



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

# SPNS IHIP Webinar

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## Transcript

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**Please stand by for real time captions.**

**>>Please stand by. The conference will begin shortly.**

**>> [Operator instructions]**

**>> Thank you so much everyone. My name is Sarah Cook-Raymond and I will be helping moderate today's Improving Health Outcomes, Moving Patients Along the HIV Care Continuum and Beyond, the first in a three-part webinar series brought to you by the HRSA Special Projects of National Significance. A few housekeeping rules. Right now we have a quick survey on the screen. If you have not taken a look at the survey or answered it, please do so now. As the operator said the phones are in listen-only mode. We will take questions and answers. We will hold those and answer those at the end of the full webinar presentation. However, there is a chat box that is open at the left of your screen. Should questions or ideas arise during the presentation, you're more than welcome to submit them via that chat box and we will address those questions during the end of the main Q&A session.**

**>> At this moment we will just give a few more seconds for you to finish the poll and then we will take them off the screen and get started.**

**>> Melinda I think we are ready to take them off the screen.**

**>> Here is a quick agenda. First of all, as far as audio, there are two ways to be listening to this webinar. We have the dial-in information here in the chat box with both the dial information and the passcode. You can also enable the audio on your computer screen and you should be able to listen through your computer speakers as well.**

**>> Today's agenda. We will be providing a brief overview about Special Projects of National Significance. We've brought here today two special speakers. We have Jacob Dougherty from the Wisconsin Department of Health AIDS/HIV program, and in particular he will be presenting on the social networks testing intervention. We will also hear from Ann Avery from Care Alliance Health Center and she will be presenting on their ATLAS Jail Linkage intervention. Following that, we will have a question and answer and then a brief --no more than one minute-- feedback survey to find out how you enjoyed the webinar and how we can make improvements for future webinars.**

**>> A quick overview, SPNS reflects changes in the overall HIV epidemic as well as the health care landscape at large. It aligns with a number of national HIV policy strategies; changes in the healthcare environment; and its core focus is on funding and researching the replicable and sustainable care models. In particular, the SPNS program advances the HIV care continuum to include all stages of the care continuum from diagnosing and linking individuals into care all the way to viral suppression and beyond. This webinar is part of a**

three-part series followed by forthcoming technical assistance resources that focuses on a plethora of different interventions that in fact focus in on different specific care continuum intervention steps and how we can together as providers in the health care community at large advance people living with HIV along the continuum.

>> IHIP integrating HIV innovative practices came about in terms of trying to address a challenge that the SPNS program had. In particular, SPNS is funding great models of care and lessons learned were coming out of these four to five-year intervention projects but were often times being housed in peer-reviewed journal articles without sort of broader national dissemination and updates. The solution was the IHIP project whose core goal is to synthesize findings across interventions and across programs and try to provide easy to pick up technical assistance implementation manuals, curricula, pocket guides and technical assistance webinar series to ensure that organizations and providers know what the capacity resources and strategies are necessary to replicate these interventions. And can do so at whatever scale is most applicable to their practices.

Altogether IHIP creates a more informed provider network, a stronger workforce, and ultimately a core goal is healthier patients. And as I stated earlier, it also advances the number of federal priorities and strategies.

>> IHIP at-large produces implementation tools and resources. Each tool and resource focuses in on an evidence informed SPNS intervention as well as specific grantee interventions. We'll hear from two of them today. It focuses on national dissemination and also measuring the uptake and dissemination of these evidence informed

interventions and provides for that rebuilding assistance among healthcare providers.

>> Where can you find IHIP resources-- both existing ones and forthcoming ones? That would be the TARGET center. Which is the Ryan White technical assistance clearinghouse. And that is at [Careacttarget.org/ihip](http://Careacttarget.org/ihip). There you can find both a further overview of IHIP as well as previous IHIP interventions and technical assistance materials. from jail linkage to oral health to opioid treatment, engaging hard to reach populations, and more.

>> Here is a further list of currently available IHIP resources on the TARGET center. Following our three-part webinar series, you will also find HIV Care Continuum Technical Assistance resources.

>> Without further delay I would like to hand things over to Jacob Dougherty from the Wisconsin Division of Public Health who will be talking to us today about their social networks testing and SPNS intervention.

