Post-Release of People Living with HIV: New and Innovative Models of Discharge Planning

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HIV/AIDS Bureau (HAB)
Health Resources and Services Administration (HRSA)

Health Resources and Services Administration (HRSA) Overview

Supports more than 90 programs that provide health care to people who are geographically isolated, economically or medically vulnerable through grants and cooperative agreements to more than 3,000 awardees, including community and faith-based organizations, colleges and universities, hospitals, state, local, and tribal governments, and private entities

Every year, HRSA programs serve tens of millions of people, including people living with HIV/AIDS, pregnant women, mothers and their families, and those otherwise unable to access quality health care

HIV/AIDS Bureau Vision and Mission

Vision

Optimal HIV/AIDS care and treatment for all.

Mission

Provide leadership and resources to assure access to and retention in high quality, integrated care, and treatment services for vulnerable people living with HIV/AIDS and their families.

Ryan White HIV/AIDS Program

Provides comprehensive system of HIV primary medical care, medications, and essential support services for low-income people living with HIV

- More than half of people living with diagnosed HIV in the United States – more than 550,000 people – receive care through the Ryan White HIV/AIDS Program (RWHAP)

- Funds grants to states, cities/counties, and local community based organizations
  - Recipients determine service delivery and funding priorities based on local needs and planning process

Payor of last resort statutory provision: RWHAP funds may not be used for services if another state or federal payer is available

84.9% of Ryan White HIV/AIDS Program clients were virally suppressed in 2016, exceeding national average of 59.8%

Source: HRSA. Ryan White HIV/AIDS Program Annual Client-Level Data Report 2016; CDC. HIV Surveillance Supplemental Report 2016;21(No. 4)

Post Release of People Living with HIV

As individuals leave confinement, they may face an array of barriers as when reentering their communities and engaging in medical care after release.

Reentry can be challenging for any prison population, but can be particularly complicated for PLWH due to stigma, costs, and re-establishment of medical care

Studies show that few inmates living with HIV receive discharge planning or linkage to care following release

Post Release of People Living with HIV

Today's presentations will

- Discuss components of an effective discharge plan to better meet the needs of post released detainees living with HIV
- Highlight barriers that may prevent successful reintegration into the communities and care
- Discuss lessons learned from two programs that have promising models for effective discharge planning

2018 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

Transitional Care Coordination: Linking Jail and HIV Community Care

Presenters

- Boston University/Abt Associates
  - Jane Fox, MPH, DEC, Co-PI
- AIDS United
  - Hannah Bryant, MPH, ITAC, Program Manager
- University of North Carolina at Chapel Hill
  - Claire Farel, MD
- Cooper Health System
  - Cheryl Betteridge

- This presentation is supported by grant #U90HA29236, "Dissemination of Evidence Informed Interventions", through the U.S. Department of Health and Human Services Administration's HIV/AIDS Bureau, National Training and Technical Assistance.

Objectives

1. Describe the components of the standardized intervention.
2. Identify lessons learned from implementation at the three funded clinical sites.
3. Discuss ways to integrate the model into an agency/clinic practice, specifically the provision continuous of case management for your clients, both inside the jail setting and in the community.

Dissemination of Evidence-Informed Interventions (DEII)

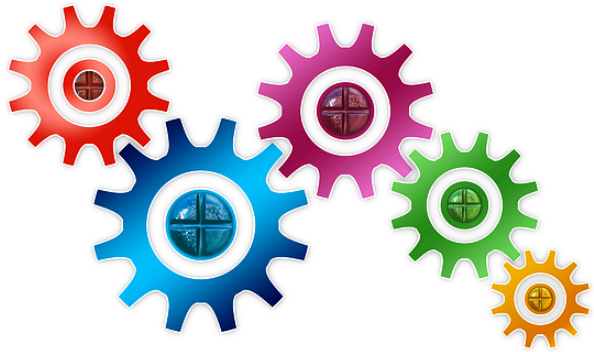
- Five-year Cooperative Agreement with HRSA/HAB Special Projects of National Significance (SPNS)
- Two sites funded to work together
  - Implementation and Technical Assistance Center (ITAC) – AIDS United (2015-2019)
  - Dissemination and Evaluation Center (DEC) – Boston University (2015-2020)
- Replicates four adaptations of previously-implemented SPNS initiatives
- Conducts a multi-site evaluation of the implementation and patient outcomes

