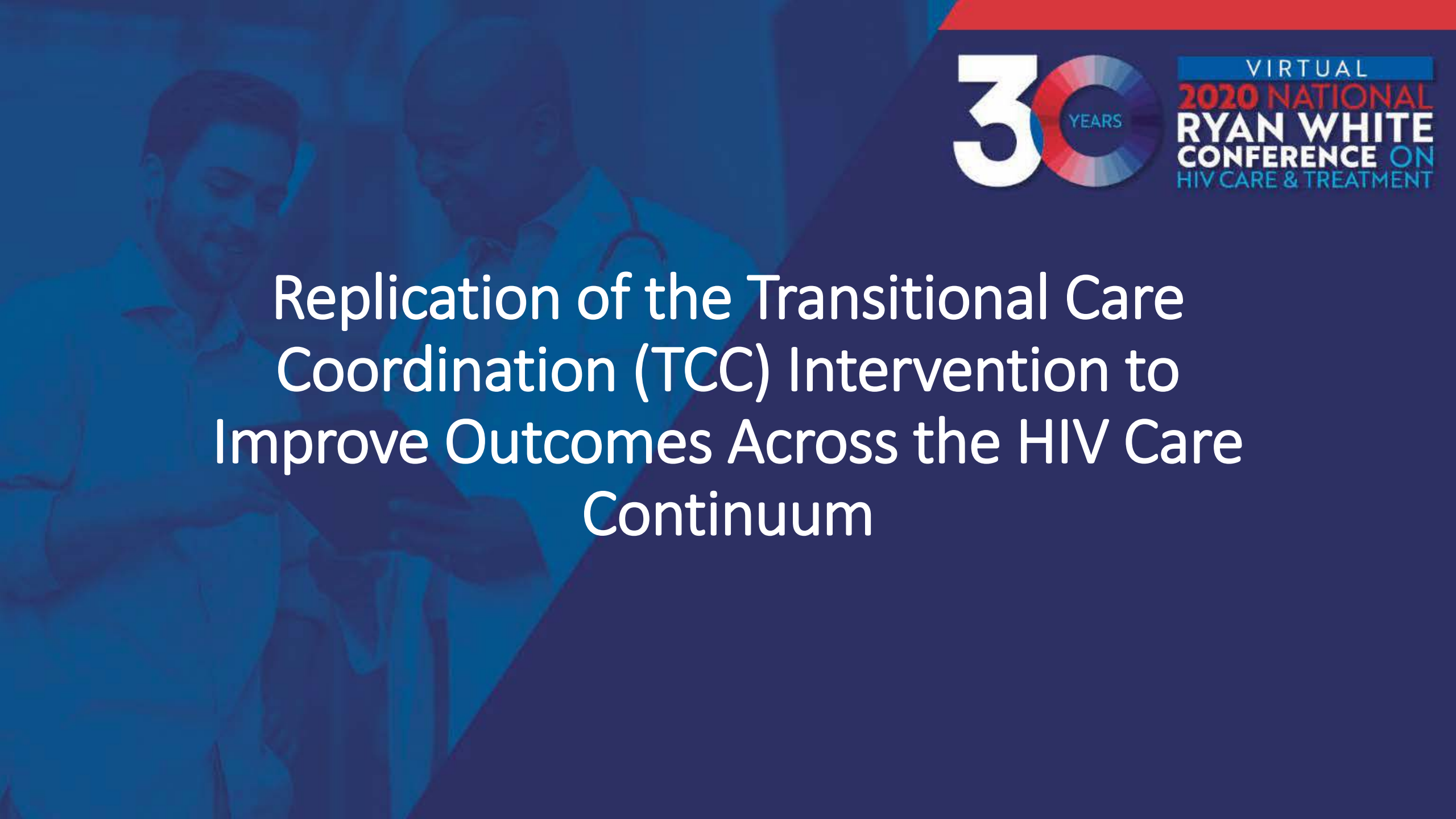


Replication of the Transitional Care Coordination (TCC) Intervention to Improve Outcomes Across the HIV Care Continuum

Presenters

- Boston University/Abt Associates
  - Jane Fox, MPH, DEC, Co-PI
- AIDS United
  - Hannah Bryant, MPH, ITAC, Program Manager
- Cooper Health System
  - Cheryl Betteridge, Transitional Care Coordinator

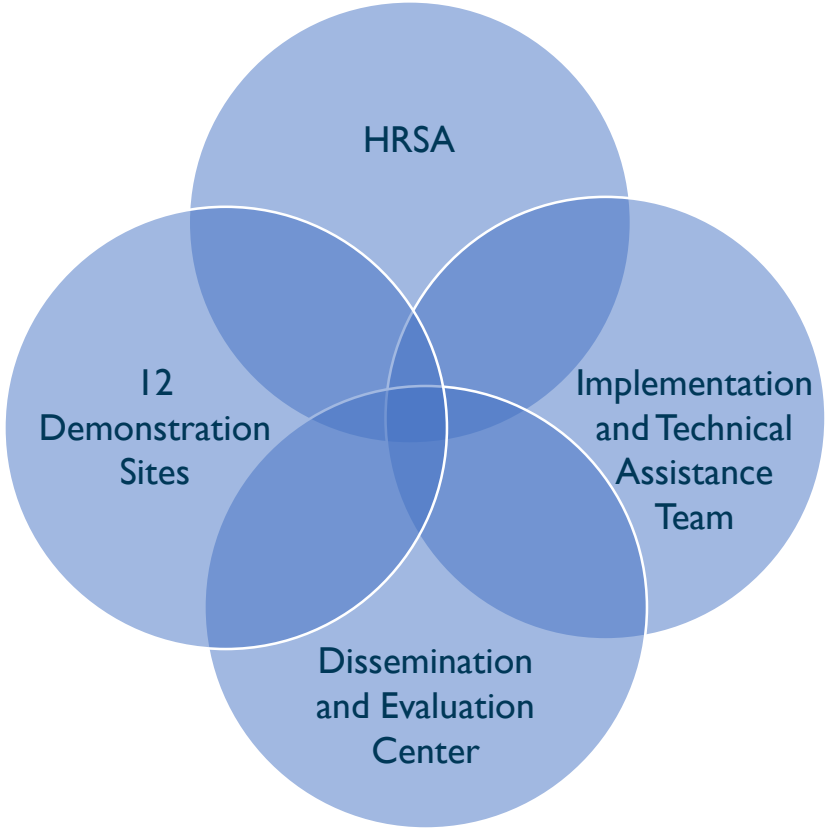
- These products were supported by grant #U90HA29237 and #U90HA29236, “Dissemination of Evidence-Informed Interventions,” through the U.S. Department of Health and Human Services Administration (HHS), Health Resources and Services Administration (HRSA), HIV/AIDS Bureau (HAB). The contents are solely the responsibility of AIDS United/Boston University/Abt Associates and do not necessarily represent the views of the funding agencies or the U.S. Government.

