Improving Health Outcomes

Moving Patients Along the HIV Care Continuum and Beyond

JUNE 2017

INTERVENTION OVERVIEW & REPLICATION TIPS

Care Coordination Intervention

Virginia Department of Health

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

Prescription of ART & Medication Access

The U.S. Department of Health and Human Services (HHS) Panel on Antiretroviral Guidelines for Adults and Adolescents recommends immediate initiation of, and lifelong adherence to, antiretroviral therapy (ART) for all HIV-positive adults and adolescents, regardless of CD4 count. This recommendation is based, in part, on mounting evidence over the last decade on the benefit of ART as a means of prevention.

Using treatment as prevention gained greater attention—and traction—when data from the landmark HIV Prevention Trial Network (HPTN) 052 found that use of ART reduces HIV transmissibility by 96%.[127]

However, a growing body of anecdotal evidence points to gaps in understanding and practice among providers when it concerns starting HIV-positive clients on ART. A recent study found that only 1 in 7 clinicians immediately began treatment of clients who tested positive.[128] This contributes to the HIV Care Continuum gap between retention in care, prescription of ART, and subsequent medication access. It also further delays viral suppression, which is known to decrease transmissibility and result in improved health outcomes and longer life expectancy.

Providers can position their clients for success by leveraging the Ryan White AIDS Drug Assistance Program (ADAP) and pharmaceutical/patient assistance programs, by assisting clients with health insurance and benefits enrollment, and by offering education about the importance of ART adherence.

The Virginia Department of Health's Care Coordination intervention illustrates that even for highly vulnerable populations, such as clients who are about to be released from incarceration, medication access programs are possible, and they work. By ensuring active rather than passive follow-up, leveraging available medical and social support systems, coordinating with other care providers and staff (e.g., patient navigators, ADAP coordinators), and being flexible to client needs, lifesaving medications can get into the hands of people who need and will use them. Adherence and improved health outcomes can then follow.

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[127] Cohen MS, Chen YQ, McCauley M, et al; HPTN 052 Study Team.Prevention of HIV-1 infection with early antiretroviral therapy. *N Engl J Med*. 2011.11;365(6):493–505.
[128] Kurth A, Mayer K, Beauchamp G, et al; HPTN (065) TLC-Plus Study Team. Clinician Practices and Attitudes Regarding Early Antiretroviral Therapy in the United States. *J Acquir Immune Defic Syndr*. 2012;61(5):e65–9.

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)

Care Coordination Intervention

Virginia Department of Health

The table below provides a general overview of the Care Coordination intervention so readers can assess the necessary steps required for replication. This intervention promotes HIV medication access, coverage, and pickup for individuals transitioning from correctional facilities.

Intervention at-a-Glance	
Step 1	**Coordinate with Department of Corrections (DOC) or Jail Medical Staff** Receive referral from correctional facility and collaborate with existing medical staff to coordinate the discharge process. Obtain consent to share client information prior to release along with other critical information needed to begin enrollment of the client into an expedited AIDS Drug Assistance Program (ADAP).
Step 2	**Facilitate Referrals** Facilitate referrals to community support services, such as case management, linkage to support services, mental health services, patient navigation, and any other existing pre- and post-release programs that can assist in meeting client needs and supporting their transition.
Step 3	**Link Clients to Certified Application Counselor and Support Staff** Connect clients to certified application counselors within 60 days post-release. Link referred clients (if not already enrolled) with additional case management, patient navigation, and other services.
Step 4	**Facilitate Medication Access** Per agreement with DOC, facilitate client access to HIV medications upon release and confirm clients are active and enrolled in ADAP or other prescription coverage program. Note: It is not uncommon for the supply of antiretroviral therapy (ART) to vary from prisons and jails.
Step 5	**Monitor Medication Pickup and Medical Appointments** Monitor to ensure that HIV medications are dispensed, picked up, and consistently accessed over a 12-month period. Monitor client attendance at HIV medical visits for 12 months. If clients miss medication pick up or medical appointments, care coordinators follow up with clients by phone.
Step 6	**Conduct Follow-up/Re-engage Clients** Follow up with clients and those lost to care for more than 6 months, and refer them to a patient navigator or disease intervention specialist to assist in bringing them back into care.

Source: Virginia Department of Health. Care Coordination Implementation Manual. Virginia Department of Health, Special Projects of National Significance, System Linkages and Access to Care Initiative. Final Report. October 2015.