DISSEMINATION OF
EVIDENCE-INFORMED
INTERVENTIONS

Interventions

Boston University: Dissemination and Evaluation Center (DEC)

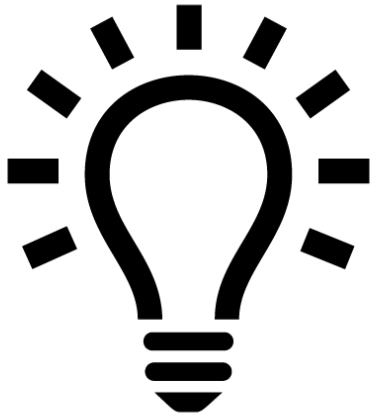
- Adapt and design 4 intervention models for replication
- Design and implement multi-site evaluation
- Studying both patient outcomes (including retention in care and viral suppression) and implementation findings (what works in practice and what facilitates/hinders implementation)
- Publish and disseminate final adapted interventions and study findings



AIDS United

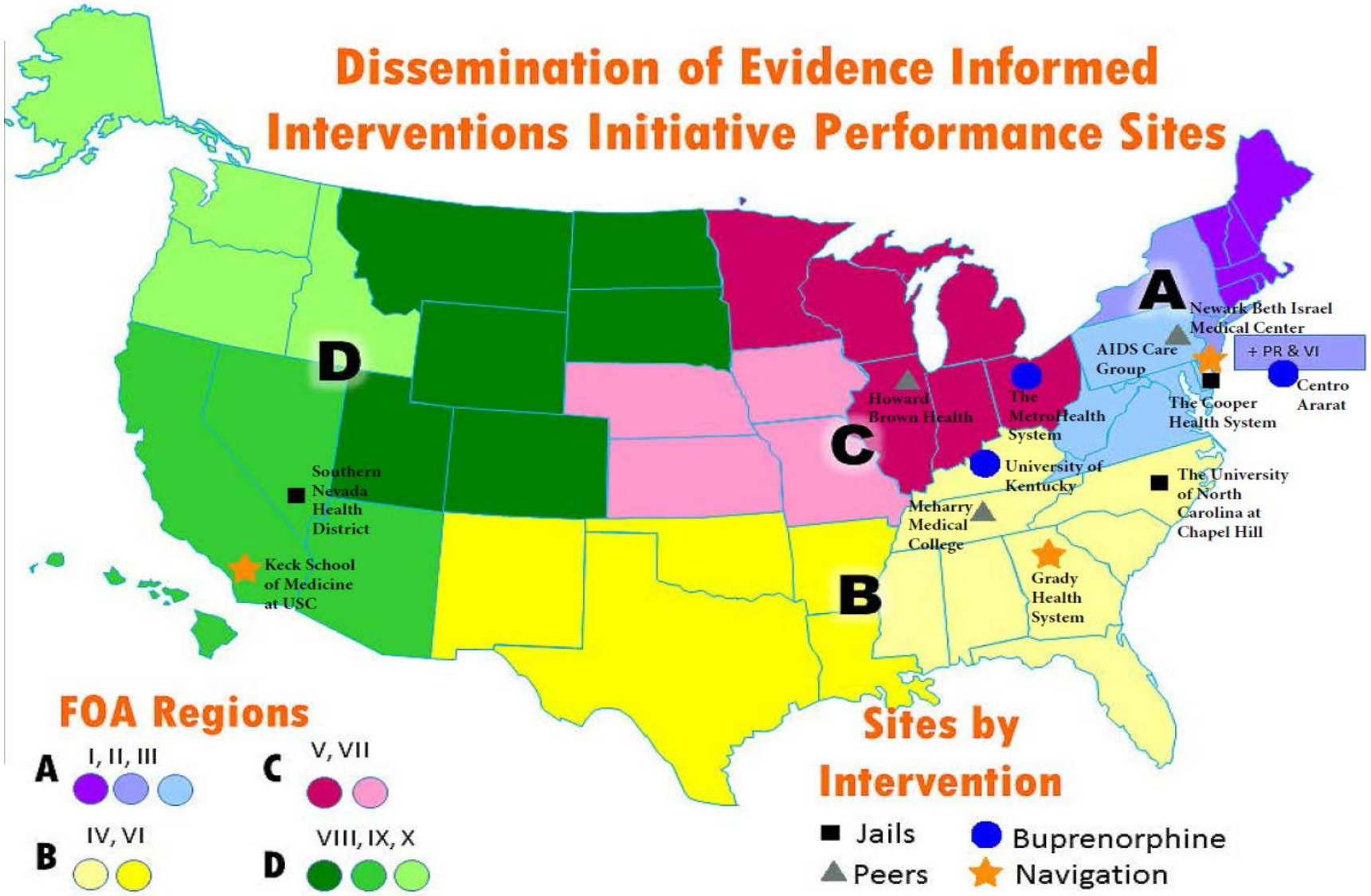
Implementation and Technical Assistance Center (ITAC)