Objectives

1. Define core components of the Transitional Care Coordination intervention
2. Identify successes, challenges, and lessons learned resulting from the implementation of the TCC intervention at three sites
3. Discuss tools to support and strategies through which the TCC intervention can be adapted and replicated in jurisdictions across the country

Dissemination of Evidence Informed Interventions Project Background

- Funded through HRSA's Special Projects of National Significance (SPNS)
- Implementation science study of four previously-implemented SPNS initiatives
- AIDS United: Implementation & Technical Assistance Team
- Boston University and Abt Associates: Dissemination & Evaluation Center



Interventions

- TRANSITIONAL CARE COORDINATION FROM JAIL INTAKE TO COMMUNITY HIV PRIMARY CARE
- PEER LINKAGE AND RE-ENGAGEMENT FOR WOMEN OF COLOR LIVING WITH HIV
- INTEGRATING BUPRENORPHINE TREATMENT IN OPIOID USE DISORDER IN HIV PRIMARY CARE
- ENHANCED PATIENT NAVIGATION FOR WOMEN OF COLOR LIVING WITH HIV

TRANSITIONAL CARE COORDINATION
From Jail Intake to Community HIV Primary Care

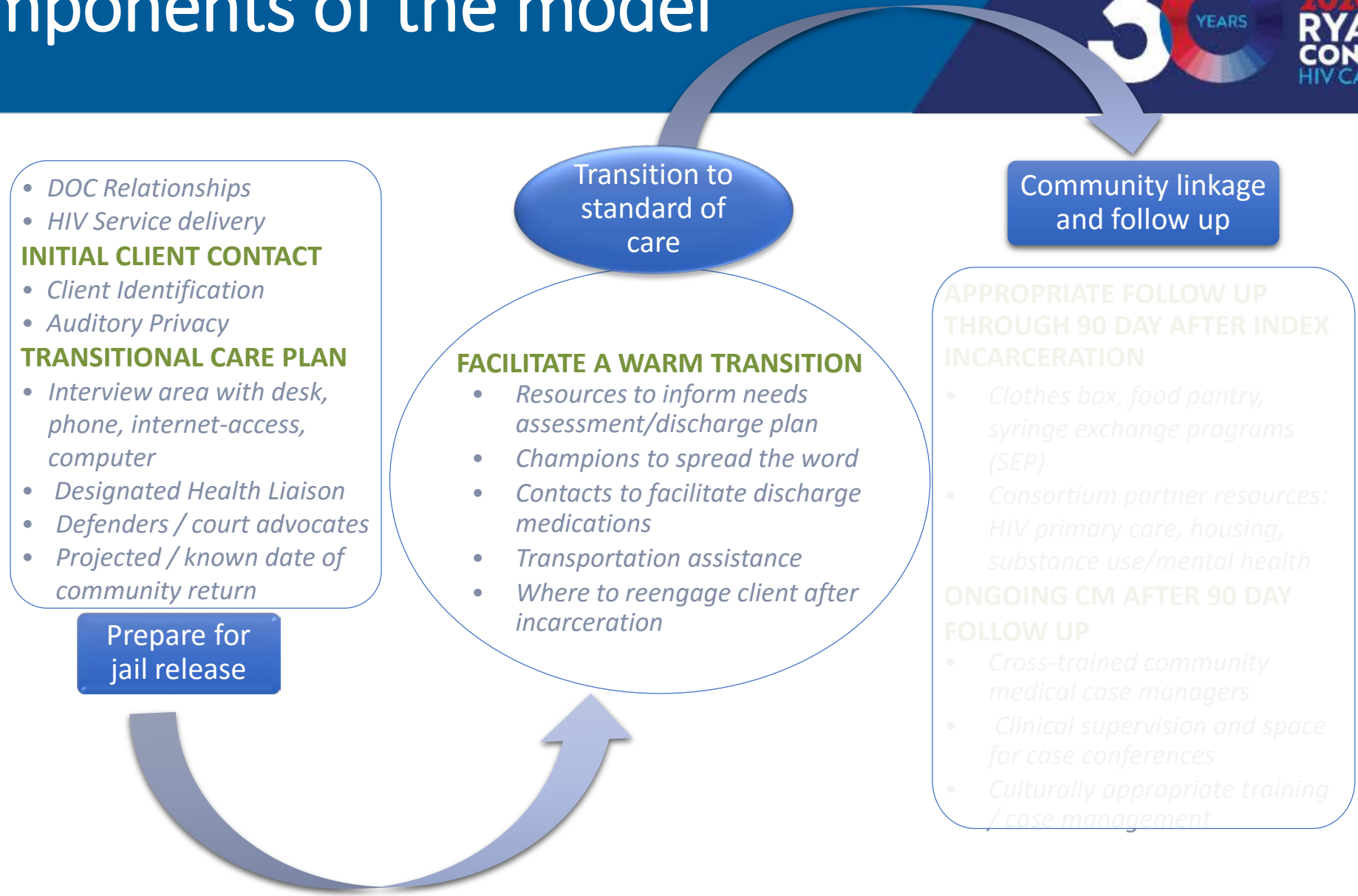
Intended for organizations and agencies considering strengthening connections between community and jail health care systems to improve continuity of care for people with HIV (PWH) recently released from jails.