>> Hello. I'm getting a bit of an echo on my phone. I hope that is not going to cause a challenge. I'm having a hard time here so I apologize in advance. Other presenters please mute your lines.

>> Okay. I'm going to go forward. So thank you for that introduction. I'm going to talk about the testing program that the State of Wisconsin implemented with our partners in the community.

>> The presentation I will be giving will start out with a brief overview of the project. I will talk about capacity for project implementation, our successes and challenges, lessons learned, and sustainability.

**>>A brief overview of Wisconsin Department of Health Services AIDS/HIV program. We support several local public health offices and community-based organizations to conduct HIV CTR which is HIV Counseling, Testing and Referral (CTR). The department has supported a social networks testing model at our agency since 2008.**

**>> We are funded as a demonstration project under a HRSA announcement, System Linkages. There were two components to our project. The first was expanding and standardizing social networks testing. The second was using linkage to care specialists with clients to abstain and engage in medical care. The project began in 2013.**

**>> In terms of our capacity for implementation, the Wisconsin AIDS/HIV program contracts with sites to deliver these social networks testing services to populations at highest risk for HIV infection. And the goal is to provide access to testing for persons with undiagnosed HIV infection who may not access testing through other venues. It's a peer driven community-based recruitment strategy. So basically the model is that we have recruiters who are identified by HIV testing counselors at our agencies who then work with those counselors through an orientation and coaching process to identify individuals who are in a target population who would benefit from the HIV testing and linkage to other services.**

**>> The recruiters were limited to 20 individuals to bring into the agency and many of them brought in fewer than that. Both the recruiters and the individuals they brought in were known as Network Associates and were incentivized for their efforts.**

**>> We developed a protocol to standardize social network's testing across the funded agencies. And this protocol was delivered to all**

agencies funded. We trained the protocol in person at a grantee meeting that included all of the agencies that were going to be participating in the program. And we also held regular calls -- conference calls with the agencies participating.

>> The responsibilities of the agencies are laid out in the protocol. The first responsibility is to integrate social networks testing into their current services, promote the program, identify key staff, identify the target population and identify participant incentives. There are tools that correspond to each of these responsibilities in the appendices of the protocol that we developed. The next highlight of the protocol is the implementation process. There are five phases of implementation of the social network testing protocol. The first phase is recruiter enlistment and that is the process that the HIV testing agency and counselor goes through to identify individual that they have worked with or that they are in contact with through regular HIV testing that would make a good recruiter. We provided them with some training and advice on the characteristics of a good recruiter.

>> Recruiter engagement is the process of actually working with a recruiter after they've been identified and indicate that they are interested in helping with the program; to give them an orientation to the program; and to help them through coaching; and to understand and offer technical assistance for them as they are working to actually identify their network associates that they could bring in for testing.

>> The next phase is the recruitment of network associates. This is when the recruiter actually goes out and talks to the individuals that they've identified that they believe would benefit from HIV testing. The agencies actually gave out cards to the recruiters. So that when a

network associate would come in they could also hand that card in to the HIV test counselors so they knew that this was a person who was brought in by a specific recruiter.

>> The next phase is the counseling, testing, and referral phase for network associates. And that is when the network associate was actually tested for HIV and if the individual tests positive, they were connected back to the linkage to care specialist. Which was the other major piece of our SPNS initiative.

>> We initially contracted with 11 agencies around the state to conduct the social networks testing alongside their regular HIV testing. So six of those agencies were in Milwaukee, which is the city in Wisconsin that has the highest prevalence of HIV. Two of the agencies were in south central Wisconsin. And then three agencies were in northern and western Wisconsin. Some of those were actually at various locations of the AIDS Resource Center of Wisconsin which has locations throughout the state. Each agency was tasked with identifying their own target population. And that was actually part of an implementation plan that each agency was asked to complete.

