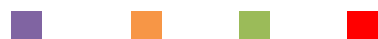# CARE COORDINATION
IMPLEMENTATION MANUAL

VIRGINIA DEPARTMENT OF HEALTH

SPECIAL PROJECTS OF NATIONAL SIGNIFICANCE

SYSTEMS LINKAGES AND ACCESS TO CARE INITIATIVE

OCTOBER 2015

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Background: System Linkages and the HIV Continuum

This manual offers insights on ways to implement state and local level efforts to revise systems of care to improve linkage, retention, and viral suppression under the HIV Care Continuum.

The concept called the continuum of engagement in HIV care emerged in 2004-2005 as a framework for defining the extent to which persons living with HIV (PLWH) are engaged in care. At one end of the spectrum are the undiagnosed, who are not in HIV care because they do not know their status. At the other end are those who are virally suppressed.[1] The value of the continuum in managing the HIV epidemic is compelling. PLWH who are fully engaged in care, fully adherent to antiretroviral therapy and achieve viral suppression, can manage their HIV infection as a chronic condition and simultaneously reduce the risk of transmitting the virus to others. The continuum concept was developed by the Health Resources and Services Administration (HRSA), an agency within the U.S. Department of Health and Human Services (HHS), as part of a national initiative to improve care engagement. This version has since been refined and is now called the HIV Care Continuum (HCC)[2] and is part of the National HIV/AIDS Strategy,[3] most recently updated in 2015.

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[1] Outreach: Engaging People In HIV Care. HRSA HIV/AIDS Bureau. 2006.

[2] HRSA, HIV Continuum of Care, 2010. http://hab.hrsa.gov/data/reports/continuumofcare/continuumabstract.html

[3] National HIV/AIDS Strategy. Available at: http://aids.gov

Virginia's SPNS Systems Initiative

Virginia's Systems Linkages and Access to Care Initiative focuses on the HIV Care Continuum by enhancing existing and establishing new collaborative relationships among Ryan White and other non-traditional HIV organizations. The overall goals are to increase the percentage of newly-diagnosed patients who engage in care within three months post-diagnosis, to increase the retention rate in care, and to develop a referral system maximizing funding and linkage resources while coordinating and streamlining patient services.

- **Linkage**. Increase the percentage of newly diagnosed HIV-positive patients in Virginia who link to HIV care within 90 days of diagnosis.

- **Referrals**. Develop a referral system maximizing funding and linkage resources while coordinating and streamlining patient services.

- **Retention**. Increase the percentage of HIV-positive patients in Virginia who remain in HIV care over a period of 12 and 24 months.

- **Viral Suppression**. Increase the percentage of HIV-positive patients in Virginia who have undetectable viral loads.

Strategies

VDH crafted four strategies to address the HCC and gaps identified in the HIV care system. While the end product of each intervention was a standardized protocol for linking and retaining patients in HIV care, implementation ranged in scope from statewide to regional, covering urban and rural sites, consistent with the epidemic's impact in the state. Strategies included:

- An Active Referral model under which Disease Intervention Specialists (DIS) staff and testing and referral agencies across the state worked to ensure patients were rapidly linked to care upon diagnosis. DIS staff accomplished this by working directly with referral sources as well as with the assistance of Patient Navigators where available (another strategy under this project) and medical providers.

- A Patient Navigation model was implemented in the Central and Southwest regions of the state to link and retain patients in the treatment process. Patient Navigators were hired through contracts with clinics to carry out linkage and retention activities.

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- A Care Coordination system was operationalized to enhance statewide linkages with the Virginia Department of Corrections to more effectively ensure HIV care and medication access for recently released HIV-positive inmates. Coordination work with local jails was also implemented in latter stages of the project.

- A Mental Health screening and referral system was implemented at a comprehensive service site with a focus on addressing the mental health barriers to linkage and retention in HIV care.

Table 1: Summary of SPNS Linkages Strategies in Virginia

Goal	Active Referral	Care Coordination	Mental Health	Patient Navigation
Educate persons at the time and/or after of their HIV diagnosis	🟥			🟩
Start HIV medical care shortly after a positive HIV test result	🟥	🟪		🟩
Support long-term retention in HIV medical care		🟪	🟧	🟩
Re-engage into HIV medical care persons if they have dropped out of care	🟥	🟪	🟧	🟩
Outcomes				
Linkage	🟥	🟪		🟩
Retention		🟪	🟧	🟩
Suppression		🟪	🟧	🟩

Guiding Implementation: Collaborative Learning Model

All four strategies of the SPNS Systems Linkages Initiative were implemented through robust collaboration among state, regional and local entities as well as internal collaboration within VDH units. Those efforts were guided by use of an innovative project design combining the Institute for Healthcare Improvement's Collaborative Learning Model to develop and pilot interventions with a more traditional approach to outcome evaluation in the analysis phase of the project. The Collaborative Learning Model is a systematic approach to health care quality improvement in which systems, organizations and providers implement and measure small-scale interventions, then share their experiences in an effort to accelerate learning and widespread implementation of successful ideas for change. The combination of these approaches allowed for continuous refinement of interventions and process and outcome evaluation to improve linkage, retention and viral suppression for PLWH.

Care Coordination Strategy

Purpose

The Care Coordination program at VDH was developed to ensure access to HIV/AIDS related medical care and medications for PLWH released from correctional facilities as they re-enter Virginia communities.

Target Population

In Virginia, in 2013, approximately 13,000 inmates were released from state and federal corrections facilities in the Commonwealth.[4] Prior to the Care Coordination intervention, less than 50% of HIV-positive offenders identified by the Virginia AIDS Drug Assistance Program (ADAP) released from prison picked up ADAP medications within 6 months of release. Justice-system involved individuals typically have many issues that create barriers to accessing medical care, including high rates of mental health challenges and substance abuse or dependence prior to incarceration. Care Coordination's initial focus was on those recently released from the state's 23 state DOC facilities. This built upon a program established between VDH and DOC in 2000, called the "Seamless Transition Program (STP)", which focused on providing medications to clients between release and linkage to their first HIV medical appointment. The target population was expanded to include clients released from local and regional jails, which proceeded on a facility-by-facility basis. Efforts continue to establish additional local and regional jail partners, with 11 participating at this time.

Summary of the Care Coordination Process

The Care Coordinator is based at VDH. However, at all points, the Care Coordination process is heavily collaborative, with the provision of referrals and linkages to care provided by key entities. These entities include contractors under an HIV Prevention-funded program Comprehensive HIV/AIDS Resources and Linkages for Inmates (CHARLI), Patient Navigators, local ADAP Coordinators, medical case managers, community health workers and/or other statewide community partners. Care Coordinators work

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[4] Bureau of Justice Statistics. National Prisoner Statistics Program, 2012–2013. In Table 9, http://www.bjs.gov/content/pub/pdf/p13.pdf

collaboratively with multiple agencies and programs, including VDH, Virginia ADAP, DOC, and the Virginia Commonwealth University Health System (VCUHS), which treats most HIV-positive DOC inmates while they are incarcerated. The process starts approximately three months prior to the inmate's release date. At this point, corrections medical staff complete the medical discharge summary, which includes basic inmate demographics, date of diagnosis, a current list of HIV medications, signed authorization to exchange and disclose health information, and other information regarding medical appointment after release (see attachments for these forms). This information is sent to the Care Coordinator via secure fax. Services are set up as follows:

- **Medication Access**. The provision of medications is upon release. DOC provides a 30-day supply while regional and local jails provide a 3-7 day supply dependent upon their available funding. An additional 30-day supply is dispensed by the AIDS Drug Assistance Program (ADAP) to a local health department or other ADAP medication distribution site, where the client is expected to go within 30 days of release. Simultaneously, the Care Coordinator works to set up longer-term medication access with Virginia ADAP (i.e., expedited enrollment) where medications are ordered from the Central Pharmacy. The pharmacy then sends medications to the local health department or other ADAP medication distribution site where the inmate plans to reside.

- **Medical Appointments**. Corrections staff schedule the first medical appointment for the recently released patient, to occur within 60 days of release, while the Care Coordinator confirms that the medical appointment was kept.

- **Linkages to Care**. Care Coordinators also facilitate access to community-based HIV medical care, support services and non-ADAP medications for HIV-positive patients within 60 days of release from a corrections facility. Care Coordinators schedule and confirm future medical appointments and also follow up with the local health department or ADAP medication distribution site to confirm that the patient is picking medications up for 12 months to ensure engagement in medical care, medication access, and linkage to support services. Care Coordinators connect the recently released to a case manager, Patient Navigator, or other advocate such as CHARLI workers located at community-based organizations across the state. Patients with additional needs after 12 months are referred to CHARLI.

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Care Coordination: Modifying Existing Systems

Area	Pre-Initiative Program	Implementation Period
Staff	Percentage of existing ADAP position monitored referrals from DOC	One full-time staff dedicated to Care Coordination, eventually expanding to two
Training/Program Marketing	Sporadic follow up with DOC nurse liaison	Regular meetings with DOC nurse liaison Inclusion of DOC in protocol development Facility-by-facility meetings with local jails Meeting with medical contractor staff for local jails
Linkages to Care	Passive referrals: received referrals from DOC for 30-day medication provision at local ADAP medication distribution sites	Actively seek referrals from DOC and local/regional jails
	No follow-up with clients	Contacts clients by telephone to follow up on missed medication pick-ups; contacts case managers by phone at least monthly to verify client information
	No referrals to support services or medical appointment coordination	Facilitates referrals to multiple services, including medical appointments

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Area	Pre-Initiative Program	Implementation Period
Linkages to Care (Continued)	No local or regional jail involvement	Recruits local/regional jails to participate in program
	No active data collection	Defines data collected, and database maintained in real-time
	Medication provision not consistent in jails prior to release	Partners provide 3-7 days of medications to clients upon release
	ADAP eligibility determination was initiated	Expedited ADAP eligibility occurs within 48 hours of referral
Retention	No follow-up with clients after release	Clients are followed for up to 12 months on average, with some specific cases followed for 18 months
Operational Framework	Procedure for referrals written as part of ADAP Manual	Specific Care Coordination protocol
	No specific linkages to other programs	Intentional collaboration with other referral and navigation services, including CHARLI and Patient Navigation

Implementation Insights

This manual is not an evaluation. Formal quantitative and qualitative evaluation of SPNS strategies is being conducted at VDH and across all SPNS Linkages sites through the national SPNS Evaluation and Technical Assistance Center at the University of California at San Francisco. Rather, this document has a related goal: to explore and present implementation insights that can help other projects as they seek to revise their HIV systems of care to better engage people in HIV care.