Designed to implement a new linkage program for PWH to support their engagement and retention in care while incarcerated and post-incarceration and as they re-enter the community.

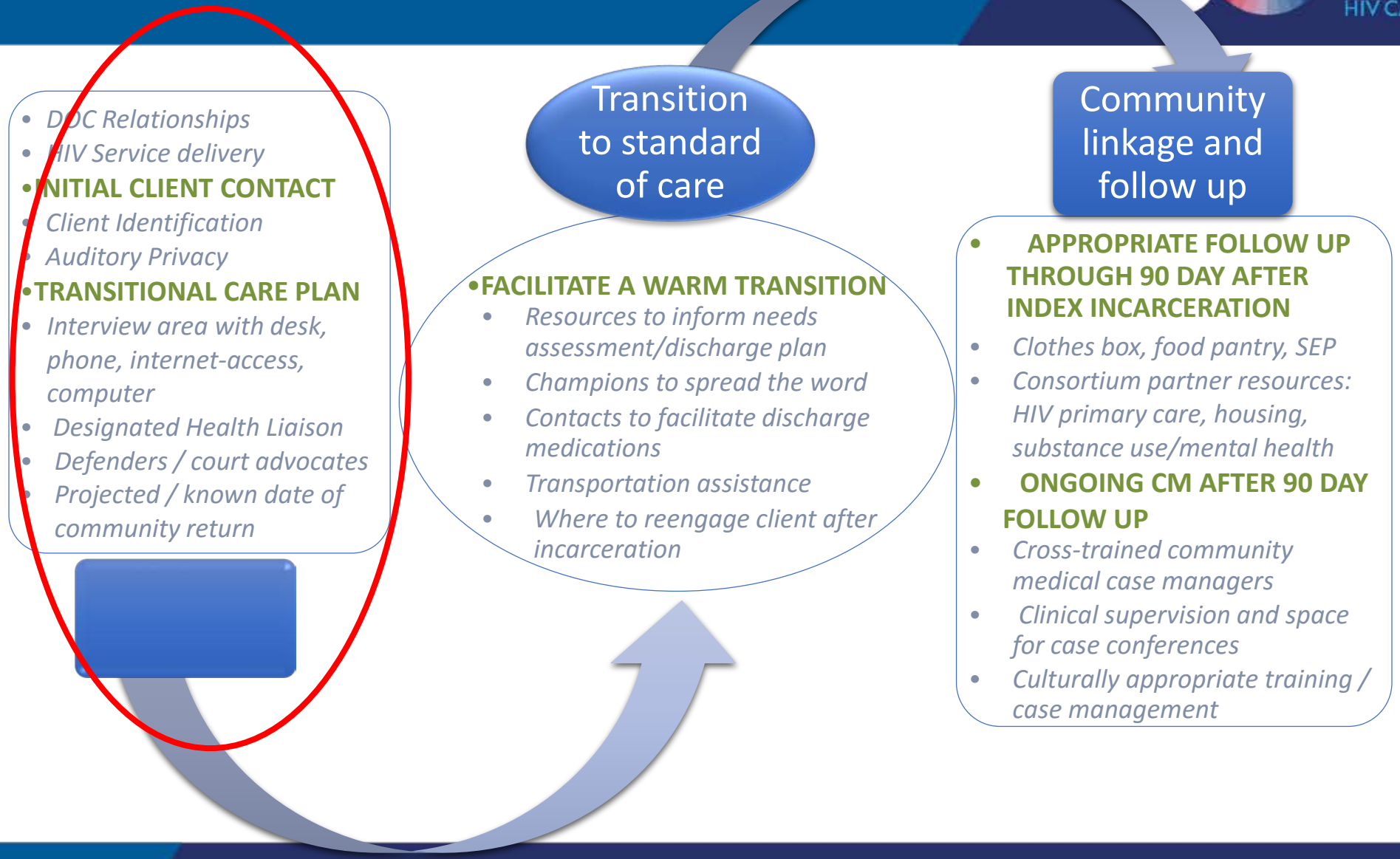
Overview

- Sites Funded: Cooper Health System in Camden, NJ; University of North Carolina in Raleigh, NC; and Southern Nevada Health District in Las Vegas, NV.
- Intervention Target population: People with HIV who are incarcerated.
- Time frame of the intervention: From when a client completes an intake and assessment in the jail to 90 days post-release.
- Enrollment numbers: Across the 3 sites, 249 clients were enrolled into a multi-site evaluation study.