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 the Care Coordination Intervention. Questions to consider include:

- ☐ Does your organization have access to a correctional facility to partner with in your service area?
- ☐ Is your organization filling a need for the DOC and recently released individuals, or is another agency already conducting similar work?
- ☐ Does the proposed care coordinator have a driver's license or other transportation to commute to correctional facilities and meet with DOC and community organization staff?
- ☐ Can the proposed care coordinator pass security clearance requirements to enter the DOC and local/regional jails?
- ☐ Does your organization have—or have access to—a certified application counselor who can enroll recently released individuals into health insurance?
- ☐ Does your organization have a pharmacist on staff or a partnership with a specialty pharmacy? Is the pharmacist/pharmacy familiar with ADAP and pharmaceutical assistance programs?
- ☐ Does your organization receive Part B base and/or ADAP funding or have other means to provide medication access to recently released clients?
- ☐ Does your organization offer case management services or have access to a community partner who does?
- ☐ Does your organization offer or have contact with other agencies that offer HIV primary care and social support services where clients can be referred? If not, can these relationships be fostered?
- ☐ Is staff interested in, educated about, and compassionate toward individuals who have been incarcerated?

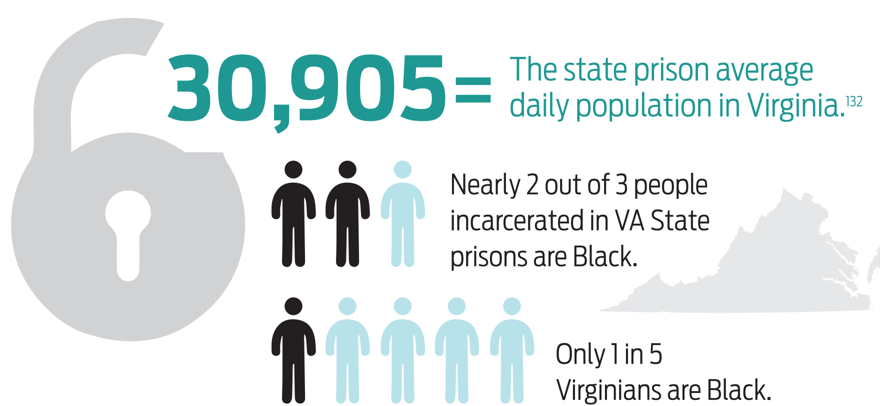
Source: Virginia Department of Health. *Care Coordination Implementation Manual. Virginia Department of Health, Special Projects of National Significance, System Linkages and Access to Care Initiative.* Final Report. October 2015.

Setting the Stage: Grantee Intervention Background

Without effective linkage and medication access interventions, the same barriers to care that exist prior to incarceration remain upon release. Even when health insurance, medications, and referrals are available, post-release is a time of vulnerability and competing priorities. Many individuals released from prisons and jails are uninsured before incarceration. Even if they are eligible for Medicaid or Medicare beforehand, their benefits are often discontinued while incarcerated. Most clients do not know how to reactivate them when released. This barrier is difficult to navigate and additionally impedes access to medication and HIV primary care.[129] Without access to HIV treatment, viral suppression cannot occur, placing individuals and communities at greater risk for infection.[130]

The Virginia Department of Health (VDH) originally sought to address this challenge through a Seamless Transition Program—a collaborative but unfunded, passive referral system between the state ADAP program and the DOC. In this program, HIV medications were made available for pickup; however, less than 50% of HIV clients picked up ART within 6 months post-release.

Recognizing the need for more active interventions, VDH applied for and received SPNS funding under the ***Systems Linkages and Access to Care for Populations at High Risk of HIV Infection (System Linkages) Initiative.*** This funding coincided with new state HIV testing provisions in Virginia DOC facilities (prisons not jails) from opt-in to opt-out testing.



The SPNS intervention, called Care Coordination, replaced the Seamless Transition Program. VDH coordinated with partners to gather baseline HIV data (including unmet need and epidemiology) to create an accurate picture of the State's HIV care needs. What they saw was approximately 13,000 HIV-positive clients being released from state and federal correctional facilities in Virginia each year. Leveraging the statewide focus of the SPNS initiative, VDH set out to implement the Care Coordination intervention across 23 state prison facilities and later expanded to add 11 local jails.[131,132]

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[129] HRSA, Special Projects of National Significance. Training Manual: Creating a Jail Linkage Program. September 2013. Available at: **https://careacttarget.org/sites/default/files/file-upload/resources/Jail%20Linkage%20Program%20IHIP%20Training%20Manual.pdf**.

[130] Cohen MS, Chen YQ, McCauley M, et al; HPTN 052 Study Team.Prevention of HIV-1 infection with early antiretroviral therapy. *N Engl J Med*. 2011.11;365(6):493–505.

