Improving Health Outcomes

Moving Patients Along the HIV Care Continuum and Beyond

JUNE 2017

INTERVENTION OVERVIEW & REPLICATION TIPS

Assess, Test, Link: Achieve Success (ATLAS) Program

Care Alliance Health Center (OH)

This intervention document is part of a training manual, **"Improving Health Outcomes: Moving Patients Along the HIV Care Continuum and Beyond"** and is published by the Special Projects of National Significance (SPNS), under the HIV/AIDS Bureau (HAB) of the Health and Human Service's (HHS), Health Resources and Services Administration (HRSA).

The full manual highlights 10 interventions along the HIV Care Continuum. Individual intervention chapters as well as the full manual are available.

- Diagnosing HIV
- ▶ Linkage to Care
- Retention in Care
- Prescription of ART & Medication Access
- Beyond the Care Continuum: Addressing HCV Comorbidity and Coinfection

U.S. Department of Health and Human Services
Health Resources and Services Administration
HIV/AIDS Bureau

Linkage to Care

Linkage to care, as it relates to the Care Continuum, refers to linking individuals who are HIV-positive to HIV primary care. This may include newly diagnosed individuals, persons previously diagnosed who have never been linked to care, or persons who have fallen out of care and are being re-linked. The standard of care for linkage is that persons who are diagnosed with HIV be linked to HIV medical care as soon as possible and no later than 30 days following diagnosis.[34]

Underserved populations, including many racial, ethnic, and sexual minorities, face numerous structural, financial, and cultural barriers that impede their linkage to and engagement in care.[35] Of those newly diagnosed, 74.5% of persons age 13 and older are linked to care within one month of diagnosis though just 56.5% are retained in HIV care.[36] Delaying HIV care and treatment can lead to poorer health outcomes and earlier death, instead of better health.[37] Delaying initiation of HIV care and treatment also creates the opportunity for HIV transmission to occur.[38]

Addressing several key areas has been found to improve linkage and re-engagement in care, including

- removal of structural barriers;
- increased social support services;
- use of peers, client navigation, and care coordination;
- a culturally responsive approach;
- appointment scheduling and follow up;
- timely and active referrals post-diagnosis;
- integrated one-stop-shop care delivery (e.g., co-located substance use, mental health, and other service offerings);

[34] CDC. Monitoring selected national HIV prevention and care objectives by using HIV surveillance data—United States and 6 dependent areas, 2014. *HIV Surveillance Supplemental Report* 2016;21(No.4). **www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-supplemental-report-vol-21-4.pdf** Accessed September 16, 2016.

[35] CDC. Monitoring selected national HIV prevention and care objectives by using HIV surveillance data—United States and 6 dependent areas, 2014. *HIV Surveillance Supplemental Report* 2016;21(No.4), Table 5a. **www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-supplemental-report-vol-21-4.pdf** Accessed September 16, 2016.

[36] CDC. Monitoring selected national HIV prevention and care objectives by using HIV surveillance data—United States and 6 dependent areas, 2014. *HIV Surveillance Supplemental Report* 2016;21(No.4). **www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-supplemental-report-vol-21-4.pdf** Accessed September 16, 2016.

[37] Horstmann E, Brown J, Islam F, et al. Retaining HIV-infected Clients in Care: Where are We? Where Do We Go From Here? *Clin Infect Dis.* 2010;50:752–61.

[38] AIDSInfo. *Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents.* Clinical Guidelines Portal. Available at: **https://aidsinfo.nih.gov/guidelines**

- active approaches to reach and re-engage individuals who are out of care—for instance, using the Internet and mobile devices (e.g., for social networking, texting); and
- assistance with entitlements/benefits paperwork to secure additional financial, insurance, identification, and social support services.

A warm transition is also critical. This is the act of "applying social work tenets to public health activities for those with chronic health conditions, including HIV-infection."[39] Often the HIV tester is linking a client to another provider and possibly even to another facility. What this linkage looks like, how active it is, how comfortable the client is made to feel in establishing yet another new relationship shortly after receipt of their diagnosis can either help increase the likelihood of linkage to care or add to challenges that complicate it. Without a caring, supportive, and warm transition approach, pre-existing barriers to care and other stressors will continue to take priority.[40]

SPNS has tested and identified interventions that have proven effective in linking, re-engaging, and retaining clients in care, even for some of the hardest-to-reach and most vulnerable populations.

