CARE AND TREATMENT INTERVENTIONS

Transitional Care Coordination: From Jail Intake to Community HIV Primary Care

DISSEMINATION OF EVIDENCE-INFORMED INTERVENTIONS

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Executive Summary

Purpose of This Manual

This manual is designed to share best practices for implementing the Transitional Care Coordination: From Jail Intake to Community HIV Primary Care (TCC) intervention. This intervention is intended for organizations and agencies (including city, county, and state agencies) considering building or strengthening connections between community and jail health care systems to improve continuity of care for people with HIV recently released from jails. This manual provides an overview of the TCC intervention to facilitate implementation of this linkage to care program, to support retention and engagement of people with HIV post-incarceration and as they re-enter the community. This manual details the staffing, training, and infrastructure needed to implement such a program at a health department or HIV primary care clinic.

Intervention Description

The goal of the intervention is to facilitate continuous HIV care between jail and community settings upon a person's release. This linkage is facilitated by a transitional care coordinator who works across jail and HIV primary care settings.

Intervention activities include identifying and engaging people with HIV during their jail stay, identifying "right fit" community resources, developing a client plan for their time during and post-incarceration, and coordinating activities to facilitate rapid linkage to HIV primary care post-incarceration.

Rationale and Need

The majority of people with HIV who pass through jail are released without being sentenced to prison. They return to the communities they left and the opportunity to make the linkage between jail-based and community-based HIV care, which is a crucial component of comprehensive HIV service delivery,[1, 2] is lost. As such, health departments, local healthcare providers, and community-based organizations have a vested interest in the provision of HIV testing, treatment, and linkage to both care and treatment during and after incarceration.

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[1] Spaulding AC, Seals RM, Page MJ, et al. HIV/AIDS among inmates of, and releasees from, U.S. correctional facilities, 2006: declining share of epidemic but persistent public health opportunity. *PLos One*. 2009;4(11):1-8

[2] Emory University Rollins School of Public Health. Enhancing linkages to HIV primary care and services in jail settings initiative: linkage to social support services (link is external). *Policy Brief*. Spring 2010.

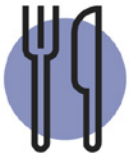
Intervention Summary

The following are key activities conducted by transitional care coordinators ***while clients are incarcerated:***

- Identify eligible clients in the jail and conduct an assessment of co-occurring health concerns and unmet ancillary needs;
- Provide intensive care coordination intervention and drafting of individualized transitional care plans (ideally within 48 hours of jail intake as jail stays are often brief and there is frequent uncertainty around discharge dates and times);
- Provide HIV education, including harm reduction, treatment support, and counseling (ongoing during the jail stay);
- Assist with ensuring that clients have access to their HIV medications while in jail;
- Serve as a health liaison to the courts, collaborating with court advocates, judges and prosecutors, to provide health information to facilitate placement in community programs (including skilled nursing facility, hospice, and drug treatment programs) and alternatives to incarceration programs (ongoing during the jail stay);
- Provide health insurance and AIDS Drug Assistance Program (ADAP) assistance (for submission post-release); and
- Arrange discharge medications/prescription scripts, including arrangements for those released from court (at the time of jail release).

The following are key activities conducted by transitional care coordinators ***after clients are released from incarceration:***

- Provide case management, accompaniment, and home visiting to:



Address needs for food, clothing, transportation, and shelter;

Verify linkages to HIV primary care within 30 days of returning to the community;

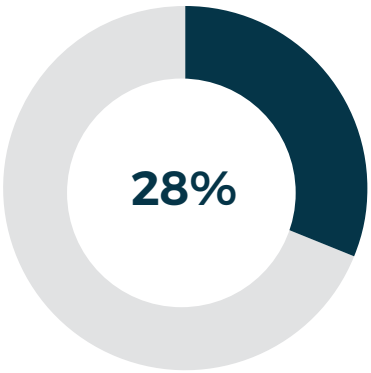
Address ongoing mental health and substance use disorder treatment needs, as assessed;

Support consistent access to health insurance and medication; and

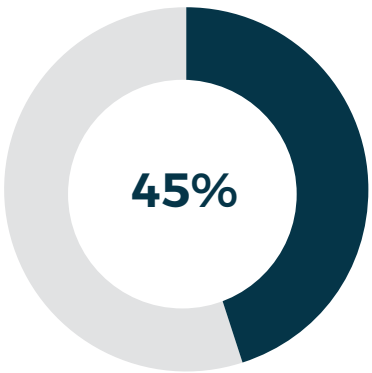
Facilitate ongoing care management and social supports after 90 days.

Evaluation of the Transitional Care Coordination Intervention

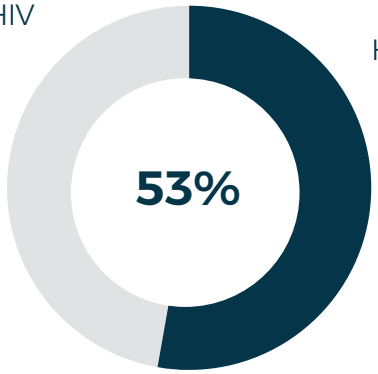
Over the course of this project (2016–2019), a **total of 268 people with HIV identified in jail were served across the three sites. Of the clients released to the community (N=229):**



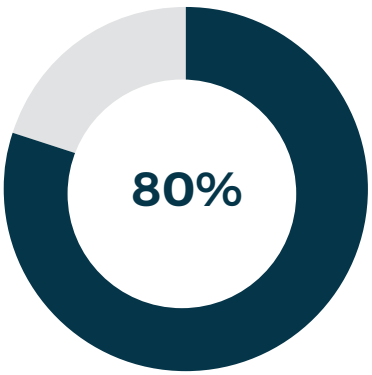
28% of clients were linked to community HIV care within 30 days post-release



45% of clients were linked to community HIV care within 90 days post-release



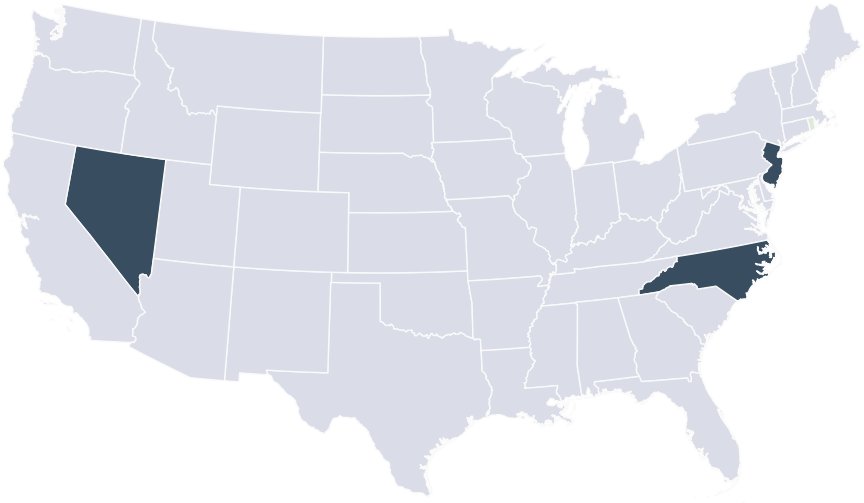
53% of clients were linked to community HIV care within 120 days post-release



80% were virally suppressed at 6 months post-release

INTRODUCTION

From 2016 to 2019, three Ryan White HIV/AIDS Program (RWHAP) recipients (Cooper Health System in Camden, NJ; Southern Nevada Health District in Las Vegas, NV; and University of North Carolina, Chapel Hill in Chapel Hill, NC) replicated a HRSA Special Projects of National Significance (SPNS) initiative that had previously demonstrated success in linkage and retention to care outcomes. These three sites were selected based on their existing relationship with their local jail, in which they were conducting HIV testing at the jail, or providing HIV clinical care to people with in jail. The sites represent varying organizational settings, including an outpatient HIV clinic in a larger hospital organization, a local health department, and a partnership between a university HIV care clinic and the local county social services department.

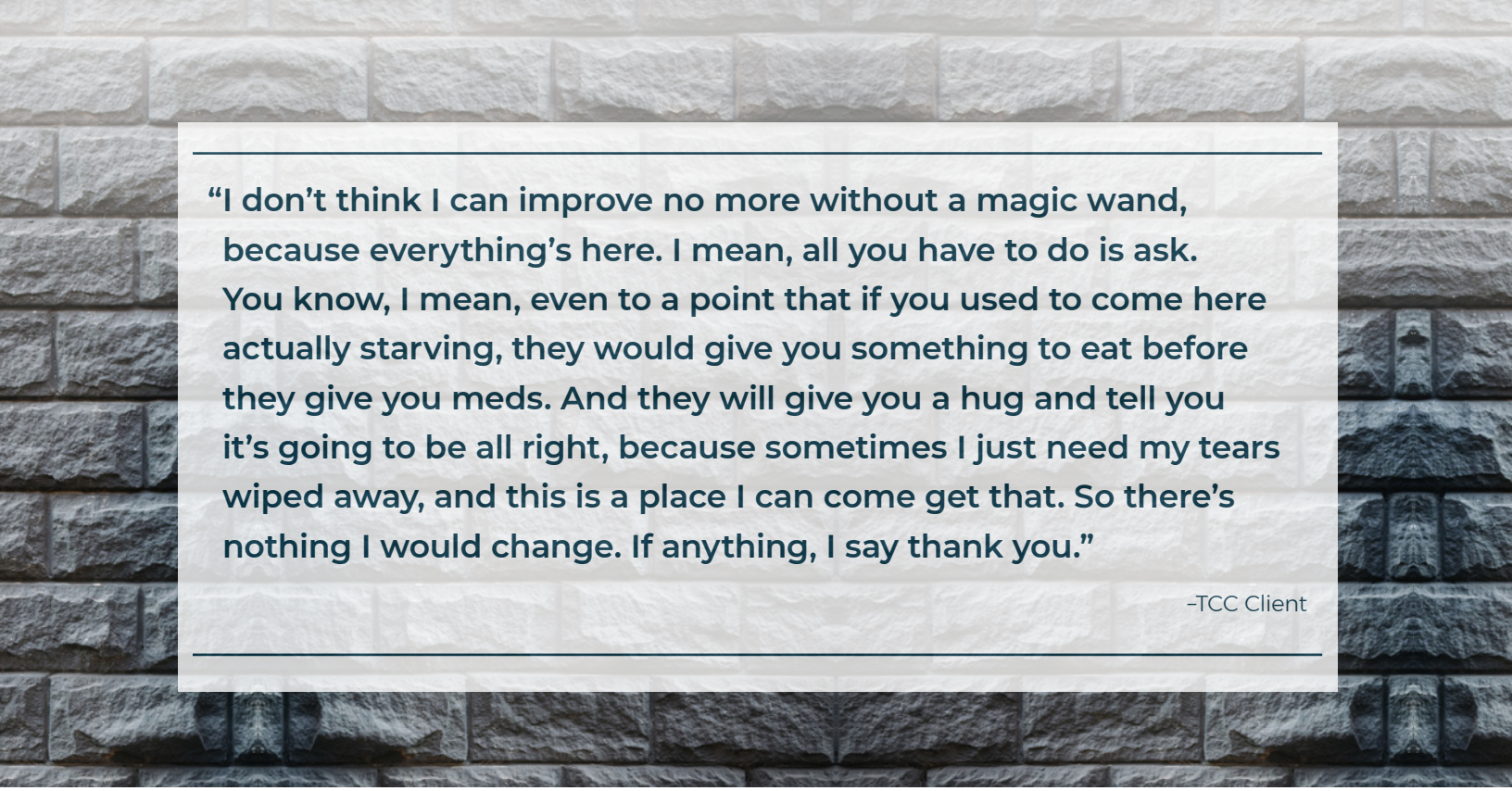


Cooper Health System (Camden, NJ)

Southern Nevada Health District (Las Vegas, NV)

University of North Carolina, Chapel Hill (Chapel Hilll, NC)

The intervention was funded through a grant made available to AIDS United through the U.S. Department of Health and Human Services, Health Resources and Services Administration, HIV/AIDS Bureau, Special Projects of National Significance. The funding was part of the Dissemination of Evidence-Informed Interventions (DEII) initiative, which focused on using an Implementation Science framework to replicate models of care in diverse geographic and organizational settings.



> **"I don't think I can improve no more without a magic wand, because everything's here. I mean, all you have to do is ask. You know, I mean, even to a point that if you used to come here actually starving, they would give you something to eat before they give you meds. And they will give you a hug and tell you it's going to be all right, because sometimes I just need my tears wiped away, and this is a place I can come get that. So there's nothing I would change. If anything, I say thank you."**
>
> –TCC Client

Key Objectives

This is a short-term intervention in which a transitional care coordinator works intensively with eligible people with HIV in jail to link them to community HIV primary care within 30 days of release. The transitional care coordinator then continues working with clients for at least 90 days post-release to identify and address barriers to care, and provide continuity of HIV care between the jail and community care, with the ultimate goal of improving HIV health outcomes.

Implementation Science Approach

DEII sites implemented previously tested interventions that demonstrated improved outcomes along the HIV Care Continuum for people with HIV. Rather than ask "does this intervention work?" DEII asked "what makes the intervention work?" To answer this question, the DEII initiative used an implementation science approach to study the implementation process itself. DEII evaluators used qualitative and quantitative instruments such as key informant interviews, patient encounter forms, and site visit reports to document key factors for successful implementation, challenges encountered by the interventionists, and adaptations needed for successful implementation. This manual reflects findings from implementation science data collected throughout the initiative.

At-a-Glance: Transitional Care Coordination

Main Challenge: The transition from incarceration back into the community is known to be a high-risk period for increased deaths,[3] discontinuity of care and treatment (including antiretroviral therapy (ART)), exacerbation of mental health conditions, unstable housing, and opiate overdose. The adverse health outcomes that occur during this high risk period underscore the need for transitional care coordination and support services.[4] The majority of people pass through jail and are never sentenced to prison but return to the communities that they left,[5] making the linkage between jail-based and community-based HIV care a crucial component of HIV service delivery. As such, health departments, local healthcare providers, and community-based organizations have a vested interest in the provision of HIV testing, treatment, and linkage to both HIV care and services during and after incarceration. It is useful for health care and correctional staff to view jails as part of the continuum of care rather than independently, as this approach may encourage strategic retention-in-care planning.

Collaborations between public health agencies, community-based organizations, and jail health services have implications for public health and safety efforts and have been proven to facilitate linkage to care after incarceration.[6] Medical screenings and early linkage to care that happen for all incarcerated people during the jail intake process

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[3] Teixeira PA, Jordan AO, Zaller N, et al. Health outcomes for HIV-infected persons released from the New York City jail system with a transitional care-coordination plan. *Am J Public Health*. 2015 Feb; 105(2): 351–7.

[4] International Advisory Panel on HIV Care Continuum Optimization. IAPAC Guidelines for Optimizing the HIV Care Continuum for Adults and Adolescents. *J Int Assoc Provid AIDS Care*. 2015;1–32; Wohl DA, Scheyett A, Golin CE, et al. Intensive case management before and after prison release is no more effective than comprehensive pre-release discharge planning in linking HIV-infected prisoners to care: a randomized trial. *AIDS Behav*. 2011 Feb;15(2):356–64; and deVoux A, Spaulding AC, Beckwith C, et al. Early identification of HIV: empirical support for jail-based screening. *PLos One*. 2012;7(5):1–7.

[5] Spaulding AC, Seals RM, Page MJ, et al. HIV/AIDS among inmates of, and releasees from, U.S. correctional facilities, 2006: declining share of epidemic but persistent public health opportunity. *PLos One*. 2009;4(11):1–8. and Emory University Rollins School of Public Health. Enhancing linkages to HIV primary care and services in jail settings initiative: linkage to social support services (link is external). *Policy Brief*. Spring 2010

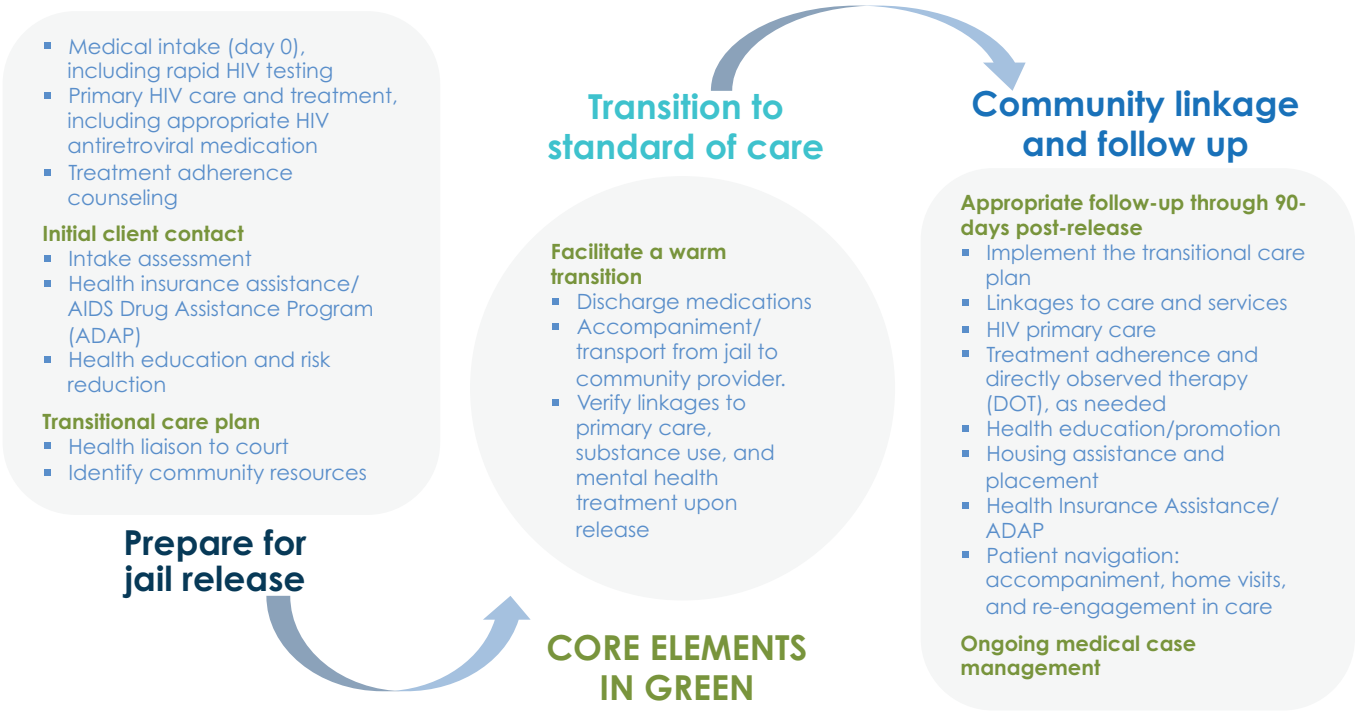
[6] Jordan AO. Linkages and Care Engagement: From NYC Jail to Community Provider. New York State Department of Health AIDS Institute, End of AIDS and the Criminal Justice System. September 16, 2015 [Webinar].

offer an opportunity to implement such interventions, as do booking processes and intervention intake.[7]

The Centers for Disease Control (CDC) strongly recommends jail-based HIV testing.[8] Routine HIV screening in jails is also consistent the Ending the Epidemic (EHE) initiative. Nonetheless, many people with HIV in jails are unaware of their HIV status and/or were not in HIV primary care at the time of jail admission. While HIV testing was not a component of the TCC intervention, each of the sites provided or supported HIV testing efforts in their local jail through other projects and funding sources.