[131] Bureau of Justice Statistics. *National Prisoner Statistics Program, 2012-2013*. Available at: **www.bjs.gov/content/pub/pdf/p13.pdf**

[132] Virginia Department of Health. *Care Coordination Implementation Manual. Virginia Department of Health, Special Projects of National Significance, System Linkages and Access to Care Initiative*. Final Report. October 2015.

Description of Intervention Model

CHALLENGE ACCEPTED

THE CHALLENGE: The passive nature of referrals provided to HIV-positive clients leaving Virginia correctional facilities with regard to ADAP medications contributed to poor uptake of ADAP and linkage to medical, mental health, and other services (e.g., fewer than 50% of releasees picked up ADAP-supported medications within 6 months of release).

Intervention Model: Care Coordination

The Care Coordination intervention is designed to enhance services to ensure uninterrupted access to HIV medications and medical care for HIV-positive clients re-entering the community.[133]

The **Institute of Healthcare Improvement (IHI)** Collaborative Learning Model approach informs the Care Coordination intervention. As VDH explains,

> *"The Collaborative Learning Model is a systematic approach to health care quality improvement in which systems, organizations, and providers implement and measure small-scale interventions, then share their experiences in an effort to accelerate learning and widespread implementation of successful ideas for change."*[134]

The Care Coordination intervention involves collaboration across multiple entities and individuals, including:

- *The Virginia Department of Health*
  - ➪ VDH, including health department programs, such as patient navigators, disease intervention specialists (DIS), and the Comprehensive HIV/AIDS Resources and Linkages (CHARLI) program
  - ➪ Virginia ADAP program, including local ADAP coordinators.
- *Correctional Facilities and Correctional Contractors*
  - ➪ The Virginia DOC
  - ➪ Local/regional jail administration and medical contractors
  - ➪ Virginia Commonwealth University Health System, which provides telemedicine services to clients while incarcerated in DOC facilities.
- *Community-based Partners*
  - ➪ Case managers at Ryan White and HIV prevention-funded community-based organizations (CBOs)
  - ➪ Community health workers at medical and social support organizations.

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[133] Virginia Department of Health. *Virginia Department of Health Care Coordination Implementation Manual: Special Projects of National Significance, System Linkages and Access to Care Initiative*. October 2015.
[134] Virginia Department of Health. *Virginia Department of Health Care Coordination Implementation Manual: Special Projects of National Significance, System Linkages and Access to Care Initiative*. October 2015.

The cornerstone of the care coordination intervention is providing medication access to incarcerated clients being released. ADAP provides the backbone of the program by facilitating and confirming linkage, as well as providing a consistent 30-day HIV medication supply to supplement medications given to clients by the correctional facility. (Virginia prisons provide 30 days of HIV medications to clients upon release, while jails provide 3–7 days of medication, depending on resources.)

In the intervention, DOC staff contact care coordinators and provide them with client discharge packets. Care coordinators collaborate with certified application counselors to enroll clients in health insurance and also work with ADAP counselors to secure expedited client enrollment into ADAP.

Because of the central involvement of ADAP in the intervention, the VDH HIV Care Services Assistant Director for Medication Access who oversees ADAP serves as the point person for hiring and supervision of care coordinators. This additionally facilitates care coordinator access to the ADAP database and ADAP eligibility determination team.

A cornerstone of the program is getting a 30-day HIV medication supply to clients.

Unlike case managers and patient navigators, care coordinators do *not* routinely meet directly with clients. Care coordinators primarily work with DOC, pharmacies, ADAP/benefits counselors, and community partners to ensure medications and associated coverage are available, and that clients are accessing them. However, they do frequently interface with clients via telephone primarily to coordinate referrals, facilitate access to medication and medical care, and conduct follow-up to confirm retention.

If clients are already enrolled in the pre- and post-release CHARLI program, CHARLI staff will link clients to community services. If the client is not in CHARLI, then the care coordinator provides post-release referrals to CHARLI or directly to social support services.

By proactively engaging, enrolling, tracking, and following up with clients to ensure health insurance coverage, prescription access, medication pickup receipt, and access to medical care, clients are able to reach viral suppression on the HIV Care Continuum.

The Care Continuum Team Roster

Several programs and interventions across Virginia, including those operating through the State health department, have clear synergies. As such, it is important to know the key "players" and how their work fits together to advance the HIV Care Continuum.