Core components of the model



Core components of the model



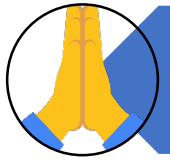
Considerations for Replication: Working in the Jail Setting

- Leverage existing relationships with the jail
  - If you are a health department, do you support epidemiological surveillance in the jail?
  - If you are a health care provider, have you collaborated with the jail to provide HIV care?
  - Do you provide HIV testing or education in the jail?
- Build buy-in
  - Why is the TCC intervention a value add for both your organization and the jail?
- Develop relationships at multiple levels of jail administration for instance, the warden, the medical director/contracted medical staff, officers, etc.
  - How will you nurture these relationships over time?
    - Consider providing health education via formal training processes and through more informal “lunch and learns”
- Navigating relationships without stepping on toes: “you are a guest in their house”
- Hiring the “right” staff

Considerations for Replication: Working in the Jail Setting

- Every jail is different: conduct a workflow assessment and obtain a security briefing
  - Determine how you will identify people living with HIV in the jail
  - Determine where, when, and how you will meet with your clients
    - Will you have auditory privacy?
    - Will an escort be required?
- Assess opportunities for securing a dedicated workspace and any limitations on supplies that can be brought into the jail

Considerations for Replication: Developing a Transitional Care Plan



Private interview area with desk, phone, internet-access, computer

Determine who will serve as the health liaison

Public defenders and court advocates

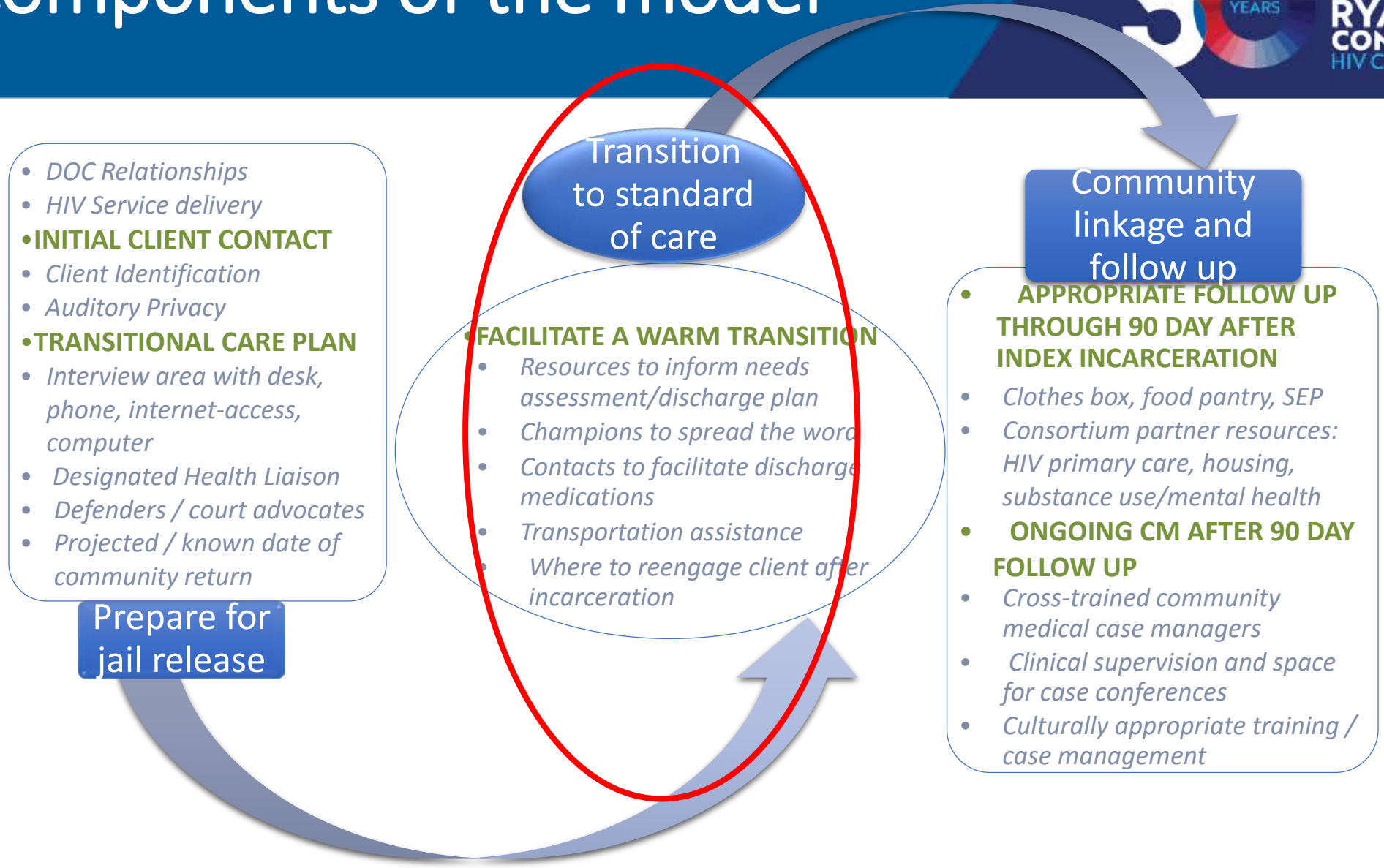
Projected / known date of community return

Strong network of medical and social service providers

Cooper Experience: Preparing for Jail Release

- Existing relationship with local jail system via Cooper physician who provides medical care in jail
- There is strong support from the past and current warden for the intervention
- Majority of clients receive medical care and support services through Cooper, which enhances the site's ability to facilitate connection to services and tracking
    - TCCs meet with clients in jail on an ongoing basis, serving as the health liaison and supporting identification of and navigation to medical care and auxiliary services upon release