The manual presents the following implementation insights, which culminated in the development of a Care Coordination Protocol, crafted during the multi-year process of input and refinement.

- Up Front Planning

- Collaborative Framework

- Staffing

- Training

- Collaborative Activities

- Protocol Development

- Implement Care Coordination

- Sustainability and Program Integration

- Measuring Program Effectiveness

Each of these areas is described with a narrative overview followed by tangible implementation ideas, in the form of tips, task lists, and essential considerations that can guide others looking to implement a similar project.

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Implementation Insights at a Glance

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Up Front Planning

The SPNS Systems Linkages Initiative built upon existing VDH engagement in care activities. On the strategic planning level, this involved review and incorporation of insights from needs assessment and planning activities, particularly those under Ryan White legislative and policy directives. On the programmatic side, SPNS work was incorporated within existing transition services for incarcerated individuals soon to be released from facilities. These planning steps are described below.

■ *Review HIV/AIDS and Population-Specific Data*

Virginia's decision to revise its care engagement strategy was based on a review of epidemiologic data of PLWH. Virginia matched its data on engagement in care, following the outline as presented nationally by Gardner et al[5]. Among the diagnosed, approximately half were not retained in care. Additional data analysis presented information on those at different points along the care continuum, including those newly identified, the unaware, aware and not linked to care, and those not retained in care.

At the time a grant application was being developed to support the implementation of the SPNS Systems Linkages initiative, limited data regarding the incarcerated population was available. The state prison average daily population in Virginia was 30,905 in December 2010. Black persons made up 55% of all new court commitments in FY 2009 in VA and 62% of the confined population,[6] despite being only 20% of VA's population. HIV testing in VA state prisons prior to 2011 was performed at inmate request (and inmate expense), if the inmate was involved in an accident that put them at risk for contracting HIV, if there was a clinical indication of possible infection, or if there was a court order for testing. The reported HIV-positive population in VA state prisons was 1.3% in 2008, approximately 430 cases. While this number is comparable to many other states who had similar testing policies, it was much lower than the expected prevalence. In a study of HIV in ten correctional systems in the United States, Vlahov et al. found seroprevalence rates that ranged from 2.2 % to 14.7%, with an average rate of 4.3%.[7] It was

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[5] The Spectrum of Engagement in HIV Care and its Relevance to Test-and-Treat Strategies for Prevention of HIV Infection. Clinical Infectious Diseases. 2011.

[6] Virginia Department of Corrections, State Responsible Offender Population Trends, FY2005-FY2009, http://www.vadoc.state.va.us/about/facts/research/new-statsum/offenderpopulationtrends_fy05-fy09.pdf

[7] Vlahov D, Brewer TF, Castro KG, Narkunas JP, Salive ME, Ullrich J, Muñoz A. Prevalence of Antibody to HIV-1 Among Entrants to US Correctional Facilities. *JAMA. 1991;265(9):1129-1132.*

expected that VA's positivity rate would increase, given new legislation implemented in 2011, requiring opt-out HIV testing prior to release (see "Relate to Existing Activities, Address Identified Gaps" below).

Those involved with the criminal justice system (offenders), often have a wide range of issues that create barriers to accessing medical care, indicating a need for increased assistance. In 2002, 68% of inmates had substance abuse or dependence prior to incarceration[8] and less than a third of these receive treatment while in prison.[9] Mental health issues are also more common among offenders than the general population, with over half of state prisoners having a recent history of a mental health problem in 2004, with 42% of state inmates reporting both mental health and substance abuse issues.[10]

Build Upon Existing Planning

In 2010, VDH began an effort to coordinate HIV planning across multiple units of the Division of Disease Prevention (DDP). These activities were spread across units and funding streams, including: Field Services [11](testing in health department settings and oversees DIS); HIV Prevention Services (oversees community-based prevention interventions); HIV Care Services (HCS) (medical, support, and medication services to people living with HIV disease); Surveillance; and Health Informatics.[11]

Coordination of partners initially focused on gathering baseline HIV data from all involved entities. The purpose was to determine data needs in order to develop a more accurate picture of the spectrum of HIV care needs in the state. This included a review of the unmet need and epidemiological data for PLWH, on the basis of populations and geographic areas. This information was used to determine how to target the SPNS project work in terms of geographic and population needs and issues.

Relate to Existing Activities, Address Identified Gaps

The Care Coordination program was designed to enhance services to ensure uninterrupted access to HIV medications and medical care for HIV-positive inmates re-entering the community. From 2000 – 2011,

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[8] James D,Karberg JC. Substance dependence, abuse and treatment of jail inmates, 2002. 2005. Bureau of Justice Statistics, NCJ 209558.

[9] Belenko S, Peugh J. Estimating drug treatment needs among state prison inmates, Drug and Alcohol Dependence. 2005; 77: 269-281.

[10] James D, Glaze, LE. Mental Health Problems of Prison and Jail Inmates. Sept 2006. Bureau of Justice Statistics, NCJ 213600.

[11] Field Services was later reorganized as Field Operations, and merged with Health Informatics to become the STD Surveillance, Operations & Data Administration (SODA) unit.

prior to the introduction of Care Coordination, HIV medication assistance to PLWH being released from DOC was conducted through a longstanding but unfunded collaborative relationship between the state ADAP and DOC. That project, called the Seamless Transition Program (STP), was a passive model that largely focused only on the provision of medications with no follow-up, no referrals or medical appointment coordination, no local or regional jail involvement, and no active data collection. Referrals from DOC were faxed to an existing ADAP staff member, who arranged for 30 days of ADAP medications to be shipped to an ADAP distribution site close to the inmate's planned residence post-release. Medication pickup from distribution sites (most of which were local health departments) within 6 months of release under that model was less than 50%. Additionally, the development and implementation of the new Care Coordination program coincided with a new state law put in place in 2011 requiring state correctional facilities to provide routine opt-out HIV testing for offenders within 60 days prior their release. Care Coordination services were positioned to be able to serve newly identified HIV-positive inmates.

Finally, due to an ADAP wait list in Virginia from 2010 to 2012, ADAP and Care Coordination staff played a key role in facilitating access to HIV medications for PLWH being released from incarceration from all appropriate resources including ADAP, pharmaceutical patient assistance programs, Medicaid, Medicare, or other third party payers.

Collaborative Framework

Collaborative Learning Model

Collaboration. What does it mean? Sharing information. Agreeing to work together on a leadership, program and resource level. And actually working together.

Collaboration means sharing information and agreeing to work together on a leadership, program and resource level. Collaboration for Virginia was a key method employed for designing, refining, and finalizing each of its four strategies. Collaboration required "building rapport with patients and co-workers, building a community with patients but also a professional community." This required a high level of collaboration at the state, regional, and local levels. Partnerships with local health districts, HIV medical providers, testing agencies and PLWH were an integral part of the SPNS project design.

VDH used the Institute for Healthcare Improvement's Collaborative Learning Model to develop and pilot interventions. This model, combined with the SPNS outcome evaluation, provided a framework for continuous exploration and improvement. The Collaborative Learning Model is a process whereby systems, organizations and providers implement and measure small-scale interventions, then share their experiences in an effort to accelerate learning and widespread implementation of successful ideas for change.[12] The focus is on the continuous refinement of interventions, along with formal process and outcome evaluation. Highlights:

- Each Strategy Group (discussed below) produced a strategy process map in the Plan, Do, Study, Act (PDSA) process, a narrative description of the group's processes, and finally, a list of tools and resources that would be needed to implement the strategy.

- Strategy Groups were also charged with developing the standardized protocol for their intervention during the first 2-3 years of the project.

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[12] *The Breakthrough Series: IHI's Collaborative Model for Achieving Breakthrough Improvement.* IHI Innovation Series white paper. Boston: Institute for Healthcare Improvement; 2003. (Available at www.IHI.org)

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Collaborative Entities

■ *Key Partners*

While the Virginia corrections system had limited services for those soon-to-be released, there were multiple efforts and agencies involved in supporting transitions to the community. Below is a summary of key partners.

- **Related Programs**. The Comprehensive HIV/AIDS Resources and Linkages for Inmates (CHARLI) program, is an HIV Prevention-funded program providing discharge planning and post-release services to PLWH. Activities begin with HIV/STD education for inmates 60 to 90 days prior to release with HIV testing offered and additional services offered to those testing positive. CHARLI services are available to certain correctional facilities statewide. Pre and post release case management includes: discharge planning; housing resources; access to food resources; assistance with Social Security applications; assistance with employment opportunities; mental health services, substance abuse support and services; transportation assistance; and referrals to support groups.

  In addition to CHARLI, Patient Navigation has become an essential tool for re-engaging clients in care. During the fourth year of SPNS, Care Coordination established a referral relationship with Disease Intervention Specialists (DIS) to assist with locating difficult to reach clients and refer them back to Care Coordination. CHARLI contractors and program coordinators, Patient Navigators and DIS were all actively involved with the SPNS initiative, from initial statewide learning sessions to planning and strategy group calls and meetings.

- **Health District Services**. Local health departments continued their involvement with the recently released as ADAP medication distribution points for the 30-day post-release supply of medications. Additionally, the local health department staff coordinate with Care Coordinators to access expedited ADAP eligibility determination and facilitate contact with clients.

- **Health Services**. For inmates at DOC facilities statewide, HIV medical care is provided by the Virginia Commonwealth University Health System (VCUHS), including telemedicine (provided during incarceration) and assistance with discharge planning. For inmates incarcerated at regional and local jails, health services are typically provided through a contracted provider. Care Coordination staff worked with VCUHS to strengthen the referral protocol for Care Coordination and ADAP services, and initiated communication with both the local/regional jails as well as a health services contractor that serves multiple jails.

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- **Insurance Enrollment**. The recently released population is eligible for special enrollment under the Affordable Care Act. Care Coordinators facilitate expedited ADAP enrollment for immediate medication access and assist with referrals to Certified Application Counselors (CACs) for insurance enrollment.

As the Care Coordination strategy developed and was implemented, additional partners were identified whose collaboration is being pursued. Some of these partners included:

- **Departments of Social Services:** A statewide website, CommonHelp, developed by the Department of Social Services, serves as a single portal to apply for a variety of benefits, often delivered through local Departments of Social Services. Services include: use of computers; post-release coordination with employment boards/councils; family reintegration approaches; mentoring programs; and partnerships with volunteer and non-profit groups.

- **Virginia Reentry and Community Collaboration Councils**: These Councils are located across the state, and address policy/practice issues within communities (i.e., housing, employment options and approaches for released offenders). Councils generally coordinate service delivery through coordination teams.