Select & Fund 12 Sites



Provide TA

Coordinate Experts


Dissemination of Evidence Informed Interventions Initiative Performance Sites
A
B
C
D
Newark Beth Israel Medical Center
AIDS Care Group
+ PR & VI
Centro Ararat
The Cooper Health System
Howard Brown Health
The MetroHealth System
University of Kentucky
Meharry Medical College
The University of North Carolina at Chapel Hill
Grady Health System
Southern Nevada Health District
Keck School of Medicine at USC
FOA Regions
A I, II, III
B IV, VI
C V, VII
D VIII, IX, X
Sites by Intervention
Jails
Peers
Buprenorphine
Navigation

Transitional Care Coordination

TRANSITIONAL CARE COORDINATION

From Jail Intake to Community HIV Primary Care

Intended for organizations and agencies considering strengthening connections between community and jail health care systems to improve continuity of care for people living with HIV who have recently been released from jails.

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

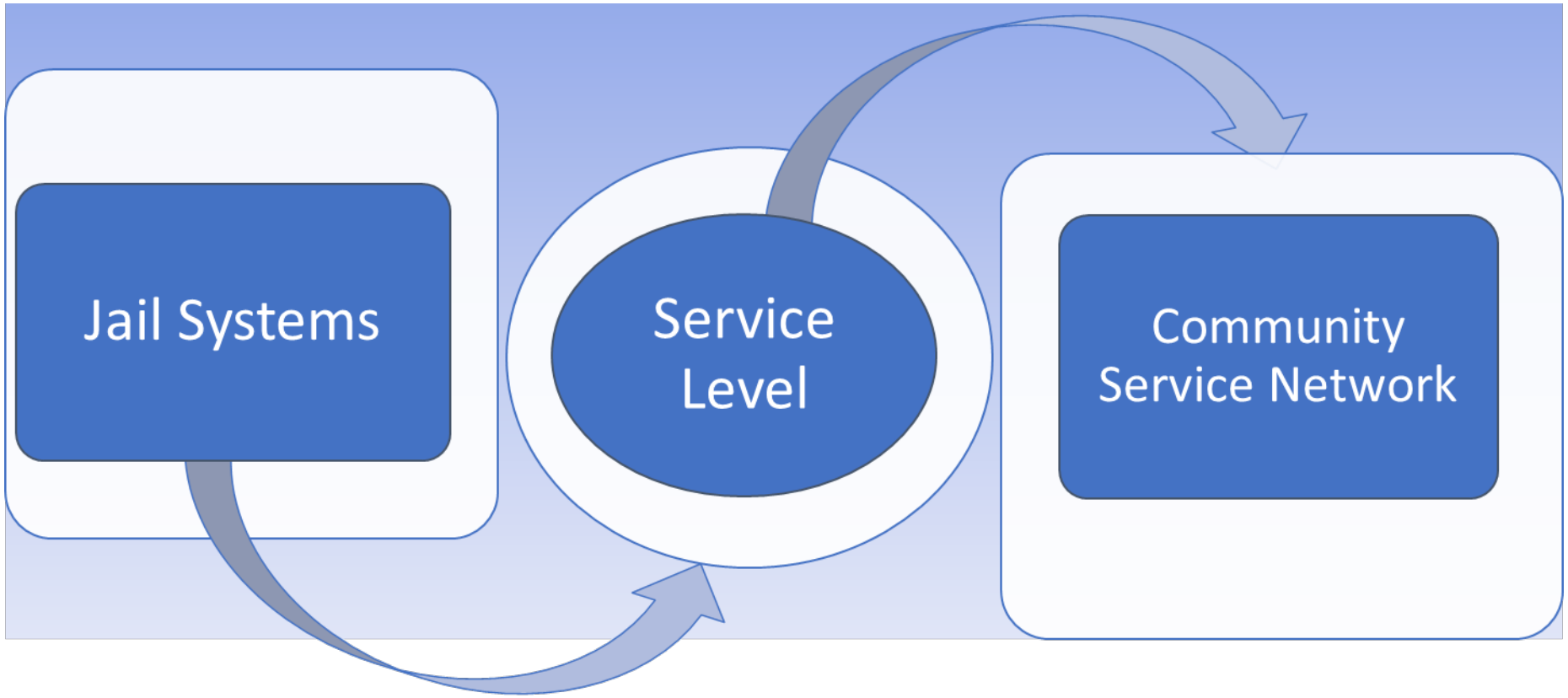
Overview

Target population: People living with HIV who are incarcerated.

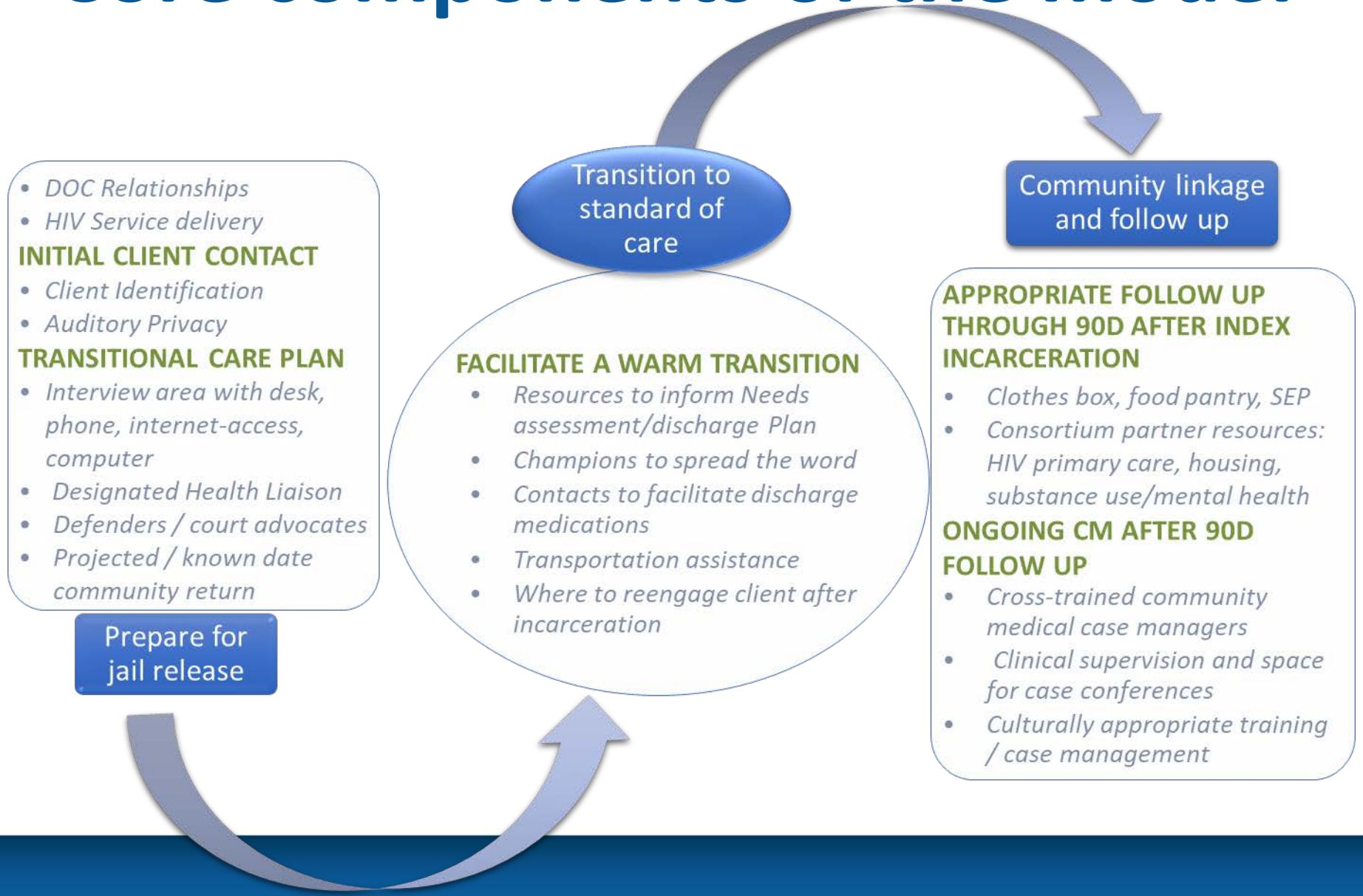
Time frame of the intervention: From when a client completes an intake and assessment in the jail to 90 days post-release.

