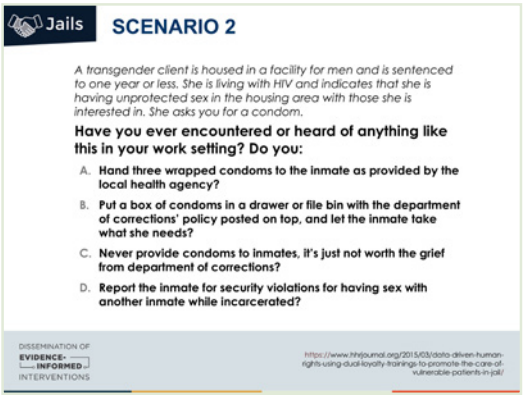
Facilitator #1 and #2:

Facilitator #2 will synthesize key ideas from feedback to prepare for "conclusion/wrap-up" while results are tabulated by Facilitator #1.



SLIDE 28: Facilitators #1 & #2

Review results from Glowa paper (cited on page 32) and compare to the class responses.



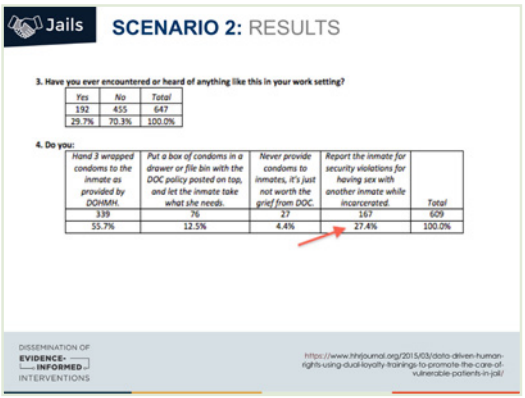
SLIDE 29: Facilitators #1 & #2

Facilitator #2:

Show Scenario 2 to the full group and ask participants to vote on a response option (A, B, C, or D, as listed on slide). After the responses are recorded, Facilitator #2 receives feedback from Group 2 and checks to see if any of the 3 groups raised similar concerns. Use problem-solving among the class to identify ways to improve confidence in patient advocacy.

Facilitator #1 and #2:

Facilitator #2 will synthesize key ideas from feedback to prepare for "conclusion/wrap up" while results are tabulated by Facilitator #1.



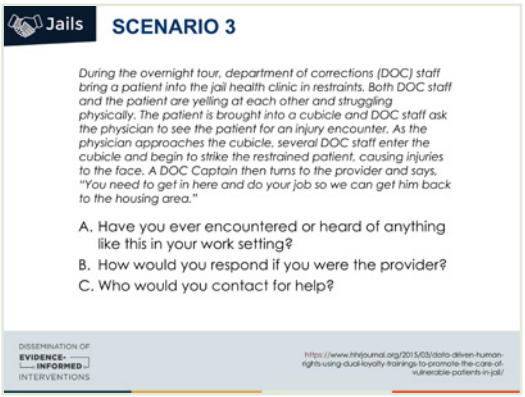
SLIDE 30: Facilitator #1

Review results from Glowa paper (cited on page 32) and compare to the class responses.

Note the rate of health professionals whose loyalty has been transferred to the correctional authorities.

Refer to World Health Organization (WHO) guidelines on condom distribution in correctional facilities: *http://apps.who.int/iris/bitstream/handle/10665/43806/9789241596190_eng.pdf;jsessionid=B32280FF48ABE1CE8CE96D534CDBCC78?sequence=1*

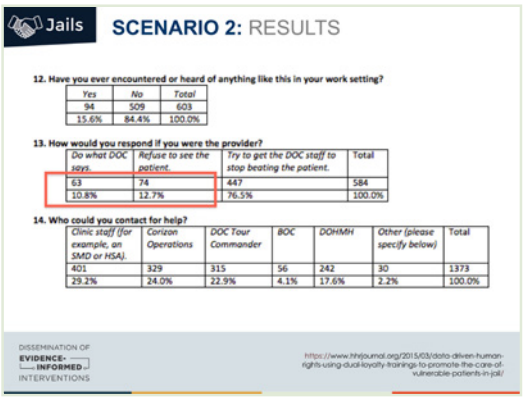
(See also Washington, DC example, NYC Operating Order in Transitional Care Coordination Handbook, and Philadelphia, PA and Los Angeles County, CA jails for guidance.)



SLIDE 31: Facilitators #1 & #2

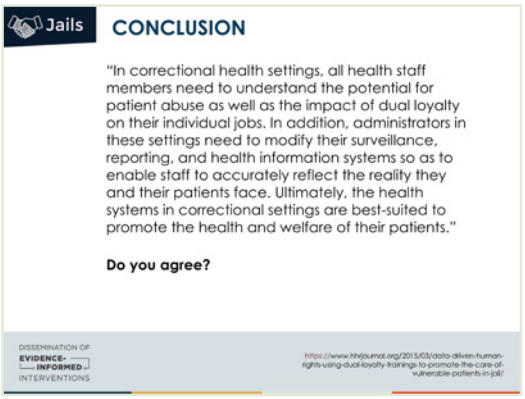
Show scenario 3 to the full group and ask participants to vote on a response to each of the three questions (A, B, and C), as listed on slide. After responses are recorded, Facilitator #2 receives feedback from Group 3 and checks to see if any of the 3 groups raised similar concerns. Use problem-solving among the class to identify ways to improve confidence in patient advocacy.

Facilitator #2 will synthesize key ideas from feedback to prepare for "conclusion/wrap up" while results are tabulated by Facilitator #1.



SLIDE 32: Facilitator #1

Review results from Glowa paper (cited on page 32) and compare to the class response.



SLIDE 33: Facilitators #1 & #2

Review all feedback and conduct a "conclusion/wrap-up" by bringing in important points/topics raised by participants in scenarios as well as engaging participants in a discussion about the quote shown on the slide.

Facilitator #2:
At the conclusion of the module, Facilitator #2 should collect notes (flip chart paper) or take pictures if notes recorded on white board.

Facilitator #1:
In the next module, we will move on to how policies and guiding principles are put into practice.

CLOSING

"Next, we will move on to how these guiding principles are put into practice."

Jails

MODULE 5 :
Transitional Care Coordination Model

Topics Covered: Core Elements

OBJECTIVES

By the end of this module, participants will be able to:

- Identify the Core Elements of the Transitional Care Coordination Intervention
- Conduct a functional assessment and set goals to strengthen intervention implementation based on the assessment.

MATERIALS NEEDED

POWERPOINT

HANDOUTS

– "Functional Assessment Tool" (from module 2, slide 4) and "Goal Setting Tool" (from module 2, slide 5)

FLIP CHART SHEETS

REFERENCE MATERIALS

Care and Treatment Interventions (CATIs) Manual: Transitional Care Coordination: From Jail Intake to Community HIV Primary Care: *https://targethiv.org/deii/deii-transitional-care*

PROCESS

ACTIVITIES:

Organization-specific groups will review the "Functional Assessment Tool" and the "Goal Setting Tool." They will complete the tools using the instructions in Module 2. First, teams will assess the system as it exists on the "Functional Assessment Tool" and then they will use the "Goal Setting Tool." Teams will review each of the Core Elements, identifying the lead entity and assessing readiness to implement core competencies. Using the "Goal Setting Tool," teams will identify areas where supplemental or modifications to existing protocols, policies, and practices may be needed.