- **Department of Motor Vehicles:** Virginia's Department of Motor Vehicles works in state correctional facilities to help those about to be released obtain valid Virginia IDs prior to release which is a common challenge, especially for those being released to homelessness.

■ *Collaborative Forums*

Throughout the project, VDH convened statewide meetings among all stakeholders, monthly conference calls among a core group of planning representatives, and technical working sessions across the four project strategy areas during the development phase of the initiative. Each is described below.

Planning Group

The Project Planning Group served to guide the overall project design and implementation. Its members included representatives from all four SPNS strategies and focused on overlap and intersection of strategies and opportunities for synergy and efficiencies in linkage and retention strategies. Members were drawn from several units within VDH, community partners at DOC, pilot sites, and other stakeholders in the Central and Southwest regions of the state. They met on a monthly basis during the first two years and shifted to a quarterly basis in Year Three, once full implementation occurred. Note:

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Each intervention had a Strategy workgroup (see below) that was specific to the intervention, which reported to the Planning Group.

Community Advisory Committee

The Planning Group recruited several consumers to attend and participate in the initial learning session about the SPNS project. In order to more systematically gather valuable consumer feedback on interventions carried out under the initiative, VDH formed a Community Advisory Committee under the SPNS Learning Collaborative. The objectives of the committee included: providing feedback on the interventions particularly during the "Study/Act" part of the PDSA cycle; evaluating whether the interventions were feasible and beneficial to PLWH; providing guidance on involvement of consumers within the collaborative; and participating in the Collaborative trainings. VDH recruited seven consumers from across the state's five health regions to participate on the committee. VDH hosted a committee orientation to bring the consumer representatives together to learn about the goals of the SPNS initiative and articulate the role and structure of the committee. Members also participated in subsequent learning sessions. The existing HIV Community Planning Group, which includes consumers who represent the epidemic in Virginia, provided input on all four SPNS strategies.

Strategy Groups

Each strategy under Virginia's SPNS project formed a group to provide input on the development of the protocol. All groups operated under the direction of the Planning Group. The Care Coordination strategy group's features were as follows:

- **Members**. This group consisted of representatives from the CHARLI program, Care Coordinators at VDH and one DOC representative.

- **Purpose**. To increase the number of PLWH released from correctional facilities who access HIV medications and are retained in medical care during the first year post-release.

- **Interventions/Activities**. The planning team determined a need to move the strategy work groups forward by having them focus on "doing" rather than "planning." The sequence of tasks (defined as interventions for the group) included the following, developed as a "process map" with timelines. The group initially focused on streamlining and developing Care Coordination procedures in collaboration with CHARLI and ADAP.

- **Monitoring.** Monthly PDSA reports were submitted to document progress for each of the four strategy groups.

Staffing

Two Care Coordinators were hired to work at the Central office of VDH. They were housed within VDH's Division of Disease Prevention HIV Care Services Unit. Their job responsibilities include: receiving and processing new referrals for soon-to-be released clients; coordinating with Central Pharmacy to ensure provision of medications; assisting with scheduling medical appointments and arranging transportation, following medication pick up and fills to monitor adherence; linking clients to services through referrals to case management; communicating with case management regarding adherence or barriers to accessing services; and updating client status and encounters in the VDH database.

Of these responsibilities, Care Coordinators reported that the easiest tasks to handle were medication pickups and appointments. The most difficult were barriers to care and making linkages to services that may or may not be readily available in patient communities.

Of note, a typical Care Coordinator caseload may vary due to a variety of factors. Those factors include acuity of client needs, how active clients are in the Care Coordination relationship, and availability and type of resources within a client's community (with fewer resources requiring more Care Coordinator time).   Staffing was reduced to one Care Coordinator as the caseload was built, and a second Care Coordinator was added in Year 4 to manage the increasing numbers of clients receiving Care Coordination services.

■ *Establish Management/Supervision*

Hiring and supervision of Care Coordinators is provided by the VDH HIV Care Services Assistant Director for Medication Access. Oversight was placed in this office because of the role Care Coordinators play in facilitating access to HIV medications upon release.

- **Orientation**. Care Coordinators are provided with a 90-day orientation plan to acclimate and orient them to Care Coordination activities and other HIV/AIDS programs (e.g., Ryan White Part B including ADAP, and CHARLI).

- **Supervision**. Weekly supervision meetings are held during the 90-day orientation period. On an on-going basis, Care Coordinators meet monthly and as needed with the Assistant Director for Medication Access for input and guidance concerning client issues, implementation of the program protocol and expansion of the Care Coordinator role. Work products and progress toward the goals

and objectives are reviewed and approved by the Assistant Director to provide continual guidance and oversight.

- **Liaison with ADAP/Other Offices**. Care Coordinators also attend ADAP team meetings and VDH staff meetings to continue information exchange and obtain updates on all program activities regarding ADAP, planning and HIV services. Additional guidance and program coordination is provided by the Assistant Director for HIV Services when Care Coordination directly impacts Ryan White Part B-contracted services.

Identify Core Competencies

Care Coordinators work with incarcerated individuals and those released from the correctional system. A high proportion of PLWH in correctional settings have mental health and substance abuse challenges. Thus, services and needs are varied and addressed by multiple agencies. Core competencies of Care Coordinators include:

- Background working with low-income populations.

- Strong interpersonal skills.

- Familiarity with the correctional system.

- Knowledge of varied health and social systems of care.

- Cultural competency and sensitivity

- Fluency in other languages, particularly Spanish

Position Description: Care Coordinators

Virginia prepared a general job description for Care Coordinators. Activities relate to their work in providing recently released PLWH access to medical care and medications and include:

Coordinates access to medication and medical care through the state's AIDS Drug Assistance Program (ADAP) and other available resources for PLWH being released into the community from state DOC and regional and local jail systems. Tracks and follows up on medication access and medical care for each client for a period of 12 months including verification of medical appointments and pick up of HIV-related medications. Collaborates closely with community partners including, patient navigators, case managers, pharmacists, Local Health Departments, and staff at infectious disease clinics across the state

to coordinate additional resources for clients including access to transportation, mental health services, and other support services to facilitate retention in HIV medical care over time.   Maintains relationships with partners at DOC and local jails and seeks new partners in the community to enhance the Care Coordination program, including expansion of services to new jail sites.

Provides technical assistance (i.e., on-site and telephone) to community partners to ensure the referral process to Care Coordination program is followed including use of required VDH forms and consent processes. Conducts community education on new policies, updates to the state ADAP program, and other items as necessary. Attends and presents program information to community partners at statewide meetings and conferences.

Conducts routine data entry of client information, medical care, medication access, and care coordination activities in local database. Uses database queries to identify clients in need of coordination services. Periodically reviews program protocol and provides input on necessary updates and changes to the program.

Training

As with all VDH employees, Care Coordinators undergo a 90-day training plan specific to their position. Overall, mastery of the position can take 12-18 months and includes completion of formal training and achieving understanding of the care and corrections systems in a manner that will enable the person to complete care coordination tasks.

Identify Training Topics/Curricula

VDH developed a core set of training topics for Care Coordination, covering the following.

- **HIV/AIDS Basics**. This training covered the facts and fundamentals about HIV disease.

- **ADAP**. Understanding all medication assistance programs under Virginia ADAP is essential given the central role of Care Coordinators in facilitating medication access for clients and assisting with expedited enrollment in ADAP. Training is also designed to help staff build a close relationship with ADAP staff.

- **Understanding the Corrections System**. Training on the correctional system is generally the starting point. Beyond understanding rules and requirements of state, regional and local systems, the goal is to enable the individual to build strong relationships with correctional facilities.

- **Client Resources**. Trainings and meetings were designed to identify resources available for clients across the state, including the use of resource inventories and agencies funded for specific services in certain health regions.

- **Motivational Interviewing**. Care Coordinators were not using this intervention technique until later in the project but did use similar skills in their work. Training on formal Motivational Interviewing now occurs annually with refresher courses offered periodically.

Use Multiple Training Methods

Varied techniques were used to train Care Coordinators, including: In-person Learning Sessions; Individual supervision; Webinars; and Monthly planning group calls.

Collaborative Activities

As described above, Care Coordination was not the first inmate release assistance program for HIV-positive clients in Virginia, with both STP and CHARLI having provided services for several years. Coordination thus had to occur in relation to existing programs. Simultaneously, Care Coordination needed to establish relationships with staff in correctional settings as well as referral sources and existing programs for the general population recently released. The following sections are observations on collaboration efforts.

■ *Collaborate with Multiple Parties*

Care Coordination had many partners statewide, including VDH and its HIV/AIDS programs, correctional systems (state, regional and local), and VCUHS. Below are insights on ways to enhance the building of coordination among multiple entities in a statewide project.

- **Establishing the Program**. One of the biggest challenges was clarifying roles between Care Coordination and other existing programs to maximize the benefits from all involved, but avoiding service duplication or treading on others' territories. Identifying leadership for existing programs across the state was important to ensure consistent and accurate information about roles was discussed, as well as establishing relationships with "front line" staff who actually delivered services and worked with clients. This was addressed through frequent meetings, communication, and delineating the scope of services. Printed brochures and palm cards were helpful in reinforcing information about the role of Care Coordination and how it could further assist clients.

- **Accommodate Staff Turnover**. Turnover is relatively high in corrections facilities as well as in community agencies that are potential referral sources for the recently released. This requires ongoing and repeat sessions with DOC and jail staff to maintain relationships and avoid breakdowns in the referral process. Face-to-face orientations work best in establishing and re-establishing relationships. Repeat briefing sessions allow for the sharing of success stories and additional tweaking of the intervention. Ongoing orientations are also supported by written policies and procedures between VDH and the corrections sites (e.g., a discharge summary and procedures for sending, receiving, and following up on missing inmate information).

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Collaborate with CHARLI

As stated above, CHARLI was an existing HIV prevention-funded linkage to care project with contracted providers in certain areas around the state. CHARLI already had established itself within some Department of Corrections sites and thus had much to offer Care Coordination in terms of learning systems and staff. Collaboration between Care Coordination and CHARLI was strengthened through the following methods:

- **Establish Regular Meetings**. Internal weekly meetings were held within VDH between Care Coordination and CHARLI. These sessions allowed the teams to regularly discuss challenges and review shared client cases on an ongoing basis.

- **Collaborate Around the Practicalities**. Care Coordination and CHARLI each had their own processes. Collaboration served to identify how best to link these programs together as well as avoid duplication of services for clients.