>> Data collection was very important for this program. So we had data on both HIV testing through the regular CTR program and the social networking testing HIV task. They were all reported in the evaluation lab, which is the web-based secure reporting system for HIV testing data supported by the CDC. We used evaluation web reporting tools to track outcomes of both testing programs and compare the differences between the two. We actually set up evaluation web so that a recruiter was designated as such in

**evaluation web and then network associates that were tested could be linked to that individual recruiter.**

**>> We were able to do this because at the time Wisconsin was using a Wisconsin specific version of evaluation web not the overall national CDC version.**

**>> Some of the successes of the implementation of the strategy. We increased the number of agencies that were trained to perform the strategy. And we definitely reached higher risk populations with testing services. Most of the agencies identified target populations that were at the highest risk for HIV. And worked very well with the recruiters to target members of the specific population.**

**>> Some of the challenges related to the implementation of the program. First was agency buy-in. So we had many agencies involved with this process. And some of them didn't necessarily buy into the strategy from the beginning. The use of incentives to recruit, incentives are kind of a double edge sword. On the one hand they do work in bringing individuals in for testing. But on the other hand agencies can become reliant on incentives to actually use as their main tool to recruit individuals for testing.**

**>> There was a limited service area and a saturation of services both at the same time. So as I said before, several of the agencies that we were working with were in Milwaukee because that is where the highest prevalence of HIV is in the state. Unfortunately, when you have that many agencies offering a strategy, several recruiters would go to multiple agencies and work with multiple agencies simply because the service area was not that large.**

**>> Staff skills and turnover. So some of the staff that were the main point people on the social networks testing strategy perhaps weren't doing the coaching that we had expected them to do when working with recruiters and we also encountered a bit of turnover within the agencies that were working on the project.**

**>> A couple of lessons learned from our implementation of the strategy. First of all, it's very important to conduct on-site visits with participating agencies early in the implementation to ensure that the protocol is understood and implemented properly. We did have that face to face meeting where we went through the protocol but I think it would've also help to have had on-site visits with those agencies early in the process. And that could have also helped get more agency buy-in into the process.**

**>> Providing technical assistance to agencies that were not meeting their goal early on. So we were able to track outcomes using evaluation web in terms of the number of recruiters identified and also the number of HIV tests done on network associates. And when we saw that goals were not being met early on, it was an opportunity to provide technical assistance that wasn't necessarily taken with all of those agencies right away.**

**>> Obtaining community and peer buy-in before implementing the strategy. So we did present the strategy to the agencies but the agencies didn't necessarily get the peer and community buy-in that this was a strategy that would really help the community.**

**>> Some more lessons learned. Monetary incentives. I think it's important to really think critically about whether or not those monetary incentives are actually necessary. And if you decide they are**

necessary when you think about implementing social networks testing, think about the amount that should be consistent about across all of the agencies to reduce competition. So it really should be the exact same incentive being offered for every agency that is actually implementing the strategy, rather than allowing different agencies to choose different types of incentives.

>> Do not implement the strategy at all of your HIV testing sites but rather select a limited number of agencies that have established and trusted relationships with target populations. At the state health department level, you are probably in a unique position to know which agencies you are working with are really good at targeting and recruiting for HIV testing in high-risk communities. And it gives you an opportunity to think about which agencies you should work with on maybe a social network strategy that specifically targets a high-risk community.

>> Also defining the service area clearly to reduce competition. So if you have one or two agencies that you're going to work with, help them to find what service area they are going to work in. Look at very specific ZIP Codes. Or look at specific sites that they will be doing outreach to for recruiters. And that they can help the recruiters work within those same defined service areas.

>> Another lesson learned is using the social networks testing strategy as one strategy among several. It usually works best if it is used in conjunction with other HIV testing recruitment strategies such as Internet outreach. And it shouldn't be the sole recruitment strategy for an agency. So social networks testing is great, but it's definitely not the only strategy out there for recruitment for HIV testing. And

agencies tend to be more successful when they use it as one piece of a larger overall strategy for targeting and recruitment.

>> In terms of sustainability. As many of you probably know the social networks testing strategy has been used by many publicly funding sites for many years. And will continue to be used at those sites. It's a strategy that is strong evidence-based and is effective when used properly with a mix of other strategies. And the SPNS demonstration project allowed us to learn valuable lessons and how best to help implement the strategies for the future within our own agencies.

>> So that's my contact info. And we've also written a manual as part of our project about the social network strategy along with the linkage to care strategy project as well. There are manuals out there for both of those projects.