Focus Population: People with HIV identified while in jail who are 18 years or older.

Model Description: Three funded sites in Camden, NJ; Las Vegas, NV; and Chapel Hill, NC, conducted the activities outlined below to link people with HIV identified in jail to community HIV primary care within 30 days post-release and to community case management at 90 days post release (as appropriate). Each site had two full-time transitional care coordinators with caseloads of 20 to 25 active clients at a time.



[7] Flanigan TP, Zaller N, Beckwith CG, et al. Testing for HIV, sexually transmitted infections, and viral hepatitis in jails: still a missed opportunity for public health and HIV prevention. *JAIDS (Suppl)*. 2010;55(2): S78–83 and Emory University Rollins School of Public Health. Enhancing linkages to HIV primary care and services in jail settings initiative: linkage to social support services. *Policy Brief*. Spring 2010.

Teixeira PA, Jordan AO, Zaller N, et al. Health outcomes for HIV-infected persons released from the New York City jail system with a transitional care-coordination plan. *Am J Public Health*. 2015 Feb;105(2):351–7.

[8] https://www.cdc.gov/correctionalhealth/rec-guide.html

Intensity of Services: On average, TCC clients received **2.3** encounters while in jail (range = **0–25**) and an additional **7.7** encounters post-release (range = **0–53**). The average length of time a client received TCC intervention services was **9.1** months, with a range of **0–27** months.

Resources Needed:

- Private or semi-private dedicated workspace within the jail for confidential conversations
- Laptop computer (if allowed by the correctional facility) or access to a computer within the correctional facility and a desk phone
- List of community resources including mental health and substance use treatment services, housing support services, food banks, shelters, domestic violence support, legal services, and employment agencies
- In-jail escort services by corrections officers
- Client hygiene kits that include t-shirts and socks (if allowed by the facility)
- Discharge pack with TCC program contact information, referrals, medications or prescription for medications, transportation assistance, and food vouchers

> **"It was like when before I never felt like doing anything, but talking to [the transitional care coordinator], she opened my eyes to a whole other level, where even with the HIV, I'm still human, I can still move around, I can still stay motivated. And because of her, that's what I'm doing now."**
>
> –TCC Client

Staff Background and Training:

- Two full-time transitional care coordinators employed by the health center working in both the jail and community settings
- One part-time project manager/administrative supervisor with experience with HIV programs and/or jail-based projects
- One part-time clinical supervisor, a licensed mental health professional

Management and Integration: A project manager/administrative supervisor manages the transitional care coordinators and their work. This person is also responsible for maintaining an administrative relationship and communications with the local jail and connecting with community partners to build referral relationships. A clinical supervisor provides biweekly or monthly support to transitional care coordinators in managing clients and addressing self-care needs. All project staff meet for weekly project and client updates, and at some sites, regular meetings are held with the health care team as part of clinic huddles. All staff communicate via email or phone when in-person team huddles are not feasible.

Financing: The adjusted average cost per participant per year across the three sites was $3,185 (2019 dollars, range $2,710–$3,959). The number of clients served ranged from 149–249 per year. The calculated costs included: salary and fringe benefits for intervention staff and supervisors, materials and consumables for non-research related activities, transportation cost for staff and clients, other direct costs to provide client services such as incentives for medical care and agency overhead rates. Startup costs for the intervention, including staff training and salaries, averaged $34,874 (range: $7,200–$53,098). Data were gathered from administrative reports provided by the agency at the close of the fiscal grant year reported to AIDS United.

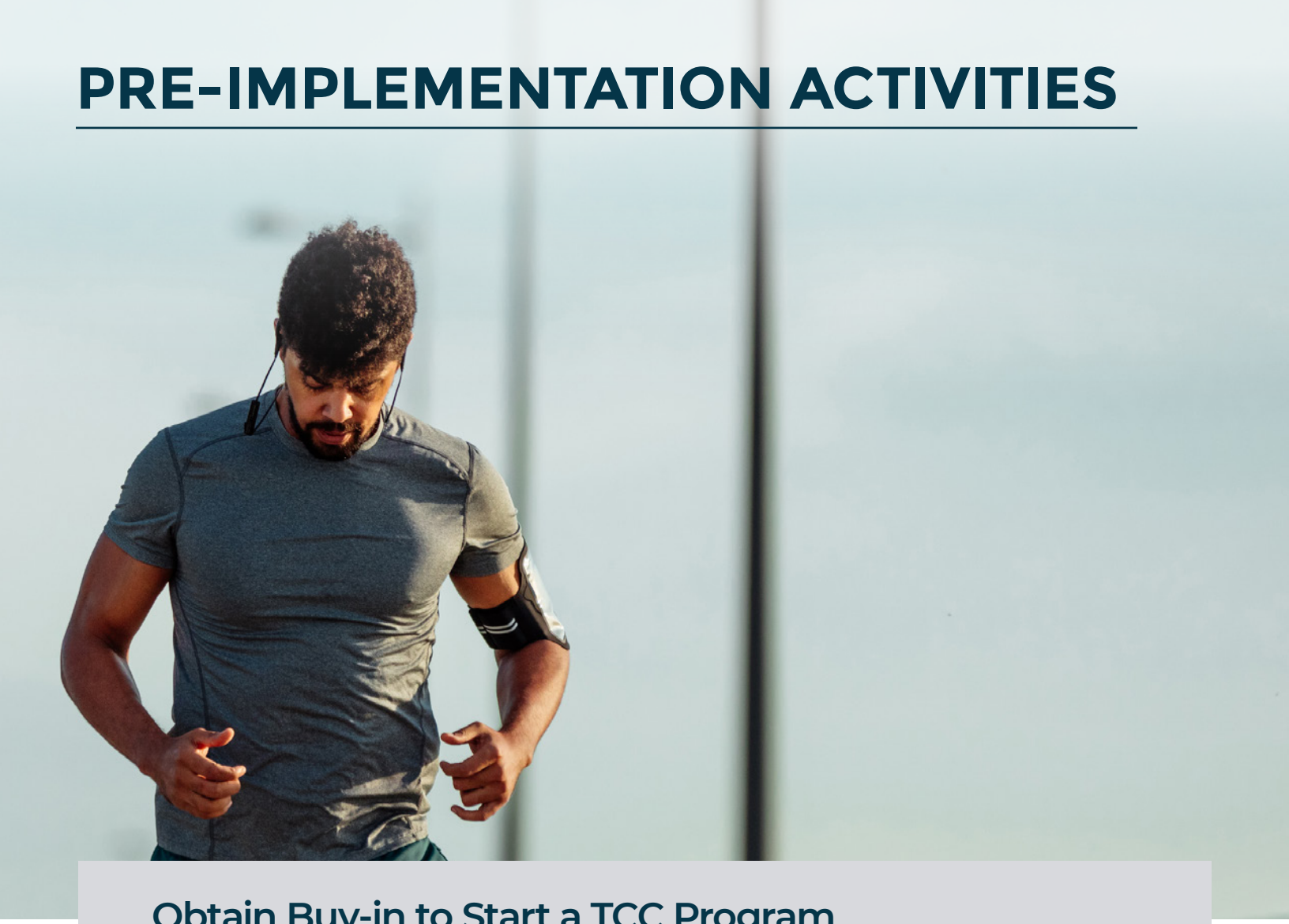
Model At-a-Glance

Pre-implementation	
Step 1	**Establish formal relationship with local jail** Establish a formal working relationship with the local jail through discussion at the administrative level about the elements of the TCC program. Jointly develop a memorandum of understanding (MOU) outlining the roles and responsibilities of each agency, program expectations, the staff/client flow, and elements of jail access for the intervention staff.
During incarceration	
Step 2	**Identify eligible clients** Eligible clients are people with HIV in jail. They may be identified by HIV testing conducted in the jail, by self-report upon booking/intake, or during the initial medical intake in jail. Work with agency/clinic staff and jail staff to identify eligible clients.
Step 3	**Assess client interest and conduct needs assessment** Meet with clients while in jail to assess their interest in the program, as well as their medical and social needs. Explain the goals of the intervention (to link the client to HIV medical care in the community post-release). Provide client education on HIV, adherence, risk reduction, and other health issues.
Step 4	**Create a transitional care plan with the client** Work with client to create a transitional care plan immediately as clients can be discharged at any time. The plan should address the client's basic needs, community resources, referral information to HIV care in the community, and arrangements for discharge medications and prescriptions. The transitional care plan should be revisited and updated every time the transitional care coordinator and the client meet in the jail.
Post-release	
Step 6	**Assist client in accessing needed services** Assist the client in accessing community services to meet their basic needs such as housing, food, and transportation. Make an appointment to ideally link the client to medical care within 48 hours of release. Conduct home visits and provide accompaniment to appointments as needed.
Step 7	**Document services in the electronic medical record to share with care team** As part of the client's chart, document TCC services provided in the electronic medical record to keep care team informed.
Step 8	**Attend regular care team meetings** Attend regular care team conferences and huddles with clinic staff to update them about TCC services provided.
Step 9	**Provide a transition to community standard of care** At 90 days post-incarceration, and after the client has received support to address immediate auxiliary needs, work with the clinic team and client to determine if the client is ready to be transitioned to a community case manager or if they should continue to work with the TCC intensively to improve their stability. For clients who are ready, provide a warm hand-off to the case manager, preferably via an in-person meeting.

The transitional care coordinator provides a warm transition between jail and community by:

- Creating a plan with client for one of these two transitional situations - from jail to community and from TCC to community case management
- Identifying supports for the client in accessing the services they need
- Planning client for transportation
- Providing contact information for key service providers
- Providing materials/items (clients property upon discharge, medical and legal paperwork, prescriptions, IDs, referral paperwork, etc)
- Facilitating a discussion between transitional care coordinator, client and community providers about scheduling, expectations and services to be offered
- Creating a plan to check-in with the client immediately after the transition event (release from jail, connection to community care, etc)

PRE-IMPLEMENTATION ACTIVITIES



Obtain Buy-in to Start a TCC Program

- Ideally the TCC intervention is built upon an existing relationship with a local jail in which there is active communication between agency administrators and jail administrators (including the warden and the medical director) and existing collaborative programs conducted in the jail.
- If one does not already exist, identify an **internal champion** to create an organizational culture supportive of the TCC program. This internal champion does not have an established list of activities, rather, the champion will develop and maintain a relationship with key jail administrators and jail medical staff, as well as help the TCC intervention team gain the internal and community support and resources necessary to implement the program. The internal champion may or may not be part of the intervention, but must be on staff at the agency/clinic and available to the intervention team. At the three replication sites, the internal champions were the county HIV program director, the clinic administrator, and an HIV clinician.
- Work with human resources to develop a job description for transitional care coordinators that aligns with both jail and clinic/agency policies.

- Strengthen relationships with jail leadership (local jail, sheriff's office, and/or other entity overseeing jail system) to ensure ongoing cooperation and support throughout implementation. During this relationship building process, clinic administration, and jail leadership will address logistical issues that may impact implementation of intervention activities, as detailed in the chart on the following page.

Programs in the Jail Setting

Programs conducted by community agencies/clinics in the jail setting can include one or several of the following:

- Provision of voluntary HIV testing and counseling
- Offering of HIV clinical training to jail medical staff using agency/clinic clinical staff or through collaboration with the regional AIDS Education and Training Center
- Integration of community HIV provider into the jail clinic to provide HIV care to clients
- Assistance in accessing 340B pricing for HIV medications provided in jail
- Provision of lab testing (viral load and CD4 testing) for persons with HIV in jail
- Integration of a benefits counselor in the jail medical setting to assist clients in signing up for medical benefits prior to release

Assess Existing Jail-Based Health Care and Conduct Jails Workflow Analysis

Assessed (Y/N)?		Considerations (What do you need and why?)
	Model of how medical care services are provided in the jail setting	◆ Is medical care provided through a contract with a for-profit outside agency? ◆ Is it provided by the jail? ◆ How is specialty care such as HIV care provided in the model? ◆ What related work is taking place?
	Alignment with HHS and CDC recommendations	◆ Are jail-based medical health screenings, mental health screenings, and physical exams, (including voluntary HIV testing, rapid HIV testing and provision of ART) provided? ◆ Is the manner in which these services are provided in accord with HHS and CDC recommendations? https://www.cdc.gov/correctionalhealth/rec-guide.html
	Assessment and availability of space	◆ Learn where medical and social services are delivered in the jail. ◆ Negotiate dedicated space to conduct intervention activities that provides some level of client confidentiality and auditory privacy, but follows jail policies. ◆ Determine what office supplies and technology are allowed in the office space.
	Relationship between intervention and jail processes	◆ Assess the need for additional consent forms, prescreening procedures, and escort restrictions. ◆ Determine what materials and resources are and are not permissible in the jail. ◆ Discuss any impact the intervention may have on existing jail processes with jail leadership and corrections officers. ◆ Identify how to access health records and any Electronic Health Records (EHR) systems within the jail medical department.
	Medication distribution methods in the jail	◆ How do clients access or request jail medical services and how are medications provided daily?
	Average length of stay and release information	◆ What percent of those admitted are released within 72 hours and what percent are released within a week?
	Facility release plan	◆ Jails typically release clients with very little notice and well into the evening hours. Learn the release process in the jail and determine ways to best address a client's needs once released, including adding items to their personal belongings. ◆ Learn what time of day people are typically released. ◆ Upon release, will clients be provided with: – An ID – Transportation – Medications or a prescription for medications – Their personal property, including intervention materials and contact information for the transitional care coordinator

Formalize MOU with Jail

Formalize logistical commitments and develop a Memorandum of Understanding (MOU) Linkage Agreement with the jail (See Appendix I for sample MOU). This MOU will include:

- Explicit permission to conduct intervention activities as outlined in this manual.
- A commitment to a semi-private space for the transitional care coordinators to conduct their work. Examples may include:
  - An office in the medical unit
  - A rotating office near discharge planning or benefits enrollment (if applicable)
- A commitment to provide transitional care coordinators with access to the jail-based record system(s) to identify people with HIV who have entered jail, monitor client transfers, and review client health information.
- A commitment from the jail to allow clients to access TCC services using the existing sick call protocol, but without a fee.
- A commitment from the jail to provide access and security training for transitional care coordinators.
- A commitment for correctional officers to provide escort services (i.e. dedicated jail security staff and correctional officers are assigned to partner with the intervention team). In cases where escort services are not available, determine a plan for how staff can move about the facility as needed. Escort services can include:
  - Officers escorting clients to and from TCC workspace.
  - Officers escorting transitional care coordinators to other areas in the jail to meet with clients.
- A commitment from the jail to provide clinic administration and intervention staff with an annual jail-specific security briefing.
- A commitment from the jail to coordinate with transitional care coordinators on release of TCC clients. This includes:
  - Informing transitional care coordinators of the timing for client release if possible;
  - Coordinating with the transitional care coordinators for a client release time during business hours, when possible, and when transportation for the client can be set-up; and
  - Including existing HIV medications or prescriptions, transportation, meal gift cards, and TCC materials (contact information for key referrals, medical and/or legal paperwork, and contact card for the transitional care coordinator) in the client's property upon release.

Conduct a Community Partner Assessment to Strengthen Community Partnerships and Referral Resources

Assessed (Y/N)?		Considerations
	Relevant state and local policies that may impact TCC program implementation	◆ Available substance use and mental health treatment options ◆ National and local substance use policies (For instance, not all states have legalized marijuana.) ◆ Mental health care policies ◆ Bail reform
	Organizational capacity of community medical and social service partner agencies	◆ Do they have the capacity to accept referrals? ◆ What is the process for making a referral? ◆ What is the number of clients they can work with at any given time? ◆ Are there any restrictions on the clients they are able to work with? ◆ Can they provide consistent transitional care and social supports that are culturally sensitive and trauma-informed? ◆ Can they create daily "open" appointment times for transitional care coordinators to quickly schedule released clients for appointments post-release?
	Organizational assessment and capacity of existing post release, transitional, and community programs	◆ Assess the jail's existing relationships with these programs. ◆ Do they have the capacity to accept referrals? ◆ What is the process for making a referral? ◆ How do these programs work with community health service systems and other social services programs? ◆ Are there any restrictions on the clients they are able to serve?
	Protocols with community-based partners	◆ Define roles and responsibilities for staff at community partner settings and intervention team members related to working with intervention clients. ◆ Determine points of contact for referrals and processes for referrals. ◆ Draft protocols for release of information protocols. ◆ Facilitate ongoing communication between staff and community-based service providers regarding intervention operations and expectations for documenting linkages to and maintenance in care. ◆ Facilitate the continuity of care through data sharing (which may necessitate data sharing agreements). ◆ Streamline the process for coordination among service providers to avoid duplication or omission of service provision to each client (to remain consistent with the client's transitional care plan). ◆ Formalize logistical commitments and develop mutual Memoranda of Understanding (MOU) including a Linkage/Data Sharing Agreement with each community partner that includes a commitment to provide the transitional care coordinator access to data that verifies linkage to care (see sample attached in Appendix I).

Organize a quarterly meeting between community partners and referral resources to continue throughout the intervention. Use this meeting to assess gaps in services, identify new community partners, and case conference both challenging and successful client cases. Identify and attend existing community coalitions on social determinants of health topics such as housing, justice reform, and care coordination.