Enrollment numbers: At least 50 participants enrolled in the first 12 months of implementation and at least an additional 20 enrolled in the following six months of implementation.

Transitional Care Coordination Model



Core components of the model



Cooper Health System

Site Highlights

Cooper Health System (Camden, NJ)

- Existing relationship with local jail system via Cooper physician who provides medical care in jail
- There is strong support from the past and current warden for the intervention
- Majority of clients receive medical care and support services through Cooper, which enhances the site's ability to facilitate connection to services and tracking

Cooper Health System

Camden City

- Located directly across the Delaware River from Philadelphia, Pennsylvania.
- Population of 77,344 (2010 U.S. Census)
- Poorest city in the United States with a high incidence of drug abuse, homelessness, and HIV infection
- Reputation for its violent crime rates, once ranked as the highest in the country

Cooper Health System

Successes

- Exceeded Target enrollment
- Engagement of HIV positive patients never linked to care
- Reengagement of clients previously out of care
- Highlighted gaps in community partners

- **Update**
  - Enrolled 85 – target was 70
  - MAT is an incentive to getting clients linked to care
  - Relationships established offering housing and MAT

Cooper Health System

Challenges

- Active Addiction
- Housing
- Transitioning: Impediments
  - Relationship established in the jail can impede transitioning
  - Poor Adherence

- **Update**
  - MAT services in EIP: Peer Leader, D&A Counselor, MD, and Psychiatrist
  - Housing Collaborative
  - TCC play role in navigating client in linkage to care

Cooper Health System

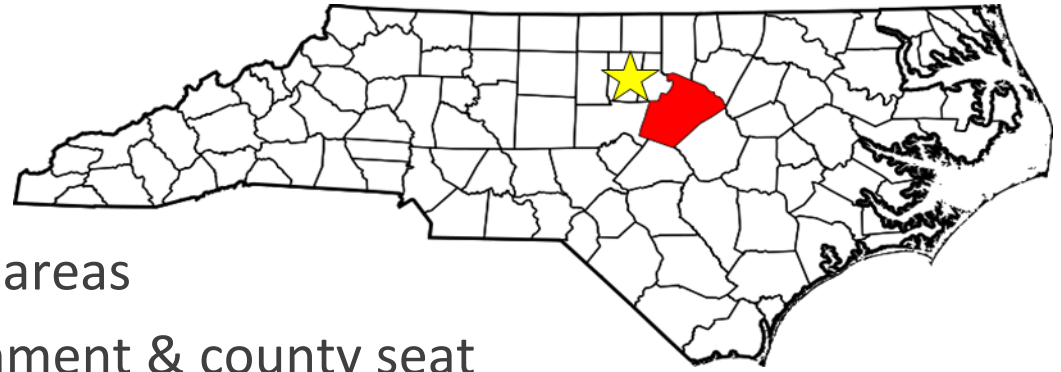
Lessons Learned

- Validity of the Jail linkage program
- Importance of community partners for implementation
- Importance of a team

- **Update**
  - Previous relationship in the Jail identified positives
  - As needs were identified partnerships were developed
  - It takes a village

UNC-CH & WCHS

- **The University of North Carolina at Chapel Hill (UNC-CH)** has decades-long relationships with academic, public health, correctional, and community organizations in Wake County, including **Wake County Human Services (WCHS)**.