>> Great. Thank you so much Jacob. Now we will turn things over to Ann Avery over at Care Alliance Health Center to tell us about the ATLAS Jail linkage program.

>> Thanks Sarah. Thanks everyone for joining the webinar and Jacob that was a great presentation. We will definitely change gears a little bit as our project is very local and was focused in retention in care and engagement in care for patients mostly for individuals living with HIV that were already diagnosed. We did do some testing but the focus of today's presentation is going to be more on the linkage piece. The program that we developed is called ATLAS. ATLAS stands for Assess, Test, Link, Achieve Success. First I'll talk a little bit about the project itself, go over the capacity and needs, our successes and challenges, and then staffing models, lessons learned and sustainability. Care Alliance was the group that had the ATLAS grant. I actually worked for

a different group and I worked on the ATLAS grant as a PI. Care Alliance is a Federally Qualified Health Center located in Cleveland, Ohio, and it's just down the road from the county jail. The focus of Care Alliance is on outreach to homeless populations as well as public housing -- primarily uninsured or underinsured-- and they have a very robust Part C program that was the focus of our SPNS project leveraging the Part C resources to go into the jail. It has primary medical and dental care on-site. There are actually three sites that offer this service. The picture in the slide you see is the main one right down the road from the jail.

>> It's important to think about why we care about the jails and what is going on. So, nationwide, HIV is very common in the incarcerated setting. I know this data is a little bit old but the statistics remain the same – that over 1% of the prison population is felt to be HIV-positive. Locally in Ohio, it was almost 1% when we looked at it in 2008. But, nonetheless it was still significant. The thing is that, in the jails it is a little different and it is very hard to track the exact numbers as there are not the formal tracking systems that the prisons have and more importantly the population in the jail is very fluid. We noticed that people were coming in and out of the jail multiple times in a year and often for the same charge.

>> The state did a needs assessment in 2009 and the jails reported anywhere from 0 to 174 HIV-positive inmates in that prior year. The county jail for Cuyahoga County is the jail for the greater Cleveland area, and it housed anywhere – usually it has about 20 inmates which is about 1% of our jail population. They had a general census as of 2,000 inmates on a daily basis.

**>> For those of you who are a little less familiar with the difference between a jail and a prison, I think it's important to take a moment and think about that. Jails in general hold people while they are awaiting trial or sentencing. You get charged and booked and you go to jail. Yet you can stay in jail. Some jails will hold people for months, up to a year. Others house them even longer than that. In general prisons are where sentenced individuals go off and spend a longer period of time. It tends to be also -- prisons tend to hold people for more serious crimes.**

**>> The jails are operated locally. So, in our area, we have the county jail, a city jail, and then multiple small jurisdictions have jails as well and they might just have one or two cells. And then another one might have 30, and another one might have 2000. There is a huge variety in flavor of jails. The average length of stay in a jail is 21 days nationally. But if you talk to the jail staff of the local jail, they will probably tell you it's more like 24 to 48 hours. There are very long jail stays occasionally but there are very frequent short jail stays where people get booked and released very quickly.**

**>> Again, the most significant difference for us with prisons is that inmates are there for a longer period of time but, more importantly, we know when they are released. So that release date is known and it might change if someone has say a reduction in sentence, but then there would be a new posted stated release date. In jail that generally doesn't happen. So knowing when there is a release date offers the opportunity for discharge planning and securing appointments for individuals. At least in Ohio, and I know in other states, there are focused programs for HIV patients to be able to have discharge**

planning services leaving prison. That does not exist in the majority of jails.

>> So the SPNS grant that we had was back in 2007 and lasted through 2012. It was the Enhancing Linkages to HIV Primary Care and Services in Jail Settings initiative. There were 10 sites total and had local and multi-site evaluations similar to other SPNS projects.

>> As I mentioned, our program had four components. That includes testing, HIV prevention, prevention for positive, and Linkage case management. And we also did community follow-up although that was for evaluation purposes.

>> The HIV testing that we did was voluntary rapid testing so it was an opt-in testing project. That was based on space capacity and willingness of the jail to have another type of option, like opt-out testing.

