Improving Health Outcomes

Moving Patients Along the HIV Care Continuum and Beyond

JUNE 2017

INTERVENTION OVERVIEW & REPLICATION TIPS

Enhancing Linkages to Care for Women Leaving Jail

University of Illinois at Chicago

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);

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[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

INTERVENTIONS AT-A-GLANCE | INTERVENTION SUMMARY TABLE

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)

Enhancing Linkages to Care for Women Leaving Jail

University of Illinois at Chicago

The table below provides a general overview of the Enhancing Linkages to Care for Women Leaving Jail intervention so readers can assess the necessary steps required for replication. This intervention integrates jail-based case managers to work with jail-based discharge planners and peers to support HIV-positive women as they transition from jail to the community.

Intervention at-a-Glance	
Step 1	**Provide HIV Testing in the Jail** Offer expanded HIV testing services marketed to women incarcerated in the jail facility.
Step 2	**Conduct Needs Assessment** Meet with clients to identify needs and identify community services to reduce barriers to linking to HIV primary care and supportive services.
Step 3	**Enroll Interested Women into Intervention** Conduct pre-intervention survey and enroll interested and eligible women into the intervention.
Step 4	**Create Discharge Plans** Develop discharge plans based on client needs, and review plans with client.
Step 5	**Jail-based Discharge Planner Provides "Warm Transition" to Transitional Case Manager** Jail-based discharge planner introduces clients to the intervention's transitional case manager who will assist clients in exercising their discharge plan on the "outside." Transitional case manager outlines what the "jail-to-community linkage" component looks like and what clients can expect.
Step 6	**Provide Clients HIV Medical Care During Jail Stay** HIV-positive women visit the jail medical facility and receive necessary services.
Step 7	**Provide Health Education Sessions** When possible, provide additional educational support to women around HIV and risk reduction.
Step 8	**Release Clients from Jail** Clients are offered transportation services to housing and actively connected to community-based Ryan White case managers.

Step 9	**Case Management Services Begin** Community-based case managers help facilitate medical care and social service appointments and coverage.
Step 10	**Provide Transportation and Peer Accompaniment to Appointments** Peers provide additional support around transportation and patient navigation-related services to help ensure clients attend appointments.
Step 11	**Follow-up with Clients** Follow-up is conducted to ensure clients are accessing services and, if they've fallen out of care, community outreach is conducted.

Source: University of Illinois at Chicago, School of Public Health. *Enhancing Linkages to Care for Women Leaving Jail*. Final Report. August 31, 2012.

Diagnosing HIV

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Beyond the Care Continuum

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 Enhancing Linkages to Care for Women Leaving 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 whom you can partner?
- ☐ Is HIV testing already taking place within the jail? If not, is your organization able to provide it?
- ☐ Does your organization offer HIV primary care and social support services, or are there relationships in place with agencies that do? If not, are you 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 you're hoping to replicate?
- ☐ Do you have staff interested in providing compassionate, transitional "jail-to-community linkage" services to incarcerated women?

Source: University of Illinois at Chicago, School of Public Health. *Enhancing Linkages to Care for Women Leaving Jail.* Final Report. August 31, 2012.

Setting the Stage: Grantee Intervention Background

The University of Illinois at Chicago (UIC), Community Outreach Intervention Projects, School of Public Health was funded as part of the SPNS Enhancing Linkages to HIV Primary Care & Services in Jail Setting (EnhanceLink) initiative. Prior to the SPNS grant, UIC had not worked in the jail; however, it had extensive experience conducting community work, treating populations that were frequently incarcerated, and employing a large service staff, including those reflective of the community.

In this project, the UIC intervention team worked with the Cook County Jail—one of the largest jail facilities in the country. Cook County Jail represents the sole jail for the city of Chicago (which has approximately 2.8 million residents). At the jail, there are approximately 100,000 intakes annually and an average daily population of 10,158. Of these, the women's division has a capacity of 704 beds.[57]

UIC chose to focus its intervention specifically on women and sought to better understand the associations between HIV infection, incarceration, primary care, and vulnerabilities related to gender inequality, and how best to remove barriers, actively link these women to myriad health and social support services, and assist them in obtaining the maximum benefit from entitlements and social services.[58]

Description of Intervention Model

CHALLENGE ACCEPTED

THE CHALLENGE: linking HIV-positive, highly disadvantaged women during the brief jail stay window to extensive community services upon release.