- Wake County, North Carolina
  - 860 square miles
  - Includes urban (Raleigh), semi-urban and rural areas
  - City of Raleigh is the center of the state government & county seat
  - ~1,025,000 residents
  - Population is forecasted to maintain substantial growth of ~25,000 new residents per year for the next few decades

UNC-CH & WCHS

- **HIV in North Carolina, 2017:**
  - 20-29 year-olds comprised 41.0% of the newly diagnosed population
  - 70.5% of all diagnoses are aged 40 and above
  - Black/African Americans represented 64.8% of all adult & adolescent infections (45.5 per 100,000)
  - Highest prevalence (78.0 per 100,000) among adult & adolescent Black/African American men
  - Reported transmission routes among newly diagnosed:
    - Men and transgender women who have sex with men (MSM) (64.5%)
    - Heterosexual sex (29.8%)
    - Injection drug use (IDU) (3.4%)
    - Both MSM & IDU (2.4%)

HIV/AIDS Statistics	North Carolina	Wake County
HIV diagnoses	35,045	3,818
Newly diagnosed HIV infections	1,310	132
Avg. rate of new HIV diagnoses: 2014-2016 (per 100,000)	15.8	16.7
AIDS diagnoses	15,999	1,778
Newly diagnosed AIDS cases	597	68
Avg. rate of new AIDS diagnoses: 2014-2016 (per 100,000)	7.5	7.7

11%

10%

11%

11%

Data Source: North Carolina HIV/STD/Hepatitis Surveillance Unit. (2018). 2017 North Carolina HIV/STD/Hepatitis Surveillance Report. North Carolina Department of Health and Human Services, Division of Public Health, Communicable Disease Branch. Raleigh, North Carolina.

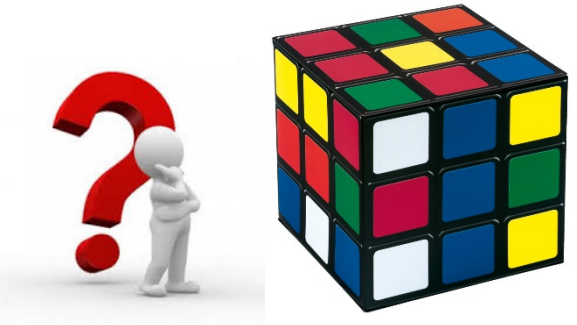
UNC-CH & WCHS

- **Local TCC implementation highlights**
  - » UNC-CH subcontracts with WCHS to provide TCC intervention staff
  - » As county employees, TCC staff have easier access to the jail facilities
  - » There is a high degree of support and buy-in from the local jail system and Jail Health Services Administrator
  - » HIV primary care is provided to detainees at clinic locations outside of jail facilities
    - Majority of HIV-positive detainees receive their care at the WCHS HIV clinic staffed by UNC providers

UNC-CH & WCHS

- Successes
  - » Gained TCC staff access into both Wake County jail detention facilities
  - » Increased access to HIV medications for detainees and recently released
  - » High acceptance rate of TCC services
  - » Smoothly transitioning several clients to long-term case management on-site at Under One Roof
  - » Establishing working relationships with local court system (e.g. public defenders & district attorneys)
  - » Facilitated introduction of WCHS Hepatitis C Bridge Counselors into jail detention facilities

UNC-CH & WCHS



- Challenges
  - » Collaboration with organizations sometimes means navigating through the different priorities and goals
  - » Impediments to smooth medication and care access include frequent Ryan White eligibility renewals and lack of Medicaid expansion in NC
  - » Specific to detained populations:
    - High Wake County Sheriff's Office and other key staff turnover
    - Logistical challenges related to appointment scheduling, especially with healthcare providers outside the WCHS
    - Contact information post-release often changes or is nonexistent

UNC-CH & WCHS

- Lessons Learned
  - » Communication is key
    - Promote connections between intervention team, correctional staff, correctional and community medical providers, and other community partners.
  - » Staff self-care is important
    - Protect administrative time
    - Promote self-care and avoid burnout
  - » Prior correctional experience is beneficial
    - Allows TCC staff to navigate the system and train new team members
  - » Cultivate collaboration
    - Partnerships between private/academic entities and state and county-level public health and correctional infrastructure promotes shared commitment to improving the health of persons living with HIV involved in the correctional system