HANDOUTS:

Have printouts of the "Functional Assessment Tool" and "Goal Setting Tool" (from module 2) ready for participants. As you review relevant slide sections, have participants reference the Intervention Implementation Activities: Core Elements and Assess Existing Jail-Based Health Care and Conduct Jails Workflow Analysis sections of the CATI manual: *https://targethiv.org/deii/deii-transitional-care*

FACILITATED DISCUSSION:

- Participant "Functional Assessment Tool" and "Goal Setting Tool" are reviewed. If multiple organizations are participating in training, facilitate a discussion between the organizations. This will allow participants from different organizations to learn about each other's settings and solicit ideas on how to address identified gaps.
- Participants will engage in a discussion throughout the module. They will share strategies to implement the workflow and Core Elements within their local setting. Teams will reconsider their functional assessment tool with this added knowledge, identifying where supplemental or modifications to policies and procedures may be needed. Questions to guide discussion can include:
  - Do those responsible for each Core Element have the core competencies in place for the tasks?
  - What additional resources or modifications may be needed?
  - Are there any strategic shifts needed in roles and responsibilities?
  - Do you have the responsibility/authority/resources to complete each of the Core Elements and perform the core competencies?
  - Are related processes/workflows developed?
  - Do they need to be modified to fit the transitional care coordination workflow?

Key Words and Phrases

- *Core Elements*
- *Initiating Contact*
- *Transitional Care Plan*
- *Warm Transition*
- *Linkage to Care*
- *Transition to the Standard for Care*

Method(s) of Instruction

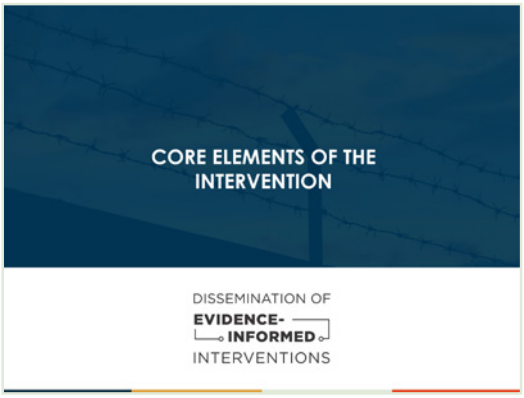
This is a co-facilitated Module: Module uses a "tag team" approach, facilitated discussion, and activities.

The approximate length of time the session will take.

Total: 2 hours, 15 minutes

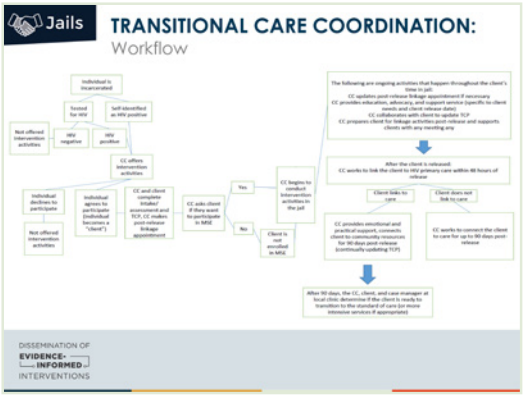
- 2 units/14 slides:
  1 hour and 45 minutes
- Activity:
  30 minutes

UNIT 1



SLIDE 1: Facilitator #1

Throughout this presentation, please refer to the Transitional Care Coordination CATI Manual and review intervention implementation activities for each of the Core Elements.



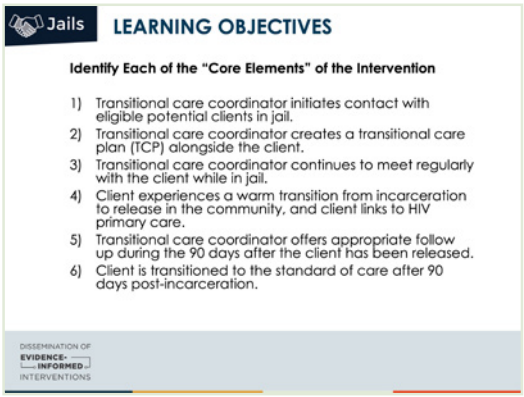
SLIDE 2: Facilitators #1 & #2

Facilitator #1:

This slide contains a sample workflow for the TCC intervention, provided to sites who implemented the TCC intervention through the DEII initiative. The aim of this intervention is to establish a linkage program for people living with HIV to support their engagement in HIV primary care and necessary support services post-incarceration and as they re-enter the community.

Facilitator #2:

As Facilitator #1 discusses this workflow, rove among the participants to help assist them in locating the relevant sections in the Transitional Care Coordination CATI Manual.

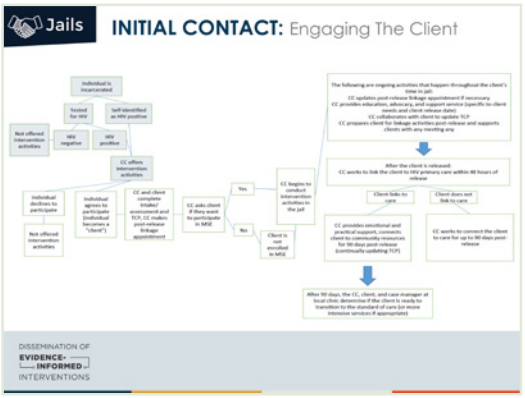


SLIDE 3: Facilitator #1

We are going to review each of the Core Elements. Please be sure to follow along with the Transitional Care Coordination CATI Manual to ensure your complete familiarity and understanding of each Core Element and what needs to take place at each phase of intervention implementation.

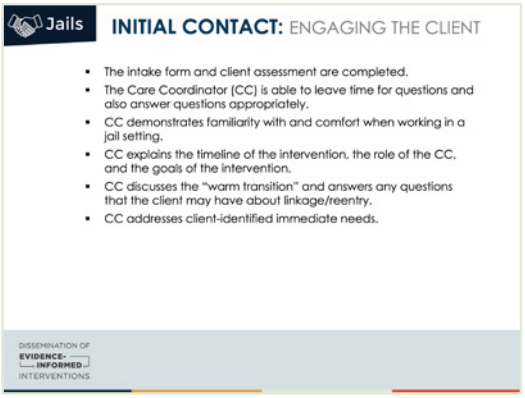
The Core Elements of the intervention that cannot be modified, adapted, or changed are:

1. Transitional care coordinator initiates contact with eligible potential clients in jail.
2. Transitional care coordinator creates a transitional care plan (TCP) alongside the client.
3. Transitional care coordinator continues to meet regularly with the client while in jail.
4. Client experiences a warm transition from incarceration to release in the community, and client links to HIV primary care.
5. Transitional care coordinator offers appropriate follow up during the 90 days after the client has been released.
6. Client is transitioned to the standard of care after 90 days post-incarceration.



SLIDE 4: Facilitator #1

We will now review the activities and steps in the workplan that relate to the first Core Element: establishing contact with a client in the jail setting.