- **Collaborate Where it Helps**. CHARLI planned on convening Latino focus groups with DOC. The bilingual Care Coordinator was able to facilitate these sessions, thus building a relationship with both CHARLI and DOC by providing this service.

- **Share evidence of success**. Preliminary data evaluating the linkage, retention and viral suppression rates of clients helped by a combination of Care Coordination and CHARLI services showed excellent results. These results are being shared at conferences and will be shared through publications as data are finalized. Tangible evidence of the positive impact on clients serves to reinforce the collaboration and motivate continued work together.

Collaborate with Corrections Systems

- **Build Upon Established Connections**. Frequent communication and program marketing were required to build successful relationships. Relationship building with DOC focused on leveraging existing relationships from the STP and CHARLI programs. The ADAP Coordinator and the CHARLI program's VDH Contract Monitor facilitated introduction of the Care Coordination staff to key DOC staff. This process included explaining the Care Coordination model, providing technical assistance to DOC staff on state HIV testing laws, and development of relationships with DOC discharge planning staff.

- **Collaborate on Specifics**. The process of working together works best when it is mission-focused, and when there is agreement on the mission. One approach is shared development of procedures.

VDH developed the consent form to refer patients into Care Coordination services through a joint process including both Care Coordinators at VDH and nurse managers and corrections staff at DOC.

- **Collaboration with Regional and Local Jails Can Be Time Intensive**. VDH started out by working with state corrections staff and later expanded to reach regional and local jails across the state. "Relationships with local jails often took a long time to build." One possible reason: regional and local jails (typically, they serve as short term lock-up facilities) do not have the same legal requirements about providing medications upon release as do corrections sites. Local and regional jails are overseen by sheriff's departments and maintain their own policies and procedures, often relying upon local budgets. Meetings with jail administrators focused on their needs and requirements. Below are examples:

- At one jail, a task force was formed, including representatives from VDH and the jail, to develop needed infrastructure, processes and tools for an effective Care Coordination relationship.

- The Care Coordinator initiated contact with the medical contractor for several local and regional jails to seek increased participation with Care Coordination services and identify opportunities to provide training to jail staff. By working with this contractor, Care Coordination was "able to work with at a higher level, focus on high need jails" and work more efficiently in reaching multiple sites through a single contact.

◼ *Secure Buy-In*

How does one secure buy-in? There is professional courtesy. One Care Coordinator puts that into practice as follows: "I return all calls quickly. I prioritize their needs so that I can expect the same treatment when I need them." Equally important is appreciation of time limits. "I streamline my phone calls so that I am not burdening persons with an already high work load." And then there is respect. "I get to know them, show genuine interest and pay high regard to the work that they are accomplishing."

Those personal observations say a lot about building a relationship and buy-in. Below are observations about the process of setting up a program and securing support.

- **Convene Meetings**. Initial sessions with key players to discuss the program consisted of VDH SPNS collaborators, VCUHS, the CHARLI contract monitor and the health services division of DOC. Subsequent meetings involved medical contractors with regional and local jails.

- **Learn About Current Activities and Tailor the Buy-In Pitch**. Part of buy-in is learning what a corrections site is currently doing in order to determine what buy-in you need and want to seek.

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Early in the project, Virginia was only getting referrals from specific facilities and tried to figure out why. It turns out that certain sites were facilitating discharge for HIV services on their own. Lesson learned? First find out what corrections sites are currently doing.

- **Buy-in Takes Time**. There is "lots of marketing of the program" that goes into securing buy-in with a corrections facility. One marketing technique is to explain to corrections staff that, when audited, they can show they have a plan of care. Also, pitch the program as reducing recidivism by helping clients establish services and support as soon as possible after discharge.

- **Find the Right Person**. Equally important is finding the right connection, from corrections managers to contract staff who have a relationship in delivering health services in the corrections site. Given "the nature of the bureaucracy," the right person might not always be the top official. The strongest relationships were those built between the Care Coordination staff and corrections front line staff, such as medical providers and nurses. Tips for finding that individual: agency-to-agency referrals; contacts with related programs (e.g., "CHARLI was a huge resource for us"); staff who have contacts with key staff, like corrections medical providers.

▪ *Collaborative Insights*

- **Territoriality Can Impede Collaboration**. Each regional and local jail and each DOC site have their own systems and ways of doing things. This can be challenging, but won't hinder collaboration if these system differences are openly discussed and solutions are identified.

- **Forums To Build Relationships**. Participation in meetings with partners at both the state and community level for continued growth and understanding of existing networks and to build working relationships.

- **Data Sharing Consent Facilitates Coordination**. A data sharing consent form among agencies can enhance services for clients. For example, in Virginia, the probation and parole office could serve as the address for receipt of benefits for inmates being released to a shelter and could be a resource for lost to care inmates who were in a probation or parole program. Ensuring a client consent is in place with these programs can be beneficial.

- **Share Up-to-Date Resource Lists**. One way to facilitate connections to care is to provide corrections agencies with updated lists of community-based primary care centers and ADAP Coordinators at local health departments.
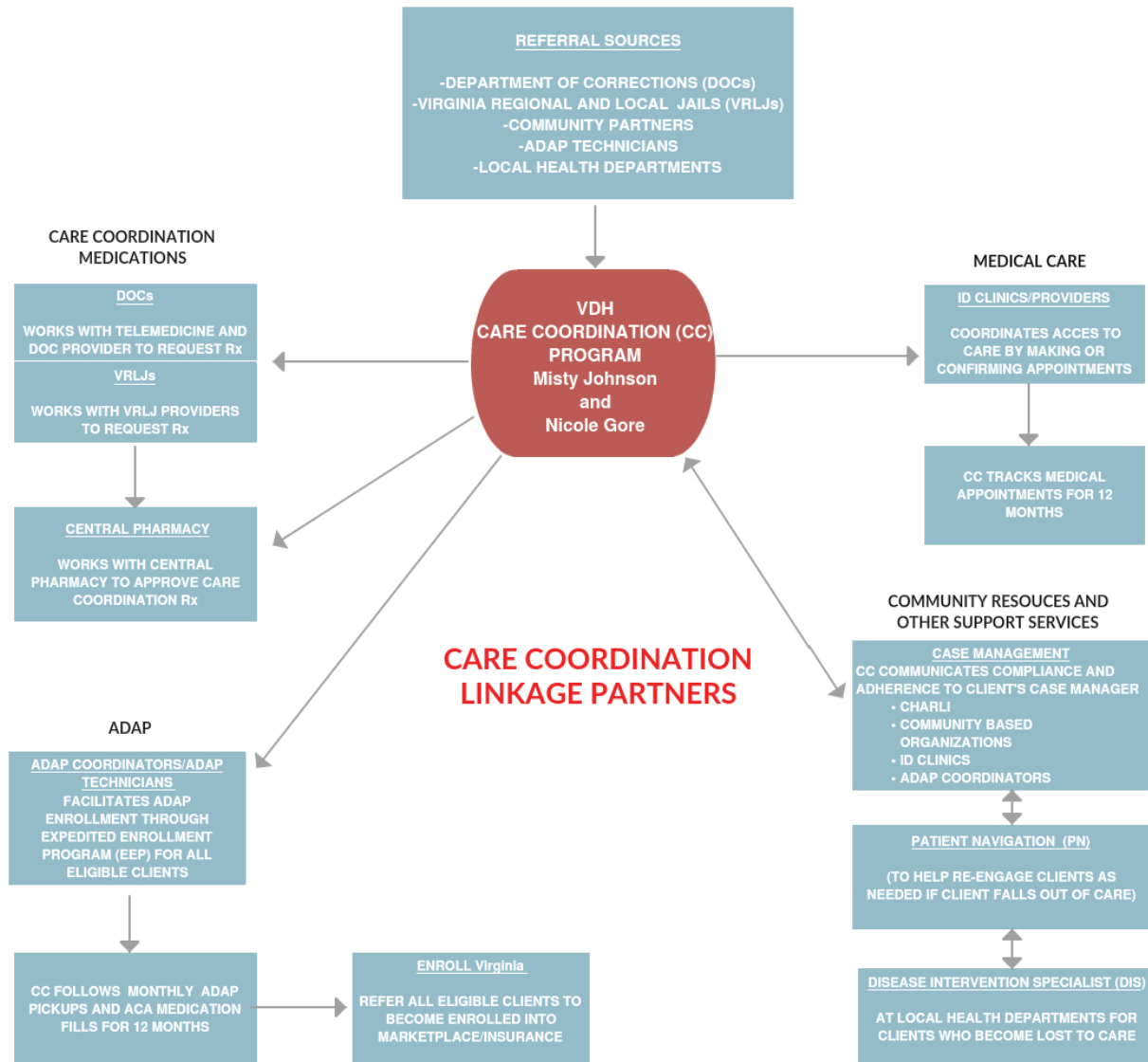
CARE COORDINATION

- **Explain the Value of Continuous Care**. The state of Virginia does not have authority on management of medical care at local jail sites. Approaches to emphasize the importance of HIV care included educating regional and local jails about the importance of continuous treatment on both the health of the client and how this can prevent HIV transmission to others, and explaining how medications could be provided to individuals upon release.

- **Leverage Contractors**. Community based contractors play critical roles in care in corrections settings and thus can enhance collaboration on medical care for inmates and the recently released.

- **Set Limits on What Can be Covered From the Beginning**. Be prepared for correctional agencies to seek coverage of HIV medication costs for people while they are incarcerated, which is generally prohibited under Ryan White funding as corrections agencies have this legislated responsibility and are not considered "outpatient" settings.

- **One Way to Set Up a Relationship with a correctional agency**. If working with managers, start by identifying the administrator for health services and set up meetings to discuss the Care Coordination program and the role and responsibilities of each party. Contact through email initially and a phone call if no answer. Be kind, and persistent. Offer to meet them at their facility on a day/time that works best for them. Meet with them no less than two times to establish a working relationship and iron out responsibilities. Have a follow up phone call to discuss any questions that may have come up and plan additional meetings as needed.

- **Identify Priority Populations**. It may help to prioritize populations to work with at a given site. For example, one site might have undocumented Latinos whose needs are not being met. One Virginia Care Coordinator leveraged her bilingual skills to address this need for the facility.