[39] Jordan AO, Cohen LR, Harriman G, et al. Transitional Care Coordination in New York City Jails: Facilitating Linkages to Care for People with HIV Returning Home from Rikers Island. JAIDS (Suppl). 2013;(2); S212–219.

[40] Jordan AO, Cohen LR, Harriman G, et al. Transitional Care Coordination in New York City Jails: Facilitating Linkages to Care for People with HIV Returning Home from Rikers Island. JAIDS (Suppl). 2013;(2); S212–219.

Improving Health Outcomes

Moving Patients Along the HIV Care Continuum and Beyond

Diagnosing HIV

INTERVENTION OVERVIEW & REPLICATION TIPS

Social Networks Testing
Wisconsin Department of Health Services

Linkage to Care

INTERVENTION OVERVIEW & REPLICATION TIPS

▶ Assess, Test, Link: Achieve Success (ATLAS) Program
Care Alliance Health Center (OH)

Enhancing Linkages to Care for Women Leaving Jail
University of Illinois at Chicago

Video Conferencing Intervention
Louisiana Department of Health and Hospitals

Active Referral Intervention
Virginia Department of Health

Louisiana Public Health Information Exchange (LaPHIE)
Louisiana State University, Health Science Center and Louisiana Department of Health Hospitals, Office of Public Health

Retention in Care

INTERVENTION OVERVIEW & REPLICATION TIPS

My Health Profile
New York-Presbyterian Hospital

Prescription of ART & Medication Access

INTERVENTION OVERVIEW & REPLICATION TIPS

Care Coordination Intervention
Virginia Department of Health

Beyond the Care Continuum: Addressing HCV Comorbidity and Coinfection

INTERVENTION OVERVIEW & REPLICATION TIPS

Hepatitis Treatment Expansion Initiative
University of California, San Francisco, San Francisco General Hospital HIV Clinic

Hepatitis Treatment Expansion Initiative
Washington University School of Medicine (MO)

Assess, Test, Link: Achieve Success (ATLAS) Program

Care Alliance Health Center (OH)

The table below provides a general overview of the Assess, Test, Link: Achieve Success (ATLAS) intervention so readers can assess the necessary steps required for replication. This intervention integrates jail-based case managers into the community HIV case management system to engage and subsequently link incarcerated individuals as they transition from jail to community.

Intervention at-a-Glance	
Step 1	**Provide HIV Testing or Promote Existing Testing in Jail** Offer and advertise HIV testing.
Step 2	**Conduct Client Needs Assessment** Meet with client after intake and conduct screenings and needs assessment.
Step 3	**Create a Discharge Plan** Draft a discharge plan complete with referrals for HIV primary care and social support services.
Step 4	**Case Conference with Community-based Case Manager** Collaborate with community-based case manager to ensure communication and "warm linkage" upon release to promote continuity of care.
Step 5	**Offer Health Education (if possible)** Provide health education classes (open invitation) covering HIV/sexually transmitted infections (STIs), hepatitis, tuberculosis, and general health and heath management.
Step 6	**Prepare Clients for Discharge** Finalize discharge plans, document all referrals, and furnish a copy of discharge plan and client's jail chart medical review.
Step 7	**Follow up Post-Release** Follow up with clients and community-based case managers to ensure connection to care.
Step 8	**Support Community Outreach** Support community-based case managers in locating clients who fall out of care.

Sources: Care Alliance Health Center. *Special Projects of National Significance (SPNS) Program: Enhancing Linkages to HIV Primary Care in Jail Settings Initiative, EnhanceLink Program Description Form*. 2012.

Care Alliance Health Center. Enhancing Linkages to HIV Primary Care & Services in Jail Settings. Final Report. 2012.

Resource Assessment Checklist

Organizations should walk through a Resource Assessment (or Readiness) Checklist to assess their ability to conduct this work. If organizations do not have these components in place, they are encouraged to develop their capacity so that they can successfully conduct this jail intervention. Questions to consider include:

- ☐ Does your organization offer case management services? If so, is there a case manager who passes jail clearance requirements?
- ☐ Does your organization have access to a jail within your service area with which you can partner?
- ☐ Is HIV testing already taking place within the jail, or is your organization able to provide it?
- ☐ Does your organization offer HIV primary care and social support services or have relationships in place with agencies that do? If not, is your organization able to establish and maintain such relationships?
- ☐ Is your organization filling an unmet need for the jail, or is another organization already offering the services and intervention being proposed?
- ☐ Is staff interested in working with and providing compassionate services to incarcerated individuals?