Disease Intervention Specialists (DIS): DIS are part of an "active referral" intervention, focusing on rapidly linking newly diagnosed HIV-positive individuals into care. DIS are given lists of names (generated from local and state health departments) of newly diagnosed clients. DIS identify priority cases on the lists, reach out to these clients, discuss their diagnosis, provide HIV education, and actively link them to patient navigators who will then help them manage their way through the healthcare system. DIS also assist clients who have fallen out of care and work to bring them back.

Patient Navigation: Patient navigators and community health workers work across all five-health regions of the state to carry out linkage and retention activities by providing healthcare systems navigation and support.

CHARLI (Comprehensive HIV/AIDS Resources and Linkages): This is a pre- and post-release correctional program operating with state funds and focusing on HIV testing, establishment of a release plan to CBOs, and emphasizing linkage to support services.

Care Coordination: Care coordination's primary focus is on ensuring access to medication and HIV medical care for recently released clients, including facilitation of coverage and support for and tracking of medication pickup and medical appointments. This includes referral for expedited ADAP coverage and supply of ART upon release.

Sources: Virginia Department of Health. C*are Coordination Implementation Manual: Virginia Department of Health, Special Projects of National Significance, System Linkages and Access to Care Initiative.* Final Report. October 2015.

Virginia Department of Health. *Active Referral Implementation Manual: Virginia Department of Health, Special Projects of National Significance, System Linkages and Access to Care Initiative.* Final Report. October 2015.

Staffing Requirements & Considerations

Staffing Capacity	**Based on the VDH work, here are the types of staff necessary to replicate this intervention.** *Care coordinator*: This is a full-time position and includes the following responsibilities: • Recruiting local/regional jails to participate in the care coordination intervention • Helping maintain client-tracking database in real time • Coordinating with certified application counselors, ADAP, DOC, and community partners (including, case managers, patient navigators, pharmacists, local health departments, ID clinics) • Processing and facilitating new referrals for soon-to-be released clients • Supporting linkage to case management and medical care • Communicating with case managers to address any barriers to adherence or accessing of services • Supporting client follow-up for up to 12 months (special cases up to 18 months). Client caseload and the number of partnering correctional facilities will inform how many care coordinators there should be (VDH began with one care coordinator and, as the intervention expanded, a second coordinator was hired). Note: *Care Coordination does not replace case management.* Care coordinators are an extra layer of support to ensure medications, referrals, and other service offerings. Care coordinators do not meet directly with clients, whereas case managers do. *ADAP counselors*: These persons facilitate expedited enrollment into ADAP to ensure longer-term access to HIV medications from all appropriate sources (e.g., direct ADAP for the uninsured, pharmaceutical/patient assistance programs, Medicaid, Medicare, or other third-party payers). *Certified application counselor*: This person helps with client insurance applications and clearance for insurance enrollment to enable longer-term access to care. This position may be at the same site as the care coordinator or at a partnering site. *Partnering positions*: These are persons to whom the care coordinators should have access within community and organizational partners. In particular, it includes the DOC for referrals, pharmacists, case managers, patient navigators (if available), and disease intervention specialists or outreach workers (for out-of-care follow-up).
Staff Characteristics	Core competencies include • background working with low-income populations; • interpersonal skills; • familiarity and comfort with correctional system; • knowledge of health and social system supports and services; • cultural competency and sensitivity with target population; • fluency in other languages that are common to the target population; and • for those working directly within DOC (such as care coordinators), ability to pass required security clearance.

Sources: Virginia Department of Health. Care Coordination Implementation Manual. Virginia Department of Health, Special Projects of National Significance, System Linkages and Access to Care Initiative. Final Report. October 2015.

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.

Do the Necessary Planning

Create a project-planning group to help guide the overall project design and subsequent implementation. This group should include key stakeholders as well as individuals working across the state in other related interventions. This will help identify any possible overlap or intersection across intervention strategies as well as identify synergistic opportunities for linkage and retention efficiencies. For VDH, this group met on a monthly basis in early intervention years, and then on a quarterly basis after the project was fully up and running.

Engage individuals who will be directly involved in the intervention to create a standardized protocol, narrative description of the intervention, and list of tools as well as conduct Plan, Do, Study, Act (PDSA) cycles.

Build Trusting Relationships

To get started on a Care Coordination intervention, it is critical to establish relationships with the correctional facility where you're hoping to work. Spend the time to facilitate these relationships with DOC and bring them to the table. It is important to learn the DOC structure and how their medical contractors and other contractors work within the system. Building the communication and "buy-in" piece will help ensure DOC understands what a Care Coordination intervention is trying to do. If your intervention is addressing regional/local jails, then you will need to spend time learning each individual system, as they are usually regulated and managed locally.