Intervention Model

Transitional Jail Care Coordination with a Prevention Case Management

The UIC intervention sought to improve the following:[59]

- HIV counseling and testing within the jail
- Access to and use of primary care for HIV-positive women (beginning with needs assessment and discharge planning in the jail and continuing into the community)
- Post-release follow-up for 6 months
- Understanding among intervention participants about HIV, risk reduction, and the importance of accessing services.

Critical components of the intervention include the integration of jail-based transitional case managers, active linkage to Ryan White case managers, assistance in securing identification (IDs), and use of peers as outreach workers/patient navigators to accompany clients to medical and social service appointments and who have shared life experiences.

[57] Draine J, Ahuja D, Altice FL, et al. Strategies to Enhance Linkages Between Care for HIV/AIDS in Jail and Community Settings. *AIDS Care*. 2011;23(3):366-77

[58] University of Illinois at Chicago, School of Public Health. *Enhancing Linkages to Care for Women Leaving Jail.* Final Report. August 31, 2012.

[59] University of Illinois at Chicago, School of Public Health. *Enhancing Linkages to Care for Women Leaving Jail.* Final Report. August 31, 2012.

The UIC intervention is based on the Centers for Disease Control and Prevention's (CDC's) Prevention Case Management Model. This model was designed to address complex needs for persons likely to have difficulty practicing HIV risk reduction behaviors.*[60] The model has been evaluated in prisons but, prior to the SPNS initiative, had rarely been evaluated in jails.[61]

At large, Prevention Case Management includes the following seven essential components,[62, 63] pictured at right.

More specifically, within the UIC intervention, these seven steps played out as follows:

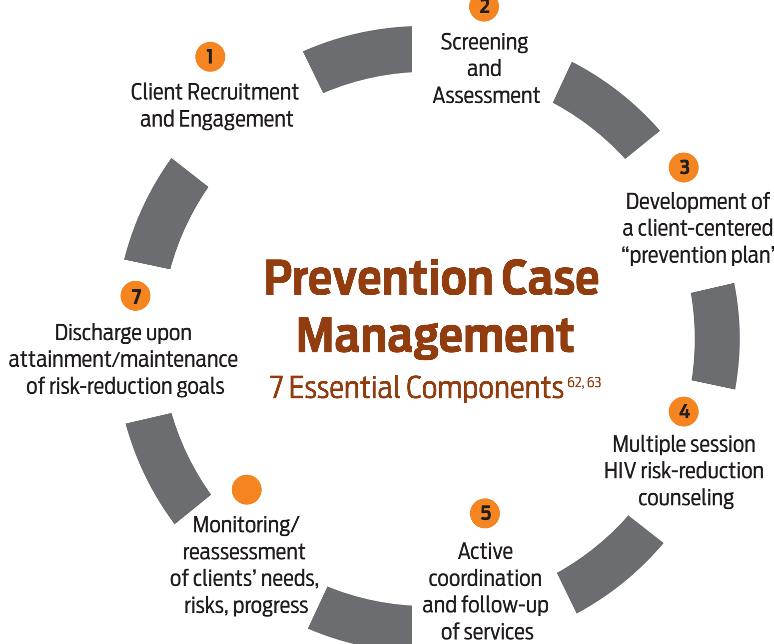

Table: University of Illinois Prevention Case Management Model in Action

COMPONENTS	DETAILS
Client Recruitment and Engagement	Protocols to recruit and engage clients, staff training
Screening and Assessment	Demographic information, STI/HIV risks, substance use, sexual history, mental health, social support, skills to reduce risks, barriers to safer behavior, protective factors and strengths
Client-Centered Discharge Plan	Primary care and treatments, adherence to treatment, secondary prevention, social services, education and information, mental health services
HIV Risk-Reduction Counseling	Perceived risk and susceptibility, intentions to change, knowledge, self-efficacy, barriers, social support
Active Coordination and Follow-up of Services	Collaboration, written referral process protocols, referral tracking system, annual assessment, mechanism for emergency psychological or medical services
Monitoring and Reassessment of Needs	Ongoing assessment of needs, risks, and progress, revision of plans
Discharge and Maintenance	Timeline, attainment of goals, evaluation