Sources: Care Alliance Health Center. *Special Projects of National Significance (SPNS) Program: Enhancing Linkages to HIV Primary Care in Jail Settings Initiative, EnhanceLink Program Description Form*. 2012.
Care Alliance Health Center. *Enhancing Linkages to HIV Primary Care & Services in Jail Settings*. Final Report. 2012.

Setting the Stage: Grantee Intervention Background

The Care Alliance Health Center created and implemented the ATLAS program in downtown Cleveland's Cuyahoga County Corrections Center. Ohio's Cuyahoga County has approximately 1.2 million residents, including Cleveland's 438,000 residents. The demographics of the incarcerated population at this urban jail are approximately 80% male, with a capacity of 1,800 and 26,000 bookings annually (depending on the size of the specific jail facility).[41] *Booking* is the process of entering an official charge against an arrested person on a police register.

"We, as a community, are responsible for getting people on their meds and into care, so if we can partner with the jails to optimize care then that benefits us all."

– Dr. Ann Avery,
Care Alliance Principal Investigator

of incarcerated individuals pass solely through jails.[48]

Prior to coming to jails, many individuals have not received health care. If they have, services are often fragmented due to co-occurring health conditions or barriers that interfere with access (e.g., substance use, mental illness), and structural inequalities, including poverty, unstable housing, limited educational attainment, and un- or underemployment.[42, 43] Vulnerable populations are less equipped to address health issues when faced with competing needs related to survival, such as food and shelter.[44] In these communities, health disparities may lead to risky behaviors, which in turn contribute to acquisition of HIV infection, and crime leading to arrest.[45, 46]

These activities are particularly critical given the nature of the jail environment, where marginalized individuals with a range of social and health problems congregate in one place. More people pass through jails than prisons, offering a unique and promising opportunity to intervene and engage them.[47, 48] However, such individuals are often discharged quickly, creating an important—but small—window of time for conducting an intervention.[49, 50] Discharge planning and associated linkage to care upon release are critical, since the majority of detainees never move on to prisons and, instead, return to the same communities they recently left.

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[41] Care Alliance Health Center. Enhancing Linkages to HIV Primary Care & Services in Jail Settings. Final Report. 2012.
[42] Kushel MB, Hahn JA, Evans JL, et al. Revolving Doors: Imprisonment Among the Homeless and Marginally Housed Population. *Am J Public Health*. 2005;95:1747–52.
[43] Centers for Disease Control and Prevention (CDC). *HIV Testing Implementing Guidance for Correctional Settings.* 2009.
[44] Zellman H. Philadelphia FIGHT Institute for Community Justice. *Establishing the Need for an Intervention Program.* 2012.
[45] HRSA, SPNS. Enhancing Linkages and Access to Care in Jails. *What's Going on @ SPNS.* July 2012.
[46] Flanigan TP, Zaller N, Beckwith CG, et al. Testing for HIV, Sexually Transmitted Infections, and Viral Hepatitis in Jails: Still a Missed Opportunity for Public Health and HIV Prevention. *JAIDS (Suppl).* 2010;55(2):S78–S83.
[47] Zack B, Hane L. At the Nexus of Correctional Health and Public Health: Policies and Practice, American Public Health Association Annual Meeting. 2015 [Presentation]
[48] Spaulding AC, Seals RM, Page MJ, et al. HIV/AIDS among inmates of, and releases from, US correctional facilities, 2006: declining share of epidemic but persistent public health opportunity. *PLos One.* 2009;4(11):1–8.
[49] Spaulding AC, Perez SD, Seals RM, et al. Diversity of Release Patterns for Jail Detainees: Implications for Public Health Interventions. *Amer J of Public Health.* 2010;1010(S1):S347–52.
[50] Tinsley M, Health Resources and Services Administration (HRSA), HIV/AIDS Bureau (HAB), Special Projects of National Significance (SPNS) Program. Enhancing Linkages to Primary Care & Services in Jail Settings: A Critical HIV/AIDS Bureau Initiative. [Presentation.]
[51] Spaulding AC, Seals RM, Page MJ, et al. HIV/AIDS Among Inmates of, and Releases From, US Correctional Facilities, 2006: Declining Share of Epidemic but Persistent Public Health Opportunity. *PLos One.* 2009;4(11):1–8.