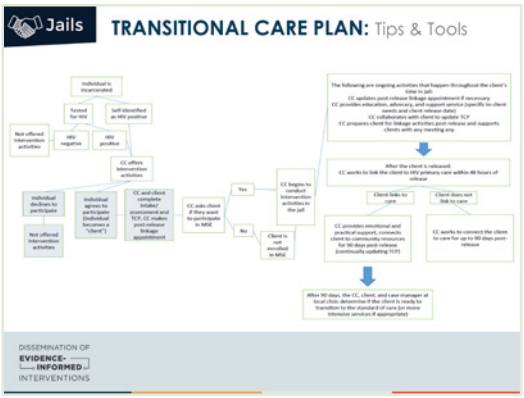
SLIDE 5: Facilitator #1

As described in the Transitional Care Coordination CATI Manual, we will discuss activities that support initiating the TCC intervention while the client is incarcerated.

The following intervention activities take place while the client is incarcerated.

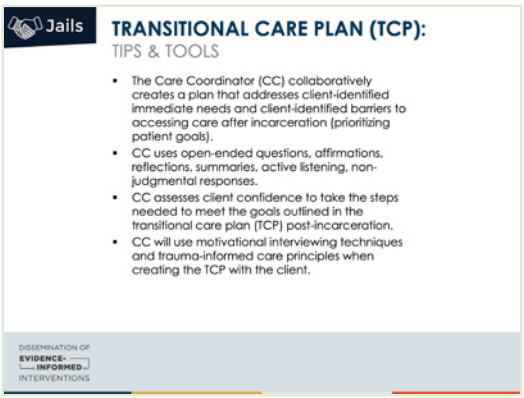
The care coordinator:

- Identifies eligible potential clients. (The systems to identify clients may vary between systems and may involve multiple stakeholders.)
- Contacts potential clients, meet face to face 24-48 hours from jail/ medical intake and explains the intervention, including the duration of the intervention (e.g., through 90 days after incarceration) and its goal of linkage to community HIV primary care, and timeline.
- Obtains consent if client wishes to receive services, including consent for service referrals.
- Completes the intake form and client assessment with the client.
- Discusses the warm transition and answers client questions about re-entering the community after incarceration. What is a "warm transition?" Remember from the introduction that this is more than a warm hand-off and requires a coordinated service delivery system. Let your client know that you work closely with the community provider(s) to make sure their essential needs, especially the areas that impact living with HIV, are addressed.
- Discuss needs identified by the client, including: housing, employment/ income, mental health/substance use treatment needs, and transportation/ access to care issues that may affect linkage to and retention in HIV care and treatment.



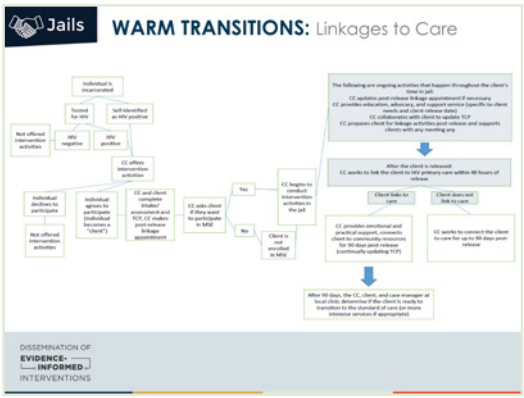
SLIDE 6: Facilitator #1

We will now review the activities and steps in the workplan that relate to the Core Element: creating the transitional care plan.



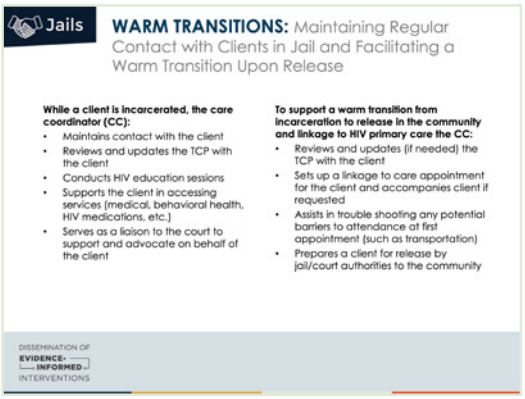
SLIDE 7: Facilitator #1

- Start with the client's "Wish List." It's their plan, not yours.
- Make sure you listen to the client before you start to fill out any forms. Remember to always make two plans for at each session: 1) one if they stay in jail and 2) the other in case of unexpected jail release (as discussed in the introductory training module).
- Consider a client's readiness for change. Is the client interested? Willing? And confident that they can manage each of the steps that need to be taken? Be careful to make an appropriate plan that works in practice, not one that looks pretty on paper and will never happen.
- Have you taken a motivational interviewing course? This is a recommended skill for transitional care coordination and is helpful to make sure that you and your client are working together on a realistic action plan to improve health outcomes.
- Use readiness rulers, tools frequently used with motivational interviewing to visualize readiness to change, to help create benchmarks so you can then build on strengths and coach toward next steps.
- Trauma-informed care training is also recommended as many clients will have experienced trauma related to home life and well as incarceration experiences.



SLIDE 8: Facilitator #1

We will now review the activities and steps in the workplan that relate to the Core Element: facilitating a warm transition during and after incarceration.



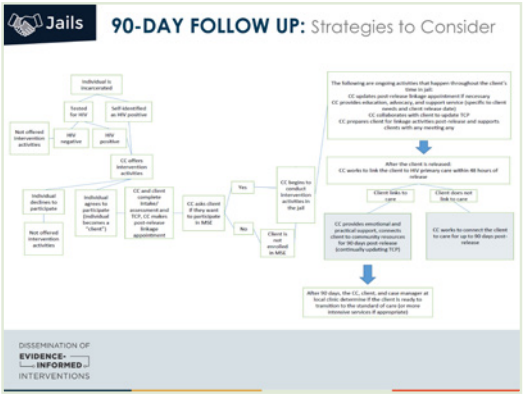
SLIDE 9: Facilitator #1

Using a warm-transition approach is key to facilitating linkages to care and having clients make it to the community provider. Anticipate the potential barriers with your client as you make a plan. Check-in with the client at each session to make sure no new barriers come up and so that you can reinforce the critical first steps after incarceration.

Consider the following:

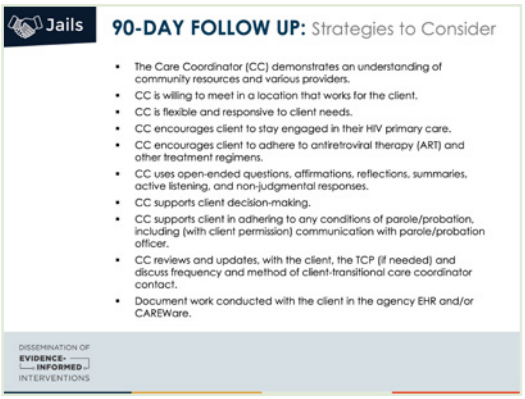
- Did you arrange for continuity of care and treatment, including 7 days' supply of medication and a prescription that can be filled after community return?
- Do you have a car or public transit pass that will allow you to accompany your client to appointments after incarceration?
- Do you know where you can locate your client in the community? Do you know who to call in case of an emergency?
- Does the client need a safety plan due to intimate partner violence or risk of drug overdose?

Make sure you document the linkage to care, including staying in regular contact with your provider network and keeping track of what appointments were made and kept. Are you sending folks to a program that's the right fit for them or just one with open slots? Make sure the providers are culturally appropriate and address the multiple needs of the client, such as housing, employment, and treatment. Do you have a one-stop shop that is geared to folks coming home after incarceration?



SLIDE 10: Facilitator #1

We will now review the activities and steps in the workplan that relate to the Core Element: offering appropriate follow up during the 90 days after the client has been released.