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Care Coordination Linkage Partners

REFERRAL SOURCES

-DEPARTMENT OF CORRECTIONS (DOCs)
-VIRGINIA REGIONAL AND LOCAL JAILS (VRLJs)
-COMMUNITY PARTNERS
-ADAP TECHNICIANS
-LOCAL HEALTH DEPARTMENTS

CARE COORDINATION MEDICATIONS

DOCs

WORKS WITH TELEMEDICINE AND DOC PROVIDER TO REQUEST Rx

VRLJs

WORKS WITH VRLJ PROVIDERS TO REQUEST Rx

CENTRAL PHARMACY

WORKS WITH CENTRAL PHARMACY TO APPROVE CARE COORDINATION Rx

VDH CARE COORDINATION (CC) PROGRAM
Misty Johnson
and
Nicole Gore

MEDICAL CARE

ID CLINICS/PROVIDERS

COORDINATES ACCES TO CARE BY MAKING OR CONFIRMING APPOINTMENTS

CC TRACKS MEDICAL APPOINTMENTS FOR 12 MONTHS

CARE COORDINATION LINKAGE PARTNERS

COMMUNITY RESOUCES AND OTHER SUPPORT SERVICES

CASE MANAGEMENT
CC COMMUNICATES COMPLIANCE AND ADHERENCE TO CLIENT'S CASE MANAGER
• CHARLI
• COMMUNITY BASED ORGANIZATIONS
• ID CLINICS
• ADAP COORDINATORS

PATIENT NAVIGATION (PN)

(TO HELP RE-ENGAGE CLIENTS AS NEEDED IF CLIENT FALLS OUT OF CARE)

DISEASE INTERVENTION SPECIALIST (DIS)

AT LOCAL HEALTH DEPARTMENTS FOR CLIENTS WHO BECOME LOST TO CARE

ADAP

ADAP COORDINATORS/ADAP TECHNICIANS
FACILITATES ADAP ENROLLMENT THROUGH EXPEDITED ENROLLMENT PROGRAM (EEP) FOR ALL ELIGIBLE CLIENTS

CC FOLLOWS MONTHLY ADAP PICKUPS AND ACA MEDICATION FILLS FOR 12 MONTHS

ENROLL Virginia

REFER ALL ELIGIBLE CLIENTS TO BECOME ENROLLED INTO MARKETPLACE/INSURANCE

Protocol Development

In Virginia, with multiple entities and initiatives at work to address releasee services across multiple correctional settings (state corrections and regional and local jails), there was no standardized process in place to guide work with inmates leading up to release. Each system and its support project had its own set of protocols.

The Care Coordination protocol was developed to create a universal guide for statewide corrections system and jail HIV referrals. The protocol is in use by the two Care Coordinators working with the state corrections system and with 11 regional and local to enhance care connections with recently released individuals.

■ *Establish Protocol Components*

The Care Coordination protocol evolved out of existing protocols in use by the state corrections system, regional and local jails, and the state health department. Its development started through Strategy Groups and meetings held from 2012-2014. The protocol itself was largely written during a several month period in mid-2014. The full protocol is included in the appendices. Sections cover:

- Purpose and Scope
- Procedures
- Discharge and Referral
- Coordinating Medication Access
- Scheduling and Confirming Medical Appointments for Patients
- Client Follow-up/Engagement
- Coordinating with CHARLI
- Transitioning from Seamless Transition Program
- Referring Patients to Other Services
- Documents and Attachments/Forms
- VADOC Discharge Summary (DC-1 and DC-2)
- VDH Authorization to Exchange and Disclose Health Information
- VDH EEP Discharge Summary

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- VDH EEP Medication Request Form

- VDH Medication Request Form

- VDH STP Checklist

- VDH Referral Form

- VDH STP Notes

- VDH Contact Letter

- VDH STP Form

- VADOC Process map

■ *Protocol Development Insights*

- **Starting Point: Identify Common Elements**. Identifying the essential and most effective elements from each program was seen as the initial step to undertake to create one comprehensive protocol. Substantial pre-planning of that effort "helped make the program successful."

- **Use Current Practice as a Guide**. VDH chose to explore how clinicians were currently working with incarcerated and recently incarcerated persons and to use that information in designing its protocol. That approach was adopted in the course of the broader development process of working jointly with state corrections and regional and local jails system representatives.

- **Protocol Process Needed Alignment with Hard to Track Population**. The target population was difficult to track and was a group that had many needs and barriers. As such, the protocol needed to both provide streamlined methods for working with difficult to find individuals while simultaneously outlining a broad array of needed services to address identified needs. Training of Care Coordinators also needed to have a special focus on handling difficult cases.

- **Protocol Needs to Adjust to a Highly Variable System**. There were many variations across Virginia that needed to be accommodated in the protocol, necessitating a broad set of steps. For example, the protocol needed to be flexible enough to work in varied communities (some of which have few resources and thus little of a referral network) and variable methods (e.g., referral methods, prescription authority, regulations).

- **Centralized and Face-to-Face Options**. The protocol was strengthened by blending its centralized, standardized procedures approach with allowances for ongoing face-to-face approaches (primarily through community partners) to tailor to unique conditions.

- **Practicalities of Actual Interventions**. In the field, work with clients was often highly individualized and intensive. The protocol needed to address the details likely to emerge from different types of situations.

Implement Care Coordination

As initially envisioned, the Care Coordination process was designed to address the full range of care access issues upon release. In practice, relatively more emphasis was put on assisting individuals with accessing medications and medical care, with less focus on support service access. This shift was due to a need to help patients address the fundamentals and leverage existing community resources for other support services, such as the CHARLI program and case management programs.

- For purposes of initial engagement, client objectives were to pick up medications at an ADAP medication distribution site near the client's residence upon discharge within 30 days; complete an ADAP application; keep medical appointments; and complete intake and referrals with case management.

- For ongoing retention in care, objectives involved ACA health coverage enrollment or other appropriate ADAP medication access program; and the receipt of case management services to address barriers to care and to support treatment adherence.

Below are specific implementation insights and challenges.

Handle Discharges and Referrals

The front-end process of Care Coordination begins with preparing for a seamless transition to the community and needed services. Below are ways to smooth this effort.

- **Have Necessary Information on Hand**. Access to information from the correctional facility including the date of release and other essential pieces of information (e.g., home addresses and contact numbers) can be difficult to obtain because this population is often transient and faces many barriers upon release, like homelessness. Knowing this in advance can prepare staff for the challenge of gathering information.

- **Create Both Centralization and Personalization**. The creation of a centralized referral system was beneficial for purposes of standardizing referrals and enhancing the organization and maintenance of referral resources. However, for areas that did not have many resources or a referral network, centralization was not a stand-alone solution. Face-to-face collaboration with community partners was needed as well.

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- **Take the Time to Build the Build Referral Network**. In Virginia, DOC and regional and local jails comprise a diverse system with varied existing referral processes. Advance knowledge of variations in protocols and referral processes can help staff in navigating across systems.

- **Prepare Sources to Serve as Informal Referrals.** Some PLWH were not being referred to services upon release, including clients who seemed less interested in linking to care. Thus, relationships were needed to prepare referral sources to handle non-direct referrals, meaning building a trusting agency-to-agency relationship to create openness to the recently released who might be referred through less formal channels. In essence, this is a "no wrong door" approach for handling referrals so that the system is set up to receive referrals from many sources.

- **Focus on the Referral Focal Point: Case Managers**. According to one Care Coordinator, most time is spent communicating with case managers about care needs of clients. "I'm more of a facilitator, keeping people informed, making sure they get to the right person." Thus, Coordination work involves frequent communication with case managers to ensure they have all the information needed to assist clients, sometimes gathered from a variety of sources. For example, when a Coordinator learned that a client was not making an appointment as a result of conversation with the client or information provided from another community service provider, a call was placed to the case manager to share that the client was not going to appointments, serving as a helpful prompt for case management intervention.

- **Build and Reinforce Relationships with Case Managers**. The Collaborative Learning Model used to plan the intervention gave various parties an opportunity to clearly define the purpose of Care Coordination, and differentiate its role from others. Care Coordination staff was able to interact with case managers in a variety of forums, such as statewide contractors meetings where staff explained the program and provided some client successes. Making those connections face-to-face was important and needs to be reinforced through refresher trainings and outreach to keep Care Coordination on the radar of case managers, thus helping generate referrals over time.

■ *Build Rapport, Engage Patients*

How do you build rapport and trust with clients? The tips are as apparent as good manners.

- **Be Non-judgmental**. Conversations are sincere and supportive. Said one Care Coordinator: "I understand their limitations without judgment and offer assistance and support when possible." Said another: "With [clients], it is also necessary to approach a conversation with warmth and compassion, giving them the ability to speak freely of their current situation and without judgment."

- **Be Available**. Being ready when clients need help is also essential. "Give the client permission to call whenever they need additional support and follow up with client until barriers have been resolved."

- **Tailor Responses**. It is also important to consider individual needs and limitations, such as arranging for appointments and medication pickups at sites that are geographically near, or are perceived as safe and confidential by the client.

- **Establish the Case Management Connection**. Link clients to case management so that other barriers can be identified and addressed.

Provide Access to Medications

Medication access support under Care Coordination represented a major shift from earlier efforts, which entailed the provision of 30-day supplies from corrections (and none from regional and local jails) and passive referrals to medication access and support. Care Coordination tracked medication pickup and medical appointments. The rates of pick-up and appointment follow-through were significantly increased. Below are insights on how medication access works and challenges that arose.

- **Be Aware of Variations in Medication Policies**. Prescription authority and procedures are often inconsistent across correctional facilities, especially DOC versus regional and local jails. In Virginia, efforts to address those variations included developing innovative strategies to manage prescription access. For example, jails often do not use electronic prescriptions because their medication is provided in-house. VDH worked to develop a document that was approved by the Central Pharmacy and could be faxed by the prescriber to the pharmacy to resolve this issue.

- **Clarify Scope of Coverage**. Some parties may not be aware that ADAP often covers more than just HIV medications. Clarifying this point can help clients and providers better appreciate the value of a linkage to Care Coordination for overall client care and as a doorway to a wide spectrum of support services.

- **Establish Access to Prescriptions During Incarceration**. The transition to medication support, post-release, was greatly enhanced when Care Coordinators requested, and had access to, inmate data (i.e., most recent labs and a list of prescriptions) prior to their release. Information is obtained from providers at DOC, as well as regional and local jails, using a client consent form that was collaboratively developed during the protocol development phase. Prescriptions are faxed directly to the ADAP central pharmacy to ensure a 30-day supply is provided to an ADAP medication distribution site of the client's choice.

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- **Use Electronic Prescription Services**. Virginia medical providers send e-scripts to its central pharmacy, facilitating access through efficient electronic channels. This methodology may not be available in all settings but has greatly facilitated prescription efficiency.

■ *Support Ongoing Care Engagement*

This much is a given. Recently released individuals tend to have many needs, face numerous barriers to care, and are often difficult to track. Flexibility and adaptability are in order. Below are insights.