Care Alliance received SPNS funding as part of the Enhancing Linkages to HIV Primary Care & Services in Jail Settings (EnhanceLink) to address these barriers and link transitioning clients from jail into HIV primary care upon release.

Description of Intervention Model

CHALLENGE ACCEPTED

THE CHALLENGE: finding hard-to-reach, high-risk, HIV-positive, previously undiagnosed individuals and actively linking them to HIV primary care and services.

Intervention Model:
Transitional Jail Care Coordination with Strength-Based Case Management

The ATLAS intervention involves:

1. creation and implementation of a jail-based HIV testing and linkage case management program (if jail-based HIV testing program does not currently exist);
2. providing client education and risk reduction counseling;
3. identifying HIV-positive clients and providing linkage case management during their jail stay;
4. coordinating resources and communication with community and jail providers so clients connect to medical care and social services while incarcerated and upon community release;
5. encouraging retention in care upon release to the community; and
6. conducting client follow up, as necessary.[52,53]

The Continuum of Care was in full effect and the client has a collaborative release plan in place.[54]

The intervention involves transitional jail care coordination grounded in strength-based case management. Strength-based case management focuses on identification of personal and environmental resources that assist clients in reaching their goals (specifically medical and social goals).

This intervention includes a particular innovation: the integration of jail-based case managers into the community's HIV case management network, which enhances linkages and subsequent retention in care. As the ATLAS program describes:

> *"Jail-based case managers become integrated into the HIV case management network in the community, meeting with supportive services providers monthly, forming strong working relationships which provide ease and open communication when case conferencing and providing referrals for care upon release. The Continuum of Care was in full effect and the client has a collaborative release plan in place."*[54]

[52] Care Alliance Health Center. Special Projects of National Significance (SPNS) Program: Enhancing Linkages to HIV Primary Care in Jail Settings Initiative EnhanceLink Program Description form. 2012.
[53] Care Alliance Health Center. Enhancing Linkages to HIV Primary Care & Services in Jail Settings. Final Report. 2012.
[54] Care Alliance Health Center. Special Projects of National Significance (SPNS) Program: Enhancing Linkages to HIV Primary Care in Jail Settings Initiative, EnhanceLink Program Description Form. 2012.

Staffing Requirements & Considerations for Replication

Staffing Capacity

Based on the ATLAS work, here are the types of staff necessary to replicate this intervention.

Jail-based case manager: An important part of the intervention is a case manager based within the jail who also actively engages with community-based case managers. This facilitates more thorough discharge planning and more active linkage. This position requires:

- typically a Bachelor's degree in social work, psychology, public health, or related field; and
- training in case management techniques and (if conducting research) training in evaluation methods and human subjects research protocols.

Although this is a full-time position, organizations serving a smaller caseload and, thus, implementing a smaller-scale intervention can have a case manager in the jail part-time. A part-time position would split their time between the community and the jail or have the jail help facilitate in-reach. (See also Text Box "**Replicating on a Budget.**") Splitting time between the jail and the community is not necessarily a bad thing. If agencies already invest in case management personnel, no new monies are needed; instead, this requires re-imagining or re-defining the jail as an extension of the community—which it is.

Community-based case manager: It is imperative that the jail-based case manager has a community-based case manager where he/she can refer recently released clients . This community-based manager may work within the same agency as the jail-based case manager, or at a partner organization. Regardless, the two persons should have open lines of communication and a means for confirming linkage to, and subsequent follow-up of, appointments. This work is part of the case manager's regular caseload; it may include clients who have experienced recidivism. While clients are still detained, community-based case managers can keep apprised of their status and anticipated discharge dates by contacting the jail-based case manager for updates. This position has similar schooling requirements as the jail-based case manager.

HIV tester: A full-time HIV tester works in the jail to bolster testing and identification of HIV-positive clients. This is done because prior to the intervention, there was minimal access to or routinization of HIV testing within the jail. This position requires:

- a high school degree; and
- training in HIV testing and education.