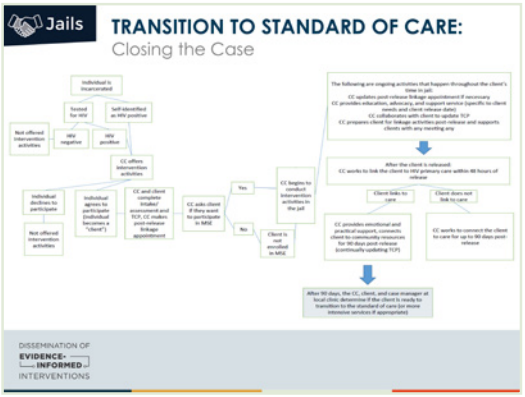
SLIDE 11: Facilitator #1

From jail release through linkage and beyond, supporting your client and staying in touch to check-in is important. Remember your client may be at high risk of death in the first weeks after incarceration (e.g., overdose and stress-related illnesses). Keep in touch. Be a beacon.

Consider how will you complete the following activities, within the realities of your local system:

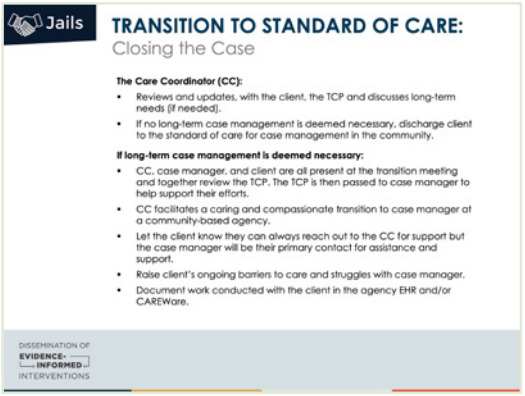
- Help filling out forms
- Making referrals and appointments
- Reminder calls/messages
- Arranging for transportation, child care, interpreting services, and advocacy
- Assistance with social services included, but not limited to, accessing food, clothing, and securing consistent housing
- Assistance with entitlements and benefits
- Addressing any ongoing mental health and substance-use disorder treatment needs
- Assistance arranging consistent access to health insurance
- Assistance arranging consistent access to medication

Continue to utilize client-centered, trauma-informed, and motivational interviewing techniques to support clients' linkage and maintenance in care.



SLIDE 12: Facilitator #1

We will now review the activities and steps in the workplan that relate to the final Core Element: transitioning a client to the standard of care and case closure.



SLIDE 13: Facilitator #1

Let's now discuss how to transition your client to the standard of care. Do you have Ryan White HIV/AIDS Program case management services at your organization or system? Do you have relationships with other case managers?

Remember that the transitional care coordination intervention provides clients follow-up for 90 days post-release from jail. While you introduced the timeframe at the initial session, begin to actively facilitate the transition to the standard of care no later than 4 weeks prior the end of the 90-day post-incarceration period.

For those who are not yet ready for the standard of care, the intervention may be extended on a case by case basis. For example, if the client is not yet linked to care. If the intervention is extended, re-assess the client's readiness to transition to the standard of care every 30 days.

Do you have concerns that the client will be in good hands? Good! Make sure that your dedication, commitment, and hard work are mirrored by your community partner and pick partners that meet and exceed your standards for taking the right next steps.

Make sure that you meet together with the community case manager and the client to transfer knowledge and support their ongoing relationship with your client. For example, give a tip or resource to the community case manager to share with the client (rather than sharing it yourself) to foster their relationship. Show that you are both part of the same team!

TIP: Keep in mind that transitioning the client to the standard of care may require additional training, technical assistance, and support as the idea of providing a short-term intervention and then passing the baton to another provider tends to create anxiety for the interventionists who can then transfer that anxiety to the client. Be watchful of this and address it as practicable during this and subsequent trainings.

Clinical supervision by a licensed mental health professional is strongly recommended as part of implementing the transitional care coordination intervention to address this and other staff wellness issues, including transference and counter-transference.

Also consider offering training to community case managers so that they understand the intervention and the multiple intersecting issues people who have been incarcerated may face.

UNIT 2

SLIDE 14: Facilitator #1

Activity: Refer back to module 2 (Functional Assessment: Mapping/ Assessing the Flow), Slide 3 for instructions on the Functional Assessment/ Goal Setting activity. First, organization-specific teams will assess the system as it exists on the Assessment Worksheet and then they will use the Goal Setting Worksheet tool.

This guided activity will require both facilitators moving between the teams and involve each team reporting back. Ideally, each team will have access to a computer to adjust the font color, first on Slide 4 of Module 2 and then on Slide 5 of Module 2 for each listed Core Element and competency. If not, they can use the two worksheets (Slides 4 and 5 of Module 2) to write the name and type of the organization on the paper worksheets. Participants completing the activity on paper should also be provided with colored pens/pencils to adjust the font color, according to the definitions provided in Module 2.

Facilitator #1:
Review each of the Core Elements, identifying the lead entity, and assessing readiness to implement the core competencies, identifying where supplemental activities or modifications to existing protocols, policies, and practices may be needed.

- Do those responsible for each Core Element have the core competencies in place for the task?
- What additional resources or modifications may be needed?
- Are there any strategic shifts needed in roles or responsibilities? Do you have the responsibility, authority, or resources to complete each of the Core Elements and perform the core competencies?
- Are related processes and workflows developed? Do they need to be modified to fit the transitional care coordination workflow?
- In what ways will partner organizations be involved? Do you need to educate your partners about the intervention or negotiate with them?

CLOSING

"Now we will discuss the court liaison. This is an important function of the transitional care coordination (TCC) intervention which can help meet clients' needs."

MODULE 6 :
Introduction to the Court Liaison

Topics Covered: Understanding the resources needed to implement a court liaison as part of the Transitional Care Coordination intervention.

OBJECTIVES

By the end of this module, participants will be able to:

- Understand the underpinnings of the court liaison, including Ryan White Part A: Non-Medical Case Management, Treatment Courts and Affiliates
- Identify population/resources to meet presenting issues by jurisdiction
- Identify different approaches to arranging alternatives to incarceration/alternative sentencing placements and methods for jail diversion
- Understand workflows initiated by the court liaison
- Demonstrate potential outcomes by a) referral source and b) presenting issues
- Identify challenges and resources
- Develop networking strategies

MATERIALS NEEDED

POWERPOINT

HANDOUTS

- Presentation handout (worksheets embedded in PowerPoint slides)

FLIP CHART SHEETS

REFERENCE MATERIALS

- Care and Treatment Interventions (CATIs) Manual: Transitional Care Coordination: From Jail Intake to Community HIV Primary Care: *https://targethiv.org/deii/deii-transitional-care*
- Cruzado-Quinones, J, Jordan, AO, et al. Tool + Tips for Providing Transitional Care Coordination Handbook. *https://targethiv.org/ihip/tools-tips-providing-transitional-care-coordination*
- Resource Identification Guide: National & Local
- Jordan, A.O., Cruzado-Quinones, J., Sinnreich, R., Hane, L., MacDonald,R., Rosner, Z., Venters, H.D., Zack, B., Sterns, M., Siegle, A. Dansby, A., Paine-Thaler, C., Ptah-Riojas, A., & DiLonardo, S. (2015). At the Nexus of Correctional Health and Public Health: Policies and Practice. Presented at the American Public Health Association Annual Meeting. *https://apha.confex.com/apha/143am/webprogram/Session46024.html*

PROCESS

ACTIVITIES & FACILITATED DISCUSSION:

Participants will engage in small group discussions throughout the module to begin the groundwork for developing a Health Liaison to the Court Advocates approach, known as a court liaison. Participants will practice the court liaison function (slide 16), by engaging in a role play exercise to identify a need, brainstorm potential solutions, and negotiate to find a solution. The role play will wrap-up with a facilitated discussion focused on the following questions:

- Did Identifier find that Requestor understood the identified need?
- Did the Requestor feel they understood the identified need? Feel heard by the Respondent? Make progress toward mutuality of agreement to address identified need?
- Did Respondent feel prepared to address the Requestor? Were the right people in the room? Did the Respondent find value (buy-in) in helping the Requestor?