In addition, look at where CHARLI (or other similar programs) are located and what they do. Take the time to adequately introduce the care coordination program and underscore synergies. It is important that other programs see that you're all working toward a shared goal (patient and public health) rather than competing with one another.

After planning has taken place and protocols have been developed, the care coordinators begin orientation and training.

Train Care Coordinators

Care coordinators undergo a 90-day orientation to familiarize themselves with the position and associated HIV programs (e.g., Ryan White Part B, ADAP, and other HIV care and prevention programs across the state and within the jail). Orientation training covers HIV basics, correctional setting rules and regulations as well as tips for building relationships with correctional staff, available client resources in the community (including use of resource inventories), and motivational interviewing training. In addition to the 90-day

orientation, new care coordinators can shadow veteran care coordinators to "learn the ropes" of the job. This type of shadowing or mentorship can help expedite the training process and learning curve. During the orientation period, care coordinators receive assistance and oversight from the assistant director for medication access. This person provides input and guidance on any implementation protocols and addresses any care coordinator questions or concerns. Monthly meetings take place thereafter.

Implement the Care Coordination Intervention

Once trained and oriented, care coordinators actively seek referrals from DOC and local/regional jails of HIV-positive individuals soon to be released. When clients are within 30 days of their release date, the corrections medical staff will develop a medical discharge summary (including client demographics, date of diagnosis, list of HIV medications, and signed authorization to exchange and disclose health information). This information is sent, via secure fax, to the care coordinator.

Within 48 hours of referral receipt, the care coordinator will work with the Central Pharmacy to expedite client ADAP eligibility. Meanwhile, corrections staff schedule a medical appointment for clients to be released. Corrections staff schedule these appointments within 60 days post-release.

Upon release, clients are linked to case management services, patient navigation, and CHARLI as well as given a supply of HIV medications from the correctional facility (in Virginia, prisons provide a 30-day supply of ART and jails provide a 3–7 day supply). The care coordinator ensures ADAP has dispensed an additional 30-day supply to a local health department or other ADAP medication distribution site near where the client is planning to live.

Then, care coordinators help monitor client engagement, including:

- confirmation that the client has picked up their initial HIV medication supply (and continues to pick up medications thereafter);
- confirmation that the client has attended their initial medical appointment (and continues to attend appointments thereafter);
- helping maintain the client-tracking database in real time, including documentation of medication pick-up and medical appointments; and
- contacting case managers at least on a monthly basis, to verify client information and discuss any barriers to adherence or accessing of services and, for clients not readily engaging, discuss whether or not a re-engagement intervention is necessary.

Care coordinators conduct these activities for up to 12 months (or 18 months in special cases).

Securing Buy-in

Find the right people to connect with; these may be top officials or they may be frontline staff, such as medical providers and nurses. Existing contractors within the jail may be able to point you in the right direction for key contacts. Because of high turnover, as well as the need for access and information, it

is critical to maintain and frequently update a contact list. Be sure to educate new contacts about the intervention and the value-add.

Show partners you're accessible, interested, and easy to work with. This includes returning calls quickly and streamlining requests to avoid overburdening individuals as well as taking the time to get to know them and the work that they do.

Overcoming Implementation Challenges

Because other organizations or interventions may exist within the correctional facility, it's imperative that roles be clarified so as to avoid duplication of services and feelings of "turf wars."

It may be necessary to schedule meetings with the DOC medical provider and other individuals coming into contact with your program and other community partners operating in the jail. Printed informational materials may also help illustrate the work you're doing—or proposing to do.

Promoting Sustainability

VDH continues to track data on the care coordination intervention and can point to the increase in medication pickups that have taken place since the intervention's rollout. The work is sustained through Ryan White HIV/AIDS Program funding, particularly Part B.

Conclusion

The importance of medication access and its role in curtailing HIV incidence cannot be underscored enough. As the VDH project demonstrated, effectively creating an intervention like care coordination requires developing successful partnerships with various institutions and ensuring access to medication (e.g., through ADAP).

Although correctional populations can be challenging to reach and engage in care, this work is certainly feasible. VDH found that clients appreciated having options for their care upon release, and in knowing there were services on the outside to which they could engage in to meet their needs and help them stay healthy.

Other Available Resources

- **Systems Linkages and Access to Care for Populations at High Risk of HIV Infection (System Linkages) Initiative**
- ***The Impact of Care Coordination Services on HIV Care Outcomes Among Formerly Incarcerated Individuals in Virginia***