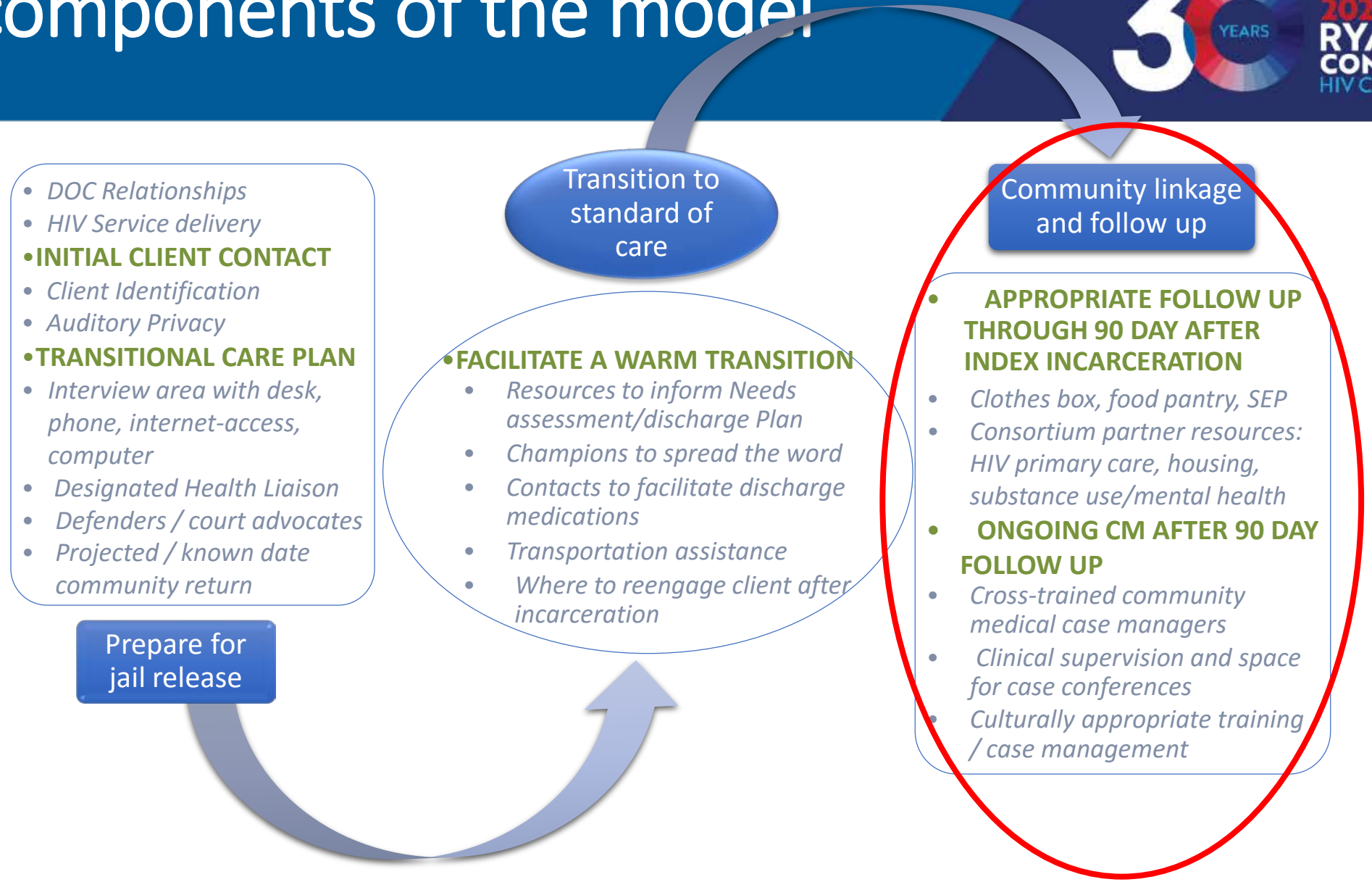
Core components of the model



Considerations for Replication: Facilitating a Warm Transition

- Coordinating around discharge
  - Work with the jail to identify and/or schedule clients' release date and time
  - Collaborate with the jail to determine what clients' will be released with
    - Can you put the TCC's business card or an appointment reminder card in client's property upon release? What about a gift card for meals or bus tokens?
    - Will the jail release the client with a supply of ARVs?
  - As needed, support clients with obtaining transportation services
  - Plan for how the TCC and the client will reconnect
  - Leverage community partnerships to support clients' engagement with medical care and other supportive services, including ongoing transportation, housing, mental health support, and/or substance use treatment
    - Communicate with clinic staff and community partners frequently
- Think creatively

Core components of the model



Considerations for Replication: Community Linkage and Follow Up

- Continue to leverage partnerships within and across organizations
  - Identify new stakeholders that may need to be brought to the table to fill gaps
  - Promote a culture of collaboration with client engagement and linkage to both medical and supportive services
- Develop a client-centered protocol for transitioning clients to the standard of care
  - Identify a timeframe as a goal for transition, that is adapted based on clients' needs
  - Warm transition between TCC, client, and standard of care case manager

Cooper Experience: Facilitating a Warm Transition, Community Linkage & Follow up

- Maria is a 44 year old woman with HIV. She has a history of substance use, homelessness, anemia, anxiety, depression, endometrial cancer (HCC) and treatment, fistula, frostbite, gunshot wound, H/O nephrostomy, hernia, and bilateral amputation of her feet.
- Maria has been incarcerated in jails and prisons multiple times and was re-incarcerated during the course of Cooper's implementation of the TCC project.
- Maria consented to TCC services and worked with a care coordinator during her most recent incarceration. However, upon release she struggled with adherence and linkage to care.
- The TCC team conducted multiple community outreach efforts. Maria was able to link to support services, but not HIV care.
- After Maria was hospitalized, the care coordinator re-connected with her and was able to link her to long term housing at a rehabilitation center. The center provides housing and transportation. Maria has engaged in medication-assisted treatment (MAT) and HIV care at Cooper EIP. She is now virally suppressed.