HANDOUTS:

Worksheets are provided to help participants identify key collaborators (slide 7), health issues that impact referrals to a court liaison (slide 9), referral sources (slide 13), and workflows (slide 11). Participants will practice the court liaison function (slide 16).

Key Words and Phrases

- *Health Liaison to the Court*
- *Court Liaison*
- *Alternatives to Incarceration*
- *Jail Diversion*
- *Court Advocate*

Method(s) of Instruction

This is a Co-Facilitated Module: Module uses a "tag team" approach, facilitated discusssion, and activities.

The approximate length of time the session will take.

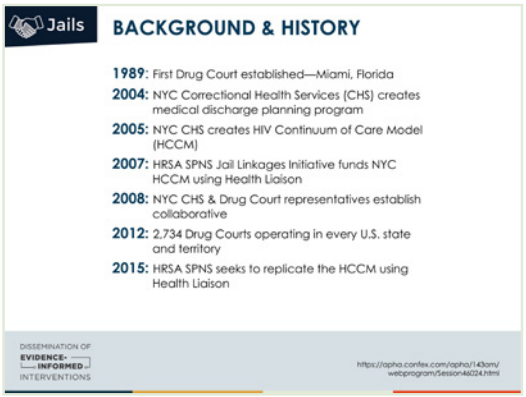
Total: 2 hours

- 5 units/15 slides: 2 hours

UNIT 1

SLIDE 1: Facilitator #1

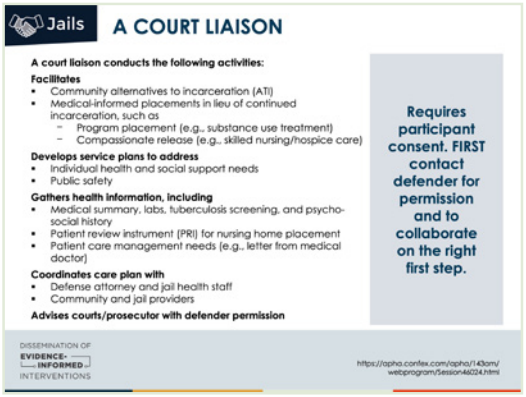
The purpose of this training session is to understand the underpinnings of the Health Liaison to the Court Advocates approach, using a court liaison function, as part of the Transitional Care Coordination intervention.



SLIDE 2: Facilitator #1

To begin, we will provide background for context related to court diversion and alternatives to incarceration. This timeline includes inception of the transitional care coordination model where NYC found that people living with HIV were staying in jail longer than other people as a systemwide average. This includes people held by parole due to lack of medical treatment options at the state correctional residential treatment program (Edgecombe).

The U.S. Department of Health and Human Services, Health Resources and Services Administration, HIV/AIDS Bureau's Special Projects of National Significance (SPNS) program launched an "Enhancing Linkages to HIV Primary Care and Services in Jail Settings Initiative" (more commonly known as the Jail Linkages Initiative or EnhanceLink). This Initiative helped demonstrate that the court liaison coupled with Ryan White HIV/AIDS Program case management services could send documents with signed consent to the client's attorney to supply information to help the courts make an informed decision about treatment alternatives and sentencing. Providing a treatment plan to the court advocates also helped to resolve court cases and reduced the amount of time people spent waiting for a case disposition, with many (80% vs. 60% pre-implementation) released to the community.



SLIDE 3: Facilitator #1

This is a list of activities to be conducted by the court liaison in order to provide the information needed by court advocates to help with the client's legal case. Outcomes can include placement in a program, reduced sentence, or other disposition.

SLIDE 4: Facilitator #1

The next two slides will provide a blueprint for beginning a court liaison process. Partnerships with other organizations are key for the court liaison, including partnerships with legal aid and public defenders. Working with treatment courts is also critical. This takes a bit more work because they also require mental health or substance use assessments. Treatment court staff will likely have a list of programs they work with and will be looking to determine both program availability and client eligibility for these programs. The attorney needs to be involved and the jail health provider records will be needed. This can be challenging as it requires you to navigate across systems, which involves continuous communication, networking, relationship building, diligent follow-up, and persistence.

SLIDE 5: Facilitator #1

Let's now look at what is available in your community. Looking at the list of potential court affiliates and collaborators in your area, do you have a sense of where to start? Do you know what resources exist in your community?

Who is part of the criminal justice system in your area that you might want to work with? Can you invite these individuals to a meet and greet discussion?

Make a list of resources in you community. Use worksheets as a guide (see slides 7, 9 ,11, 13, and 16).

SLIDE 6: Facilitator #1

There are a variety of different approaches in regards to alternatives to incarceration and jail diversion programs. While this is a list of resources in NYC, the take away point is to identify approaches used and resources available in your jurisdiction.

Different treatment courts exist in New York and the programs are paid through agreements with the courts. The judge may refer to Treatment Accountability for Safer Communities (TASC). If available in your area, who helps to streamline this process? The TASC staff are experts in this area and will be grateful to have a partner working in the jails.

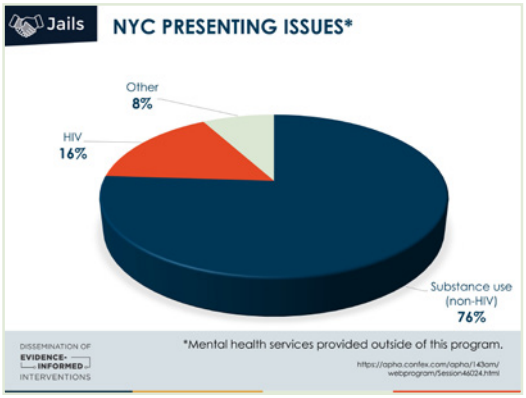
SLIDE 7: Facilitator #1

Each entity may have similar roles but have different eligibility and documentation requirements–they may have different jurisdictions, populations, charges, and types of activities and resources. You need to know what door to go through for each client situation–and will likely learn as you go. To help get you started we will work through an activity.

Activity

Reference worksheet handout (slide 7) and have participants start with what you found in preparation for the training and National Resources they know. Use this as a jumping off place to research and review alternatives to incarceration and other court affiliated programs in participants' jurisdictions.