- **Flexibility in Coordination Support**. Client needs vary considerably when released from corrections. Although the protocol timeline for Care Coordination follow up is 12 months, that timeline was shortened for clients who showed six months of compliance and stated that they could successfully self manage. However, access to medications/medical care was not a primary perceived need for some clients, including those in the program 12 months who were still not consistently picking up medications and/or were regularly missing scheduled doctor appointments. For these patients, Care Coordination was typically extended up to 18 months.

- **Be Thoughtful in Frequency of Contacts**. Care Coordinators needed to be involved only to the extent that Care Coordination needs were not being met. Said one Coordinator: "I don't want to bombard them with calls. I try to keep from calling them unless it's necessary."

- **Be Aware of Medical Appointment Scheduling Differences**. DOC and regional and local jails varied in how they scheduled infectious disease appointments for patients. DOC staff scheduled appointments for their clients, whereas CHARLI contractors handled scheduling for jailed clients. Care Coordinator understanding of these differing processes helped them track appointments and know who to contact if there were questions or problems.

- **Adjust to Case Manager Variations**. Care Coordinators worked extensively with case managers, some of whom had extremely high caseloads and covered multiple sites. As a result, there could be delays in returned calls or challenges in locating case managers covering several locations. Knowing this helped Care Coordinators strategize the best methods for reaching particular case managers or anticipating time frames for responses.

- **Create and Maintain Contact Lists**. Contact lists must be continuously maintained as staff turnover is often high and agency services may fluctuate with funding changes. Virginia's program created a statewide list with staff contacts providing various types of HIV care, including Ryan White services. Those lists were reviewed and updated on a routine basis.

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- **Keep Case Files Open on Successful Referrals**. One Care Coordinator commented that sometimes case managers or other providers may close a client's file if the client seemed connected to care, without actual verification of care receipt. The Care Coordinator, however, will keep the file open according to the time frames of the protocol as the need to contact the individual might arise. For example, a Patient Navigator tried to contact a patient, without success. The Care Coordinator was able to observe that the last contact was with DIS staff. Information was sent to the DIS, along with a confidentiality form to allow for release of information, which led to a determination that the patient had moved to another state. Then the case was closed.

- **Be Creative in Locating Patients**. Care Coordination utilizes many tools to locate clients. Examples include people search engines (such as Accurint), internal VDH database searches to gather recent demographic information, and the National Victim Notification Network (VINE) which locates incarcerated or re-incarcerated clients. Other methods include training ADAP technicians to identify the recently released during bi-annual recertifications.

- **Manage Challenging Cases Collectively**. The best way to manage challenging cases and problem solve, said one Care Coordinator, is to open up a dialogue with the client, case manager, the clinic, and other entities that are involved in the client's care. This allows everyone to share their ideas on the best response while clarifying all roles in strategies.

Re-Engaging a Client

The client had missed two consecutive appointments and was no longer picking up his medications. Care Coordination called him and learned he got insured through the Affordable Care Act but was unable to afford co-payments for medical office visits. The client attempted to reach out for help through his clinic but was informed no funds were available to help with these costs. He faced many additional other obstacles. The closest clinic was almost two hours away. No transportation. And no case manager in his region.

The client was very happy to hear from Care Coordination as he had essentially given up on how to maneuver through the system. The Care Coordinator reached out to various Community-Based Organizations. Transportation to the clinic was lined up for six months, where he would receive co-payment assistance before graduating to telemedicine closer to his home, although he would still receive transportation services to onsite appointments. A caseworker helped him find housing and employment. He is now employed and receives housing assistance. The client is now extremely compliant. He is taking great care of his health and reestablishing his life in the community with the help of the linkage to care project. He is going to all scheduled appointments and filling his medications through his insurance company for the remainder of his time under Care Coordination. He is still employed and remains in stable housing and graduated from Care Coordination at 12 months of Care Coordination services.
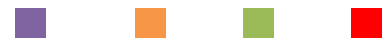
CARE COORDINATION

■ *Manage Data and Paperwork*

Record keeping is inherent in the process of working with inmates and the recently released, across corrections and health care. Inconsistencies, duplication, and variable quality of data were some of the challenges of keeping the data engine going. Below are observations on Virginia's system.

- **Data System Has Real Value**. Early on, Virginia data on the recently released had more of a repository feel with staff not clear on how the data could be used. Now, keeping track of client care encounters has practical applications in supporting client care engagement efforts of Care Coordinators. "You actually use the data to do Care Coordination," said one staffer, commenting on reports that show clients who miss medical appointments and using this information to systemize follow-up with high need clients.

- **Make the ADAP Tie-In**. Care Coordination relies heavily on ADAP to maintain access to medications. That requires an interface with the ADAP database, which was achieved under the SPNS project.

- **Segment Data for Surveillance v. Care Support**. Virginia's data system was developed in a manner to provide a secure place for client information used for surveillance and data purposes, along with separate access features to provide "user-friendly" and relevant information for Care Coordinators to use in tracking client care and compliance.

Sustainability and Program Integration

Funding

The Care Coordination model and staffing has been incorporated under the state ADAP and will continue to be funded as a part of ADAP. The functions of Care Coordination are allowable under a variety of Ryan White service categories, including eligibility determination and medication provision under ADAP, and multiple HRSA service categories including "Outreach services", "Health education/risk reduction" and "Non-Medical Case Management ". Furthermore, the entire model can be justified under funding through the ADAP Flexibility Policy, as it supports access, adherence and monitoring services.

Medication Provision

ADAP will continue to provide the 30-day supply of medications, post-release. At this time, DOC is committed to continuing to providing their 30-day supply of medications to clients upon release, and most participating regional and local jails are able to sustain provision of 3-7 days of medications upon release.

Ongoing Collaboration and Training

Virginia will provide additional training and continue to build working relationships with state corrections facilities and participating regional and local jails to ensure that all facilities are consistently benefiting from the Care Coordination effort. The relationship with VCUHS, as the provider of HIV care for DOC inmates, continues to be strong. The referral and communication process needs to be periodically reviewed and updated to account for health system and VDH changes, including any staff transitions that may occur.

Expansion to Regional and Local Jails

Care Coordination was implemented in 11 regional and local jails. A future goal is to expand to new jails as program capacity allows and new referral sites are identified.   A challenge is that some regional and local jails may not have resources to provide the 3-7 days of medications to clients upon release. This challenge will be met by strengthening the referral to Care Coordination prior to release so that the

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ADAP-provided 30-day supply is already waiting for the client at an ADAP medication distribution site at release, and an expedited ADAP enrollment can be completed to guide clients into the most appropriate ADAP medication access program.

Measuring Program Effectiveness

Data collection and the evaluation of processes and outcomes were critical to ensuring program effectiveness. Below is the basic framework for collecting data and conducting basic evaluation under the Care Coordination strategy and reporting data for program management, coordination of services and medication, and program evaluation purposes.

■ *Outcome Goals*

The main goal of the Care Coordination strategy was to facilitate timely linkage to medication and medical care for recently incarcerated HIV-positive individuals being released from correctional facilities.

■ *Variables for Data Collection*

VDH collected primary data for evaluation of this strategy in a secure SQL-server database contained within the ADAP program database at VDH. Data were entered locally by Care Coordinators from DOC discharge forms and encounter data based on the services they provided clients. In addition to other key demographic and patient information routinely collected by ADAP, the following data were collected for all clients enrolled in Care Coordination Services:

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Data Collected

Field Name	Field Description	Options/Response Values
Client Information		
Client Name	First, Middle, Last	Text Field (s)
Client Gender	Client's Current Gender	• Male • Female • Transgender • Unknown
Client Race		Race Field Options
Client Ethnicity		• Hispanic • Non-Hispanic • Unknown
Client Phone Number		Numeric Phone Number Field
Client's HIV Diagnosis date	Diagnosis Date Provided on DOC discharge forms	MM/DD/YYYY
Client's Actual Release Date	Date Client was Released from Correctional Facility	MM/DD/YYYY
Facility Release Name	Name of Correctional Facility Client was Released from	Text Field OR Drop Down Menu of Facilities
Type of Facility	Type of Correctional Facility	• DOC/Prison • Jail
Client Need Level	Care Coordinator Assessment of Client's Current Need Level	• Stable/Monitoring Needs • At Risk/Moderate Needs • Unstable/High Priority
Date Consent Signed	Date Client Consent Forms Signed	MM/DD/YYYY
Did Client Spend First Night Post-Release in Stable	Did Client Spend First Night Post-	• Yes

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Field Name	Field Description	Options/Response Values
Housing?	Release in Stable Housing?	• No • Unknown
Did DOC/Jail Provide HIV Medications upon release?	Did DOC/Jail Provide HIV Medications upon release?	• Yes • No • Unknown
Number of Days of Medication Supply Provided by DOC/Jail	Number of Days of Medication Supply Provided by DOC/Jail	Numeric Field Unknown
Referred to Services:	Check Box: Patient Navigation Case Management DIS/Health Department Other	Date of Referral: MM/DD/YYYY MM/DD/YYYY MM/DD/YYYY MM/DD/YYYY
Client Provided 30 day Care Coordination Medications from VDH	Client Provided 30 day Care Coordination Medications from VDH	• Yes • No • Unknown
Date 30 Day CC Medications Approved		MM/DD/YYYY
Health Department for Medication Pick Up	Health Department for Medication Pick Up	Text Field or Drop Down Menu of Local Health Departments
Did Client pick up 30 day Care Coordination supply of medications from Local Health Department?	Did Client pick up 30 day Care Coordination supply of medications from Local Health Department?	• Yes • No • Unknown
Date Client Picked up 30 Day Care Coordination supply of medications from Local Health Department	Date Client Picked up 30 Day Care Coordination supply of medications from Local Health Department	MM/DD/YYYY
Insurance Type/Status	Insurance Type/Status	Single select: • ADAP

| Field Name	Field Description	Options/Response Values
		• Medicaid • Medicare • Private Insurance • ACA Plan • None • Other
Date Insurance Status Updated	Date Insurance Status Updated	MM/DD/YYYY
ADAP Program Data (for ADAP clients only)		
Date ADAP application Approved	Date ADAP application Approved	MM/DD/YYYY
Did client pick up first ADAP medication?	Did client pick up first ADAP medication?	• Yes • No • Unknown
Date of First ADAP Pick Up	Date of First ADAP Pick Up	MM/DD/YYYY
Post-Release Date(s) of Subsequent ADAP Medication Fills	Post-Release Date(s) of Subsequent ADAP Medication Fills	MM/DD/YYYY (multiple fields for medication pick ups/fill dates)
Medical Care		
Date Medical Appointment Attended	One to Many Record	MM/DD/YYYY
Medical Provider		Text Field or Drop Down Menu of Providers
Next Scheduled Medical Appointment	One to Many Record	MM/DD/YYYY
Care Coordination Service Encounters		
Date of Care Coordination Service Encounter	Date of Care Coordination Service Encounter	MM/DD/YYYY