Finding DEII Materials

https://targethiv.org/nextlevel

Tools for HRSA's Ryan White HIV/AIDS Program

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Dissemination of Evidence-Informed Interventions

DISSEMINATION OF EVIDENCE-INFORMED INTERVENTIONS

Project Goals and Resources

The end goal of the initiative is to produce and evaluate four evidence-informed Care And Treatment Interventions (CATIs) that are replicable; cost-effective; capable of producing optimal HIV care continuum outcomes; and easily adaptable to the changing health care environment. The multisite evaluation of this initiative will take a rigorous Implementation Science (IS) approach, which places greater emphasis on evaluation of the implementation process and cost analyses of the interventions, while seeking to improve the HIV care continuum outcomes of linkage, retention, re-engagement, and viral suppression among client participants.
Read the HRSA HAB Overview.

The four interventions are:

- Transitional Care Coordination: From Jail Intake to Community HIV Primary Care
- Integrating Buprenorphine Treatment for Opioid Use Disorder in HIV Primary Care
- Peer Linkage and Re-Engagement of HIV-Positive Women of Color
- Enhanced Patient Navigation for HIV-Positive Women of Color

Contact Information

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Funding:

Funding Mechanism: Cooperative Agreement

Intervention Manuals

Contains step-by-step guidance on:

- Pre-implementation activities, including resources and infrastructure needed for successful implementation
- Intervention implementation
- Integrating and sustaining interventions

Contains resources to support replication such as:

- Logic models
- Job descriptions
- Client handouts
- Templates for care plans

Site Spotlights

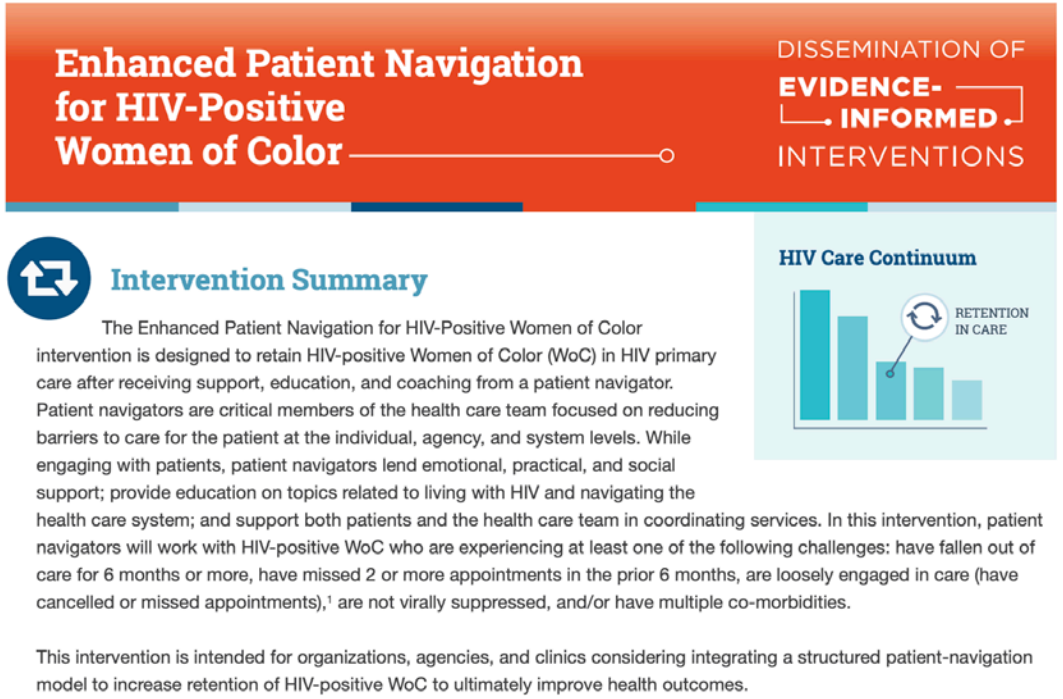
Site spotlights highlight the experience of implementation site-staff.

They provide practical, actionable tips that all Ryan White providers can use when working to support people with HIV.

Intervention Fact Sheets

Designed to provide an overview to the intervention, these fact sheets include:

- An intervention summary
- A review of the published literature related to the intervention
- The theoretical basis for the intervention
- Core intervention components and activities and programmatic requirements
- Staffing requirements
- Additional resources