[60] U.S. Centers for Disease Control and Prevention. HIV prevention case management—guidance. September 1997. Available at: **http://stacks.cdc.gov/view/cdc/13299**
[61] University of Illinois at Chicago, School of Public Health. *Enhancing Linkages to Care for Women Leaving Jail.* Final Report. August 31, 2012.
[62] Centers for Disease Control and Prevention. HIV prevention case management—guidance. September 1997. Available at: **http://stacks.cdc.gov/view/cdc/13299**.
[63] Myers J, Zack B, Kramer K, et al. Get Connected: An HIV Prevention Case Management Program for Men and Women Leaving California Prisons. *Am J Public Health.* 2005;95(10):1682–84.
* Prevention case management model is no longer readily used by CDC.

These activities are particularly critical because women represent a significant and growing segment of jail detainees and persons living with HIV.[64] Compared to men, more women report homelessness, reduced adherence to prescribed antiretroviral therapy (ART), worse health, more severe substance use disorders, more chronic health conditions, and more chronic mental and psychiatric disorders.[65] Additionally, as the number of expressed needs increase, women are more likely to drop out of care than men.[66]

Women often report different needs upon release than men. As such, gender-responsive intervention strategies are recommended in order to link and, ultimately, retain women in HIV programs post-release and move them along the HIV Care Continuum.[67]

Women in the Cook County Jail are highly disadvantaged (for example, evidence of poverty, substance use, mental health problems, lack of adequate housing, hunger, limited social support, and high HIV risk behavior) and require extensive services on the outside in order to successfully link into HIV care. Most of the women enrolled in the SPNS project had been on ART, but less than one-half reported taking medication the week before incarceration, and one-half of the women had CD4 counts below 350, a level associated with greater likelihood of opportunistic infections and cancers.[68]

The time period immediately following correctional release is a critical juncture for engagement as it represents a time of increased vulnerability. Moreover, during this time, engagement into medical care is often a lower priority, particularly if basic needs have not been addressed. The UIC intervention model includes transportation to a safe destination at discharge; assistance in securing safe housing, mental health support, and harm reduction services; a 1-800 emergency contact number; and expedited linkage—and peer accompaniment to—medical care.[69]