Internal Clinic/Agency Tasks to Prepare for TCC Implementation

Addressed (Y/N)?		Considerations
	Review and know the policies on safety and liability	◆ What are your agency's policies? Do you need to create them? ◆ What are the jail's policies?
	Develop protocol to identify eligible TCC clients	◆ How are clients identified in the jail system? ◆ How are clients identified by others outside of the jail system (other clinicians or case managers)? ◆ How will this list be created daily or every other day by the administrative supervisor? ◆ How will individual clients be assigned to transitional care coordinators?
	Create easy access to HIV care	◆ Work with your clinic or the community clinic administration to create daily "open" appointment times for transitional care coordinators to quickly schedule released clients for HIV medical appointments post-release.
	Staff communications	◆ Create a staff communication and decision-making plan so the team knows who to approach for various needs.
	Develop a grievance procedure	◆ Develop a grievance procedure that clients can use to report problems in accessing or receiving services. The procedure should include information on how to file agency-level grievances to funders, including if the client's complaint cannot be resolved. Filed agency grievances must be maintained by the project manager and be available for audit. They must include problem presentation, issue resolution, and evaluation of client satisfaction.
	Develop a health liaison procedure	◆ Identify existing court advocacy programs and current processes for arranging Alternative to Incarceration (ATI) services, jail diversion, and compassionate release. ◆ Develop procedures for integrating health liaison services conducted by intervention staff into the court's existing practices. ◆ Develop mutual Memorandum of Understanding (MOU) Linkage Agreement with each justice system partner including Treatment Accountably for Safer Communities (TASC), defenders, prosecutors, and courts.

Hire and Identify Staff to Implement the Program

Key Roles for the Intervention

- Two full-time transitional care coordinators who are able to work in both the jail and community;
- One part-time project manager/administrative supervisor; and
- One part-time clinical supervisor.

Post job descriptions and share posting with other community agencies and clinics, as well as jail and other jail partner organizations, using job descriptions are available in ***Appendix B***.

Hiring Transitional Care Coordinators (see also *Appendix B*)

- Work with human resources to develop job descriptions that fit within your agency/clinic job titles.
  - For transitional care coordinators, define the role and responsibilities and the specific kind of skills required, which may include:
    - Previous experience working in the jail system or the social service system
    - HIV knowledge (understanding of HIV transmission, the life cycle of the virus, lab values, and HIV medications)
    - Ability to work with a variety of clients in a non-judgmental manner using a client-centered approach
    - Ability to build and maintain community relationships
    - Assertiveness and ability to work independently, but also a strong team player with respect for authority, which is required when working in a jail system
- Interview candidates using a panel inclusive of administrators and staff who would be partnering with the transitional care coordinators. During interviews, discuss:
  - The need for clear boundaries with jail staff and clients
  - Differences in tasks between transitional care coordinators and clinic or community case managers, and how all the roles work together
  - Expectations of how transitional care coordinators work within the jail system based on both jail and agency protocols and policies
- If possible, take final candidates on a tour of the jail. Use this tour to allow candidates an opportunity to assess their comfort with the jail procedures, staff, and environment.

You are a guest in their house

It is important to recognize and remember that the goal and job of corrections is very different than the goal and work of the intervention. The overall goal of the correctional officer role is to maintain order and overall safety for all. This requires respect for all rules and regulations of the jail as well as knowing and following the hierarchy of the jail.

Hiring Clinical and Administrative Supervisors (see also *Appendix B*)

An administrative supervisor provides daily support for the transitional care coordinators by managing client caseloads, identifying resources, documenting their work as part of the client's clinic records, and managing relationships and communications with jail and community partner agency administrators. The administrative supervisor has project management experience, preferably with HIV or other chronic conditions, and may have a master's degree in public health or social work. Ideally, they should have established relationships with the jail administration, care teams, and community partners so the transitional care coordinators can be easily introduced with credibility.

A clinical supervisor helps support the transitional care coordinator's mental health and wellbeing. Because transitional care coordinators work both in and out of the jail system with a highly vulnerable population, their work with clients may be difficult and may bring up feelings of vicarious trauma. A clinical supervisor can also help ensure the transitional care coordinators are working with clients and staff in a productive and effective way for the team and client. This includes helping the transitional care coordinators support clients when they are ready to transition to community case management. They are licensed professionals, either psychologists, social workers, or counselors. It is critical that they have experience with the community being served, HIV, homelessness, substance use and/or mental health.

Both of these part-time roles may be filled by current employees or new hires.

Once a team has been hired, establish a supervisory structure.

Key points to consider when establishing the structure for a TCC supervision system:

- ☑ Ensure the administrative supervisor can spend at least 25% of their time managing the TCC program
- ☑ Provide training on supervision techniques
- ☑ Create a network and shadow supervisors who are doing similar work; this creates a knowledge base for the supervisor and bridge for resources

Training and Orienting Team Members

Train new staff members and those who are currently working at your agency in different roles.

Agency-Specific Training

- ☑ **Review general organizational policies**.
- ☑ **Identify workflows and clear tasks** for each member of the intervention team.
- ☑ **Introduce new transitional care coordinators to community partners**. Take new team members to community meetings, organize one-on-one meetings, and orient new team members to where community partners are physically located and what services they provide. It's one thing to receive a list of community partners in an orientation packet, but in order to best support clients, team members need to know who to call for specific services as well as have familiarity with processes to acquire services. Encourage staff to meet regularly with partners, such as the AIDS Consortia, the health department, planning councils, and jail staff.

Job-Specific Training

- ☑ **Harm reduction** for those with history of substance use.
- ☑ **Conduct a jail specific orientation**, including background checks, dress-code, security regulations and access, etc.
- ☑ **Discuss boundaries** between transitional care coordinators and clients, e.g. not giving out personal cell phone numbers or other personal information, etc.
- ☑ **Provide mental health first aid training** to support staff in identifying signs and symptoms of mental illness and substance use concerns, and strategies for how to assist in both crisis and non-crisis situations. (https://www.mentalhealthfirstaid.org/)

- **Provide motivational interviewing training** to give staff the skills to interact positively with clients and assist them in identifying and achieving their program goals.
- **Provide a list of client resources and contact information.**
- **Identify continuous learning and professional development opportunities for supervisors and transitional care coordinators.** An organizational environment that supports learning is the best way to ensure that transitional care coordinators are adequately prepared to do their job. Transitional care coordinators and administrative supervisors should take classes to support their intervention activities and broader skills. Opportunities may be available through college classes, webinars, and other local trainings. Community partners may offer trainings on cross-cutting issues (like trauma-informed care) or skills (motivational interviewing).

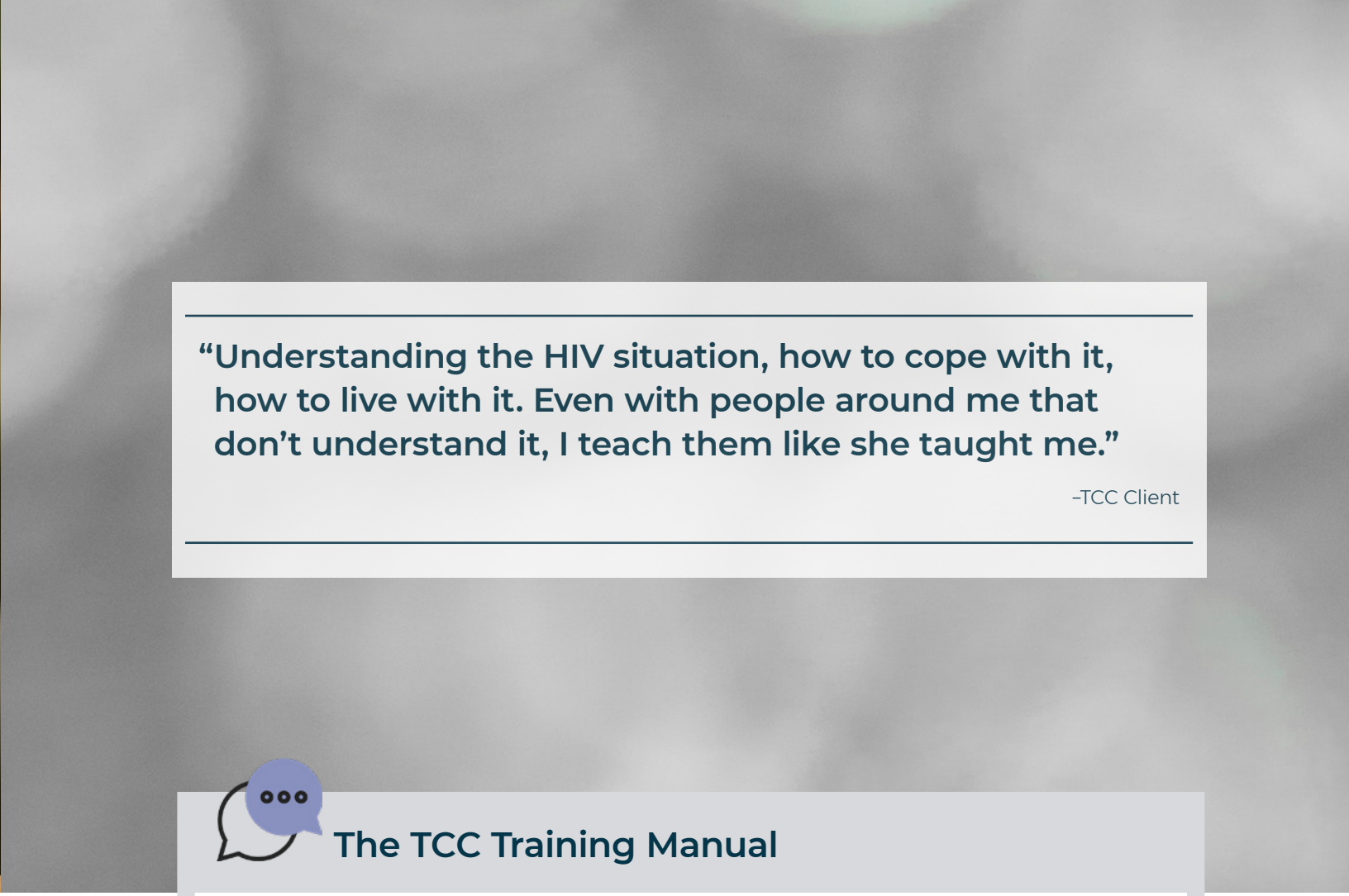
Tip: Working Inside the Jail Setting

It is crucial to build a strong collaborative relationship with the correctional officer in the jail. They are gatekeepers and important resources for the TCC program. DEII sites did this this through a number of ways:

1. Serve as a health resource, sharing and offering information to the correctional officers about HIV, STIs, and other co-morbidities that impact people with HIV.
2. Attend existing correctional officer meetings, as well a new officer orientation to share information on the TCC model. One site developed a short video about the TCC model that was shown at orientation.
3. Attend informal gatherings such as lunches or break-time activities to get to know the correctional officers. If appropriate, have snacks or candy to share with officers.
4. Maintain a friendly and respectful demeanor at all times.

Technology Training

- ☑ **EHR system training**: Transitional care coordinators must understand what is captured in the jail EHR and if and how they may access jail medical files. They must also know what is captured in the agency EHR and what intervention information needs to be entered into the system.
- ☑ **Ensure the transitional care coordinators are comfortable using technology in general**, as well as any other online systems used at the organization to document work.



> **"Understanding the HIV situation, how to cope with it, how to live with it. Even with people around me that don't understand it, I teach them like she taught me."**
>
> –TCC Client

The TCC Training Manual

The ***Transitional Care Coordination training manual*** is available online.

The training manual can be used by individual staff or program supervisors to build skills and capacity related to the TCC intervention protocols. Modules include:

- Introduction to the Transitional Care Coordination Model
- Functional Assessment: Mapping/Assessing the Flow
- Culture of Corrections: Transitional Care Coordination in a Non-Traditional Setting
- Policies and Practice: At the Nexus of Correctional Health and Public Health
- Implementing the Transitional Care Coordination Model
- Introduction to the Court Liaison
- Network of Care

IMPLEMENTATION ACTIVITIES

Intervention Implementation Activities: Core Elements

The aim of the TCC intervention is to establish a linkage program for people with HIV identified in jail, to support their engagement with HIV primary care and other support services post-incarceration and as they re-enter the community. In order to achieve similar outcomes as the DEII initiative, the intervention should be implemented using the following core elements:

Core Element	Tasks and Competencies
Transitional care coordinator initiates contact with eligible potential clients in jail	Transitional care coordinator: ◆ Completes the intake form and client assessment with the client ◆ Demonstrates ability to leave space for questions and answer questions appropriately ◆ Demonstrates familiarity with and comfort when working in a jail setting ◆ Asserts timeline of the intervention, their role, and the goals of the intervention ◆ Discusses the "warm transition" and answers any questions that the client may have about linkage or re-entry ◆ Addresses client-identified immediate needs
Transitional care coordinator creates a transitional care plan (TCP) alongside the client (ideally during the initial jail contact)	Transitional care coordinator: ◆ Collaboratively creates a transitional care plan that addresses client-identified immediate needs and client-identified barriers to accessing care after incarceration (prioritizing patient goals) ◆ Uses open-ended questions, affirmations, reflections, summaries, active listening, non-judgmental responses ◆ Assesses client confidence to take the steps needed to meet the goals outlined in the TCP plan post-incarceration ◆ Uses Motivational Interviewing techniques and principles of trauma-informed care when creating the TCP with the client
Transitional care coordinator continues to meet regularly with the client while in jail	Transitional care coordinator: ◆ Maintains contact with the client ◆ Reviews and updates the transitional care plan with the client ◆ Conducts HIV education sessions ◆ Supports the client in accessing services (medical, behavioral health, HIV medications, etc.) ◆ Serves as a liaison to the court to support and advocate on behalf of the client

Core Element	Tasks and Competencies
Client experiences a warm transition from incarceration to release in the community, and client links to HIV primary care	Transitional care coordinator: ◆ Reviews and updates (if needed) the transitional care plan with the client ◆ Sets up a linkage to care appointment for the client and accompanies client if requested ◆ Assists in troubleshooting any potential barriers to attendance at first appointment (such as transportation) ◆ Prepares a client for release by jail/court authorities to the community
Transitional care coordinator offers appropriate follow up during the 90 days after the client has been released	Transitional care coordinator: ◆ Reviews and updates, with the client, the transitional care plan (if needed) and discuss frequency and method of client-transitional care coordinator contact ◆ Demonstrates understanding of community resources and various providers ◆ Is willing to meet the client in a location that works for the client ◆ Is flexible and responsive to client needs ◆ Encourages client to stay engaged in their HIV primary care ◆ Encourages client to adhere to ART and other treatment regimens ◆ Uses open-ended questions, affirmations, reflections, summaries, active listening, and non-judgmental responses ◆ Supports client decision making ◆ Supports client in adhering to any conditions of parole/probation, including (with client permission) communication with parole/probation officer ◆ Documents work conducted with the client in the agency EHR and/or CAREWare
Client is transitioned to the standard of care after 90 days post-incarceration	Transitional care coordinator: ◆ Reviews and updates, with the client, the transitional care plan and discusses long-term needs (if needed). ◆ If no long-term case management is deemed necessary, discharge client to the standard of care for case management in the community. If long-term case management is deemed necessary: ◆ Transitional care coordinator, case manager, and client are all present at the transition meeting and together review the TCP. The TCP is then passed to case manager to help support their efforts. ◆ Transitional care coordinator facilitates a caring and compassionate transition to case manager at a community-based agency. ◆ Let the client know they can always reach out to the transitional care coordinator for support but the case manager will be their primary contact for assistance and support. ◆ Raise client's ongoing barriers to care and struggles with case manager. ◆ Document work conducted with the client in the agency EHR and/or CAREWare If client is not ready for transition (actively using substances or is in substance use disorder treatment, experiencing active mental health challenges, or is experiencing unstable housing or homelessness) update the transitional care plan to continue work with the client with a plan to re-assess in 30 days. If needed, continue to re-assess every 30 days until the client is ready for transition.

Initiating TCC While the Client Is Incarcerated

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

- ☑ The administrative supervisor and the transitional care coordinators identify eligible potential clients using the protocol developed in the pre-implementation phase. In the first three months of the intervention, the existing client roster will be reviewed by the administrative supervisor to determine who may have been admitted to the jail prior to the start of intervention activities. Eligible clients will be identified by the administrative supervisor from this existing list of incarcerated individuals. Active incarceration rosters will be reviewed daily throughout the intervention by the administrative supervisor and transitional care coordinators to make sure all eligible potential clients have been asked at least twice if they would like to participate in the intervention.

  - ☑ Clients may be identified while in jail through:
    - » Self-disclosure to medical staff or mental health or substance use disorder staff while in jail
    - » Referral from community medical staff (community providers who know their clients have been incarcerated)
    - » Testing positive for HIV while in jail
    - » Referrals from family/community members who know the client is served by your agency
    - » Public documents such as local newspapers or websites

  Eligible clients in the TCC intervention included individuals who:

  - ☑ Have a HIV/AIDS diagnosis. Acceptable documentation of HIV infection includes:
    - » Positive HIV antibody test results
    - » Documentation of detectable HIV viral load results
    - » Physician (M.D., N.P., P.A.) signed/written statements/progress notes
    - » Photocopy of enrollment card for the AIDS Drug Assistance Program (ADAP) or for an HIV Specialty Care program
    - » Other medical form documenting HIV status
    - » If none of the above are available—client self-report (due to the transient nature of the client population, services can be initiated pending HIV/AIDS diagnosis documentation)
  - ☑ Are currently incarcerated in a local jail or recently released in the previous 48 hours (if TCC staff were unable to connect with client while in jail due to timing or extenuating circumstances)
  - ☑ Are 18 years or older

Adapting the TCC Intervention for Different Patient Populations

Issues of consent and other legalities must be considered and addressed when considering adaptation of the TCC model to focus on youth with HIV in youth detention facilities. Other expansion populations who would benefit from intervention inside the jail as well as while transitioning to services in the community upon release may include persons with Hepatitis C identified in the jail setting, as well as persons with a diagnosed substance use and/or mental disorders.