Organizations replicating this work should investigate the degree of existing HIV testing within their jails. For ATLAS, the introduction of more extensive HIV rapid testing is supported by the Ohio Department of Health.

Staffing Capacity

Optional positions:

Part-time community-based research assistant: This position filled evaluation requirements for the SPNS initiative; however, agencies without a more formal evaluation component do not necessarily require it. Responsibilities mainly included conducting community follow-up evaluation. If used, this position requires:

- a Bachelor's degree in social work, psychology, public health, or a related field; and
- training in case management techniques and protocols for evaluation and human subjects research.

Part-time data management assistant: Without a more formal evaluation component, this position is not required. Primary role involves input and assistance with study data. This position requires similar schooling requirements as the part-time community-based research assistant.

Health educator: This individual provides health education classes within the jail, covering topics such as HIV, STIs, hepatitis, tuberculosis, and risk reduction. This position requires:

- a Bachelor's in education, social work, psychology, public health, or a related field; and
- training in HIV education, risk reduction, and HIV testing/counseling.

It is highly recommended, if possible, to incorporate a health educator into the intervention. After SPNS funding, ATLAS was not able to sustain this position so it has woven educational topics into clients' broader risk and needs assessment discussions, reinforced by the community-based case manager during discharge planning.

Staff Characteristics

Jail-based case managers need to be

- flexible to the unique challenges of working with people who are in jail and those soon-to-be released;
- able to meet jail security clearance criteria;
- genuinely interested in working with incarcerated individuals; and
- willing to follow jail policies and guidelines while in the jail.

All staff should:

- have an extensive awareness of community resources;
- be able to foster cooperation and communication with jail staff and community-based case managers;
- be able to deliver culturally appropriate services;
- offer non-judgmental services;
- ideally be reflective of racial and ethnic backgrounds of clients; and
- ideally have language ability (e.g., Spanish) as appropriate for your jail population.

Sources: Care Alliance Health Center. *Special Projects of National Significance (SPNS) Program: Enhancing Linkages to HIV Primary Care in Jail Settings Initiative, EnhanceLink Program Description Form.* 2012.

Replication Tips for Intervention Procedures and Client Engagement

This section provides tips for readers interested in replicating the intervention and, where applicable, includes grantee examples for further context.

It is useful to know what the process looks like for clients when they arrive at the jail in order to better understand the transitional jail care coordination intervention work. Upon arrest, clients come into the jail and are booked—a process that typically involves recording of the individual's name, fingerprinting, "mug shot," assessment of any personal property, and review of any outstanding warrants. For these first few hours, they're kept in a general holding area.

After approximately 4–6 hours, incarcerated individuals are taken to an intake "pod area." Pods are large dormitories housing many people in one room. This is where clients receive their initial health screening with a jail nurse.

After screening with the jail nurse, the intervention steps officially begin. These include:[55, 56]

1. **Providing HIV Testing.** The HIV tester offers opt-in rapid HIV testing to incarcerated individuals during their routine health assessments, and to those housed during their first 24 hours in the jail intake pods. (Note: Opt-out testing is preferable; however, space constraints or jail policies may prohibit intervention staff from meeting with every individual and providing routine opt-out testing.)

   Testing also takes place via medical staff referral. Other ways the HIV tester seeks to increase awareness of and access to HIV testing, includes:

- Securing buy-in from correctional officers who can encourage people to sign up for testing.

HIV Testing in Jails

The CDC strongly recommends jail-based HIV testing, which is also consistent with national goals.

HIV testing in jails provides public health officials the opportunity to identify new cases and reestablish contact with previously diagnosed individuals, many of whom never entered care or have dropped out of care. The presence of incarcerated clients throughout the HIV Care Continuum, and all present in one place, underscores the strategic role jails have to play in curtailing the epidemic.

To be successful in structuring HIV programs in jails, healthcare and correctional officials will be well served to:

1) Understand the HIV Care Continuum from the standpoint of engagement interventions that promote participation;

2) Be aware of jail, community, and prison interventions that promote engagement in care and may already be in operation;

3) Anticipate and plan for the unique barriers that come with working in the unpredictable and evolving environment of jails; and

4) Be creative in designing engagement interventions suitable for both newly and previously diagnosed individuals.