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  - Jacqueline Cruzado
- Southern Nevada Health District (Las Vegas, NV)
- Cooper Health System (Camden, NJ)

Southern Nevada Health District

Site Highlights

Southern Nevada Health District (Las Vegas, NV)

- Long-standing relationship with the county correctional system, SNHD provides epi surveillance.
- High degree of support for integration of the intervention into the jail system and for sustaining it past the conclusion of this funding.
- Working collaboratively with the jail on concrete changes to support client re-engagement in care.
- HIV primary care is provided at the jail through a private medical contractor.

Southern Nevada Health District

Successes

- Unescorted access throughout jail allowing staff to easily connect with clients while incarcerated
- Expansion of resources to locate homeless clients, including use of a homeless management information system, field visits, social media, outreach organizations, parole and probation, etc.
- Integration of this project into overall workflow at health district's RW clinic and pharmacy
- Providing health liaison services in the court system– ability to attend court, refer clients to alternatives to incarceration, and request reduced sentencing due to participation in this project

Southern Nevada Health District

Challenges

- Turnover among correctional leadership staff
- Geographical distance between correctional facility and health district creates transportation barrier for clients
- Severe lack of community resources for clients, specifically affordable housing and substance use and mental health treatment, leading to recidivism
- High proportion of unsheltered homeless population living in parks, tunnels, desert, etc. leads to difficulties locating clients

Southern Nevada Health District

Lessons Learned

- Build a team that understands and fits-in with the culture among correctional officers and staff
- Build connections
  - Market the project to as many stakeholders as possible (within law enforcement, corrections, court system, community partners, etc.)
- Use harm reduction principles
  - Meet a client where they're at, not where you expect them to be and withhold judgements

Implementation Results

Pre-Implementation Lessons Learned:

Facilitators of successful implementation:

- Strong leadership from clinic administration and supervisors
- Existing collaborative relationships with the jails
- Proactive and engaged staff that have existing relationships with the jails

Barriers to implementation:

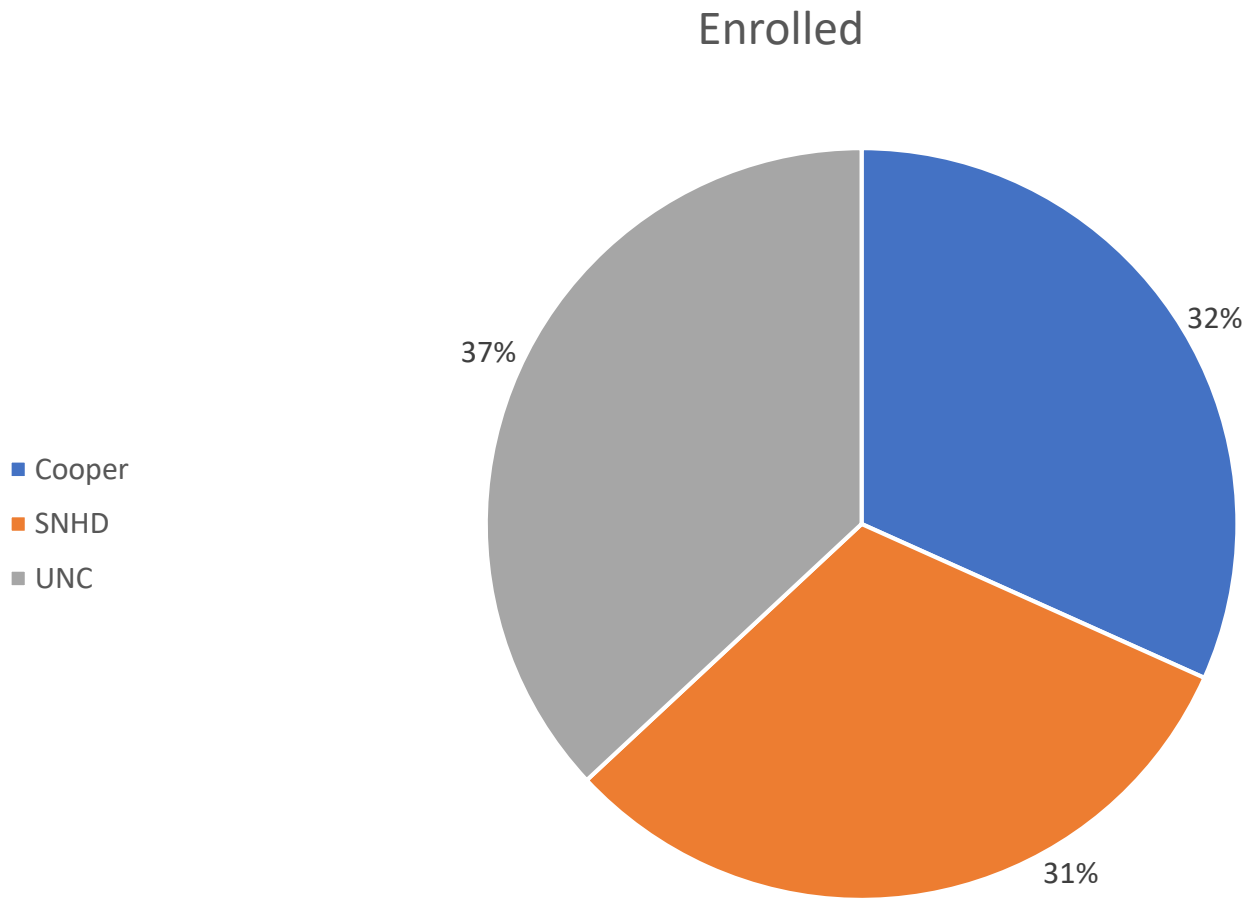
- Lack of leadership
- Policies specific to each jail setting (for example, people being released from the jail in the middle of the night)