- ☑ The administrative supervisor works with the TCC team to assign eligible potential clients to a transitional care coordinator for the initial visit. The assignment is based on the case load and number of clients assigned to the transitional care coordinators. Both transitional care coordinators will work in the jail and community setting, and should be interchangeable so clients are familiar with both transitional care coordinators.
- ☑ The transitional care coordinator contacts the potential client and meets one-on-one with them in jail, in locations such as housing area day rooms or the jail health clinic (ideally within 48 hours of medical intake). This may be a very stressful time for clients and they may be angry, shut-down and/or refuse the TCC services. Transitional care coordinators can let the client know they have the right to refuse TCC services, and they will be back the next day to offer services again if the client changes their mind.
- ☑ After connecting with the patient, the transitional care coordinator will explain the intervention including their role, the goal of linking the client to HIV primary care after incarceration, the transition between the care coordinator and the case manager post-incarceration, and the timeline of the intervention. If an individual initially declines TCC services, they will be given at least one more opportunity to accept the intervention on a following date prior to release.
- ☑ The transitional care coordinator will complete an intake assessment with all clients interested in participating in the intervention either when they agree to participate, or during the following 24 to 48 hours (see ***Appendix C*** for the intake and assessment form).

Note that intake and assessment conversations may be difficult to have if a client is stressed or detoxing. Use of judgement by the transitional care coordinator is highly encouraged as to when to conduct the intake and assessment. If a client is unable to engage in a meaningful exchange or refuses, attempt to see the client the next day to offer TCC services again.

"Just put your pen down and just have a conversation with them, because during this conversation, quite honestly, one, they're going to feel like you truly care, which we do, but you're going to get all the information you need out of that conversation without having to ask them, 'Okay, let me ask you this question. Do you have sex with men, do you have sex . . .' You know, you've got to kind of take that business part out of it and let them talk, and they'll tell you everything you need to know, and then some."

–Transitional Care Coordinator

Any information from secondary sources (e.g. EHR or other health records) will be discussed and confirmed with the client and modified as needed. In the intake and assessment process, the transitional care coordinator will:

- Obtain HIPAA consent to coordinate care with other service providers, the defense attorney, and family members (as appropriate).
- Determine the client's presenting problem, substance use history, medical history, educational experience, vocational experience, and legal history.
- Assess recent living arrangements, past utilization of community services, mental health service needs, and any other service needs.
- Determine health insurance status and prepare and submit health insurance or ADAP application if necessary.
- Determine eligibility for other entitlement programs and complete applications as available and practicable (i.e. Supplemental Nutrition Assistance Program).
- Determine any needs related to child care (i.e. custody support or issues related to freezing child support payments during incarceration).
- Determine client interest in, and eligibility for, court advocacy and/or compassionate release:
    - ◊ Determine if client meets criteria for an Alternative to Incarceration (ATI) program, placement in substance use treatment program, assistance in restoration of parole terms and conditions as an Alternative to Sentencing (ATS), or skilled nursing care with or without hospice care.
    - ◊ If appropriate, the transitional care coordinator will contact the defense attorney before engaging in discussions with court advocates and/or ATI/ATS programs. Reminder: Ensure client HIPAA consent is obtained for all entities prior to contact (i.e. defense attorney, justices, prosecutors and substance use, ATI/S programs).

Note: For clients who have been re-arrested, and are still in the window for 90 day follow up after incarceration, the transitional care coordinator will update the original needs assessment and care plan based on the client's progress and continued goals, and update HIPAA consent forms consistent with regulations. If the case was closed prior to the client's re-arrest, a new intake and assessment form are to be completed.

"They made me love myself more. They made me feel like I had some positive role models and influences. They build me up. They reminded me of what I'm capable of, and they made my—they talked to my family and they just . . . They made me . . . They helped me with a plan, you know. We came up with something together on what we all thought was best for me."

–TCC Client

- [x] The transitional care coordinator will develop a Transitional Care Plan (TCP) immediately after completing the intake and assessment, ideally during the same session (a sample TCP is provided in ***Appendix D***).

- [x] The TCP is based on the client assessment and done in collaboration with the client. The transitional care coordinator will:

  - Create a two-pronged plan: one for the projected release date and a contingency plan in case the client is unexpectedly released to the community before the next session.
  - Identify community resources and schedule appointments, or arrange walk-in visits with community health and social services providers as appropriate.
  - Contact community partners to alert them to any pressing client needs upon release.
  - Provide the client with a letter upon release that includes their contact information, details on scheduled appointments, their agreed upon contingency plan, and if requested by the client, a copy of TCP (however, many clients are reluctant to take any paperwork that may disclose medical or other sensitive information). At each subsequent encounter with the client in the jail, the transitional care coordinator will review the TCP and revise as necessary.
  - Conduct follow-up sessions in jail to update TCP:
    - When changes are made to planned release date;
    - Prior to next court date;
    - After return from court;
    - 30 days prior to release (if possible);
    - After lab results with latest CD4/VL are received from jail-based clinic; or
    - As needed (e.g. expiration of HIPAA consent, at client request).

"I liked how encouraging [my transitional care coordinator] was whenever she would come around. It wasn't just like she was asking a bunch of cold questions. It seemed like, after a couple times of her coming by the house to ask me these questions, we had built up some sort of professional rapport, and it became very—it was encouraging and it was nice, it was warm. It wasn't just—like I never felt judged or isolated or anything like that."

–TCC Client

☑ Based on the client's planned release date, the transitional care coordinator will make an HIV primary care appointment for the client at the intervention clinic within 48 hours of the client's planned release.

At this session or other subsequent sessions, as appropriate to meet client's needs, the transitional care coordinator will contact the case manager at the clinic or community-based case management agency and arrange for the assigned case manager to attend the primary care appointment to facilitate relationship building and answer any questions about the planned transition to case management over the next 90 days.

"They are very happy, very pleased to know that someone cares about them while they're incarcerated, because some of them, like I said, they are homeless, they have no family, they have no friends. So, just knowing that they have somebody out here that does care, would like to help them with their treatment, it's actually been a great success with that."

–Transitional Care Coordinator

☑ The transitional care coordinator will conduct ongoing activities (depending on the client's length of incarceration) while the client is incarcerated including:

- Communicate with the client *weekly* during the first 30 days of incarceration, at least *monthly* thereafter, at least once during the 24–48 hours before and 24–48 hours after each court appearance, the week before any projected release date, on client request (e.g., through sick call), anytime changes are needed to the TCP (including legal circumstances or health status), and as warranted by medical/treatment issues including changes in blood work.
- Provide three health education sessions using the curriculum outlined in ***Appendix H***. Depending on the client's release date, the transitional care coordinator may conduct some of these health education sessions in jail, and then the remainder after incarceration in the community.
- Provide antiretroviral therapy (ART) support and counseling: All clients with HIV previously prescribed ART in the community will continue treatment in the jail. Newly diagnosed clients initiated on treatment are provided treatment adherence counseling during the jail stay.
  - » For those who have not initiated ART, the transitional care coordinator will ask clients if they have discussed ART with their primary care provider (PCP). If a client has not had that discussion, the coordinator will encourage clients to speak with jail health provider and/or community PCP about starting treatment and inquire about barriers and challenges to initiating ART (e.g. substance use or unstable housing). If additional barriers are identified, appropriate interventions and/or referrals for assistance should be implemented.
  - » At each subsequent encounter, the coordinator will follow up with the client about whether or not they started ART and the outcome of any conversation with their health care provider. The provider should also follow up on any referrals addressing barriers to initiating treatment (such as a referral to a harm reduction or a housing program) at the next client encounter, if appropriate. These discussions, referrals, and subsequent linkages are documented in the client record.

> **"Well, it made me want to get back in care for one, for the most part. Mm, I think that's really it, though. Just helped me get back in care and get back on medicine and taking care of myself because that should be number one."**
>
> –TCC Client

These activities require participant consent. First, contact the defender for permission and to collaborate on the right first step. If this is not done, it can damage the relationship with the defender and impede the ability to assist the client.

☑ Provide support and advocate on the client's behalf as a court liaison.

- Conduct the following activities to assist court advocates to help with the client's legal case:
  - Facilitate connections with community alternatives to incarceration, compassionate release programs, and community behavioral health programs
  - Gather health information to support the client's case
  - Coordinate a care plan with the defense attorney, jail health staff, and community providers
- Accompany the client to court and hearings

"Well, I was wanting to know what I was going to do when I got out, because I knew I wouldn't have anything. And so, she gave me a lot of resources of places that actually give out gift cards and bus passes and all kinds of different, you know, resources that people need when they're starting over again."

–TCC Client

Preparing a Client for Release

In order to make the transition as seamless as possible, the transitional care coordinator will:

- ☑ Arrange transportation or accompaniment from jail to the community as outlined in the transitional care plan. The transitional care coordinator will coordinate jail release with corrections to facilitate transportation assistance and avoid releases during hours when public transit and transportation services are not available. If this is not possible, the transitional care coordinator will provide viable transportation alternatives to the client prior to release, such as an online rideshare program, local transportation program, or a cab/taxi voucher.
- ☑ Assess and address client's basic needs for food security, and provide items and clothing appropriate for the weather at the time of release, as well as a list of community resources and numbers (preferably toll-free) to call if they encounter challenges.
- ☑ Determine if the client will be released with medication in hand and facilitate continuity of medication. The transitional care coordinator arranges for "walking" medications and/or prescriptions (including ART and medications used to manage physical and mental health conditions) with correctional health service at the point of release from incarceration to the community, including those released from jails and courts.
- ☑ Provide TCP summary and other needed medical documentation to courts, treatment programs, and primary care providers to facilitate continuity of care. With client consent, the transitional care coordinator facilitates access to medical summary and other information needed by community providers, programs, and court advocates to facilitate placement in an ATI, ATS, or other community programs, or nursing home or hospice care for those eligible.
- ☑ Identify resources the client may need to access immediately upon release and arrange for appointments for other services such as housing assistance, substance use treatment, mental health treatment, health insurance access, case management, and/or other services as needed.
- ☑ Provide the client with harm reduction guidelines/tips if the client disclosed drug use to prevent overdose.

Housing: Essential to post-release success

- Housing is an essential component of stability and safety post release. Clients with various types of housing to return to post-incarceration may need housing assistance and arrangements for safe residence, food, and clothing.
- Consider Housing Opportunities for Persons With AIDS (HOPWA) funded programs, supportive housing programs, residential treatment programs, and day treatment programs with housing components.
- Community programs with hotel vouchers can be an option for temporary stays.
- Contact family members to negotiate temporary shelter if viable.
- If no viable alternatives are available, the last resource is to arrange for placement and/or accompaniment to community shelters or recovery houses.

Post-Incarceration Linkage and Follow-Up

☑ The transitional care coordinator will offer to accompany the client to their linkage to care appointment ideally within 30 days of release.

- Acceptable Ryan White documentation for linkage to care includes:
  - ◊ Recent CD4 result, from the agency to which the client was referred;
  - ◊ Recent viral load result from the agency to which the client was referred;
  - ◊ The word HIV or AIDS in the medical note in the context of the client's diagnosed condition, from the agency to which the client was referred;
  - ◊ Orders and/or prescription for any ART, from the agency to which the client was referred; or
  - ◊ Letter, note, or email from staff at the treating agency to which the client was referred, stating that the medical visit was HIV and/or AIDS-related.

It is important to note that the use of uniformed security at clinics may be a deterrent for clients in accessing services.

> **"If a person has housing, it relieves 40 percent of the stress. . . . It will help them to stabilize, okay? And with that, they can move forward to the next step of finding gainful employment."**
>
> –TCC Client

- If the client's home is not a suitable location because of safety, disclosure concerns, or other obstacles, the accompaniment may originate at an alternative, mutually-agreed upon location in the community (e.g. somewhere the client hangs out, the client's favorite park, or other set location near their home or work). Accompaniment is intended for people with HIV who struggle with conventional treatment regimens and the intent is that staff will provide social support and help the client connect to medical care in order to improve client health outcomes. Accompaniment may include:
  - Transportation assistance;
  - Walking with the client to the appointment, waiting with the client until seen, and going with them on the return trip home; and/or
  - Emotional support during the medical visit.

☑ The transitional care coordinator will ask the client if they can work with the client's probation officer during the 90 day post-incarceration time period.

☑ The transitional care coordinator will ideally provide 90 days of follow-up support services after the client has been released from jail based on the TCP, including:

- Providing any of the remaining health education sessions not covered while the client was incarcerated;
- Helping the client complete forms;
- Making referrals and appointments;
- Making reminder calls/messages;
- Arranging for transportation, child care, interpreting services, and advocacy;
- Providing assistance with social services (included, but not limited to accessing food, clothing, securing consistent housing, and employment);
- Providing assistance with entitlements and benefits;
- Addressing any ongoing mental health and substance use disorder treatment needs; and
- Arranging consistent access to health insurance and medication.

☑ The transitional care coordinator will conduct outreach for ongoing client re-engagement. Attempts are made for up to 90 days after client is released from incarceration.

Regardless of activities conducted with or on behalf of a client, if the client misses an appointment or fails to adhere to any part of the TCP, the transitional care coordinator will be available to identify barriers to engagement in care. For any client who does not attend their scheduled community HIV primary care appointment within 48 hours post-release, the transitional care coordinator will conduct outreach to reengage the client.

"So like, if we go out and do a field visit with some of our clients, we never go alone. Never. Always go in twos. And we find out that our clients react to men differently than women. You know, they're more open to talk to women, not as much as to men, but yet, if you have a man on your crew, it almost establishes like a dominance kind of thing. It's actually kind of weird, but it is."

–Transitional Care Coordinator

"For me, my experience was great. I got questions that needed answered, answered. I got medication timely, on time. All my HIV needs were met. . . . I mean, having the ladies there, more or less made the doctors be held accountable to take care of us."

–TCC Client

The following steps are taken by the transitional care coordinator to facilitate linkage to care:

- Calling the client starting the day of the missed appointment.
- Checking in with social service providers where the client may receive services.
- Checking in with the client's probation officer (with client consent).
- Visiting community locations where the client may "hang out."
- Sending a letter to the client (not disclosing the client's protected health information) after two sequential weeks of failed outreach by phone and home visit.
- Conducting internet searches to determine if a client's address may have changed, if phone and field outreach do not result in contact with the client.
- If the intervention agency/clinic has a relationship with the local hospital, checking to see if the client is in the hospital or was in the emergency department.
- Conducting home visits:
  - ◊ If individual is home, staff attempt to engage client in care coordination to link or re-link person to care.
  - ◊ If no one is home, the transitional care coordinator leaves a letter on agency letterhead with contact information at addresses visited.
  - ◊ If a collateral resource, such as a family member, is home and the individual's whereabouts are known, the transitional care coordinator provides a letter in a sealed envelope addressed to the client and/or obtains information to arrange the next home visit. No information that might reveal a client's HIV status should be left with anyone absent client consent.
    - » For those where contact is made with the client or a collateral resource, such as family member or designated contact person, the transitional care coordinator will continue to attempt to engage the client in care for 90 days post-incarceration.

Transitioning a Client to the Standard of Care

- ☑ The transitional care coordinator will assess the long-term needs of the client by reviewing the care plan with the client and identifying ongoing client needs.
- ☑ The case manager from the local community-based agency, client, and transitional care coordinator will meet to transfer case management support, ideally over a period of at least four weeks prior the end of the 90-day post-incarceration period.
- ☑ At the end of the 90-day post-release period, the case manager, client, and transitional care coordinator will meet to determine if the client is ready for transfer to the standard of care.
- ☑ The following are situations where the client would not be transferred to the standard of care post-release from incarceration:
  - Client requests or requires more intensive patient navigation or case management services. In the weeks leading up to the planned transition or during the transition meeting, the case manager, client, and transitional care coordinator may determine that the standard of care is not the appropriate next step for the client. If this is the case, update the care plan to continue work with the client and reassess in 30 days.
  - Client needs and/or barriers to care have not been fully addressed (particularly substance use disorder, challenges with mental health, and lack of or sub-optimal housing). If this is the case, update the care plan to continue work with the client and reassess in 30 days.
  - Client requested transfer to another provider prior to the end of the 90-day post-incarceration follow-up period. If this is the case, update the care plan to continue work with the client and reassess in 30 days to ensure the transfer is successfully completed.
  - Client is in long-term care. Long-term care may be considered linkage to care or institutional placement, depending on the setting. If this is the case, upon release from long-term care, update the care plan to continue work with the client and reassess in 30 days.
  - If a client who has not linked to care is re-incarcerated or institutionalized during the 90 day linkage period, continue to follow up in the community and attempt to link to care once re-released.
  - Client is lost to follow up/unsuccessful re-engagement efforts.
  - Client moved/relocated outside of service area.
  - Client is sentenced and transferred to facility outside of jurisdiction.
  - Client withdraws from the intervention.
  - Client is deceased.
- ☑ If the client does not need long-term case management services, discharge client to the community standard of care for case management as soon as they are ready to transfer.

Closing Cases

The case may be closed:

- Within 30 days after incarceration when there is no further information available to conduct outreach;
- After confirmation of linkage to primary care;
- Up to 90 days after release to the community when viable avenues to locate the client are present;
- If the client is determined to be deceased;
- If contact is made with the client and the client refuses services.

If a client is released to a location outside of the transitional care coordinator's service area, or the conditions of the client's probation restrict the client's geographic mobility, the transitional care coordinator will make the appropriate referrals or appointments to support the client's linkage to HIV primary care. These referrals/appointments may require the transitional care coordinator to contact agencies outside of their service area or find appropriate home visit teams.

Maintenance and Integration Activities

The following activities will be conducted by clinic administration and intervention staff:

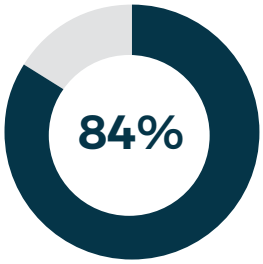
- ☑ Maintain relationships with community partners and referral resources.
  - Review and update MOUs every two years or as required.
- ☑ Re-assess points of integration with the local continuum of care and with the jail-based health services.
  - Identify amended/new jail, transitional and community programs and policies that could dovetail with or impact implementation.
  - Integrate changes to Ending the HIV Epidemic Initiative, local health agency policies and practices, corrections' security protocols/access, national and local substance use policies, and additions of newly funded programs.
- ☑ Provide trainings to agency staff on the intervention, working with incarcerated individuals, and talking points to spread awareness of the intervention throughout the community.
- ☑ Provide trainings to new jail staff (medical, correctional officers, and administrators) on the TCC model to maintain jail staff support and collaboration.
- ☑ Continue to recruit, hire, and train transitional care coordinators to expand the program as appropriate.