>> We offered prevention education sessions where we had weekly education sessions to try and engage the inmates, regardless of their HIV status, to know more about STIs, hepatitis, tuberculosis. And then we also offered individual risk reduction counseling for individuals with recognized high risk behavior, either HIV-positive or HIV-negative. And we used the AST screen curriculum for that. The linkage case management is the core of the program and that offered jail-based case management. And we also did community follow-up that was primarily for data collection and interviewing for follow-up and outcomes.

>> The linkage case management model we had case managers, they were not social workers, although ideally a social worker could

provide the service. They used a strengths-based curriculum or strengths-based focus. Identifying the strengths of the individual and focusing on those strengths to get them what they needed and identify the challenges they had with resources, be it housing, medication, insurance, or even adherence.

>> The linkage case managers had a wide variety of community collaboration which was essential for the success of the program. They had to collaborate with the jail staff, with community medical as well as social service providers, and our local planning councils. And, in fact, our case managers went to our medical case manager monthly meeting -- network meeting-- to make sure that they had the ability to reach out to the case managers and ensure continuity of care and referrals. It also offered an opportunity for those community-based case managers to know that their client was safe and off the streets and where they were. Remember some of these individuals can be some of the most challenging to care for, especially when they don't show up for visits and can't be reached by phone or even in person outreach.

>> So finding out that your client is in jail might be a relief for some of the case managers.

>> They also provided intensive, and time focus services.

>> From a capacity and needs perspective to do this project and to replicate it, I think the most important thing is to get it buy-in from administration at the jail as well as the organization that you are coming from to bring in the service, presumably if you are an outside agency. If you're an internal agency and the jail just wants to replicate

that, then you would still need to identify buy-in from community partners.

>> The jails have both medical and correctional administration. So it's important to have buy-in from both. So we actually had to meet with the sheriff and the warden as well as the director of medical services to be able to have permission to come into the jail and provide services. Once we had this buy-in, that allowed us the ability to have space to meet with clients. Then our case managers had permission to walk throughout the jail during certain times, and that allowed them to go up to the areas, like the pod area where the inmate was residing, ask the correction officer to send that person out and they would be able to meet in a semi private area to have a conversation and review whatever the needs were of that client.

>> We had to make sure that our staff could enter the jail. And that is not necessarily available for everyone. So individuals that have a prior record may not be allowed to enter the jail. And at the same time finding an individual who is interested in working with the jail population may also be challenging so the capacity for staff that can enter and want to be in the jail. And then as I mentioned a few times already, connections to community resources is essential because patients are going in and out of jail and they are going to need resources in the community.

>> The successes that we like to share with everyone is that we really had excellent success in getting people reconnected to care. With over 80% of our clients—and in fact that is fairly similar across the other SPNS sites--in the immediate follow-up time, and that would be within the first six months following release from the jail. Our

**Community Ryan White providers also thought the program was successful because they really enjoyed a greater awareness and connectedness to clients. This leveraged their ability to help the client get to a better place and stay in care. Our HIV testing program had the success of identifying both new and previously diagnosed individuals, which is an important thing to consider. When we started testing, we were somewhat surprised, although we learned from some of our other SPNS collaborators that this is not uncommon, that by offering HIV testing, individuals who were not comfortable sharing their status with the jail staff at intake were willing to get tested and then share their status in a more confidential way. And then continue or resume care while in jail. So I would encourage groups to have HIV testing available if you are working with the jail.**

**>> And then finally, the correctional staff clearly had an improved knowledge of HIV. There were numerous opportunities for casual one-on-one conversations with staff, but also more formal trainings that both the correctional staff and the medical staff took advantage of. And I think that is very important because in the jail more than anywhere else, the risk of discrimination and loss of confidentiality is very important and the stakes are high. So having everyone have a greater awareness and cultural competency is important.**

**>> Some of the challenges that we experienced were the longer-term retention in care rates following the jail-based intervention were much lower and we definitely have some ideas and needs for other ideas for additional strategies.**

**>> We were very surprised about how often people were reincarcerated, which made for a challenge with evaluation. So when**

someone came in for their initial charge it was not uncommon for them to be released, potentially on bond or bail, or make bail, and then come back in for the same charge.

>> Additionally, once people have charges they tend to come in because they missed a visit with the probation officer or have a dirty urine or some other minor infraction that violates their probation and gets them back in. So the recidivism was quite frequent.