Sources: de Voux, Spaulding AC, Beckwith, C et al. Early Identification of HIV: Empirical Support for Jail-based Screening PLos One. 2012;7(5):1–7. Rapp RC, Ciomcia R, Zaller N, et al. The Role of Jails in Engaging PLWHA in Care: From Jail to Community. *AIDS and Behavior*. 2013 (Suppl);17:S89-99.

[55] Care Alliance Health Center. Special Projects of National Significance (SPNS) Program: Enhancing Linkages to HIV Primary Care in Jail Settings Initiative, EnhanceLink Program Description Form. 2012.
[56] Care Alliance Health Center. Enhancing Linkages to HIV Primary Care & Services in Jail Settings. Final Report. 2012.

- Providing a brief 5-minute "elevator pitch" to the dorm area (if permissible) about the importance of testing. Local facts as well as access-to-care issues are highlighted to garner attention. This outreach is also provided to the general population "pods" as a way to extend the reach of the program.

2. **Meeting Client and Assessing Needs.** After intake, clients go to a long-term cell. Within a couple of days, the jail-based case manager visits HIV-positive clients (either newly diagnosed in the jail, or self disclosed during the health screening). The reason for meeting with the jail-based case manager is not advertised. The jail-based case manager and the client go to a private table outside of the general cell area, where the case manager describes the intervention.

   If the client agrees to participate, the case manager does a full needs assessment (typically taking 35–40 minutes); this includes assessing substance use, mental health symptoms, medical needs, housing needs, food access needs, support system, and any current medications.

   Discharge plans are then created, based on each client's specific needs. The jail-based case manager reviews the client's needs and discusses what type of community-based agency and medical care would be most appropriate. If a client is already connected to a community medical and/or social service provider, the case manager, discusses whether the client would like to re-connect with those agencies and secures the client's permission to make contact and share information. All communications and recommendations are documented through standard case management notes and documented release of information forms.

   Simultaneously, the jail-based case manager works with correctional staff to ensure the client has access to mental health, substance use, and any other services needed during their incarceration. The jail-based case manager also follows up with the jail infectious disease (ID) nurse to ensure HIV medications and HIV care services are coordinated during the client's jail stay.

3. **Creating a Discharge Plan.** Once the client and jail-based case manager determine which agencies to make referrals, the jail-based case manager contacts the agencies and sets up appointments for release. A discharge plan is drafted for the client. Discharge plans include referrals to mental health and/or substance use services, HIV primary care, housing, and other necessary services. The jail-based case manager works with the Ryan White community-based case manager at the agencies on the receiving end of the referrals, to ensure the client is connected directly to them or to a specific social worker once released. This close collaboration and communication between the jail-based case manager and the community-based case manager helps ensure continuity of care, from the jail to the community. It also facilitates a "warm transition" for the client.

   The jail-based case manager follows up with the client during regularly scheduled, even weekly, appointments while the client is incarcerated—though the client can request more frequent meetings if they wish to discuss HIV care, support, or have questions about their discharge plan.

Replicating on a Budget

Although the jail-based case management position is central to this intervention, there are three ways this work—or central components of this work—can be replicated on a smaller scale:

1. The same case manager manages clients in the jail and the community:

As intervention principal investigator Ann Avery explains, "During the initial three months following release, inmates often need additional assistance in connecting to services, and a consistent contact could better assist the individual…[and] without the additional task of collecting data for evaluation, the Interventionist role could effectively manage clients both in the jail and in the community."

2. Part-time jail-based case management:

The density of medical case management services should follow the density of HIV prevalence, so an area or jail with lower prevalence may not require a full-time, jail-based case manager. At its smallest scale, the intervention would need weekly visits from a case manager to establish relationships with jail staff and be better informed as to upcoming anticipated discharges.

3. Relationship building and inreach:

Avery adds, "An alternative is to create a relationship with the jail so that if someone comes in who is HIV positive, the jail can do inreach and knows to call your organization so you can send in your medical case manager."

4. **Case Conferencing with Community Provider.** The jail-based case manager conducts case conferencing with community-based medical providers and the Ryan White community case manager. These discussions take place throughout the client's stay and include coordination of appointments prior to client release.

Community-based Ryan White case managers can also contact jail-based case managers at any time to receive updates about their clients.