THE BIG KEY FINDING/IMPACT

Clients who had an encounter with their transitional care coordinator within one week post-release, were significantly more likely to link to HIV primary care within 30 days ($p < 0.001$)

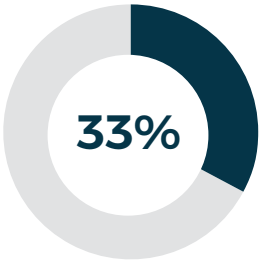
268 were enrolled in a longitudinal study.

Of those, 229 clients were released into the community with 30 consecutive days without a re-incarceration, and had not moved out of the area.

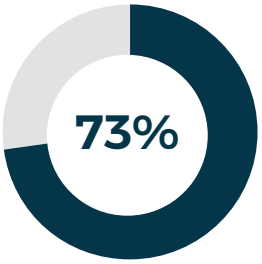


Males made up 84% of the sample.

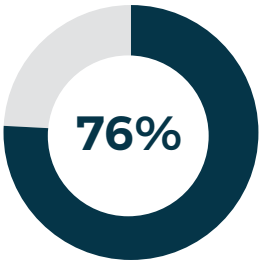
20% were under the age of 29 years and 25% were 50 years old or older.



One-third had experienced a night of homelessness in the past 12 months.

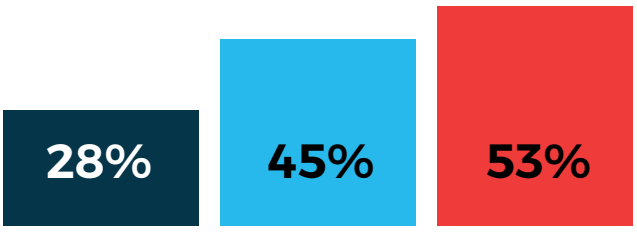


73% reported a race or ethnicity other than white/ Caucasian.



76% reported having completed high school or less than high school.

Linked to community HIV primary care

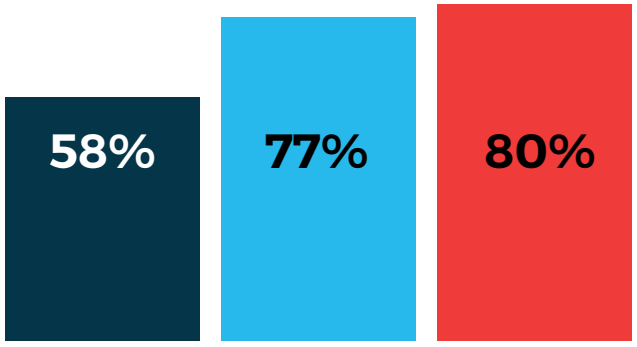


Within 30 days post-release

Within 90 days post-release

Within 120 days post-release

Viral suppression



Baseline

90 days post-release

120 days post-release

CONCLUSIONS

Transitional Care Coordinators play a vital role in identifying and linking persons with HIV in jail to community HIV care and services. Findings from this intervention show the TCC model supports clients in linking to community HIV care and accessing other needed services to support continued HIV care engagement and reaching viral suppression.

Care and Treatment Intervention (CATIs) are a series of evidence informed interventions supported by HRSA/HAB to promote linkage, retention and viral suppression across Ryan White HIV/AIDS Programs. The CATIs replicate four previously HRSA/HAB/SPNS initiatives:

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

Where to find resources from the HRSA/HAB's Dissemination of Evidence Informed Interventions Initiative:

https://targethiv.org/deii

APPENDICES

Appendix A: Logic Model

Resources	Activities	Outputs	Short Term Outcomes	Intermediate Outcomes	Long Term Outcomes
◆ TCC Staff (transitional care coordinator, administrative supervisor, clinical supervisor) ◆ Local jail facility ◆ Community partners ◆ Intervention champion and support and buy-in from agency and jail administration ◆ Standard of care community case managers or social workers who can work with clients in collaboration with the transitional care coordinator for transition to standard of care ◆ Approval to work in jail system (MOU) and access to jail-based resources (assigned/ dedicated officers, supportive jail medical staff, dedicated space) ◆ Phone and laptop ◆ Access to Electronic Health Record in the jail and community and RW service data collection reporting system	◆ Pre-implementation activities – Train TCC staff – Protocol and MOU development – Establish supervision system for TCC staff and coordinate with jails and medical facilities ◆ Implementation activities in the jail – Identification of eligible participants – Develop transitional care plan – Connect clients with services to utilize post-release – Conduct health education sessions – Assist client in accessing HIV medications – Conduct health liaison activities ◆ Implementation activities post-release – Provide post-release linkage to HIV care – Provide post-release follow-up and support in achieving goals outlines in the transitional care plan – Provide additional referrals, accompaniments, appointment reminders, and coaching as appropriate	◆ Linkage agreements in place with community providers ◆ # eligible individuals identified ◆ # eligible individuals offered TCC services ◆ # individuals who accept TCC services ◆ # clients who have a transitional care plans completed ◆ # clients released from jail/eligible for community-based activities ◆ # clients who received health liaison services ◆ # outreach attempts made to clients (post-release) ◆ # clients prescribed ART ◆ # referrals made to community partners ◆ # clients transitioned to the standard of care ◆ # referrals/ resources kept	◆ Increase in client HIV knowledge ◆ Increase in client awareness of community resources and ways to access resources ◆ Increase in adherence to existing ART prescription ◆ Increase in client access to benefits counseling and community resources ◆ Increased relations with jail medical staff and correctional officers	◆ Integration of TCC staff in both clinic/ agency and jail workflow ◆ Increase in number of clients released from jail during business hours ◆ Increase in number of clients released to alternative sentencing programs ◆ Increase in number of clients with a scheduled HIV primary care appointment within 48 hours of release ◆ # clients linked to HIV primary care in 30 days post-release	◆ Increase in long-term HIV medication adherence ◆ Increase in HIV viral suppression ◆ Improvement in long-term retention in HIV care – Housing stability and food security – Engagement in behavioral health treatment (substance use and mental disorders) ◆ Increase in client satisfaction with care ◆ Increase linkage to care coordination for those identified as in need of social supports

Appendix B. Staffing Plan and Job Descriptions

Administrative Supervisor	The administrative supervisor coordinates all aspects of the intervention with jail and community-based staff and community partners. The administrative supervisor is responsible for: ◆ Being the point of contact for the intervention and providing oversight of the project; ◆ Providing administrative supervision to the transitional care coordinators; and ◆ Serving as the liaison with local jail administration and other key stakeholders.
Transitional Care Coordinator	The transitional care coordinators have five primary responsibilities: patient engagement, patient education, discharge planning, care coordination, and facilitating a warm transition to the community and linking a client to care. *Patient engagement during incarceration.* The transitional care coordinators are responsible for: ◆ Client engagement and assessment during the client's jail stay; and ◆ Conducting care coordination with jail- and community-based organizations. *Patient education.* The transitional care coordinators are responsible for: ◆ Providing patient education on HIV, including treatment adherence and risk reduction, as well as a range of other health-related topics (e.g. STI, hepatitis, and TB overviews; prevention strategies and safe sex negotiation; relapse prevention; symptoms evaluation, etc.). *Discharge planning.* The transitional care coordinators are responsible for: ◆ Assessing client needs; ◆ Developing a plan with client to address basic needs; ◆ Identifying resources to facilitate access to community health care; ◆ Serving as a health liaison to the courts; and ◆ Scheduling an initial linkage appointment. *Care coordination for care upon release.* The transitional care coordinators are responsible for: ◆ Completing patient assessment and discharge plan to initiate the process of coordinating care upon release, meeting the person in jail and initiating follow-up to verify linkage to care after incarceration; ◆ Arranging discharge medications and prescriptions; and ◆ Obtaining consent to collaborate with external entities and individuals (e.g. community health providers, social service programs, courts). *Facilitating a warm transition to the community and linking a client to care.* The transitional care coordinators are responsible for: ◆ Accompanying individuals who are newly released to appointments to ensure connection to care; ◆ Coordinating community-based HIV care linkage services; ◆ Providing home visits, appointment accompaniment, or transportation; ◆ Conducting, arranging, or coordinating outreach activities to find individuals who fall out of care and facilitate re-engagement in community care; ◆ Assessing and addressing basic needs like housing, food, clothing, etc.; and ◆ Transitioning the client to the standard of care after 90 days post-incarceration.
Clinical Supervisor	The Clinical Supervisor is responsible for: ◆ Participating in case conferencing (as needed); ◆ Providing monthly (or as requested) individual clinical supervision to transitional care coordinators; and ◆ Providing monthly group clinical supervision to intervention team (as needed).

Administrative Supervisor

Job Description

Description of the Transitional Care Coordination Model

The Transitional Care Coordination (TCC) model is responsible for supporting the continuity of healthcare for people with HIV who are incarcerated using a nationally recognized public health model. The central aim of this model is to facilitate the linkage of a client with HIV to community-based care and treatment services after incarceration. The Transitional Care Coordination intervention activities include identifying and engaging people with HIV during the jail stay, identifying "right fit" community resources, developing a client plan for their time during and post-incarceration, and coordinating activities needed to facilitate linkage to care after incarceration. Service provision includes health education, discharge planning, and community collaborations to facilitate linkages to health care for those leaving jails. TCC works closely with the jail-based health providers to facilitate continuity of care from intake jails to community health care.

Purpose of Position

The TCC Administrative Supervisor will report to either the Senior Director or Director and be responsible for oversight and provision of administrative services, program operations, quality assurance, facilitating best practices, supervision, reporting and monitoring of direct and contracted program services.

The Administrative Supervisor is responsible for:

- Being the point of contact for the intervention and providing oversight of the project;
- Providing administrative supervision to the transitional care coordinators; and
- Serving as the liaison with local jail administration and key community stakeholders.

Key Responsibilities

1. Works in a dynamic management team environment to build commitment to program goals and initiatives by working closely with all levels of staff.
2. Provides administrative supervision of the transitional care coordinators.
3. Interprets human resource policies and procedures and relays these to staff. Performs human resources related duties (e.g.: labor relations disciplinary actions, hiring packages, interviews).
4. Monitors office budget by tracking planned and actual encumbrances and ensuring adherence to grant funding regulations and deadlines.
5. Serves as a liaison between TCC and community partner organizations and maintains positive relationships and MOUs with community partners.
6. Supervises the generation of reports including summary of referrals made to community partner organizations and rate of linkages to care.
7. Conducts in-service training to the TCC team and other community-based providers.
8. Ensures TCC practices are consistent with the implementation manual.
9. Participates in administrative staff meetings and attends other HR related meetings.

Qualifications/Requirements

- A Master's degree from an accredited college or university in healthcare, hospital, public, or business administration, industrial/organizational psychology, organizational behavior, or a related field.
- Three years of full-time experience planning, developing and monitoring programs, systems, and/or procedures in support of administrative management initiatives, two years of which must have been in a managerial or supervisory capacity; or
- A Baccalaureate degree from an accredited college or university in healthcare, hospital, public, or business administration, psychology, or a related discipline.
- A satisfactory combination of education, training, and experience.

Preferred Skills

- Comfortable working in a correctional setting.
- One or more years successfully supervising staff who operate in more than one setting (such as staff working within a jail facility and in a community office).
- Experience building relationships with stakeholders that represent varied interests (grant funders, community-based partners, etc.).
- Knowledge of community-based programs and providers in the local service area.
- Bilingual as needed to serve client population.
- Knowledge of HIV, substance use disorders, mental health, the criminal justice system, and chronic care management.

Transitional Care Coordinator

Job Description

Description of the Transitional Care Coordination Model
The Transitional Care Coordination (TCC) model is responsible for supporting the continuity of healthcare for people with HIV who are incarcerated using a nationally recognized public health model. The central aim of this model is to facilitate the linkage of a client with HIV to community-based care and treatment services after incarceration. The Transitional Care Coordination intervention activities include identifying and engaging people with HIV during the jail stay, identifying "right fit" community resources, developing a client plan for their time during and post-incarceration, and coordinating activities needed to facilitate linkage to care after incarceration. Service provision includes health education, discharge planning, and community collaborations to facilitate linkages to health care for those leaving jails. TCC works closely with the jail-based health providers to facilitate continuity of care from intake jails to community health care.

Purpose of Position
The Transitional Care Coordinator provides health-related discharge planning and education to individuals and groups incarcerated in jails, facilitating linkages to health care and supportive services and improving community health outcomes.

The Transitional Care Coordinator has five primary responsibilities: patient engagement, patient education, discharge planning, care coordination, and facilitating a warm transition to the community and linking a client to care.

Patient engagement during incarceration:

- Client engagement and assessment during the client's jail stay; and
- Conducting care coordination with jail- and community-based organizations.

Patient education:

- Providing patient education on HIV, including treatment adherence and risk reduction as well as a range of other health-related topics (e.g. STI, hepatitis, and TB overviews; prevention strategies and safe sex negotiation; relapse prevention; symptoms evaluation, etc.).

Discharge planning:

- Assessing client needs;
- Developing a plan with client to address basic needs;
- Identifying resources to facilitate access to community health care;
- Serving as a health liaison to the court; and
- Scheduling initial linkage appointment.

Care coordination for care upon release:

- Completing patient assessment and discharge plan to initiate the process of coordinating care upon release, meeting the person in jail and initiating follow-up to verify linkage to care after incarceration;
- Arranging discharge medications and prescriptions; and
- Obtaining consent to collaborate with external entities and individuals (e.g. community health providers, social service programs, courts).

Facilitating a warm transition to the community and linking a client to care:

- Accompanying individuals who are newly released to appointments to ensure connection to care;
- Coordinating community-based HIV care linkage services;
- Providing home visits, appointment accompaniment, or transportation;
- Conducting, arranging, or coordinating outreach activities to find individuals who fall out of care and facilitate re-engagement in community care;
- Assessing and addressing basic needs like housing, food, clothing, etc.; and
- Transitioning the client to the standard of care after 90 days post-incarceration.

Key Responsibilities

1. Meets with and interviews clients and conducts a needs assessment and health education/ counseling sessions, as needed.
2. Evaluates and makes recommendations regarding the counseling and discharge planning process with clients.
3. Provides direct counseling to clients with HIV/AIDS, substance use disorder, and other chronic related health conditions.
4. Identifies appropriate community-based service providers based on client's needs.
5. Makes appointments and/or provides referral information for community-based providers.
6. Serves as a liaison between clients and community-based service providers.
7. Maintains client records and updates as needed.
8. Updates HIPAA consent forms and other documents in accordance with regulations.
9. Prepares pre-release documentation for clients with a known release date.
10. Maintains documentation of services provided and referrals made.
11. Monitors enrollment for Medicaid and other public health insurances, and medical discharge planning for people leaving jail requiring continued care, treatment and social services.
12. Conducts in-service training for the TCC team and other community-based providers.
13. Arranges transportation at the time of release from jail custody to HIV primary care or supportive services appointments.
14. Accompanies clients to initial HIV primary care and subsequent supportive service appointments (if needed).

15. Facilitates access to a variety of services including primary medical care, social services, housing, entitlements, and benefits. This may include assisting with any necessary paperwork, compiling eligibility documentation required by other service providers, and other tasks required to connect the client to needed services.
16. Provides care coordination services for clients through face-to-face interactions, and phone calls with the client's medical provider and other service providers. Coordination of care also includes case conferences with other internal or external care providers.
17. Conducts re-engagement efforts when clients miss medical appointments without prior notice to the medical provider or program staff. Re-engagement activities may be conducted via phone or in person visit to the client's place of residence.
18. Provides administrative coverage in the absence of the administrative supervisor.

Qualifications/Requirements

- Ability to obtain correctional facility clearance and work within the constraints of facility guidelines which can include lock downs, screening of personal items including food, and clothing restrictions, which can be changed at the discretion of the jail.
- High school diploma or GED/HSE required, some college preferred.
- Experience counseling people with HIV on connecting to available services. Experience working with the local criminal justice system and behavioral health services.
- Experience supervising a team of staff.
- Well versed on community resources.
- Strong computer skills, and experience working with Microsoft Office and database entry.
- Strong oral and written communication skills.
- Bi-lingual as needed to serve the client population.

Preferred Skills

- Experience working in a correctional setting.
- The TCC program encourages individuals to apply who have successfully made the transition from incarceration and/or substance use disorder into a stable, productive lifestyle in the community. Please note that while we support "drop the box" employment practices, previous charges of arson, sexual assault, murder or possessing contraband, currently being on probation or parole, or having had contact with the criminal justice system in the last 2 years may disqualify individuals from receiving correctional facility clearance.

Physical Demands

- To perform this job successfully, an individual must be able to perform each essential duty satisfactorily. The responsibilities and requirements listed are representative of the knowledge, skills, minimum education, training, licensing, experience and/or ability required. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions of the job.

Clinical Supervisor

Job Description

Description of the Transitional Care Coordination Model
The Transitional Care Coordination (TCC) model is responsible for supporting the continuity of healthcare for people with HIV who are incarcerated using a nationally recognized public health model. The central aim of this model is to facilitate the linkage of a client with HIV to community-based care and treatment services after incarceration. The Transitional Care Coordination intervention activities include identifying and engaging people with HIV during the jail stay, identifying "right fit" community resources, developing a client plan for their time during and post-incarceration, and coordinating activities needed to facilitate linkage to care after incarceration. Service provision includes health education, discharge planning, and community collaborations to facilitate linkages to health care for those leaving jails. TCC works closely with the jail-based health providers to facilitate continuity of care from intake jails to community health care.

Purpose of the Position
The purpose of the Clinical Supervisor is to coordinate and provide clinical support to the intervention staff.

Key Responsibilities
1. Participate in case conferencing (as needed).
2. Conduct 1 hour, monthly, or as needed, individual clinical supervision with each Transitional Care Coordinator.
3. Conduct 1 hour, monthly group clinical supervision with the intervention team (as needed).

Qualifications/Requirements
- Licensed mental health clinician (e.g., licensed clinical social worker, psychologist, or psychiatrist).
- 2–4 years counseling or case management experience in assessing and managing the psychosocial needs of persons with HIV/AIDS.
- Experience in working with patients with complex and/or comorbid conditions, sexual and gender minorities, and communities of color.
- Knowledge of harm reduction philosophy, patient centered counseling, and motivational interviewing techniques.
- Excellent oral and written communication skills.
- Excellent interpersonal skills. Able to build relationships with individuals, groups, and organizations.