>> We were also surprised at how many clients actually went to prison, so we did not have the ability to follow our work with them because they had a longer stay and went to a different facility.

>> The case managers and the clients had the ongoing challenge that many programs experience of linking patients to community-based mental health and substance use programs. At that time our capacity in the community for both mental health and substance abuse services was limited. We have improved access to both of them since then but one of the barriers is that patients -- our staff was not able to make appointments for clients. The organizations would require that people have walk in and requested the services on their own.

>> I think in a better model it would allow for scheduled appointments like we do for medical care.

>> And then the challenge with HIV testing. It was the opt-in model, it certainly limits the success of testing and the sustainability as well as a process model that would be -- HIV testing that was done by the medical staff at intake would be a better model to ensure everyone is tested.

**>> For the staffing model. We had the luxury with the SPNS funding to have full-time case management. But after doing this with our volumes of about 20 clients at any one time, I think this could be done by a part-time staff, it could be a medical case manager, community-based Case managers as part of their responsibility. But if that is the case then that staff member should be in the jail at least three times a week. Any less frequent would make it somewhat ineffective and only touch the people who work there for the longest amount of time.**

**>> I think certainly the volume of clients in the jail would determine how frequently someone needs to be there.**

**>> Making sure that the staff is culturally competent to be based in the jail is essential. The jail is a different world. It is very different than anything we have in our medical community or when someone is living out in the community. So being able to understand the way the jail works and work with the jail and not against the jail is important.**

**>> I already mentioned the HIV testing.**

**>> The key lesson we learned was flexibility. The jail is a different house. It is not our house. And so we were really in the warden's house or the sheriff's house and for the jail, safety is the primary concern. That meant that usual items were not often allowed. For education sessions we are able to bring in papers for the inmates to take back to their cells but we were not allowed to have paper clips or staples on those papers.**

**>> We were allowed to have pencils but not pens because the pens could be taken apart and used as a weapon. But the pencils we needed to account for each of those if we brought them into the**

education session. They weren't allowed to take them back with them.

>> We weren't allowed to bring cell phones in. We were able to get a computer in our office and actually able to use the jail's Internet. But you do have limited access often when you are in a limited setting or in a correctional setting.

>> We had to be flexible when we met with inmates because regularly the movement of inmates is limited -- either for their meals or counts. Or if there is an episode where they have to lockdown and maybe someone has gotten in a fight. And at that point in time there is no ability to contact an inmate and it really makes it challenging to be in the jail.

>> And then finally we had to work on strategies in order to maintain privacy and confidentiality. Because the jail does not have a lot of privacy and confidentiality. You don't walk into a private room and shut the door and have a conversation with your client. We would bring them out into an open common area that was fairly noisy. That noise offered some confidentiality. We had to sit with the client at an open picnic bench style setting. At the same time, we also had to -- we had to make sure that the correctional officers didn't really know what we were talking to the inmates about. We wanted to make sure their HIV status was not the reason that people thought we were talking to them. So, discharge planning and being with a federally qualified health center that offers primary care and other services was helpful as a broader reason for us to contact patients. And then bringing in additional services that were not only focused on HIV

patients also added to that privacy and confidentiality, or added to our ability to have privacy and confidentiality.

>> From the sustainability perspective, we were fortunate to work with our local Ryan White Part A funders to sustain some of the jail-based services. We also had conversations with our local foundations and there were some opportunities there, given the success we had with people getting linked into care. And as we are moving forward into the ACO model of care where healthcare institutions in some ways are responsible for long-term outcomes, the care providers may be more interested in sustaining this type of service. Finally, we may see more funding streams that pay for case management available again as we move forward with ACO -- accountable care and outcome based care.

>> So in summary, hopefully you will agree with me now, that jails offer a unique opportunity to identify patients with HIV as well as individuals who are at risk for HIV or HIV positive and have been out of care.

>> I think the jail offers a great location for comprehensive HIV services from prevention, to identification and engagement in care and it is feasible to provide them in jail. Hopefully including the jail as part of the routine HIV care continuum can be made possible in your jurisdiction.