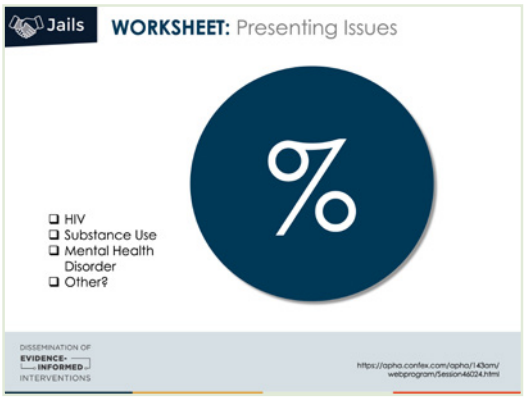
UNIT 2



SLIDE 8: Facilitator #1

The NYC transitional care coordination program, based out of Rikers' Island, found that the majority of clients living with HIV were incarcerated due to substance use and were thus being referred to and working with treatment courts. As such, they recorded and tracked a variety of indicators to understand what may be needed to facilitate the Health Liaison to the Court Advocates approach and in order to implement the court liaison activities.

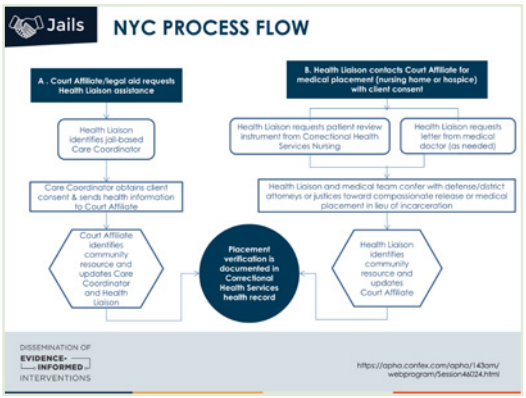
It's important to keep track of referrals to and from the defenders and to know the basis of the referral—substance use, psychiatric diagnosis, other medical condition—and to know what resources you need to meet the needs of your client.



SLIDE 9: Facilitator #1

What do you think are the presenting issues for clients in your setting?

UNIT 3



SLIDE 10: Facilitator #1

This is an example workflow diagram based on NYC implementation of the transitional care coordination model working on a population basis for all people living with HIV in the NYC jails. NYC transitional care coordination started by reaching out to court advocates to see who could help with community placements for people living with HIV, including nursing home placements for clients in need of end-of-life care. They found that the rates of people living with HIV incarcerated in jail on technical parole violations was much higher than the systemwide average and that community return rates were 20% lower than the systemwide average.

After designating a single point of contact, defenders—and even judges—started to call and make referrals, requested information that would assist in moving cases through the system, finding and identify programs that clients might be eligible for, as well as strategizing about making a transitional care plan that would address the courts concerns as well as

Continued on next page...

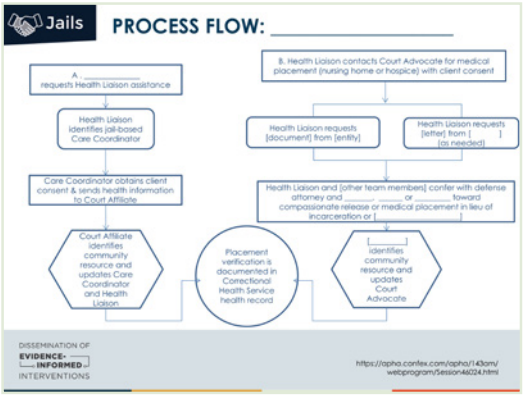
SLIDE 10: Continued

meet a client's health care and treatment needs. This work was always done through or with the permission of defense counsel. A lesson learned from this process was the importance of designating a single contact person to receive calls and track outcomes due to the large number of defenders calling for information and resources to serve people living with HIV.

Two different workflows were also developed. The workflows are similar but start from two differing vantage points: one started from Correctional Health Services and the other came from the court advocates or attorneys.

This workflow is a sample of what was done in NYC with the transitional care coordination model.

Activity:
In the next 10 minutes participants will discuss what their workflow might look like if this was to happen in their system.



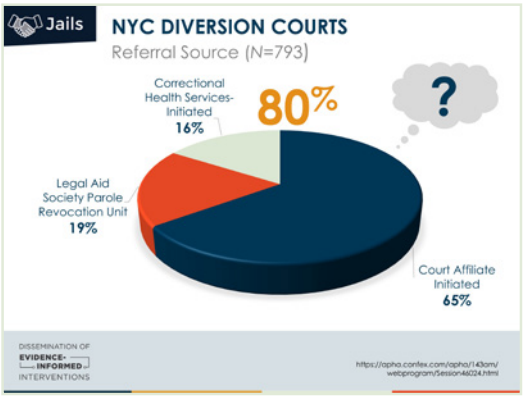
SLIDE 11: Facilitators #1 & #2

Activity:
Facilitators will handout this slide as a worksheet. One worksheet will be completed for each group; groups will be based on organization/work location. Groups will draft their workflow and report back to the larger group. Facilitators will rove between groups, providing technical advice and supporting discussion, as needed.

Have groups share what they think a court liaison workflow could look like in their system and how they would begin the process of establishing such a workflow.

Facilitator #1:
So now that you have an idea of how your system works, what might be the potential benefits and outcomes?

UNIT 4



SLIDE 12: Facilitator #1

The addition of a court liaison filled a critical gap in the NYC criminal justice system and quickly helped to better coordinate systems of care and treatment for people living with HIV.

This is the breakdown of the referral sources for the 800 people served in NYC in 2015 and shows that if you build it, they will come!

While the NYC transitional care coordination intervention integrated the court liaison as a proactive effort to place the sickest clients, including those who could be placed in a nursing home for end of life care, the largest percentage of people served were referred by court affiliates or defenders working with parole cases. Prior to this component of the intervention NYC transitional care coordination started to advocate for their clients,

Continued on next page...

SLIDE 12: Continued

the defenders and courts were requesting the full medical record from Correctional Health Services, a process that can take weeks. As a result of meetings, NYC transitional care coordination program learned the courts only need a few key pieces of information that can be provided in a brief summary, such as tuberculosis test, mental health assessment, substance use history, and lab results showing HIV status and medication needs.

Occasionally the courts would request a letter from a medical provider. As a result of reaching out, the defenders—and even judges—started to call and make referrals to the NYC transitional care coordination program, requesting information that would assist in moving cases through the system and working together to find and identify programs that clients might be eligible for.

The workflow and processes were put in place to provide the limited information needed to facilitate the court disposition and more quickly resolve the cases of people being detained in jail.

Consider tracking this and other components as part of sustainability planning. Be able to provide the systems that benefit from the service with information that shows savings in their systems.

SLIDE 13: Facilitator #1

Activity:

Use this slide as a worksheet and have each group, based on work location, draft their thoughts and report back to the larger group.

Consider court affiliates/programs that might refer to your court liaison. Take a few minutes to sit with your team and record likely referral sources. Consider court programs, community programs, as well as jail health teams or others who work in the correctional facility—anyone who may be able to identify people eligible for alternatives to incarceration.

Do you have any guesses as to how many clients you would be able to refer? Who will be your greatest referral source? Do you already have relationships with this referral source?

SLIDE 14: Facilitator #1

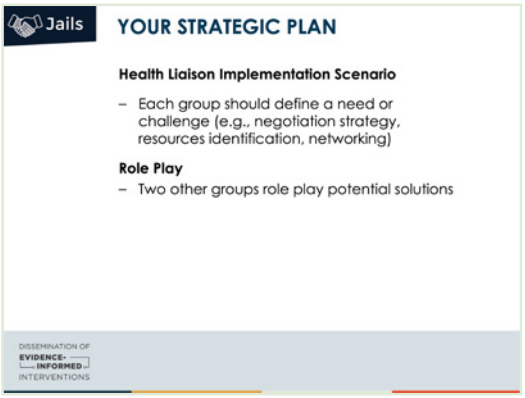
While NYC transitional care coordination was tracking referrals (referenced on slide 12), they found that 80% of the cases that were started resulted in a court-facilitated placement. They also recorded the outcomes for the 20% of cases that were not resolved through the court liaison process: some cases were dismissed with no program requirement and others remained incarcerated.