Appendix C. Sample Intake and Assessment Form

Transitional Care Coordination Intake Assessment

Today's Date: _____

Section I:

Client name:	
Client alias:	
Care coordinator name:	

1. Gender	❑ Male ❑ Female ❑ Transgender ❑ Declined to answer	**5. Date of incarceration:**	
2. Age		**5a. What are the charges being brought against you?**	
3. Primary language spoken	❑ English ❑ Spanish ❑ Other: ❑ Declined to answer	**6. Is this the first time you have been incarcerated?**	❑ Yes ❑ No ❑ Unknown
4. Have you seen a medical provider in jail?	❑ Yes ❑ No ❑ Unknown	**6a. If no, how many times have you been incarcerated prior to this period of incarceration?**	

Section II:

7. HIV Status: (Check only one)	❑ HIV+, not diagnosed with AIDS ❑ HIV+, AIDS status unknown ❑ CDC-Defined AIDS
8. HIV diagnosis date:	
9. If the client has AIDS, AIDS diagnosis date:	
10. Did you know you were HIV+ or that you had AIDS before being incarcerated?	❑ Yes ❑ No ❑ Client declined to answer
11. Do you currently have a primary care physician (PCP) or HIV primary care provider?	❑ Yes ❑ No
11a. If yes, who is your provider (doctor's name)?	
11b. Where is the provider located (clinic name)?	
11c. When was your last visit with this provider?	

12. CD4		
Last CD4 count	**CD4 %** *(optional)*	**Date (mm/dd/yyyy)**
❑ No CD4 count on record ❑ Unknown		

13. Viral Load		
Last Viral Load Count	**Viral Load Undetectable**	**Date (mm/dd/yyyy)**
	❑ Yes ❑ No ❑ Unknown	
❑ No viral load count on record		

Section III:

14. Do you have any other medical conditions requiring treatment?	❑ Yes ❑ No ❑ Unknown
14a. If yes, what conditions? (Check all that apply)	❑ Cancer ❑ Diabetes ❑ Heart disease/hypertension ❑ Liver disease ❑ Kidney disease ❑ Hepatitis C ❑ Tuberculosis (TB) ❑ Asthma ❑ Other (specify):
15. Have you ever received a mental health diagnosis?	❑ Yes ❑ No ❑ Unknown
15a. If yes, what diagnosis or diagnoses? (Check all that apply)	❑ Depression ❑ Anxiety disorder (Panic, GAD, etc.) ❑ PTSD ❑ Bipolar disorder ❑ Psychosis (Schizophrenia, etc.) ❑ HIV-associated dementia ❑ Other (specify):

Section IV:

16. Are you currently pregnant?	❑ Yes ❑ No ❑ N/A (male) ❑ Unknown *If no, n/a, or unknown, skip to section V*
17. Are you enrolled in prenatal care?	❑ Yes ❑ No ❑ Unknown
18. Estimated due date:	Enter MM/DD/YY: Or ❑ Unknown
19. Have you been prescribed ART to prevent maternal-to-child (vertical) transmission of HIV?	❑ Yes ❑ No ❑ Unknown

Section V:

20. Are you currently prescribed ART?	❑ Yes (complete table below) ❑ No (skip this table) ❑ Unknown (skip this table)	
HIV Medication Names	**Frequency—daily, twice a day, weekly, etc.**	**Date started (mm/yyyy)**

Section VI:

21. Where were you living before you were incarcerated? (complete the associated row below based on client response)	
a. Homeless/living on the street, in an abandoned building, outside, etc.	
b. Emergency shelter (non-SRO)	Name of shelter:
c. Single Room Occupancy (SRO) hotel	Name of SRO:
d. Other hotel or motel (paid for without emergency shelter voucher or rental subsidy)	Name of hotel or motel:
e. Supportive housing program	Name of supportive housing program:
f. Room, apartment, or house that you rent (not affiliated with a supportive housing program)	Total number of people in your household (including you): Annual household income:
g. Apartment or house that you own	Total number of people in your household (including you): Annual household income:
h. Staying or living in someone else's (family or friend's) room, apartment or house	Total number of people in your household (including you): Annual household income:
i. Hospital, institution, long term care facility, or substance use disorder treatment/detox center	Name of hospital, long term care facility, or treatment/ detox center:
j. Foster care home or foster group home	Name of foster care/group home:

22. When did you start living in that location?	(mm/yyyy) ❑ Unknown ❑ Client declined to answer
23. Do you anticipate going back to this location upon release?	❑ Yes ❑ No ❑ Unknown ❑ Client declined to answer
24. Have you ever been homeless?	❑ Yes ❑ No ❑ Client declined to answer
24a. If yes, when were you last homeless?	(mm/yyyy) or ❑ Unknown ❑ Client declined to answer
25. *Only ask if client reports that they were not homeless when they were incarcerated:* Did you have any housing issues prior to being incarcerated?	❑ Yes ❑ No ❑ Client declined to answer
25a. If yes, what were your housing issues?	❑ Cost ❑ Doubled-up in the unit ❑ Health or safety concerns ❑ Eviction or pending eviction ❑ Expanding household (e.g. newborn) ❑ Space/configuration ❑ Conflict with others in the household ❑ Other (specify):
26. What is your current employment status?	❑ Full-time ❑ Part-time ❑ Unemployed ❑ Unpaid volunteer/peer worker ❑ Other (specify): ❑ Client declined to answer
27. What is the highest level of education that you've achieved?	❑ Less than high school ❑ High school or GED equivalent ❑ Some college or Bachelors/technical degree ❑ Postgraduate ❑ Client declined to answer
28. Where were you born?	❑ United States ❑ US Territory/dependency (specify): _____ ❑ Other country ❑ Client declined to answer
28a. *If the client was not born in the US or in a US territory:* When did you come to the US?	(MM/YYYY)

Section VII:

29. Do you have insurance?		❑ Uninsured ❑ Insured (If insured, complete the table below) ❑ Unknown ❑ Client declined to answer	
Insurance type	**Insurance details**	**Effective Date**	**End/expiration date**
Private	*Name of plan:*		
Medicaid or CHIP	*Name of plan:*		
Medicare			
Military/VA/Tricare			
IHS (Indian Health Service)			
Other public insurance			

Section VIII: Use of prescriptions, injectables, and other substances

We will ask you questions in the next two sections about substance use and sexual behaviors. Some of these questions may seem personal in nature, but we ask them of everyone in this program.

- Please answer honestly. You may refuse to answer a question; refusing will not affect your care.
- Please feel free to ask if you need any of the questions explained to you.
- If you do not want to answer a question now, please tell me and we will return to it another time.

30. In the past 3 months, have you used:			
a. Tobacco	❑ Yes ❑ No ❑ Client declined to answer	_____cigarettes smoked weekly (for other forms of tobacco, # times used weekly) Or ❑ < weekly ❑ Client declined to answer (Reminder: 1 pack = 20 cigarettes)	❑ Orally ❑ Smoked ❑ Inhaled/snorted (snuff) ❑ Client declined to answer

b. Alcohol	❑ Yes ❑ No ❑ Client declined to answer	_____ drinks weekly Or ❑ < weekly ❑ Client declined to answer	
c. Marijuana	❑ Yes ❑ No ❑ Client declined to answer	_____ times weekly Or ❑ < weekly ❑ Client declined to answer	❑ Orally (Eaten/swallowed) ❑ Smoked ❑ Inhaled/snorted (snuff) ❑ Injected ❑ Client declined to answer
d. PCP/Hallucinogens	❑ Yes ❑ No ❑ Client declined to answer	_____ times weekly Or ❑ < weekly ❑ Client declined to answer	❑ Orally (Eaten/swallowed) ❑ Smoked ❑ Inhaled/snorted (snuff) ❑ Injected ❑ Client declined to answer
e. Crystal Meth	❑ Yes ❑ No ❑ Client declined to answer	_____ times weekly Or ❑ < weekly ❑ Client declined to answer	❑ Orally (Eaten/swallowed) ❑ Smoked ❑ Inhaled/snorted (snuff) ❑ Injected ❑ Client declined to answer
f. Cocaine/Crack	❑ Yes ❑ No ❑ Client declined to answer	_____ times weekly Or ❑ < weekly ❑ Client declined to answer	❑ Orally (Eaten/swallowed) ❑ Smoked ❑ Inhaled/snorted (snuff) ❑ Injected ❑ Client declined to answer
g. Heroin	❑ Yes ❑ No ❑ Client declined to answer	_____ times weekly Or ❑ < weekly ❑ Client declined to answer	❑ Orally (Eaten/swallowed) ❑ Smoked ❑ Inhaled/snorted (snuff) ❑ Injected ❑ Client declined to answer
h. Rx Pills to get high	❑ Yes ❑ No ❑ Client declined to answer	_____ times weekly Or ❑ < weekly ❑ Client declined to answer	❑ Orally (Eaten/swallowed) ❑ Smoked ❑ Inhaled/snorted (snuff) ❑ Injected ❑ Client declined to answer
i. Hormones/steroids	❑ Yes ❑ No ❑ Client declined to answer	_____ times weekly Or ❑ < weekly ❑ Client declined to answer	❑ Orally (Eaten/swallowed) ❑ Smoked ❑ Inhaled/snorted (snuff) ❑ Injected ❑ Client declined to answer

j. Other (specify):	❑ Yes ❑ No ❑ Client declined to answer	_____ times weekly Or ❑ < weekly ❑ Client declined to answer	❑ Orally (Eaten/swallowed) ❑ Smoked ❑ Inhaled/snorted (snuff) ❑ Injected ❑ Client declined to answer
❑ **I have not used any substances in the past 3 months.**			

If client has, at this interview, reported injecting any substance in the table above, ask the client directly about sharing injection equipment. If the client did not report injecting any substance, skip to section IX.

31. Have you ever injected any drug or substance?	❑ Yes ❑ No (If no, skip to next section) ❑ Client declined to answer
32. If yes, when was the last time you injected any substance?	❑ In the past 3 months ❑ Between 3 and 12 months ago ❑ More than 12 months ago ❑ Client declined to answer
32a. *If the client reported any injection behavior in the past 3 months:* Do you receive clean syringes from a syringe exchange program or pharmacy?	❑ Yes ❑ No ❑ Client declined to answer
33. Have you ever shared needles or injection equipment with others?	❑ Yes ❑ No ❑ Client declined to answer
34. If yes, when was the last time you shared needles or injection equipment?	❑ In the past 3 months ❑ Between 3 and 12 months ago ❑ More than 12 months ago ❑ Client declined to answer

Section IX:

35. In the past 12 months, have you:	
a. Had sex with anyone (oral, anal, or vaginal)	❑ Yes If yes, how many sexual partners have you had in the past 12 months? _____ ❑ No (skip to the next section) ❑ Client declined to answer

b. Had vaginal sex without a condom?	❑ Yes ❑ No ❑ Client declined to answer
c. Had anal sex without a condom?	❑ Yes ❑ No ❑ Client declined to answer
d. Had oral sex without a condom, dental dam, or other barrier?	❑ Yes ❑ No ❑ Client declined to answer
e. Had sex without your consent?	❑ Yes ❑ No ❑ Client declined to answer

Section X:

36. Are you deaf or do you have difficulty hearing?	❑ Yes ❑ No ❑ Not asked ❑ Client declined to answer
37. Are you blind or do you have serious difficulty seeing, even when wearing glasses or contact lenses?	❑ Yes ❑ No ❑ Not asked ❑ Client declined to answer
38. Do you have difficulty concentrating, remembering, or making decisions because of a physical, mental, or emotional condition?	❑ Yes ❑ No ❑ Not asked ❑ Client declined to answer
39. Do you have serious difficulty walking or climbing the stairs?	❑ Yes ❑ No ❑ Not asked ❑ Client declined to answer
40. Do you have difficulty dressing or bathing?	❑ Yes ❑ No ❑ Not asked ❑ Client declined to answer
41. Do you have serious difficulty doing errands alone such as visiting a doctor's office or shopping?	❑ Yes ❑ No ❑ Not asked ❑ Client declined to answer

Additional Client Notes:

Client signature	
Care coordinator signature	

Appendix D. Sample Transitional Care Plan (TCP)

Complete this Transitional Care Plan with the client to determine client needs and goals while in jail and upon release. This plan is to be used by the transitional care coordinators to guide their work with the client and to provide information to the client's other providers during case conferencing. Upon release, provide the client with a letter that includes contact information for the transitional care coordinators, details about scheduled appointments, and a contingency plan for the client. This care plan should be revisited with the client post-release.

Transitional Care Coordination: Transitional Care Plan	
Client name	
Care coordinator name	
Original TCP created on (date):	
Today's date	

Planned release date:
How can we reach you in the community?
❑ Phone:
❑ Address:
❑ Email:

Who is your Emergency Contact?
Name:
Relationship:
Address:
Phone:
Email:

Scheduling Primary Care
Provider name:
Location:
Contact information:
Appointment date:
Appointment time:
Clinic hours:

Additional Needs During Incarceration			
Does the client need any of the following:			**Plan for addressing this need:**
1. Primary care	❑ Yes	❑ No	
2. Health home	❑ Yes	❑ No	
3. Housing	❑ Yes	❑ No	
a. Help filling out forms	❑ Yes	❑ No	
b. Eligibility assessment	❑ Yes	❑ No	
c. Referral/appointment making	❑ Yes	❑ No	Details of referral: Date of appointment:
d. Reminder call/message about housing related appointment	❑ Yes	❑ No	Date of appointment:
e. Arrange childcare for housing related appointment	❑ Yes	❑ No	
f. Appointment preparation	❑ Yes	❑ No	
g. Arrange for interpretation services	❑ Yes	❑ No	

Additional Needs During Incarceration			
Does the client need any of the following:			**Plan for addressing this need:**
4. Substance use treatment	❑ Yes	❑ No	Name of provider:
5. Entitlements or benefits	❑ Yes	❑ No	
a. Help filling out forms	❑ Yes	❑ No	
b. Eligibility assessment	❑ Yes	❑ No	Client is eligible for: ❑ HASA ❑ Medicaid ❑ Medicare ❑ ADAP ❑ SSI/DI ❑ SSA ❑ VA ❑ TANF ❑ Safety Net ❑ Food Stamps ❑ Birth Certificate Request ❑ Single Stop Coordination ❑ Other _____
c. Referral/appointment making	❑ Yes	❑ No	Details of referral: Date of appointment:
d. Reminder call/message about appointment	❑ Yes	❑ No	Date of appointment:
e. Arrange childcare for appointment	❑ Yes	❑ No	
f. Appointment preparation	❑ Yes	❑ No	
g. Arrange for interpretation services	❑ Yes	❑ No	
6. Court advocacy	❑ Yes	❑ No	If yes, determine eligibility before offering services. Court date:
7. Transportation	❑ Yes	❑ No	
8. Safety plan	❑ Yes	❑ No	
9. Mental health services	❑ Yes	❑ No	

Client Needs 72 Hours or Less Before Release

Transportation			
1. Will someone be picking you up?	❑ Yes	❑ No	If yes, who?
2. Will you need transportation from the jail?	❑ Yes	❑ No	Where will you be dropped off? Is this your final destination? If no, how will you get to your final destination?
3. Will you be taking public transportation?	❑ Yes	❑ No	
4. Do you know the schedule?	❑ Yes	❑ No	
5. Do you know how you will cover the cost?	❑ Yes	❑ No	
Housing			
1. Where are you staying on your first night out?			
a. Do they know you are coming?	❑ Yes	❑ No	
b. Do they know what time you'll be arriving?	❑ Yes	❑ No	
c. Do you have a backup plan in case this place isn't safe, available, etc.?	❑ Yes	❑ No	
d. Do you need a referral for housing?	❑ Yes	❑ No	
e. Do you need support in obtaining housing (appointment reminders, help filling out paperwork, etc.)?	❑ Yes	❑ No	
f. Do you have money to pay for housing?	❑ Yes	❑ No	
Money			
1. Will you have any money when you get out?	❑ Yes	❑ No	
a. If yes, where will the money come from?			
b. How will you get the money?			
c. If the money is in the form of the check, do you know where to cash the check and do you have an ID to cash the check?	❑ Yes	❑ No	

Identification			
1. Do you have an ID?	❑ Yes	❑ No	
a. If no, do you know how to get one?	❑ Yes	❑ No	
2. Do you have a driver's license?	❑ Yes	❑ No	
a. If yes, are there any holds on your ID that you need to take care of?	❑ Yes	❑ No	
Basic Needs			
1. Will you need food when you first get out?	❑ Yes	❑ No	
2. Will you need clothing or shoes when you are released?	❑ Yes	❑ No	
a. If yes, is anyone bringing you clothes?	❑ Yes	❑ No	
3. Will you need any toiletry items (soap, toothbrush, toothpaste, comb, etc.) when you are released?	❑ Yes	❑ No	
HIV Care			
1. Will you need a supply of medications when you are released?	❑ Yes	❑ No	
a. If no, what is your plan of obtaining medications once released?			
HIV/STI/Hepatitis Harm Reduction/Risk Reduction			
1. What materials/support might you need when you get out to help reduce your risk of transmitting HIV/STI/hepatitis?			
Additional Medical, Mental Health, and Substance Use Treatment Support			
1. In addition to your primary care appointment, are there medical services that you will need when you are released?	❑ Yes	❑ No	
2. Will you need substance use services when you are released?	❑ Yes	❑ No	
3. Will you need mental health services when you are released?	❑ Yes	❑ No	

Assessing Needs Post-Incarceration			
Does the client need any of the following:			**Plan for addressing this need:**
1. Primary care	❑ Yes	❑ No	
2. Health home	❑ Yes	❑ No	
3. Housing	❑ Yes	❑ No	
a. Help filling out forms	❑ Yes	❑ No	
b. Eligibility assessment	❑ Yes	❑ No	
c. Referral/appointment making	❑ Yes	❑ No	Details of referral: Date of appointment:
d. Reminder call/message about housing related appointment	❑ Yes	❑ No	Date of appointment:
e. Arrange childcare for housing related appointment	❑ Yes	❑ No	
f. Appointment preparation	❑ Yes	❑ No	
g. Arrange for interpretation services	❑ Yes	❑ No	
4. Substance use treatment	❑ Yes	❑ No	Name of provider:
5. Entitlements or benefits	❑ Yes	❑ No	
a. Help filling out forms	❑ Yes	❑ No	
b. Eligibility assessment	❑ Yes	❑ No	Client is eligible for: ❑ HASA ❑ Medicaid ❑ Medicare ❑ ADAP ❑ SSI/DI ❑ SSA ❑ VA ❑ TANF ❑ Safety Net ❑ Food Stamps ❑ Birth Certificate Request ❑ Single Stop Coordination ❑ Other _____

Assessing Needs Post-Incarceration			
Does the client need any of the following:			**Plan for addressing this need:**
5. Entitlements or benefits (*cont.*)			
c. Referral/appointment making	❑ Yes	❑ No	Details of referral: Date of appointment:
d. Reminder call/message about appointment	❑ Yes	❑ No	Date of appointment:
e. Arrange childcare for appointment	❑ Yes	❑ No	
f. Appointment preparation	❑ Yes	❑ No	
g. Arrange for interpretation services	❑ Yes	❑ No	
6. Court advocacy	❑ Yes	❑ No	If yes, determine eligibility before offering services. Court date:
7. Transportation	❑ Yes	❑ No	
8. Safety plan	❑ Yes	❑ No	Details of referral: Date of appointment:
9. Mental health services	❑ Yes	❑ No	Details of referral: Date of appointment:

Client Goal Plan

Date of care plan:		
Suggested activity goal	**Goal**	**Obtained goal**
◆ Housing ◆ Employment/employment goals ◆ Patient-identified goals ◆ Mobile phone ◆ Education goals ◆ Insurance/insurance goals ◆ Safety ◆ Food security ◆ Legal services ◆ Family goals (and any needs the children have) ◆ Transportation ◆ Taking medication ◆ Viral suppression		
Notes about goals		

	Printed Name	**Signature**	**Date**
Client			
TCC			
PCP			

Appendix E. Health Liaison to the Courts: Sample Policy and Procedure

Policy

The health liaison to the courts and court advocates provides legal assistance to incarcerated persons with substance use and/or chronic or severe health issues in order to arrange their transition from jail to an Alternative to Incarceration (ATI) program or other transitional care or residential substance use disorder treatment program, skilled nursing facility, hospice care program, or hospital-based program. The goal of the health liaison to the courts is to facilitate program and care management through community programs that will then monitor care and treatment until court mandates or treatment needs are fulfilled. The care coordinator screens and communicates with the individual and communicates with the courts, court advocates, and/or community-based program. Case conferences or pre-screening may need to be facilitated by the care coordinator so that the court program case manager may teleconference with the individual.