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[64] Williams CT, Kim S, Meyer J, et al. Gender Differences in Baseline Health, Needs at Release, and Predictors of Care Engagement Among HIV-positive Clients Leaving Jail. *AIDS Behav.* 2013;17(Suppl 2):S195-202.
[65] Binswanger IA, Merrill JO, Krueger PM, et al. Gender Differences in Chronic Medical, Psychiatric, and Substance-Dependence Disorders Among Jail Inmates. *Am J Public Health.* 2010;100(3):476-82.
[66] Williams CT, Kim S, Meyer J, et al. Gender Differences in Baseline Health, Needs at Release, and Predictors of Care Engagement Among HIV-positive Clients Leaving Jail. *AIDS Behav.* 2013;17(Suppl 2):S195-202.
[67] Williams CT, Kim S, Meyer J, et al. Gender Differences in Baseline Health, Needs at Release, and Predictors of Care Engagement Among HIV-positive Clients Leaving Jail. *AIDS Behav*. 2013;17(Suppl 2):S195-202.
[68] University of Illinois at Chicago, School of Public Health. *Enhancing Linkages to Care for Women Leaving Jail.* Final Report. August 31, 2012
[69] University of Illinois at Chicago, School of Public Health. *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 UIC work, here are the types of staff necessary to replicate this intervention.** *HIV tester*: Because the UIC intervention includes expanded HIV rapid testing over the weekend, an HIV tester is necessary to provide HIV testing and counseling. *Jail-based discharge planner:* The discharge planner meets with HIV-positive women and works with them to create a plan that addresses their specific medical care and barriers. In most instances, this plan includes linkage to HIV primary care and other medical services. (UIC links clients to the Ruth. M. Rothstein CORE Center in Cook County—a comprehensive, "one-stop-shop" medical center.) Following the meeting the discharge planner introduces the women to one of the intervention's "transitional" case managers. *Transitional case manager:* These case managers work with women inside the jail and after they reenter the community. During the course of the SPNS study, there were two female transitional case managers; however, depending on the size of the jail and an organization's proposed intervention, one individual or even a part-time individual may suffice. Transitional case managers review the discharge plan with the women; they explain what the transition into the community will look like and how they'll provide support to the women during this time. For those interested, transitional case managers will provide transportation to housing services upon the client's release from jail. The transitional case manager also provides a "warm transition" to a community-based Ryan White case manager and follows up to ensure the client has successfully connected to the services and appointments identified in the discharge plan. *Peers:* Peers provide outreach, transportation, and patient navigation support services. They are reflective of the clients being served and are able to help women overcome barriers and remain engaged in care. *Community-based Ryan White case manager:* The transitional case manager connects clients to a community-based Ryan White case manager. This Ryan White case manager serves as the key point of contact for the client post-release. Communication and coordination between the transitional case manager and the Ryan White case manager is critical. **Optional positions:** *Research and data assistant:* This position filled evaluation requirements for UIC during the SPNS funding period; however, agencies without a more formal evaluation component will not necessarily require this.

	Health educators: The health educator provides health education sessions on HIV, risk reduction, general health, and emotional stressors. It is highly recommended, if possible, to incorporate a health educator into the intervention. After SPNS funding, UIC was not able to sustain this position. If this position cannot be filled, organizations replicating this work should consider weaving educational topics into clients' broader risk and needs assessment discussions, during discharge planning, and with reinforcement from the community-based Ryan White case manager.
Staff Characteristics	Jail-based staff 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 Ryan White case managers; • be able to deliver culturally appropriate services; • offer non-judgmental services; and • ideally be reflective of racial and ethnic backgrounds of clients.

Sources: University of Illinois at Chicago, School of Public Health. *Enhancing Linkages to Care for Women Leaving Jail.* Final Report. August 31, 2012.
University of Illinois at Chicago, School of Public Health. *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.

The intervention includes the following key steps:[70, 71]

1. **Expand HIV testing.** The UIC team created a weekend testing program for women. In this intervention model, counselors visit the women's housing areas and market this service. Women who wish to be tested ask to go to the medical clinic, where testing is conducted in private with rapid HIV tests.

   Those identified as HIV-positive are given appointments for in-jail medical care.

2. **Assess baseline needs and assets.** A discharge planner meets with all HIV-positive women to discuss medical care and social support needs, as well as barriers that may prohibit clients from accessing services post-release.
3. **Enroll clients.** Interested and eligible women are enrolled in the intervention. If replicating agencies are including a data collection component, then a pre-intervention survey will also be completed in this step.
4. **Develop service discharge plan.** Unless the client has existing care elsewhere, is moving beyond Chicago post-release, or has other preferences, the discharge plan includes a post-release medical appointment at a comprehensive, one-stop-shop medical facility. (For UIC, this is the Ruth M. Rothstein CORE Center, which is part of the Cook County hospital system.)
5. **Connect to transitional case management.** The jail discharge planner introduces women to one of the two transitional case managers, both of whom are women. The discharge planner explains that the transitional case manager's role is to help them carry out the discharge plan in the community, as well as to add or amend it as needs evolve. The transitional case manager provides the women with her contact information for post-release follow-up and offers to transport clients back to the community upon release. Additionally, the transitional case manager obtains client contact information to support follow-up efforts.
6. **Initiate HIV clinic visit in jail.** While incarcerated, HIV-positive women visit the medical facility to review any existing ART prescriptions (of known positives) and to review or update baseline labs. This visit also includes medical chart review and data abstraction.
7. **Connect women to health education sessions.** At the time of the intervention, the University of Illinois was able to conduct a client education program. Educational topics included HIV treatment; HIV transmission; the HIV service system safety net; dealing with emotions; and family, faith, and social concerns.
8. **Release from jail.** Clients are actively connected with community-based Ryan White case managers upon release from jail.