Enhanced Patient Navigation for HIV-Positive Women of Color

DISSEMINATION OF EVIDENCE-INFORMED INTERVENTIONS

Intervention Summary

HIV Care Continuum

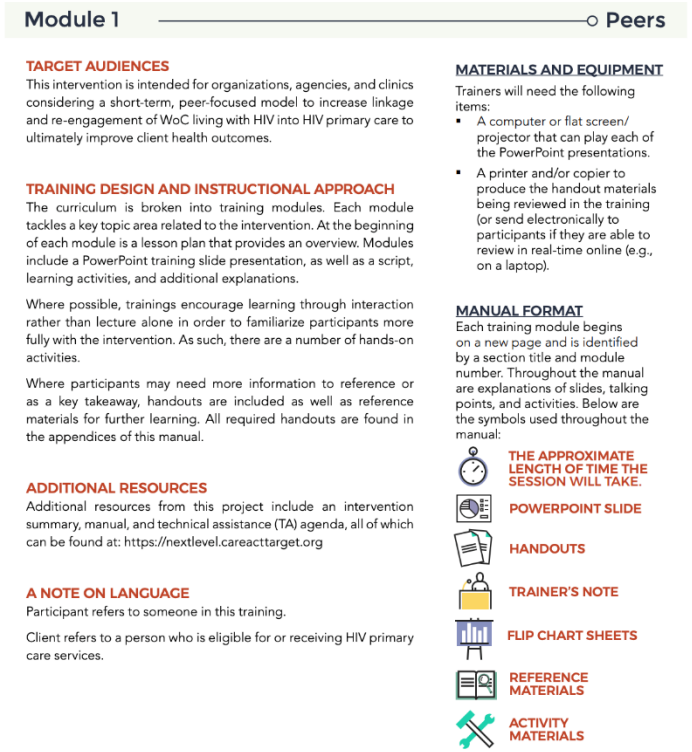
RETENTION IN CARE

The Enhanced Patient Navigation for HIV-Positive Women of Color intervention is designed to retain HIV-positive Women of Color (WoC) in HIV primary care after receiving support, education, and coaching from a patient navigator. Patient navigators are critical members of the health care team focused on reducing barriers to care for the patient at the individual, agency, and system levels. While engaging with patients, patient navigators lend emotional, practical, and social support; provide education on topics related to living with HIV and navigating the health care system; and support both patients and the health care team in coordinating services. In this intervention, patient navigators will work with HIV-positive WoC who are experiencing at least one of the following challenges: have fallen out of care for 6 months or more, have missed 2 or more appointments in the prior 6 months, are loosely engaged in care (have cancelled or missed appointments),[1] are not virally suppressed, and/or have multiple co-morbidities.

This intervention is intended for organizations, agencies, and clinics considering integrating a structured patient-navigation model to increase retention of HIV-positive WoC to ultimately improve health outcomes.

Training Materials

Training Manuals



Module 1 — Peers

TARGET AUDIENCES
This intervention is intended for organizations, agencies, and clinics considering a short-term, peer-focused model to increase linkage and re-engagement of WoC living with HIV into HIV primary care to ultimately improve client health outcomes.

TRAINING DESIGN AND INSTRUCTIONAL APPROACH
The curriculum is broken into training modules. Each module tackles a key topic area related to the intervention. At the beginning of each module is a lesson plan that provides an overview. Modules include a PowerPoint training slide presentation, as well as a script, learning activities, and additional explanations.

Where possible, trainings encourage learning through interaction rather than lecture alone in order to familiarize participants more fully with the intervention. As such, there are a number of hands-on activities.

Where participants may need more information to reference or as a key takeaway, handouts are included as well as reference materials for further learning. All required handouts are found in the appendices of this manual.

ADDITIONAL RESOURCES
Additional resources from this project include an intervention summary, manual, and technical assistance (TA) agenda, all of which can be found at: https://nextlevel.careacttarget.org

A NOTE ON LANGUAGE
Participant refers to someone in this training.

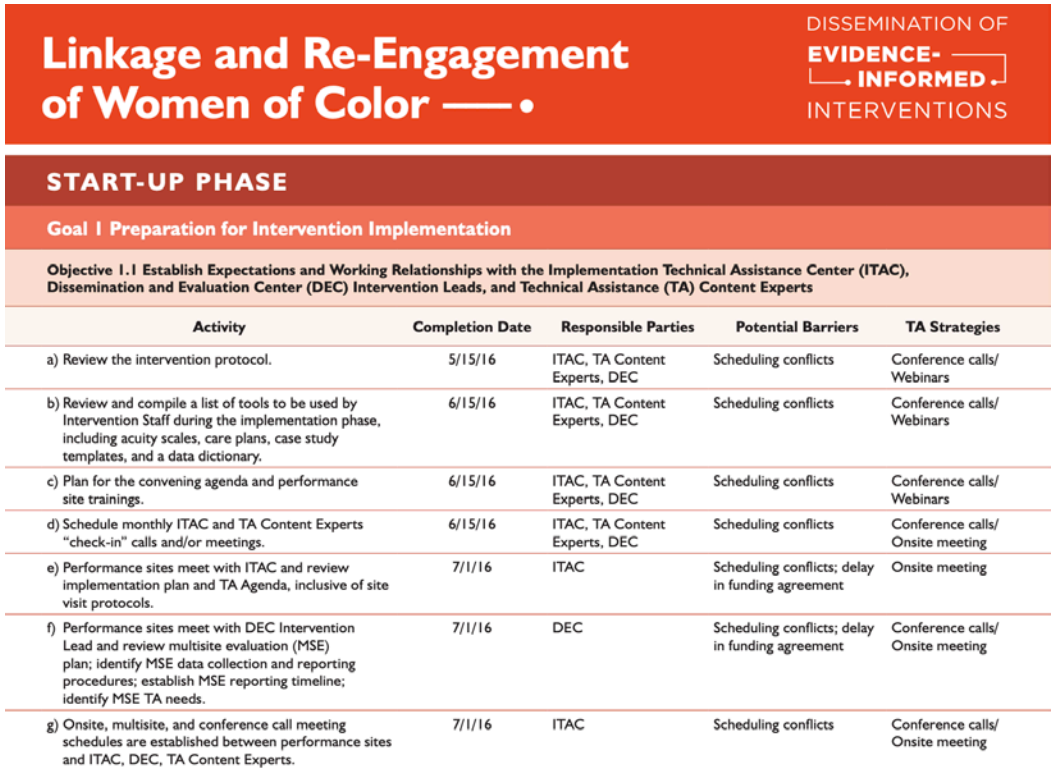
Client refers to a person who is eligible for or receiving HIV primary care services.