Procedure

1. Screen individuals to determine program eligibility. Based on court requirements and individual needs, eligibility criteria may include:
    a. Willing to enter hospice, skilled nursing facility, or residential substance use treatment program or outpatient treatment program tied to supportive housing.
    b. No violent offense on record (murder, manslaughter, rape, sex offense, pedophilia, or arson).
    c. Detainee or a parole violator for ATI
    d. People who are sentenced that may be eligible for compassionate release or time served
    e. No immigration hold
    f. Living with HIV, chronic health condition, and/or substance use disorder
2. If individuals meet eligibility criteria for court advocacy services, the project manager or transitional care coordinator obtains client consent to coordinate with courts or court advocates to arrange the Transitional Care Plan and:
    a. Identify an appropriate program (medically equipped to meet individual needs)
    b. Establish that there is a vacancy and confirm that the person will be accepted
    c. Communicate client's personal information to the court advocate, including a short summary (e.g. age, sex, ethnicity, criminal history, medical status, contact information)
    d. Document the process, discharge plan, and connection to care. The Health Liaison and other assigned staff may work on diversion and compassionate release as well

3. Considerations to include in any decision making regarding the provision of services:
    a. Legal history:
        - Parole status
        - Current case/charges
        - History of felony convictions
        - History of misdemeanors
        - Incarceration history
        - Attorney agreement
    b. Medical information:
        - Medical conditions
        - Laboratory results
        - Medications
        - CD4 count and viral load
    c. Program information:
        - Program acceptance
        - Program location

4. Based on the jurisdiction, the process for court advocacy may vary. Typically, each individual eligible for court advocacy will meet with a community-based court advocate for an interview before they arrive in court. The court advocate will review the intake/assessment to ensure that it contains all necessary information (e.g. CD4 count, Viral Load, PPD, Chest X-Ray, nursing home assessment, medications, social determinants, and letter from health liaison). The following are typical steps in the court advocacy process (your site will need to tailor this workflow to the process within your jurisdiction):
    a. The court advocate arrives in court before the hearing allowing sufficient time to meet with the individual and the court representatives (defender, district attorney, justices' clerk)
    b. With defenders' consent, the court advocate introduces themselves to the DA and presents the proposed Transitional Care Plan (and all necessary information including consent forms).
    c. The court advocate meets with the individual's lawyer to review the proposed plan and issues raised by the DA.
    d. If there is a preceding court date for the individual, the DA will let the court advocate know if they will need to attend the hearing.
    e. If the proposed plan is accepted and individual receives "time served," they will be released from the court. The court advocate shall escort the individual to the designated community program/provider.

f. If the proposed plan is not accepted, TCC intervention staff will continue to work with each client to provide discharge planning services until a final determination (release/sentencing) is made.

The health liaison obtains all documents of the proceedings, confirms the individual's arrival at the program with the court advocate, and records the linkage to the program in the electronic health record for tabulation in the monthly report. When health liaison services are no longer needed by the client, intervention staff case conference with the court advocate and health liaison, and others as needed to determine next steps.

Appendix F. Compassionate Release: Sample Policy and Procedure

Policy

The goal of the compassionate release policy is to create a method to promote the release of persons terminally ill, with a significant, permanent disability, or with chronic conditions that cannot be optimally managed within the correctional realm. Referrals from all sources (e.g. health educators, physicians, care coordinators, etc.) are accepted.

Procedure

1. TCC staff receives consent from each individual eligible for compassionate release to share their medical information between and among medical staff, care coordinators, and attorneys for the purpose of the compassionate release plan.
2. TCC staff submit a referral with the following information to jail-based medical staff (e.g. medical director or deputy medical director) or designee:
    a. Name of individual
    b. Book and case number
    c. Current facility location
    d. Current case/charges
    e. Parole status
    f. Immigration status
    g. Assessment completed by person referring the individual
    h. Familial and/or community support (to determine if discharge plan/community placement necessary)
    i. Attorney contact information
3. If compassionate release is pursued, assigned TCC staff arranges a Transitional Care Plan and may arrange court advocacy.
4. Communication between and among all staff, attorneys, Department of Corrections, community corrections (parole or probation), and U.S. Immigration and Customs Enforcement is maintained in order to execute successful compassionate release while maintaining client confidentiality consistent with HIPAA regulations.

Appendix G. Confidentiality: Sample Policy and Procedure

All records pertaining to a client's medical history, treatment, discharge planning, and transitional care are private and confidential and may not be disclosed unless the disclosure is authorized by law. Only TCC staff with a legitimate job-related reason may have access to confidential information. It is the responsibility of all TCC staff to maintain the confidentiality of all records containing confidential information. All discussions regarding confidential client information will be held as private and confidential as possible within a correctional health environment.

Personal information is to be appropriately acquired, used, maintained, and stored. Client consent is required prior to disclosing confidential information regarding the client's health status to third party community partners for the purposes of transitional care, placement, and/or reporting. In circumstances in which disclosure of information to third parties occurs, it is imperative to disclose information in a controlled manner.

"Confidential information" includes:

1. The contents of the client's medical record, including a record in electronic format;
2. The contents of records used in the discharge planning;
3. Documents which should be included in the client's medical record;
4. Other documents, including sign-in sheets, rosters, and logs that convey information concerning the health status of the client or otherwise identify the client;
5. Other private information regarding the client, including social security number, Medicaid ID number, home address, phone number;
6. Secondary documents (paper or electronic) that contain information that can be used to identify the client and concerns the health status of a client.

Procedure

1. Do not discuss confidential information in open spaces or when a third party is present. Only discuss confidential information with other TCC staff or the client outside of the presence of a third party. Maintain a private space and speak in a voice that is audible only to the person who is authorized to hear the confidential information.
2. Request written consent from individuals receiving a transitional care plan. The consent should authorize TCC to release their confidential information to any third party.
3. The HIPAA consent form should be used to obtain written consent. The HIPAA consent form must be filled out with the names of all parties or agencies to whom TCC staff plan to disclose information. Each individual receiving a transitional care plan should sign the HIPAA consent form. The HIPAA consent form is signed by each individual receiving a transitional care plan.

4. Specific consent is required prior to disclosing HIV and substance use disorder information.
5. Confidential information must be stored in locked cabinets. Keys to these cabinets are to be held by TCC staff authorized to access the records.
6. Confidential information must not be left unattended in work spaces, fax machines, conference rooms, or any space where they may disclosed to third parties, including individuals who work in the correctional setting but are not authorized to see the confidential information.
7. Do not place confidential information in the trash can. Confidential information may only be discarded in a shredder.
8. When transporting confidential information by hand, package the information in two envelopes marked “Confidential.”

Only TCC staff may photocopy, fax, or in any way handle confidential information that is not in a sealed envelope. Never include any information that can be used to identify a client in the body of an email. Where authorized, client information may only be electronically transmitted in an attachment that is password protected.

Appendix H. Sample Education Curriculum

The education sessions will address the following learning objectives:

- **Session 1: HIV, the Viral Life Cycle and Understanding HAART**

  By the end of session 1, the patient will be able to define:

  - The stages of HIV infection
  - Routes of HIV transmission
  - HIV viral life cycle
  - How medications work in body
  - How HIV medications strengthen the body's immune system (CD4 increase)
  - How medications can reduce the amount of HIV in the body (reduce viral load)

- **Session 2: Communicating with Health Care Providers about Adherence and Managing Side Effects**

  By the end of session 2, the patient will understand:

  - The relationship between missing doses of HIV medication and the amount of HIV virus in the body
  - The relationship between the time of day when medications are taken and HIV drug resistance

  By the end of session 2, the patient will be confident in their ability to talk to their doctor about:

  - How and when meds are taken and when meds are not taken
  - Potential side effects of treatment (nausea, diarrhea, dizziness)
  - Ways to cope with side effects

- **Session 3: Review Understanding of Basic Lab Tests: CD4 and Viral Load**

  By the end of session 3, the patient will be able to:

  - Identify the relationship between CD4 count and their immune system
  - Define viral load and the relationship between viral load and disease progression

Session 1: HIV Life Cycle and Medications at Work

Have a conversation about transmission:

- Today I'd like to discuss how HIV is transmitted and the different stages it goes through once it enters your blood. This includes the body fluids that transmit HIV and the ones that don't, the pathways that allow HIV to enter the body, HIV symptoms, and AIDS symptoms.
- We'll also discuss the immune system, the stages of HIV infection, and how HIV invades CD4 cells to multiply and then destroy those cells. This is called the viral life cycle.
- Knowing how the virus works gives you the power to control it.
- In a couple of weeks, we will learn how medications work in reducing replication of HIV, which allows the viral load to be low and your immune system to be stronger.
- Let's plan to meet again on _____.

Handouts for Patients

- Stages of HIV Infection
- Routes of Transmission Risk
- HIV Life Cycle—the Big Picture
- Videos to show: https://www.youtube.com/watch?v=HL02LjVDElw

HIV Transmission

Modes of Transmission:

1. Oral, vaginal, anal _____

2. Sharing _____

3. _____

Fluids:

1. _____

2. _____

3. _____

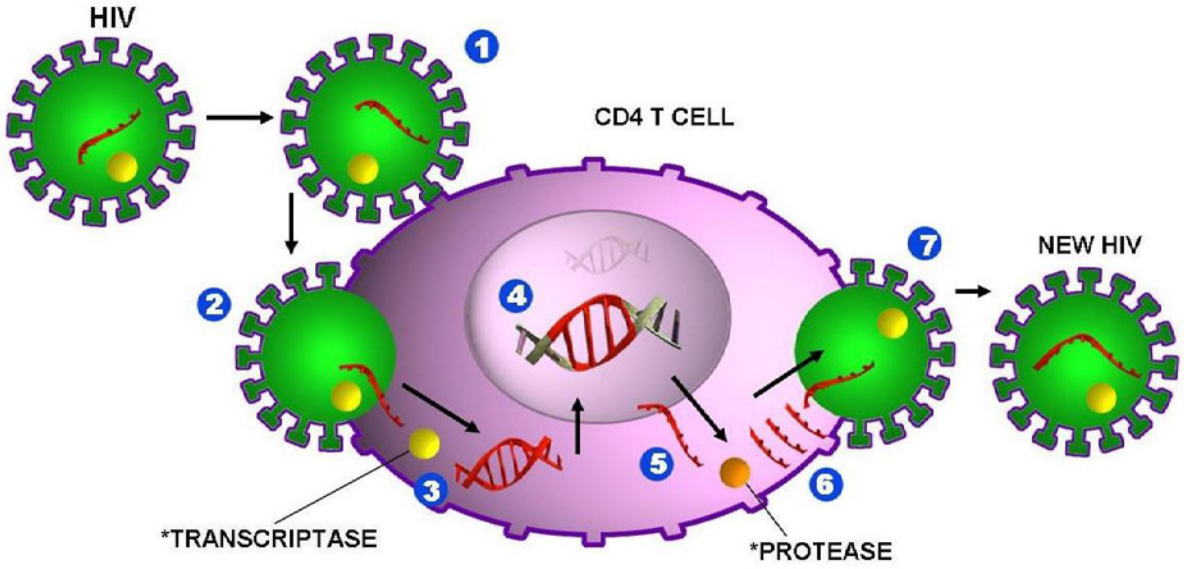
4. _____

Handout (to come)

Handout (to come)

Handout

HIV Life Cycle - The Big Picture



Attachment

1. HIV binds to receptors on the CD4 T-cell.

- A message is sent to the CD4 T-cell to let the virus in.

Fusion

2. Once bound, the virus is allowed to dump its contents into the CD4 T-cell.

- Included in its contents are HIV RNA and reverse transcriptase.

Reverse Transcription

3. The HIV RNA is turned into double-stranded DNA within the CD4 T-cell.

- The enzyme **reverse transcriptase* aids in this process.

Integration

4. Once the DNA is formed, it hides itself in the human DNA housed in the CD4T-cell nucleus.

Transcription

5. Copies of HIV DNA are made and released from the nucleus in small packages'.

- Each of the small packages' contains information for creating a new HIV.

Assembly

6. The **protease* enzyme in the cell combines the DNA 'packages' to create active virus.

Budding

7. Once the new HIV is formed, it pushes itself out of the CD4 T-cell

- The virus steals part of the CD4 T-cell protective coating.

What is HIV?

H – _____

I – _____

V – _____

A – _____

I – _____

D – _____

S – _____

Session 2: Coaching/Mentoring Patients

Conversation starter:

- Let's review the importance of communicating effectively with your providers and how that impacts your health, as well as the importance of advocating for yourself.
- Having a partnership with your health provider is important because you want to have equal ownership about health decisions. Usually, as a patient we follow whatever the doctor/nurse tells us to do; however research has shown that patients who ask questions increase their knowledge of their health/disease and have better health outcomes when fully involved in making health decisions.
- Suggestions to communicate more effectively include:
  - Coming prepared with a list of questions for your medical appointments. (I can help you prepare the list before your appointment.)
  - Writing down any symptoms you experience between medical appointments—it's called a "symptom log."
  - Letting your provider know if you have missed appointments.
  - Honestly telling your doctor that you are uncomfortable with changes they may be recommending.
  - Being truthful with your providers.
- These suggestions are all ways to increase communication with your health provider while advocating for yourself.
- Sometimes it may take a while to create a trusting relationship, but know that I can attend your appointments with you, or if there is a supportive person in your life, you can ask them to attend the appointments with you.
- Let's plan to meet again on _____.

Handouts

- How to Prepare for a Visit with your Doctor
- Symptoms Log

Preparing for a Visit with Your Doctor

Check	Task	Questions/Comments
	Keep a journal or calendar of your symptoms.	
	Be prepared to describe side effects, including symptoms.	
	Bring a list of your medications and dosages, or bring your medications in a bag.	
	Be prepared to let your provider know how many doses you missed in the past week and month.	
	Bring a list of questions.	
	Bring snacks/water and something to help you stay busy while waiting.	
	Bring a friend, family member or care coordinator to help you during your visit.	

Questions to ask your provider:

1. Why have I been prescribed this medication?
2. How should I take it?
3. Are there any special storage requirements?
4. Should I take it with or without food?
5. How many doses, and how often should I take the medication?
6. Will it make me feel worse? What are the side effects?
7. What do I do if I forget a dose?
8. How long will I have to take it?
9. _____
10. _____
11. _____
12. _____

Symptom Log

Name _____Date _____

1. Is it hard for you to take your HIV medicines the way your healthcare provider told you to?
   ❑ Yes ❑ No

2. How hard are your HIV medicines to take?
   ❑ Very Hard ❑ Not Hard At All

3. If you miss a dose, is it in the morning, evening, or middle of the day?
   ❑ Morning ❑ Evening ❑ Middle of the day ❑ I don't forget or skip doses

4. Do you ever skip a dose because the medicines make you feel bad? ❑ Yes ❑ No

5. Do you ever go a day without taking your HIV medicines?
   ❑ Yes; why? _____
   ❑ No

6. Do you ever have any of these possible side effects?

Side effect	**How many times a month?**	**How long have you had this side effect?**	**How much does it affect your daily activities?** 0=none; 1=somewhat; 2=always
Feeling sick to my stomach			
Vomiting			
Diarrhea			
Headache			
Feeling tired			
Rash			
Shortness of breath			
Trouble sleeping			
Change in skin color			
Bad dreams			
Nervousness			

7. Has your energy changed since you started taking your current HIV medicines? Mark an X on the line below.

   ❑ Lower energy ❑ About the same ❑ Higher energy

8. Are you concerned that the HIV medicines you are taking now might cause either of these side effects?

   - Weight loss in the arms, legs, buttocks, or face ❑ Yes ❑ No
   - Weight gain in the upper back and neck, breast, or trunk ❑ Yes ❑ No

9. Would you be interested in talking to your healthcare provider about whether a change to your HIV regimen is right for you? ❑ Yes ❑ No

10. If you could change one thing about your HIV treatment, what would it be?

_____

_____

_____

_____

Use your answers to talk to your healthcare provider.