SLIDE 15: Facilitator #1

Consider tracking data in these categories, and maybe others as needed. As you are making referrals, remember to keep track of the outcomes both for those who are connected to a program, and those who are not.

Tracking successes as well as gaps helps to identify the need for additional resources and approaches.

UNIT 5



SLIDE 16: Facilitators #1 & #2

Activity:
Facilitators will engage participants in a role play. First, facilitators will break participants into groups by organization. Three groups can actively participate in the role play at once. If there are more than three groups, groups should rotate through active roles. Groups without active roles should listen and provide feedback on the role play.

The three active roles in this activity are:

1. **Identifier:** Participants in this role will identify a need or challenge, such as a communications conundrum, resource gap, or systems failure. They will write up the challenge as well as identify entities or partners that could be contacted to address the need.
2. **Requestor:** Participants in this role will present the identified need to the entity or partner that could help address the issue.
3. **Respondent:** Participants in this role will listen to the need presented by the Requestor. They will consider the solution and negotiate alternatives.

Part 2: Role play.
The Identifier will present the Requestor and the Respondent with the identified situation and their respective roles. The Requestor and the Respondent will have a few minutes to brainstorm a negotiation strategy. Then, the Requestor and Respondent will act out the scenario, with the goal of negotiating a potential solution to address the need.

Facilitated Discussion:

- Did Identifier find that Requestor understood the identified need?
- Did Requestor feel they understood the identified need? Feel heard by the Respondent? Make progress toward mutuality of agreement to address to identified need?
- Did Respondent feel prepared to address the Requestor? Were the right people in the room? Did the Respondent find value (buy-in) in helping the Requestor?

CLOSING

Now that we have explored the health liaison to the court advocates component of the intervention, we will discuss how all of your partners and stakeholder can work together to provide coordinated and high-quality services.

MODULE 7 :
Network of Care

Topics Covered: Partnerships and creating a network of care

OBJECTIVES

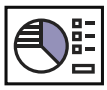
By the end of this module, participants will be able to:

- Understand the goals of collaboration
- Identify key stakeholders
- Build and strengthen collaborations
- Understand benefits and limitation of collaborations
- Develop team-building skills through a hands-on activity.

Method(s) of Instruction

- This is a co-facilitated lecture using a **"tag team"** approach, facilitated discussion, and activities.

MATERIALS NEEDED



POWERPOINT

ACTIVITY MATERIALS

- Bag of soil, pitcher of water, 4 packets of seeds, box of clay split into 4 sections, one brown paper bag, and 4 paper cups for each participant, aluminum tray for mixing ingredients . As an alternative, use cards / photos with soil, water, seeds, and clay.

FLIP CHART SHEETS

REFERENCE MATERIALS

- Care and Treatment Interventions (CATIs) Manual: Transitional Care Coordination: From Jail Intake to Community HIV Primary Care: *https://targethiv.org/deii/deii-transitional-care*
- Jordan, AO. (2017). Strengthening Collaborations, SPNS Workforce Capacity Initiative, NYC Correctional Health Services, Collaborative Convening.
- Jordan, AO. (2015) Linkages and Care Engagement: From NYC Jail to Community Provider. Health Disparities Collaborative Webinar: Addressing Health Disparities Among Incarcerated and Recently Incarcerated

PROCESS

DISCUSSION:

- Facilitators will begin with a lecture about the importance of collaboration within the transitional care coordination intervention. This will include building an understanding of the goals of collaboration, strategies to foster collaboration, and the process of building collaborative partnerships.
- During the lecture, facilitators will engage in a role play to dispel some of the common myths about collaborative partnerships.
- Participants will be engaged in a discussion regarding resources that exist in their community and mechanisms that could be used to strengthen or solidify partnerships.
- Facilitators will highlight the difference collaboration can make in intervention implementation, including opportunities for wider practice transformation, using the example of the transitional care coordination implementation in NYC.

ACTIVITIES AND FACILITATED DISCUSSION:

The training will conclude with an interactive activity focused on building collaborative negotiation skills.

Key Words and Phrases

- *Network of Care*
- *Collaboration*
- *Partnership*
- *Practice Transformation*

The approximate length of time the session will take.

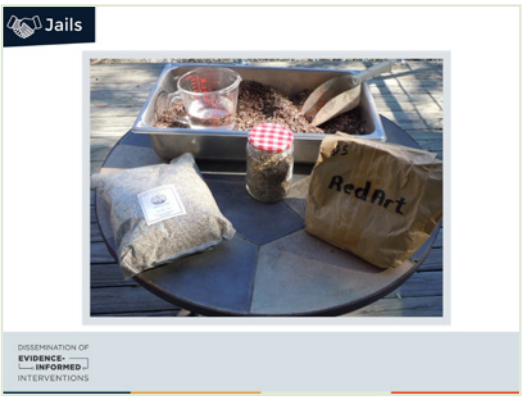
Total: 90 minutes

- 2 units/16 slides: 30 minutes
- Activity: 60 minutes

UNIT 1

SLIDE 1: Facilitator #1

Now that have we learned about the court liaison, you can likely see how important it is to coordinate and collaborate with an interdisciplinary, interconnected team—your network of care. This is essential to implementing and integrating the transitional care coordination intervention.



SLIDE 2: Facilitator #1

Consider the components of building a garden. It requires soil, seeds, water, and clay (or fertilizer). Just like in your network, you need different components in order to have a thriving garden. Keep this in mind as we go through this discussion leading to our gardening activity at the end of this session.

Citation: Jordan, AO. (2017). Strengthening Collaborations, SPNS Workforce Capacity Initiative, NYC Correctional Health Services, Collaborative Convening.

SLIDE 3: Facilitator #1

So now that we know we need to collaborate in order to implement the transitional care coordination model, what are the goals of collaborations?

Clearly, we have many systems to coordinate with, so do you know what systems you need to coordinate with? (Audience responses can include housing, health, employment, jails, and more).

Once identified, how would you let your community and partners know about the intervention? And then, how do you provide the resources to your staff—and partner organizations' staff— so that they can collaborate?

Citation: Jordan, AO. (2017). Strengthening Collaborations, SPNS Workforce Capacity Initiative, NYC Correctional Health Services, Collaborative Convening.

SLIDE 4: Facilitator #1

- Where will you begin? What other organizations are you already working with? As you are here together—look around—are there people here that can help build your network?
- Building on existing relationships and resources is a good way to enhance your network of care. Might the partners you work with now have other partners that can help?
- Are there other organizations you need to reach out to? Do you have mutual colleagues that can help carve the path?

SLIDE 5: Facilitators #1 & #2

To illustrate these myths and facts, facilitators will engage in a role play:

Facilitator #1: I would say that non-binding, non-financial agreements are not enforceable and, therefore, not worth the paper they are printed on.

Facilitator #2: That's not true. The agreements do have financial benefits because when you refer a client to clinic, they now can get paid for the services they deliver, especially to a patient who would likely have been out of care or patients they are looking for and can't find.