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[70] University of Illinois at Chicago, School of Public Health. *Enhancing Linkages to Care for Women Leaving Jail*. Final Report. August 31, 2012.

[71] University of Illinois at Chicago, School of Public Health. *Special Projects of National Significance (SPNS) Program, Enhancing Linkages to HIV Primary Care in Jail Settings Initiative, EnhanceLink Program Description Form*. 2012.

9. **Begin case management activities.** Immediately upon release, case management activities began. These include HIV primary care visits, additional housing assistance, childcare (if applicable), employment support, psychosocial health referrals, and referral to any other previously identified but unmet needs.

   An important component of these case management activities is assisting women in accessing identification. Of the women who participated in the UIC SPNS project, 80% did not have IDs. Lack of identification impedes access to social support services and impedes women's ability to maximize the entitlements for which they qualify. UIC has been able to secure payment of IDs from community groups funded for this purpose. Intervention staff assist clients in the process and manage expectations about what the process looks like (e.g., lots of forms and waiting in lines).

10. **Transportation and accompaniment at clinic site visits.** As needed, intervention staff provides additional transportation assistance to HIV primary care and social support visits. Peer outreach workers/patient navigators who share similar life experiences and are reflective of the intervention's target population typically conduct this activity.

11. **Conduct follow-up.** Intervention staff stays in continuous contact with clients through telephone calls, letters, and home visits. Transitional case managers maintain a record of client appointments with physicians, call participants prior to the visit, ask if transportation assistance is required, and provide transportation if it is needed.

    If clients appear lost to follow-up, then the intervention team will review publicly available corrections databases (which include "inmate locators" at the state and county levels) and court dockets. The team also searches in shelters, hospitals, and inpatient mental health and drug and alcohol facilities. With prior client consent, the intervention team reaches out to family and loved ones, as needed.

Figure: Project Model[72]

SPNS ACTIVITIES AT JAIL

- Expand HIV testing
- Screen for eligible HIV-positive women
- Baseline needs & assets assessment
- Describe program
- Invite enrollment
- Administer consent
- Complete survey
- Develop service plan (discharge plan)
- Introduce participant to transition case manager
  - Plan post-release meeting
  - Obtain locator information
  - Identify appropriate referrals
  - Ascertain availability
- Initiate HIV clinic visit in jail
- Treatment and follow-up plan
- Baseline lab
- Medical chart review / data abstraction
- Provide health education.

ACTIVITIES ON DAY OF RELEASE IF ABLE TO MEET WITH PARTICIPANT

- Transport to University of Illinois Community Outreach Intervention Projects or South Side Help Centers service site
- Transport to location to stay
- Review immediate needs and service plan.

ACTIVITIES IN COMMUNITY

- Begin case management activities
  - HIV primary care visits, housing, ID, childcare, employment, psychosocial health referrals.
- Provide transportation to service/clinic sites
- Re-assess service needs and revise plans
- Data collection and reporting
- Process and outcome evaluation
- Link to Ryan White case management and assist the case manager when possible.

[72] University of Illinois at Chicago, School of Public Health. *Enhancing Linkages to Care for Women Leaving Jail*. Final Report. August 31, 2012.

Intervention Preparation

Some important considerations when conducting a transitional jail linkage-to-community intervention include the following:

Find out who is in the jail. In order to initiate this work, it is important to first assess who is already in the jail and what they are doing. At the time of the SPNS project launch, a separate unit of the County was providing medical care in the jail and a University of Illinois staffer was conducting research in that unit. This researcher was able to provide introductions to key administrators in the health care unit, which became critical to securing buy-in, as the intervention requires both clearance from the jail and the sharing of medical records from the healthcare provider.

Meet with key community players. Community-based Ryan White case managers need to know about the intervention so confusion and "turf wars" can be avoided and clients can better connect to these case managers on the outside.