HIV Patient Bill of Rights

- The person with HIV has the right to considerate and respectful care regardless of race, ethnicity, national origin, religion, age, sexual orientation, gender, or payment source.
- The person with HIV has the right to, and is encouraged to obtain current and understandable information concerning diagnosis, treatment, and prognosis.
- The person with HIV has the right to know the identity of the physician, nurses, and others involved in their care, including those who are students, residents, or other trainees.
- The person with HIV has the right to work with the physician or nurse in establishing their plan of care, including the refusal of a recommended treatment, without the fear of reprisal or discrimination.
- The person with HIV has the right to privacy.
- The person with HIV has the right to expect that all records and communication are treated as confidential except in the case of abuse.
- The person with HIV has the right to review their own medical records and request copies of them.
- The person with HIV has the right to expect that an advance directive (such as a living will, health care power of attorney) will be honored by the medical staff.
- The person with HIV has the right to receive timely notice and explanation of changes in fees or billing practices.

- The person with HIV has the right to expect an appropriate amount of time during their medical visit to discuss their concerns and questions.
- The person with HIV has the right to expect that their medical caregivers will follow universal precautions.
- The person with HIV has the right to voice their concerns, complaints, and questions about care and expect a timely response.
- The person with HIV has the right to expect that the medical caregivers will give the necessary health services to the best of their ability. If a transfer of care is recommended, they should be informed of the benefits and alternatives.
- The person with HIV has the right to know the relationships their medical caregivers have with outside parties (such as health care providers or insurers) that may influence treatment and care.
- The person with HIV has the right to be told of realistic care alternatives when the current treatment is no longer working.
- The person with HIV has the right to expect reasonable assistance to overcome language (including limited English proficiency), cultural, physical, or communication barriers.
- The person with HIV has the right to avoid lengthy delays in seeing medical providers; when delays occur, they should expect an explanation of why they occurred and, if appropriate, an apology.

HIV Patient Bill of Responsibilities

- Provide your medical caregivers with accurate and complete information, and convey your understanding about what is expected of you in regard to your treatment. If you believe you cannot follow through with your treatment, let them know.
- Meet your financial obligations as promptly as possible.
- Be considerate of the rights of other patients and medical personnel in the control of noise and respect of property at your appointments or in the hospital.
- Recognize the reality of risks and limits of the science of medical care and the human fallibility of the health care professional.
- Be aware of the health care provider's obligation to be reasonably efficient and equitable in providing care to other patients and the community.
- Become knowledgeable about your health care plan.
- Report wrongdoing and fraud to the appropriate personnel or legal authorities.
- Keep appointments and notify the clinic if unable to do so.
- Inform the clinic of the existence of, and any changes to, advance directives.
- Notify the clinic of changes in your condition or care situation.

Session 3: Understanding Lab Values and Medication Adherence

Lab values conversation starter:

- Your doctor will order blood tests on a regular basis to check HIV progression, see if your medications are working (if you're taking medications), and determine the effects of HIV and medications on your organ function. This is why it's so important to come in to get your blood drawn every 3-4 months; if you don't, it will be very hard to take control of HIV and understand how the medications impact the virus.
- We're not going to cover every single blood test in this session, just the most common ones including: CD4 count, CD4 percent, viral load count, complete blood-cell count, liver function, kidney function, lipid profile, blood pressure, glucose levels, cholesterol, etc. These tests tell a story about your health and what needs to be done to keep you healthy.
- We'll also discuss heart health and the effects of HIV.
- Another reason to get your labs done regularly and understand what the numbers mean is that you and your doctor can do certain things to change the lab values if they're not normal. For example, if your cholesterol is too high, you and your doctor can intervene to lower it. If your CD4 is too low, you and your doctor can intervene to increase it.
- It's kind of like checking the oil in a car engine or taking a car in for a tune-up. If you don't do these things, what will happen to your car eventually? [Responses: A car will need costly repairs or a person may need a new car.]
- Routine screenings for preventive care are very important such as: eye exams, mammograms, Pap smear, prostate, and STD screenings. In addition, preventive care vaccines like flu, pneumonia, and hepatitis are essential to maintaining good health.
- Have you had labs done, and what were the results?
- Let's review them to ensure that you understand the different labs that are monitored. [Pull up patient's record/share printed copy of labs]. We can also track your results on a spreadsheet or a grid. That way you can monitor independently and increase understanding of labs and your health. Always ask for a copy of your labs and keep them in one place so that if you move or change physicians, your new physician has a history of your care and treatment. If you are interested in making a spreadsheet, let's make one together that you can update as you visit your doctor.
- Let's plan to meet again on _____.

HIV medications conversation starter:

- HIV medications are beneficial for you. Because of HIV meds, many people are living longer, fuller lives. I don't think many of us would be alive today if it weren't for HIV meds. Many people are living longer—10, 20, 30 years and beyond—because of HIV meds. You can too!
- Taking meds is one of the most important things you can do to take control of HIV.
- Each individual responds differently to meds: some people get intense side effects, while others get mild or no side effects; some people have side effects in the first 30 days and then they disappear. Because of this, it is important not to judge how your body will respond to medications by other people's experiences but from your own experience.
- Remember: the benefits of taking meds outweigh any difficulty taking them. Remember, too, that if they don't work for you, your doctor can put you on different meds until you find the ones that are just right for you.
- We're fortunate that today there are many meds to choose from, and newer meds have fewer side effects than the older ones.
- Taking meds can feel complicated at first, but once you develop a daily routine, it gets easier.
- I can give you ideas about how to remember to take meds on time, how to take them correctly, and I will be here for you whenever you need to talk about them.
- It's a big commitment, but one that eventually becomes second nature for most, and one that could bring you good, stable health, and a long life.
- Together we—you, me, the doctor, case manager and anyone else involved in your care—can minimize any negative experiences that may (or may not) develop.
- Now, let's take a look at the goals of HIV meds and how they work to stop HIV from multiplying in order to give your immune system a fighting chance.
- Let's look at the different combination of medications that are available and where they work in the viral life cycle to reduce the virus.
- Let's plan to meet again on _____.

Drug resistance and adherence conversation starter:

- Today's session builds on the last session we had on HIV medications: adherence, resistance, and managing side effects.
- Adherence means "sticking to your medication schedule" at least 95% of the time. It means taking your meds correctly and on time every day. It also means managing side effects so that you're not discouraged from continuing to take your meds.
- Most people who stop taking meds do so because of side effects. Perhaps they didn't have information about how to manage side effects, or no one helped them learn how to manage them. But you have a team of people supporting you in sticking to your meds and identifying possible barriers to adherence, including me. In addition, there are many methods and tools (e.g. pillboxes, calendars, alarm watches, etc.) available to help.

- We'll also talk about medication resistance; there are different types, and some are the direct result of non-adherence.
- Resistance means that the meds no longer work in blocking HIV from multiplying. HIV usually becomes resistant when it is not totally controlled by medications. Now, let's get started.
  - ***(Use Handout: Viral Load and Non-Adherence).***
  - When you take medications correctly your viral load goes down because the treatment stops the virus from growing in the body.
  - If you miss one or two doses—the virus becomes "resistant" to treatment and can start growing in the body.
  - Eventually if you keep missing doses or stop taking meds as directed by your doctor, the treatment will not work to stop the virus. The virus will become resistant until your doctor can find a new treatment.

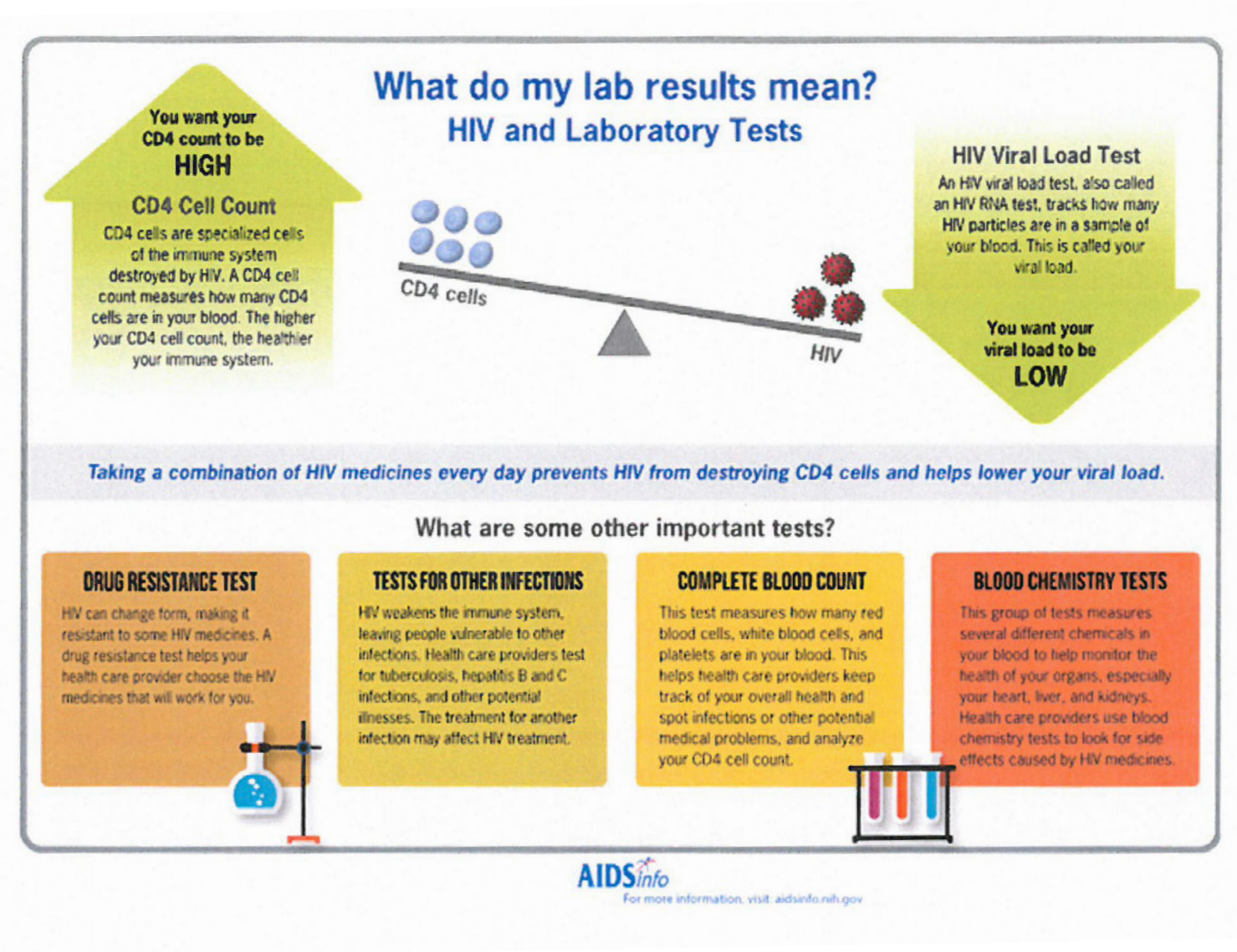
Managing side effects conversation starter:

- Many side effects are related to your digestive system, e.g., nausea, diarrhea, bloating, gas, etc. Many people manage these with other medications or certain foods:
  - BRAT diet: Bananas, Rice, Applesauce, and Toast
    - Apples and apple products like apple juice and apple sauce
    - Black or green decaf tea
    - Boiled white rice
    - White toast
  - Ginger and ginger products like ginger tea, candied ginger, ginger ale, ginger snaps, etc.
  - Yogurt
  - Soda crackers or saltines
- Fiber-rich foods or supplements
- Medication: Imodium AD (loperamide)
- It's always important to contact your provider immediately to let them know if you're experiencing side effects.
- Never stop taking your medications without getting guidance from your providers.

Handouts

- Monitoring Tests for People with HIV
- How medications work
  - Youtube videos:
    - How HIV treatment works: ***https://www.youtube.com/watch?v=06mQyXQlR08***
    - Understanding HIV treatments: ***https://www.youtube.com/watch?v=8OO3tTj2XfE***
- Assessing Adherence (below)
- Resistance and Viral Load (below)

Handout


What do my lab results mean?
HIV and Laboratory Tests
You want your CD4 count to be HIGH
CD4 Cell Count
CD4 cells are specialized cells of the immune system destroyed by HIV. A CD4 cell count measures how many CD4 cells are in your blood. The higher your CD4 cell count, the healthier your immune system.
CD4 cells
HIV
HIV Viral Load Test
An HIV viral load test, also called an HIV RNA test, tracks how many HIV particles are in a sample of your blood. This is called your viral load.
You want your viral load to be LOW
Taking a combination of HIV medicines every day prevents HIV from destroying CD4 cells and helps lower your viral load.
What are some other important tests?
DRUG RESISTANCE TEST
HIV can change form, making it resistant to some HIV medicines. A drug resistance test helps your health care provider choose the HIV medicines that will work for you.
TESTS FOR OTHER INFECTIONS
HIV weakens the immune system, leaving people vulnerable to other infections. Health care providers test for tuberculosis, hepatitis B and C infections, and other potential illnesses. The treatment for another infection may affect HIV treatment.
COMPLETE BLOOD COUNT
This test measures how many red blood cells, white blood cells, and platelets are in your blood. This helps health care providers keep track of your overall health and spot infections or other potential medical problems, and analyze your CD4 cell count.
BLOOD CHEMISTRY TESTS
This group of tests measures several different chemicals in your blood to help monitor the health of your organs, especially your heart, liver, and kidneys. Health care providers use blood chemistry tests to look for side effects caused by HIV medicines.
AIDSinfo
For more information, visit: aidsinfo.nih.gov

Addressing Adherence:
10 questions care coordinators should ask their patients

1. Which medications are you currently taking?
2. How frequently do you have to take each one of your meds?
3. What are the food restrictions for each of your meds (i.e. with or without food)?
4. Why do you think some meds need to be taken with food and some on an empty stomach?
5. Why do you think that some medications are taken once a day and others twice a day?
6. What helps you remember to take your meds?
7. What do you do when you miss a dose?
8. What problems have you encountered from taking meds?
9. How soon before you run out of medications do you order refills?
10. Do you believe the meds are helping you and if so, how?

Barriers to Adherence: To be filled out by the care coordinator and the patient

Patient name _____Date _____

Care coordinator:_____

Past/current barriers to adherence	Strategies to overcome barriers

Appendix I. Sample MOU with HRSA Language

*The following is a sample MOU from a prior SPNS initiative. This sample MOU has been provided to help guide the process of creating a site-specific MOU.

SAMPLE MEMORANDUM OF UNDERSTANDING BETWEEN CORRECTIONAL HEALTH SERVICES

This Memorandum of Understanding ("MOU") describes the intended working relationship between Correctional Health Services ("CHS"), located at XXX Tel: XXX-XXX-XXXX and _____ ("**Service Provider**") with an office at _____ Tel: _____ (each a "**Party**" and, collectively, the "**Parties**").

This MOU is a good faith agreement that demonstrates a plan for collaboration which will facilitate the referral for, and provision of, effectively coordinated and integrated services for people incarcerated in xxx county or city jail, their families, visitors and/or people returning to the community after incarceration ("patients") in need of health-related services or service referrals and is not intended to be binding on the Parties.

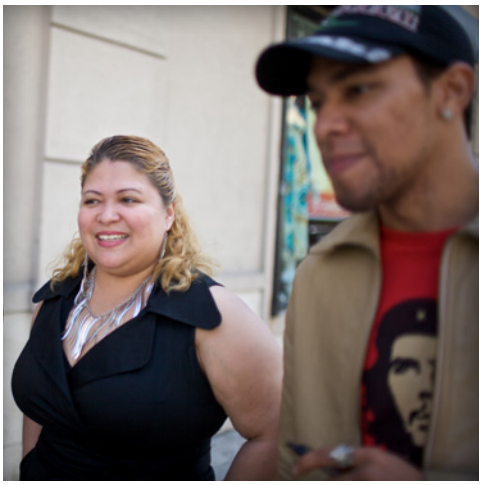
The Parties agree that they will endeavor to conduct the following:

1. CHS will make efforts to refer patients to the Service Provider for the purpose of linking patients to health providers in the community. The Parties will endeavor to accept referrals from each other in accordance with eligibility criteria.
2. The Service Provider will endeavor to participate in a collaborative program to outreach to inmates, their partners/families at the central visit center, and at other special events in order to explain the services that the Service Provider offers within its community area.
3. CHS staff may request joint participation with Service Provider in a patient case referral ("Joint Participation"). Joint Participation may include, but not be limited to, case conferences and staff risk assessment prior to making and/or accepting referrals. Further, CHS may conduct referral follow-up to insure adequate participation.
4. CHS maintains specific protocols for patient assessment, interviews, referrals, linkages, and confirmation of referrals with providers. These protocols are supplemented with detailed memoranda of understanding with other community-based partners to ensure that discharged inmates have access to HIV secondary prevention and other services (i.e. primary care, medical and mental health services, social services, respite or support services). CHS protocols are guidelines for the Service Provider to follow and will be provided by CHS, if requested by the Service Provider, for the Service Provider's benefit.
5. All referrals made should be confirmed by the Service Provider, contacting offices to set up the appointment and to confirm the appointment was kept. The service provider will seek any needed consent from enrolled participants to provide follow-up information regarding continuity of care (i.e. appointments made and kept) to CHS.

6. CHS and Service Provider should endeavor to meet on occasion to discuss issues related to program implementation, referrals or other programmatic issues.
7. In matters concerning confidential patient information, including confidential HIV-related information, all interactions between and within the Parties should conform with all relevant laws, rules, and regulations.
8. This MOU is merely a statement of the intended responsibilities among the Parties. No element of this MOU will be construed to imply any form of financial obligation or liability on to the other nor does it impose responsibility for actions of one Party upon the other.

Service Provider	
Signature:	
Printed name:	
Title:	
Tele:	
Fax:	
Email:	
Date signed:	

Correctional Health Services Provider	
Signature:	
Printed name:	
Title:	
Tele:	
Fax:	
Email:	
Date signed:	



For more resources from the Dissemination of Evidence-Informed Interventions Initiative visit: *https://targethiv.org/deii*