Facilitator #1: But some clinics aren't interested in reconnecting with "these" harder-to-serve folks and may be running their clinic without wanting the more challenging patients disrupting their flow.

Facilitator #2: Well, if we're going to get to zero new HIV infections and improve outcomes along the HIV care continuum, then someone will need to step-up to the plate and remember what the Ryan White HIV/AIDS Program is all about. I think providers want to do the right thing and don't have the resources or expertise to engage this more vulnerable population and so what your offering may be music to their ears and just the right fit for them. It will also help them save the time and effort they are spending looking for folks that you are ready to hand off.

Facilitator #1: So how do you get past the history we have with partners that have not always agreed with what we're trying to do?

Facilitator #2: Meet with each key partner, show the data and maps of areas where people return home after incarceration (such as what was shown in Module 1), and see what their catchment area is. Ask if they serve folks in this catchment area and help them see that they are already serving mutual clients and now they have a partner who can help them save money—like unnecessarily duplicating tests and knowing the last medication regimen.

Facilitator #1: Circle among the groups to facilitate participant response.

SLIDE 6: Facilitator #2

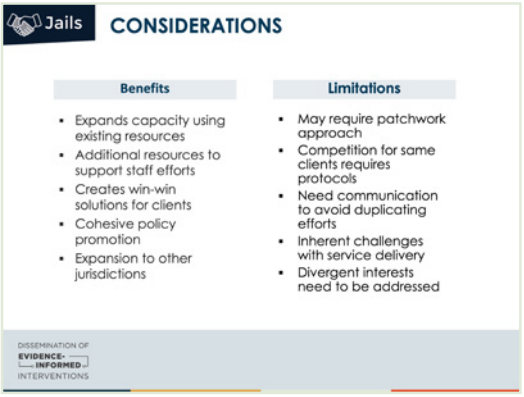
Clearly this is not about directories, though its helpful for staff to have this information. What you need are personal connections for your program to work.

SLIDE 7: Facilitator #1

Do you need or do you have these service provider groups in your network?

SLIDE 8: Facilitator #1

Remember, these relationships need to be nurtured. Do you have partner events? What opportunities exist and what might you create to show you are an active partner?



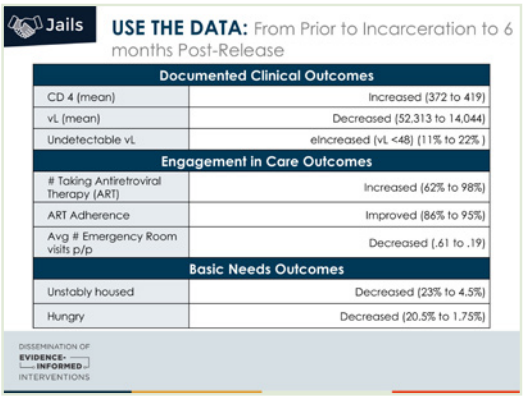
SLIDE 9: Facilitator #1

Remember this will take time to build, yet the benefits outweigh the limitations!

While collaborations help build capacity, provide additional resources, create win-win solutions, and promote cohesion and expansion, they also take time. So, as you begin, you may find gaps and need protocols to streamline the referral process, and need to err on the side of over-communicating until relationships and workflows are well-established.

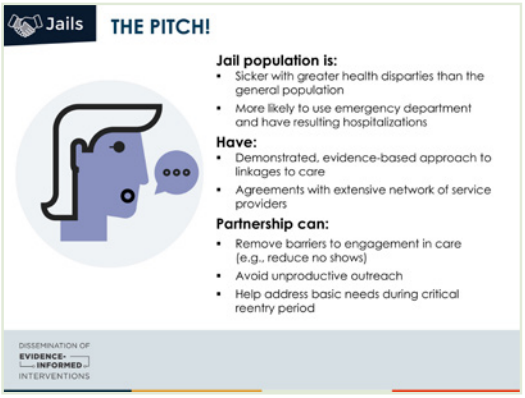
SLIDE 10: Facilitator #2

Implementing the transitional care coordination intervention will also lead to practice transformation. Is your organization ready to move to a more coordinated service model? Are you ready to collect linkage-to-care and maintenance-in-care outcomes? Consider applying for grant opportunities with commitment to reduce the portion of the population out of care. Demonstrated outcomes for the most vulnerable populations lead to a cost shift to programs with results; for example, the presentation slide outlines changes that occurred during NYC's implementation of the transitional care coordination model.



SLIDE 11: Facilitator #1

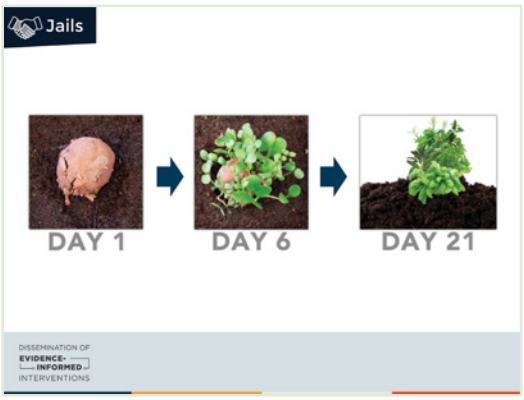
Use the data, based on results from the NYC implementation of the transitional care coordination intervention. The model has demonstrated clear evidence of improved clinical outcomes, which lead to increased undetectable HIV viral load—leading to community viral load suppression and reduced infections, which can be cost saving. This project also showed decrease use of shelters and emergency departments, which is also cost saving on a societal level.



SLIDE 12: Facilitator #1

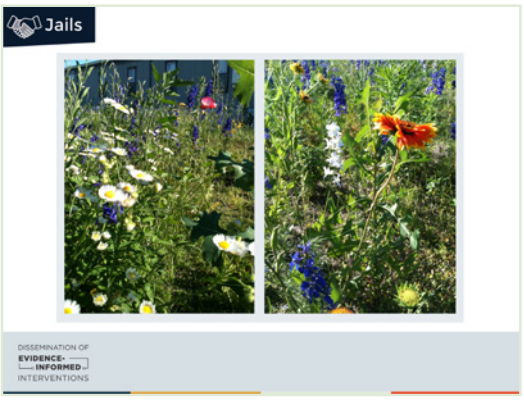
This is a sample of how to promote the transitional care coordination intervention. What's your pitch?

UNIT 2



SLIDE 13: Facilitator #2

We will now complete an interactive activity.



SLIDE 14: Facilitator #1

Activity:

How will your garden grow?

Have the class break out into four groups: one each for seeds, water, soil, and clay.

Provide the seed group with packets of seed, the water group with a pitcher of water and paper cups, the soil group with a bag of soil and paper cups, and the clay group with sufficient squares of clay for each participant.

Discuss negotiation strategies and provide the class participants with the recipe for making a seed ball: each team has only one of the four-needed ingredients and must get the other 3 groups to provide them with the other 3 ingredients.

Once all teams have negotiated for the needed materials, allow participants to make seed balls they can grow in their own garden.

The purpose is to teach negotiating skills and to illustrate the ways that collaborations require a give and take in order to improve the system-wide outcomes.

SLIDE 15: Facilitator #1

Thank participants for their engagement and allow time for them to network and obtain each other's contact information.

CLOSING

"This brings us to the end of our training. Do you have any questions for the facilitators, or your fellow participants?"