>> Here are some resources. Similarly to Jacob, we had a couple of manuals made and some white papers made and those are available on the TARGET website. My contact information is on the final slide. I will be turning it back over to Sarah.

**>> Thank you so much Ann. What I think is so fantastic about the interventions that Ann and Jacob covered is that prior to the SPNS jail linkage work, so much research around interventions focusing on individuals in correctional settings and coming out of correctional settings have been focused exclusively on prisons. So in the SPNS initiative it really was the first of its kind to delve in and reassess processes for linking individuals to community resources coming out of the jail setting. And as Jacob explained, social network testing they were adamant to add that connection to a linkage to care specialist. They were not only identifying individuals who were HIV positive but there was an active linkage to care and treatment thereafter.**

**>> One quick note before I will open up for questions and answers. Mark your calendars and save the dates with two more webinars coming up in this webinar series. The next one on September 7 at 2:00 PM. Following that on September 15 at 2:00 PM at this same webinar link. We will also be sending me out announcements as we get a little closer to the date. Shortly thereafter we will be releasing an HIV care continuum implementation manual, case studies, pocket guides, and other resources. Now I'll ask the operator to open up the lines for questions and answers. After we hear from folks via the phones, if any questions come in through the chat we will also open that up. Just a few things that we will leave on the screen: We have a capacity building assistance help desk for any questions that may arise after today's webinar that can be submitted to. We also have a dedicated IHIP listserv to receive the latest news and announcements about IHIP resources and webinar trainings both in this series and future series. And then, the dedicated page to access IHIP technical assistance**

resources and including today's archived webinar that we are recording. Operator can you please open the line for any questions?

>> [Operator instructions]

>> At this moment I am showing no questions in the queue.

>> Okay. I have a couple questions. Jacob can you tell us a little bit about why it was so important to add on that linkage to care specialist component of your social networks testing intervention to ensure that people after diagnosis got effectively linked into care? And just a quick overview of what that step looks like?

>> Sure. So the linkage to care specialist was another initiative that we had implemented with some of the agencies that we partner with. And some of the linkage to care specialists had multiple agencies that they were working with. It was a very -- it wasn't an infinite thing. Like a case manager. It was a time-based intervention that allowed individual linkage to care specialist to work with someone who is newly identified positive to link them into care. To help them get to their appointments. To make sure they understood the whole process. And when an agency that we were partnering with would identify someone as positive, was newly identified as positive, they would know to contact the linkage to care specialist first. And that linkage to care specialist would then make an appointment to meet with that newly identified positive individual and help them get into care quickly.

>> I think the main point of it is to make sure that we don't lose people in that interim period after someone is initially identified as positive, and then waiting for them to get into care on their own. The

linkage to care specialist was important in helping to make that step go much smoother.

>> Wonderful. Thank you.

>> Ann can you tell us a little bit about the steps that it took to initiate HIV testing in the jail at the inception of this intervention? Because certainly some sites whether they are certainly working with a jail or are approaching a jail to try and implement a jail linkage program may not have rapid HIV testing or any HIV testing taking place and I know that your site was really effective in terms of making that happen and tying that into the broader case management and linkage activity that were part of enhanced link.

>> That's actually kind of a funny story because getting the lancets into jail is a little bit more challenging than getting it into the clinic. So we had already had an established outreach program through the Part C project or Part C grant -- that did Rapid HIV testing. I think there are two models in the jail that can be used for HIV testing just like in an outpatient clinic and they have different benefits and different challenges. With the rapid testing, which is what we use, the benefit is that the test is run right there on the spot and we were able to give individuals results within 20 minutes. The challenge is that it does take some time and a staff member to run the test. We did the finger stick, I can't remember which platform we used at that time, but we did the finger stick which meant we had to bring in lancets and we were dealing with blood. But another option certainly could be using the oral swabs which then have -- you avoid the use of blood. In order to bring HIV testing into the jail, again we needed buy-in from the jail staff, but that was an okay thing. There was some concern

from jail administration that we might open the floodgates and identify too many people with HIV that they couldn't afford to treat. And I would say the good news is that we didn't have that happen, which reassured them that they could sustain having testing occur. The jail didn't pay for the testing. Which was a benefit to them. So the inmates were getting a service without getting a charge and the jail was not getting a charge. And we did identify new positives it just wasn't every time a test was done. They were not all positive.