5. **Offering Health Education (If Possible).** Based on sexual and substance use-related risk factors identified during the baseline assessment, clients are referred to the intervention health educator.

All incarcerated individuals, not only those who test for HIV or those who disclose their HIV diagnosis, should be offered health education classes. This helps avoid stigma or disclosure issues. Topics range from HIV/STIs, hepatitis, and tuberculosis, as well as general health and health management. The jail, especially the jail medical staff, often sees value in the classes because they fill a need. Classes utilize large group discussions, hands-on activities, videos, and other instructional techniques. Given the unpredictability and often short stays within jail, classes should be concentrated to three classes over the course of a week; this helps ensure clients obtain all of the health and risk reduction information the classes have to offer prior to their release.

After SPNS funding, the ATLAS program was not able to sustain the health educator position. As such, harm reduction and health education tips have been woven into broader needs assessment discussions during discharge planning and are reinforced by the community-based case manager.

6. **Preparing Clients for Release**. Discharge plans (sometimes also called "release plans") are finalized and a copy is provided to clients. These plans should document all activities in the jail and include all plans and referrals made for the client for the time of release, along with the jail chart medical review.

The jail-based case manager helps apply for Medicaid and other services, if clients are not enrolled or these programs need to be re-activated upon release. Bus tickets are also available for release, as needed.

7. **Following up Post-Release.** Jail-based case managers conduct monthly follow-up after the client's release (providing additional referrals, as needed). This is done to ensure continued connection to care. Follow-up work also includes monthly meetings or phone calls with clients and contact with community-based medical providers and case managers.

8. **Supporting Community Outreach.** If clients drop out of care after release, the intervention staff collaborates with community outreach workers to locate them. This is accomplished by reaching out to other community corrections centers and monitoring jail and prison records and databases to see if the person has been reincarcerated, as well as checking emergency contact numbers and listed address(es).

   Nicknames/known aliases, identifying marks (such as tattoos), and places where the client likes to hang out should all be documented on the contact information form collected during the jail stay with other more traditional information (e.g., address, phone number) to help facilitate quicker outreach and re-linkage.

Intervention Preparation

An important part of preparing for a successful intervention in a jail setting includes familiarizing yourself with the jail—including jail policies.

For instance, the ATLAS health educator had to change program supplies, since pens with caps and blue ink pens are not allowed in the jail but click-style, black pens are. Paper handouts can be brought in, but they cannot be stapled or paper-clipped together. Cellphones are not allowed into the jail. While these may sound like very specific requests, it is imperative that outside organizations coming into the jail respect that they are guests—and that means abiding by the jail's rules and regulations. This may also mean that staff you want in the jail cannot pass required clearance standards. It is important to discuss both personal and programmatic requirements with jail administrators up front.

Jails require flexibility and creativity. For instance, some activities or areas of the jail that staff are allowed into one day may be different the next. Changes can occur because of lockdowns. These changes may affect a single day, or in instances where new/different corrections officers are placed in the jail (due to reassignment or turnover), it requires development of new relationships.

It is important, therefore, to prepare for the intervention by outlining how it will work and what the benefits are for the jail. This requires that agencies do their homework in advance, if they aren't already collaborating with the jail. The goal is to fill a real need that is not being addressed by other community agencies within the jail. As such, the preparatory research should include knowing which partner agencies

and contractors are working in the jail, and what they are doing there. Some of these agencies may even assist in helping you with correctional leadership buy-in and in partnering on aspects of your intervention.

Face-to-face meetings facilitate stronger working relationships and partnerships. In the age of electronic communication, it is easy to rely on technology; however, picking up the phone and having in-person meetings can help to move things forward and build stronger partnerships for your intervention.

> "I think it's important to ask good questions, particularly to the jail because it's easy to say, *'This is what we have and what we want to bring you, and you should do this.'* It's harder to go in with an open mind of what really is needed and what would be beneficial for both of us to do together."
>
> –Dr. Ann Avery,
> Care Alliance Principal Investigator

Education is also a key to a successful intervention. Educate corrections officers about HIV—and universal precautions and confidentiality—and continue to do periodic education.

Finally, offer a spectrum of services for all individuals, not just those who are HIV-positive, so as to provide a layer of privacy and protection for the clients.