MATERIALS AND EQUIPMENT
Trainers will need the following items:
- A computer or flat screen/ projector that can play each of the PowerPoint presentations.
- A printer and/or copier to produce the handout materials being reviewed in the training (or send electronically to participants if they are able to review in real-time online (e.g., on a laptop).

MANUAL FORMAT
Each training module begins on a new page and is identified by a section title and module number. Throughout the manual are explanations of slides, talking points, and activities. Below are the symbols used throughout the manual:

- THE APPROXIMATE LENGTH OF TIME THE SESSION WILL TAKE.
- POWERPOINT SLIDE
- HANDOUTS
- TRAINER'S NOTE
- FLIP CHART SHEETS
- REFERENCE MATERIALS
- ACTIVITY MATERIALS

Technical Assistance Agendas



Linkage and Re-Engagement of Women of Color

DISSEMINATION OF EVIDENCE-INFORMED INTERVENTIONS

START-UP PHASE

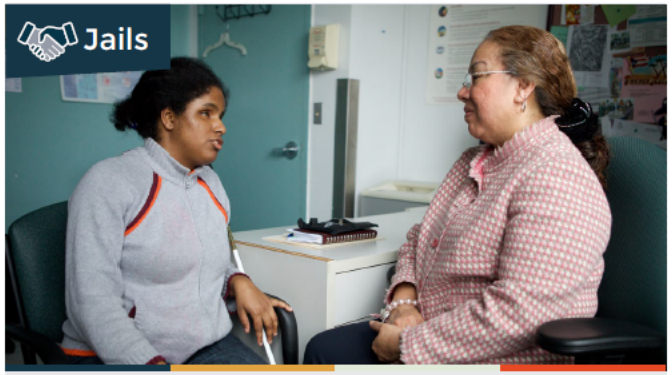
Goal 1 Preparation for Intervention Implementation

Objective 1.1 Establish Expectations and Working Relationships with the Implementation Technical Assistance Center (ITAC), Dissemination and Evaluation Center (DEC) Intervention Leads, and Technical Assistance (TA) Content Experts

Activity	Completion Date	Responsible Parties	Potential Barriers	TA Strategies
a) Review the intervention protocol.	5/15/16	ITAC, TA Content Experts, DEC	Scheduling conflicts	Conference calls/ Webinars
b) Review and compile a list of tools to be used by Intervention Staff during the implementation phase, including acuity scales, care plans, case study templates, and a data dictionary.	6/15/16	ITAC, TA Content Experts, DEC	Scheduling conflicts	Conference calls/ Webinars
c) Plan for the convening agenda and performance site trainings.	6/15/16	ITAC, TA Content Experts, DEC	Scheduling conflicts	Conference calls/ Webinars
d) Schedule monthly ITAC and TA Content Experts "check-in" calls and/or meetings.	6/15/16	ITAC, TA Content Experts, DEC	Scheduling conflicts	Conference calls/ Onsite meeting
e) Performance sites meet with ITAC and review implementation plan and TA Agenda, inclusive of site visit protocols.	7/1/16	ITAC	Scheduling conflicts; delay in funding agreement	Onsite meeting
f) Performance sites meet with DEC Intervention Lead and review multisite evaluation (MSE) plan; identify MSE data collection and reporting procedures; establish MSE reporting timeline; identify MSE TA needs.	7/1/16	DEC	Scheduling conflicts; delay in funding agreement	Conference calls/ Onsite meeting
g) Onsite, multisite, and conference call meeting schedules are established between performance sites and ITAC, DEC, TA Content Experts.	7/1/16	ITAC	Scheduling conflicts	Conference calls/ Onsite meeting

Utilizing the Training Manual

VIRTUAL 2020 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT — 30 YEARS



MODULE 1:
Introduction to the Transitional Care Coordination model

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

OBJECTIVES

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

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

PROCESS

In this activity you will:

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

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

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

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

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

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

The approximate length of time the session will take.

Total: 90 minutes

Ice breaker:
10 minutes

5 units/20 slides:
60 minutes

Facilitated discussion:
10 minutes

Wrap-up:
10 minutes

UNIT 1

SLIDE 1: Facilitator #1
Welcome participants
Introductions:

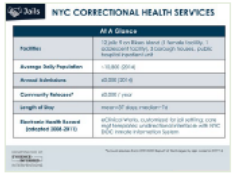
- Facilitators and participants introduce themselves, the organization they represent, and their role on the project.
- Explain the objectives of the training (from the Lesson Plan)
- Each participant is asked to share what they hope to learn from the training (the participant's training goals).

Facilitator #2
Activity: Conduct Ice Breaker activity
Ice Breaker: As part of introductory session, each participant's training goals are written on a blank flip chart sheet (ideally sticky note type) or dry erase board.

SLIDE 2: Facilitator #1
This is an aerial of view of Rikers Island and the other NYC Jails.

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

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



SLIDE 3: Facilitator #1

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

Tips & Tricks

- Assess training resources available in your community
- Assess interest for this intervention in your organization
  - Are there existing staff who can integrate evidence-informed interventions into their practice?
  - Is there an internal champion who has knowledge in this area? Can provide supervision?
- Assemble a multi-disciplinary team who is invested in addressing the identified issue
  - Establish norms around communication and coordination between Ryan White case managers and other staff who may work with clients

Intervention Specific Resources Currently Available

- The intervention and training manuals are available for download on the TargetHIV site
  - https://targethiv.org/nextlevel
- Training and Technical Assistance on the intervention available through 2020
  - Email hbryant@aidsunited.org to learn more

Questions?