Implementation Lessons Learned:

- Sites with strong implementation teams and strong leadership have been able to smoothly weather staff turnover/transitions.
- The intervention requires constant tending to the relationship with the jail (admin, medical, and officers). Staff turnover within the jail setting can impact intervention staff.
- Adaptations have been necessary to “fit” the model into each setting.
- Post release challenges are many and addressing them is key to retaining clients in HIV care. Challenges include: homelessness/unstable housing, mental health disorders, substance use disorders, transportation, and ongoing engagement with the criminal justice system.

Client Data Results

TCC Clients Enrolled (N=268)



Client Characteristics (N=268)

Demographics	N (%)
Gender: Male	230 (86%)
Gender: Female	31 (11%)
Gender: Transgender	7 (3%)
Age	40 years (SD= 10.8) Range: 19 – 64 years

Client Characteristics (N=268)

Demographics	N (%)
Race: Black/African American	168 (63%)
Race: White	99 (37%)
Ethnicity: Hispanic/Latino/Spanish origin	29 (11%)

Client Characteristics (N=268)

Demographics: Insurance	N (%)
Medicaid	136 (51%)
Medicare	20 (8%)
None	80 (30%)

Top Needs at Baseline

Reported Needs at Baseline	N (%)
Transportation Assistance	192 (19%)
Housing Assistance	187 (19%)
Assistance with Benefits	152 (15%)

Top Reported Encounters

Transitional Care Coordination

- Relationship building
- Discuss medical appointments with clients
- Provide appointment reminders
- Follow-up with provider to discuss client
- Finding clients and conducting outreach

Resources & Next Steps

DEII Available Resources

https://nextlevel.targethiv.org/

- Intervention Summary
  - Literature
  - Theoretical Basis
  - Components and Activities
  - Staffing Requirements
  - Programmatic Requirements
  - Cost

DISSEMINATION OF
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INTERVENTIONS

DEII Resources Available for Download

https://nextlevel.targethiv.org/

PDF versions of:

- Intervention Summary
- Intervention Manual
- TA Agenda
- Training Manuals

DISSEMINATION OF
EVIDENCE-INFORMED
INTERVENTIONS

Looking Ahead: Care and Treatment Interventions (CATIs)

- Continue monitoring implementation at sites and multi-site outcomes evaluation through June 2019
- Analyze data and summarize patient outcome and implementation findings
- Update adapted interventions
- Release final interventions as CATIs (2020)