Securing Buy-in

Identifying supporters in the jail administration is key to a successful intervention. The jail's medical department director and ID nurse are essential supporters of the project and may help advocate for the intervention with higher-ups in the jail administration. The medical director and ID nurse can help identify locations where the intervention team can provide services, as well as provide feedback to proposed protocols.

Meet with jail administration staff to refine the intervention and draft protocols. Provide trainings to medical and corrections staff to facilitate open dialogue and create an opportunity to address fears, misconceptions, and other concerns.

Be sure to collaborate with the community. Attend community events, including Ryan White Planning Council meetings, Regional Advisory Group prevention meetings, Ryan White Case Management Network meetings, and other places where key stakeholders congregate in order to foster working relationships, increase awareness about the intervention, and aid referrals to community organizations. Talk to community providers about how best to work together and share information to facilitate referrals and how often to have ongoing check-ins, since successful referrals and linkages rely on these relationships. Nurture these relationships to ensure everyone is on board, communicating regularly, and facilitating successful releases.

Overcoming Implementation Challenges

The nature of the jail setting is inherently challenging for several reasons:

- **High Staff Turnover:** To address staff turnover at the jail, provide regular education sessions, and prepare to re-introduce yourselves and the program throughout the intervention. Staff turnover at community-based organizations (CBOs) is also not uncommon. The jail-based case manager should keep in frequent contact with the CBOs.
- **Complicated Clients with Extensive Mental Health and Substance Use Issues:** Working with clients who have complex comorbidities involves patience. Intervention staff need to meet clients "where they're at" and ensure clients are connected to appropriate services both within the jail and via referral to CBOs upon discharge.
- **Mostly Open Jail Spaces to Meet Clients:** Open jail spaces are often the only places where intervention staff can meet with clients. Yet, confidentiality is critical. To help address this, work to de-identify the program as being HIV-specific (e.g., offering testing, health education, etc. to all individuals), work with the jail's medical director and ID nurse to find suitable locations for meeting with clients, and ensure that conversations are out of earshot from corrections officers.
- **An opt-in HIV testing program:** If the jail has an opt-in testing program, as was the case in the Cuyahoga County Corrections Center, advertisement of the availability and benefit of testing in numerous locations throughout the jail will be increasingly important.
- **Clients are Not Discharged:** It can be challenging to spend considerable time working on a discharge plan only to have the client ultimately sent to prison. Because the jail-based case manager receives lists from the jail and regularly communicates with jail staff, the "curve" at which they can accurately predict whether or not a client will be released—and when—improves. Continued communication with jail staff about predicted discharge dates is also important. Better assessment of discharge allows staff to focus on clients most likely to return to the community.

Promoting Sustainability

Ryan White HIV/AIDS Program funds may be able to support the transitional jail care coordination work. Care Alliance uses Part A transitional care coordination to sustain the jail-based case manager position and Part C funds to support the HIV tester role. Partnering with other agencies within the jail may also help promote sustainability of the intervention.

Conclusion

The transitional jail care coordination intervention helps address continuity of care issues as clients are released from the jail into the community. Although the time period from intake to release can be brief, it offers a critical window to engage an otherwise hard-to-reach population, intervene, and move them along the HIV Care Continuum. Many incarcerated individuals have undiagnosed mental illness, are unaware of their HIV status or are out of care at the time of incarceration, and suffer from many health disparities, making intervention all the more important.

"The single largest predictor of client success...is whether a client is actively linked to a Ryan White case manager in the community upon release."

–Dr. Ann Avery,
Care Alliance Principal Investigator

Community-based providers working with vulnerable populations would do well to investigate the feasibility of replicating a similar intervention. Jail interventions, however, cannot be successfully developed independently—partnerships with jail administrators are essential. The role of the Ryan White community-based case manager is also essential. The single largest predictor of client success, which is statistically associated with retention in care one-year post-release, is whether a client is actively linked to a Ryan White case manager in the community upon release.

Other Available Resources

- **Enhancing Linkages to HIV Primary Care & Services in Jail Settings Initative**
- **Enhancing Linkages to HIV Primary Care and Services in Jail Settings Evaluation Site**
- **Creating a Jail Linkage Program: Tools from the Integrating HIV Innovative Practices Project**
- **SPNS Initiative Web page and associated peer-reviewed journal articles**
- Certification as a health educator (available through the **National Commission on Health Education Credentialing**)