CARE COORDINATION

Field Name	Field Description	Options/Response Values
Service Encounter Type	Service Encounter Type	• With Client • On behalf of Client
Encounter Outcome		• Reached Client • Did Not Reach Client • Other
Service Encounter Method	Service Encounter Method	• Face-to-face • Telephone call • Text message • Email • Social network site • In a group • Postal mail • Administrative paperwork, research, etc. • Uncategorized
Type of Service Delivered by Care Coordinator and service duration in minutes	Type of Service Delivered by Care Coordinator	• Assisted with medical care; minutes • Assisted with medication ; minutes • Assisted with financial support; minutes • Assisted with transportation; minutes • Assisted with referrals; minutes • Other; minutes
Where was Service Delivered by Care Coordinator	Location of Care Coordinator when Provided or Assisted with Service	• Clinic/Medical Facility • Community based organization (CBO) • State Office (VDH) • Local Health Department • Other (please specify)
Date Of Client Note	Date Of Client Note	MM/DD/YYYY
Type of Note	Type of Note	• Note

Field Name	Field Description	Options/Response Values
		• Follow Up Action
Client Note	Client Note	TEXT BOX/FIELD
Was Issue Resolved? (Follow Up Action Notes only)	Was the issue resolved?	• Yes • No • Unknown
Date Issue Resolved (Follow Up Action Notes only)	Date Issue Resolved	MM/DD/YYYY
Staff Resolved By (Follow Up Action Notes only)	Name/Initials of Care Coordinator who resolved issue	Drop Down Menu of Care Coordinator Names/Initials
	Client Service Closure Information	
Client Graduated Care Coordination Services	Check Box if Client Graduated/Completed CC Services	Check Box
Date Care Coordination Services Completed	Date Care Coordination Services Completed	MM/DD/YYYY
Care Coordination Service Closure Reason	Care Coordination Service Closure Reason (Select only one)	• Services Completed • Deceased • Re-incarcerated • Moved out of state • Refused services • Unable to locate • Other
Care Coordination Discharge Level	Services Client Discharged To (Can Check all that Apply)	• Self-management • Case management • Patient Navigation • Unknown • Other • N/A
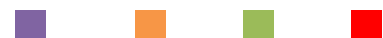
CARE COORDINATION

Summary of Queries Currently Programmed into Care Coordination Database:

Query Name	Query Result
Active Clients Query	List of all active clients (services have not been closed) between a designated date range
Medication Pick-Up Query	Pulls list of clients released between designated date range with fields needed for Care Coordinators to follow up on medication pick up with Local Health Departments.
Notes Report Query	List of notes and/or follow up actions between a designated date range, by client, or by release date and note status data.
Upcoming Medical Appointments Query	List of clients with upcoming medical appointments between a designated date range and medical provider information for follow up.

CARE COORDINATION

Outcome Measures

The following outcomes were used to measure effectiveness of the Care Coordination strategy:

Hypothesis	Key Independent Variables	Dependent Variables
Medication Access	1) Received care coordination services (yes, no) 2) Date of release from incarceration	1) Date of First Medication Pick-Up post-release
Linkage	1) Received care coordination services (yes, no) 2) Date of release from incarceration	1) Date of first care marker post-release 2) Days between release and first care marker
Retention	1) Received care coordination services (yes, no) 2) Date of release from incarceration	1) 12 month retention measure 2) 24 month retention measure
Retention/CHARLI	1) Received care coordination services (yes, no) 2) Date of release from incarceration 3) Received CHARLI services (yes, no)	1) 12 month retention measure 2) 24 month retention measure
Viral Suppression	1) Received care coordination services (yes, no) 2) Date of release from incarceration	1) Viral load measure six months after services start 2) Viral load at 12 months

*   An HIV care marker includes evidence of a CD4 or viral load lab draw, HIV medical care visit, or antiretroviral prescription

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**   Retention in Care over 12 months: An individual is considered "retained in care" over a 12 month period, if he or she has two or more care markers in the 12-month period that are at least three months apart.

***   Retention in Care over 24 months: An individual is considered "retained" in care over a 24 month period if he or she has at least one care marker in each 6-month period, with a minimum of 60 days between each visit.

▪ *Data Sources*

The variables listed above were captured in the Care Coordination/ADAP database. In addition, VDH utilized data from the Care Markers Database (CMDB), which houses HIV data from multiple statewide data systems, including the statewide electronic HIV/AIDS Reporting System (eHARS), the Virginia Client Reporting System (VACRS), the AIDS Drug Assistance Program (ADAP) and available Medicaid data to determine whether a patient has linked and retained in HIV medical care.

▪ *Data Entry and Data Quality*

Data entry and data quality were critical considerations for programs implementing the Care Coordination program. Data entry errors and/or completeness can affect process and outcome measures as well as the ability to match information into other data sources as described above. It is important to ensure adequate staffing of a data manager or data entry specialist to ensure quality assurance processes are occurring on all submitted client-level data.

▪ *Data Analysis*

For the VA SPNS Systems Linkages Initiative, linkage and retention outcomes were assessed using separate logistic regression models in which the individual likelihood of being linked to care and retained in care is estimated. Basic frequencies and means of demographic variables were produced to describe the population receiving Care Coordination services. Process measure data analysis was particularly useful for program planning purposes at the agency level.
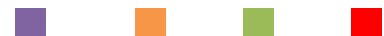
CARE COORDINATION

Care Coordination Data Collection & Evaluation Lessons

- Sites must ensure adequate data manager/data analyst/data entry specialist time to support data management activities at the site level including ensuring necessary variables are programmed into the database and conducting data quality assurance activities on a routine basis.

- Data should be entered no more than a week after a client encounter occurs and overall data should be monitored on at least a monthly basis.

- The creation of several "queries" in the Care Coordination database has facilitated Care Coordinator use of several key variables in order to better track and manage their caseloads and prompt follow up action such as medical appointment reminders or closing client cases.

- Preliminary outcomes demonstrate increases in medication pick-up rates 60 days and 90 days after release from a correctional facility as well as improvements in retention and viral suppression for clients receiving Care Coordination services. Additionally, clients who receive both Care Coordination and CHARLI services demonstrate better 12-month retention and suppression rates than clients who only received one of these programs alone indicating a synergistic effect of a centrally located program focused on medical care and medication access coupled with a local community-based case management program.

Methodology for Preparing this Manual

Implementation insights were identified through a series of interviews with project staff along with a comprehensive review of project progress reports, presentations, and products developed. The methodology was as follows.

- **Project Materials**. Virginia's SPNS project generated lots of materials on the intervention project. Among these resources: strategy protocols; presentations on project goals and activities; agendas; action plans; and tools used in planning, staffing, and other essentials of putting a project like this into place.

- **Interviews**. Few of the above resources captured the experience and thoughts of the interventionists themselves: the program managers at the state level and the people in the field working with clients. To gain their perspectives, a series of group discussions on each strategy were held over a two-month time frame during the final year of the project period (Spring-Summer 2015). Discussions were guided by a series of broad questions and follow-up prompts. The discussions covered: Staffing/Training; Collaboration and Coordination; Protocols and Processes; Working with Patients; and Sustainability. The protocol that was used to conduct these discussions was based upon SPNS sites interview tools used by three other SPNS sites. The draft underwent a few "test drives" and was subsequently modified by the project team.

- **Review of Implementation Manuals**. A review was conducted of a select set of implementation manual drafts from prior SPNS initiatives, as well as more recent manuals from other Linkages projects. This review was undertaken to identify optimal ways to present information, especially lessons learned from project implementation. As a result, an initial outline was developed, using other SPNS manuals as well as the HRSA/HAB template.

- **Analysis and Presentation**. The above information and outline was used to write the implementation manuals. The emphasis was on lessons learned, "aha moments," and other insights that could be readily adopted and adapted by others. As such, the manual maximizes use of bulleted lists that are intended to present information in an easy-to-grasp format.

Care Coordination Strategy Protocol

Special Projects of National Significance (SPNS)
Systems Linkages & Access to Care in Virginia

Virginia Department of Health

Madison Building

HIV Care Services

109 Governor Street

Richmond, Virginia 23219

Care Coordination for Recently Released HIV/AIDS-Positive Inmates: The Seamless Transition and Expedited Enrollment Programs at the Virginia Department of Health (VDH)

Purpose

To provide a seamless transition for recently incarcerated Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) positive individuals by facilitating access to HIV and all of the ADAP medications at the time of release and by providing 12 months of Care Coordination services to help clients retain in HIV care.

Scope

Care Coordination Program: assists clients who are being released from Virginia Department of Corrections (VADOC) facilities and Virginia Regional and Local Jails (VRLJ) with access to a 30 days' supply of Care Coordination medications for all ADAP covered medications and 12 months of linkage to care.

Expedited Enrollment Program (EEP): designed to help individuals in high-risk populations access their AIDS Drug Assistance Program (ADAP) medication/s to prevent medication interruption upon release. Clients who qualify for EEP do not need to provide a provider signed Medical Certification Form or financial documentation and receive 90 days of provisional ADAP approval until all documentation is completed. Under the EEP program, applications are processed within 48 hours of being received.

Collectively, the STP and EEP programs are a part of the Virginia Department of Health's (VDH) Care Coordination strategy for linking and retaining recently released individuals with (HIV/AIDS) medications and care services.

CARE COORDINATION

I   Care Coordination Program Snapshot:

A. Process New Referrals

1. Collaborate with VADOC and VRJL medical staff to coordinate the discharge process and obtain consent to share client information to coordinate care prior to release.

2. Communicate with Local Health Departments (LHD) to inform clients receiving Care Coordination medications via faxed Care Coordination Medication Request and Approval form (Attachment #4). and Discharge Summary Package.

3. Facilitate linkage to medical care by scheduling and verifying medical appointments as well as assist with transportation referrals as needed.

B. Linkage

1. Facilitate referrals for community support services such as CM including the Comprehensive HIV/AIDS Resources and Linkages for Inmates (CHARLI) program, Mental Health, Patient Navigation (PN) and Disease Intervention Specialist (DIS).