>> I think that's about it. Were there other questions you were thinking about that?

>> I have a question for both of you. Can you hear me?

>> Yes.

>> First of all I want to congratulate you both for your presentations. They were very good. Well received I hope. I want to ask you a little bit about the implementation of this interventions into actual practice from the point of view of the Department of Health. From the point of view of a community health center such as a Care Alliance Mental Health. If the Department of Health would like to provide some advice to community health centers that are interested in implementing this intervention, what are the things that you would have to consider? In a quick manner, so you don't have to go into the details. What does it take to replicate this or implement it on a wider scale with an organization that has more levels of organization? And that sort of thing? Thank you.

>> Sure. This is Jacob. I think the social networks testing strategy, luckily is a strategy that does have a lot of resources available to

support any community-based organization that is interested in implementing it. On top of the manual that we created, there are also -- there's also information about it on the CDC's website. The [effectiveinterventions.org](http://effectiveinterventions.org) website. And there are resources through the CRIS System for health departments that are funded through the CDC to request CBA technical assistance if they are interested in implementing the social networks testing strategy. A health department can look through all of those or any of those avenues to work with community agencies that might be a good fit for implementing the strategy.

>> And similarly for the jail intervention there are resources out there, especially to become more familiar with the jail. I think the first step in replicating the jail intervention is to reach out and contact the jail administration, as well as the jail medical administration. And one of the things that we found was that we were well received because we were offering to bring services in, and our jail really appreciated things being brought in that would benefit their clients.

>> I think many of us forget that the jail they are really correctional facilities. So the goal is not to punish the individual as it is to correct a behavior or correct a habit. Especially with our HIV patients that are in frequently for substance abuse issues, the ability to offer on an alternative is important. I think also talking to probation and the judges would be another way to get into the jail. And I think once you have interest and buy-in from those key stakeholders as long as an individual has the skills for case management and is comfortable in being in the jail, I think that it would be fairly straightforward to replicate providing case management services in the jail.

>> Thank you.

>> I see a question has come through in a chat. We have a question from David. Do you have the opportunity to use EIS, early intervention services, to locate patients who are linked to care then fell out of care? What did your consent look like that allowed for one organization to disclose name, address, and phone numbers to the EIS organization and to work to reengage those lost to follow-up into care? ample to share?

>>Ann I believe this is to you.

>> The latter question is easier to answer. We had a system-wide consent form that had been developed by our case management network that allowed for an individual to provide consent to share with any of our partner organizations that provided medical care or case management. And I think I can probably send you a copy of that if you want to send me an email. As far as using EIS services, at that time we didn't have EIS as a category funded by Part A, but we are currently using EIS Part A funding to sustain those services. And now we have a more robust outreach in both EIS outreach services to identify people who have fallen out of care.

>> You're welcome.

>> Are there any other questions, operator.

>> [Operator instructions]

>> I'm showing no questions in the queue.

>> Thank you. I would just like to direct attention to the note section in the upper left-hand corner again. The landing page for all IHIP

archived TA webinars as well as TA resources can be found at that link, [careacttarget.org/ihip](http://careacttarget.org/ihip). As I mentioned earlier there is currently technical assistance resources on the SPNS jail initiative on that web link and both Jacob's and Ann's specific interventions will be featured in forthcoming IHIP resources. Again, to join the IHIP listserv you can email me at [scook@impactmarketing.com](mailto:scook@impactmarketing.com) and you can also submit questions to our IHIP capacity building assistance web address. Again, that is, [ihiphelpdesk@mayatech.com](mailto:ihiphelpdesk@mayatech.com).

>> Lastly before you depart today if you could please click on this link and give us your feedback. It should take no more than just a minute. Thank you so much.

>> We will leave this link up for a couple more minutes to ensure folks can access the link for the survey. After which time we will then end today's webinar. Thank you everyone for participating. If you have any additional questions you think of after today's webinar, please do not hesitate to ask.

>> Within the next couple of weeks both the slide deck and the archived webinar recording will be available on the Target Center. If you would like to receive an announcement about that you can join our IHIP listserv. Thank you so much.

>> [Event concluded]