Consider organizing a meeting with community partners to discuss the project, seek input on how best to coordinate activities, and placate any fears that you are stealing clients. Explain that the intervention helps clients find their way to the community-based organizations. Community partners often see more clients, not fewer, because clients are being proactively linked to HIV care and services.

Understand how the jail is organized and how it works. "Jail is such an unusual place to come into that you really need to spend some time going into the setting and getting acclimated with the environment and doing background work," says Dr. Lawrence J. Ouellet, UIC SPNS intervention principal investigator. This includes assessing the physical space where meetings with clients take place and deciding how the needs of the jail staff can be accounted for in project planning.

Remember you are a visitor in the jail. It is critical to abide by jail rules when doing a jail-based intervention. This includes the processes required to work within the jail, such as background checks, fingerprints, a jail ID, and accounting for the time it takes to get through this process before intervention work can begin. Some intervention staff may have histories of incarceration, which can impede their ability to enter the jail; this possibility should be researched ahead of time. Talk to jail representatives and see if the infrastructure and materials needed for your work can be accessed or brought into the jail.

Flexibility is key. Jails have much higher turnover rates than prisons, which makes jails comparatively chaotic. Discharge windows are short and often unpredictable. Follow client court dates, review data systems, and talk to the jail-based discharge planner to assess when a person is likely to be released. This should likely happen every week to week-and-a-half. For clients released from jail with little advance notice, staff should begin contact attempts upon learning of this change.

Securing Buy-in

Establish partnerships through meetings with key community and jail members, invite these stakeholders to the table during preliminary intervention planning discussions, and take their recommendations in

earnest. Be careful not to duplicate efforts, alleviate any concerns around "turf wars" or "patient poaching," and create memoranda of understanding with formal partners.

Overcoming Implementation Challenges

In working with this population, the major challenges revolve around difficulty accepting HIV status; shame of being HIV-positive; mental illness; substance use, withdrawal, or entering a drug treatment program; extreme deprivation that makes HIV a secondary issue; waiting until HIV medications run out to schedule appointments; and habits of using the ER to obtain medical care. To address these issues, provide education early on, proactively seek to engage women into services to meet their unmet needs, encourage and aid women in advocating for themselves as they seek services, help them enroll them in benefits programs, and provide continuous support, follow-up, and patient navigation.

Promoting Sustainability

Ryan White Part A funds may be able to be used to support transitional case management, such as transitional jail-to-community care coordination services. Components of the intervention are also sustained through additional grant funding, typically for both men and women living with HIV.

Conclusion

Each year, about 14% of people with HIV experience incarceration.[73] More incarcerated people pass through jails than prisons.[74, 75] Given the number of people living with HIV passing through these facilities and the need to reach them, jail interventions afford a unique window with which to do so. Participation in the intervention has shown an increase in linkage to post-release medical care. As Dr. Ouellet explains, "We see the jail linkage work as an extension of our community work so it makes sense to be there."

Other Available Resources

- SPNS. **Creating a Jail Linkage Program: Tools from the Integrating HIV Innovative Practices Program.**
- **Enhancing Linkages to HIV Primary Care & Services in Jail Settings Initiative.**
- Williams CT, Kim S, Meyer J, et al. **Gender Differences in Baseline Health, Needs at Release, and Predictors of Care Engagement Among HIV-positive Clients Leaving Jail.** *AIDS Behav.* 2013;17(Suppl 2): S195-202.

[73] Spaulding AC, Seals RM, Page MJ, et al. HIV/AIDS among inmates of and releasees from US correctional facilities, 2006: declining share of epidemic but persistent public health opportunity. *PLoS One.* 2009;4(11): e7558.

[74] Zack B, Hane L. *At the Nexus of Correctional Health and Public Health: Policies and Practice.* American Public Health Association Annual Meeting. 2015 [Presentation]

[75] Draine J, Ahuja D, Altice FL, et al. Strategies to Enhance Linkages Between Care for HIV/AIDS in Jail and Community Settings. *AIDS Care.* 2011;23(3):366–77.