2. Refers clients to Certified Application Counselors (CAC) for Marketplace enrollment within 60 days of release.

3. Link clients with PN upon discussion with CM for clients who need to be re-engaged into care.

4. Clients who remain Lost In Care (LIC) for more than six months will be referred to the Department of Disease (DDP) protocol for Disease Intervention Specialist (DIS) for assistance to bring client back into care.

C. Care Coordination Medication

1. Facilitate access to Care Coordination medications for HIV/AIDS-positive individuals being released from VADOC and VRLJ.

2. A client cannot receive Care Coordination medications if they are active and enrolled in ADAP services, however they can still remain a Care Coordination client.

3. For clients referred to Care Coordination from VADOC, CC collaborates with Virginia Commonwealth Health System/Medical College of Virginia (VCUHS/MCV) medical providers to order HIV medications via e-prescriptions to the Central Pharmacy to release Care Coordination medications. Additionally, CC collaborates with VADOC medical providers to order all other ADAP formulary approved medications to release Care Coordination medications.

4. For clients referred to Care Coordination from VRLJ medical department, CC requests the facility to fax a prescription for all medications that match the ADAP formulary to Central pharmacy to release Care Coordination medications.

D. Expedited Enrollment Program

1. Enrolls clients into EEP for provisional 90-day ADAP approval and ensures completion of ADAP enrollment thereafter.

E. Monitoring:

1. Monitor Care Coordination medication pick up at LHD to ensure medications are dispensed no later than 30 days after clients release date.

2. Monitor EEP provisionary approval to ensure receipt all missing documentation within 90 days to continue ADAP approval.

3. Monitor client HIV medication access and adherence for a period of 12 months to confirm monthly receipt of HIV/AIDS medications and report inconsistent pickup/fills to CM.

4. Monitor medical appointment attendance for a period of twelve months and reporting as needed to CM.

F. Data Entry

1. CC enters demographic information and all service encounters into STP/ADAP database.

G. Completion of Services

1. The Care Coordinator (CC) evaluates if clients can graduate early from Care Coordination program for clients have met two care markers and have requested to graduate Care Coordination services early.

2. CC evaluates if clients are retained in Care Coordination program for an additional 6 months if they are not consistently meeting their care markers. If a client is adherent and does not need services and requests to leave services, they may be graduated after 6 months.

II Partnership Collaboration:

A. Care Coordination

1. The CC is a member of the SPNS Program and a part of the ADAP team. The CC provides technical assistance for medication access through programs such as Care Coordination medication, EEP and ADAP to HIV/AIDS-infected individuals being released from VADOC or VRLJ.

2. CC establishes a linkage system for diagnosed HIV/AIDS client's pre-released into the Care Coordination Program, which conducts innovative client and system level outreach interventions.

3. CC also interacts with VADOC and VRLJ medical departments and obtains authorized consent, demographic information and relevant clinical details from all providers to facilitate medication access and linkage to care for all clients.

4. CC will track clients for 12 months and assure that clients are attending medical appointments, picking up medications, completing ADAP applications and receiving linkage to other services in the community.

5. CC will follow clients through the Virginia Client Reporting System (VACRS) database, ADAP database, Ramsell database, CM, phone calls with client, contact letter (Attachment #6) and other sources to ensure that clients are continuing in care.

6. CC will meet monthly with leadership to demonstrate program outcomes and discuss new and relevant information. The following will be provided at each meeting:

   a   Number of Active Clients

   b   New monthly referrals and accumulative monthly referrals

   c   Number of monthly graduated clients from program and accumulative

   d   Where clients are released in the state and where clients reside

   e   Medication pick up rates for all clients who either received Care Coordination medication, are Direct ADAP or ACA enrolled.

7. CC will actively built relationships with VADOC medical teams and participating VRLJs through monthly communication, site visits, trainings, presentations and education.

8. CC will actively search for program expansion opportunities such as locating VRLJs who house large numbers HIV clients.

B. Department of Corrections

1. 30 days prior to the individuals release date, the VADOC medical department will complete the inmate's Medical Discharge Summary (Attachment #1) and acquire the signed authorization to exchange and disclose health information (Attachment #2).

2. VADOC medical department will securely fax the above required forms to VDH/HCS at 804-864-8050.

3. VADOC will notify CC of any known changes about client and their health or demographic status.

4. VADOC will secure future medical appointment if CHARLI is not available.

5. VADOC will provide 30 days of medication upon release.

6. VADOC will send a script for all non-HIV medications that are covered on the ADAP formulary to Central Pharmacy to release Care Coordination medications.

7. Participates in trainings and meetings that focus on partnership collaboration with Care Coordination.

C. Virginia Regional and Local Jails

1. Prior to the inmate's release date, the VRLJ medical department will complete the inmate's VLRJ Discharge Summary (Attachment #3), the signed authorization to exchange and disclose health information (Attachment #2), a copy of their medication list and a copy of their most recent labs.

2. The VRLJ will securely fax these forms to VDH/ HCS at 804-864-8050.

3. The regional and local jail will notify CC of any known changes regarding client and their health or demographic status.

4. VRLJ may secure future medical appointment.

5. The VRLJ may provide 3 to 7 days of medication upon release.

6. VRLJ may send a script for all non-HIV medications that are covered on the ADAP formulary to Central Pharmacy to release Care Coordination medications.

D. Comprehensive HIV/AIDS Resources and Linkages for Inmates program

1. Coordinates pre-release intake with clients leaving VADOC or VLRJ.

2. Works collaboratively with VADOC and VLRJ medical team to coordinate upcoming medical appointments and assist with transportation needs.

3. Assists with Care Coordination medication pick up and drop off to client as needed.

4. Assists with the completion of ADAP application.

5. Actively refers clients to CC who were not referred into Care Coordination program.

6. Partners with Care Coordination program for program expansion.

7. Works collaboratively with CC to address barriers to care and unmet needs.

8. Provides services such as bus tickets, food pantry, Goodwill vouchers, housing assistance, transportation and other incentives.

9. Participates in trainings and meetings that focus on partnership collaboration with Care Coordination.

E. Virginia Commonwealth Health System/Medical College of Virginia

1. Provides medical care to VADOC inmates through telemedicine while they are incarcerated.

2. Receives and acknowledge the receipt of the Care Coordination Medication Request and Approval form (Attachment #4) for the referred client by the CC

3. The VCUHS medical provider gives signed authorization for 30 days of ADAP approved HIV medication and orders medications via e-prescriptions through Central Pharmacy.

4. VCUHS conducts a financial screening to ensure eligibility requirements, which includes ADAP enrollment for clients who will receive care at VCUHS after release. Clients receive a pre-medical screening and schedule labs prior to their first medical appointment.

F. Local Health Departments

1. Provide clients with additional 30-day supply of Care Coordination medications that were ordered through the Care Coordination program.
2. Refer clients to CC to complete eligibility for ADAP at the initial visit to the LHD when picking up Care Coordination medications.
3. Inform client that an ADAP application and 6 month recertification will be needed in order to provide ongoing ADAP medications for the next 12 months.
4. Notify the CC if client does not pick up medications within 60 days.
5. Coordinate all communication and correspondence for client's pre-release/discharge through the VDH CC. The CC can be reached at: 804-864-7919, 804-864-7219 or Toll Free 855-362-0658.

G. Case Managers from Community Based Organizations and Infectious Disease Clinics

1. CC will actively refer clients to CHARLI however there are a few reasons why a client would not receive CHARLI services:
   a   Client chooses CM that is geographically closer place of residence
   b   Client has formed or had previously formed a relationship with other CM
   c   Client needs services that are not provided by CHARLI
2. Care Coordination services will remain the same for clients who receive CM from other agencies.

H. Patient Navigation Services

1. CC will refer clients to PN if there are CM available.
2. CC will refer to PN if client has not been engaged to care with their CM for no more than 3 months meaning that client has not attended scheduled appointments and/or picked-up/filled medications.
3. CC will always follow PN protocol for client referrals.
4. CC will fax PN all client encounter notes to assist with re-engagement.
5. CC will fax PN the most recent demographic information found in Nexis Lexis.
6. PN will be given 90 days to re-engage client to care.
7. CC will follow up with PN progress with client weekly either through phone calls or fax.

8. If PN locates client then CC will contact client directly and inquire where they would like to receive CM services. Client is not required to go back to original CM if that was not a good fit. Client can choose to remain on PN services if PN agrees.

9. If PN is not able to re-engage client then CC will refer to DIS.

I. Disease Intervention Specialists

1. CC can refer client to DIS for assistance to bring client back into care. This step occurs after clients CM and PN have exhausted all outlets to re-engage client and at least six months has gone by since last client contact.

2. CC will locate the DIS at the closest LHD where client resides by phone to inquire if referral can be made.

3. CC will follow all DIS protocol when referring a client.

4. CC will fax all service encounter notes and latest demographics pulled from Lexis Nexis.

5. DIS will be given 60 days to re-engage clients to care.

6. CC will not contact DIS for the initial 60 days as that is their protocol.

7. After 60 days CC will contact the DIS to inquire on client update.

8. If client has been located then CC will contact client directly and inquire where they would like to receive CM services. Client is not required to go back to original CM if that was not a good fit.

9. If client is not located by DIS then client will be dis-enrolled from the Care Coordination program.

10. CC will send a contact letter (Attachment #6) to last known address regarding disenrollment from the program.

11. Client will remain on DIS protocol for LIC clients under their protocol.

III Care Coordination Program Services

A. Processing New Client Referrals from VDOC and VRLJ:

1. Client Released from Virginia Department of Corrections:

a VADOC medical staff completes the medical Discharge Summary (Attachment #1) and acquires the signed authorization to exchange and disclose health information (Attachment #2) for clients being released from VADOC facilities. Ideally, the VADOC will refer clients to CC thirty days prior to release via secure fax. There are circumstances where a client is suddenly paroled and the referral will arrive the same day as the release date.

    b   Upon receipt of the discharge package the CC will contact the VADOC medical staff who initiated the discharge forms for any missing information via phone.

    c   CC will enter all new referrals into the STD/ADAP Data base.

    d   CC will initiate medication access and linkage to care 30 days pre-release.

2.   Client Released from Virginia Regional and Local Jails

    a   The VRLJ medical staff completes the Medical Discharge summary (Attachment #3) for clients being released and acquires the signed authorization to exchange and disclose health information (Attachment #2). Because of the short-term sentences and quick releases associated with jails, it is often difficult for these referrals to CC to occur prior to release. This package is sent to the CC via secure fax from the VRLJ medical department.

    b   Upon receipt of the discharge package the CC will contact the VRLJ medical staff who initiated the discharge forms for any missing information via phone.

    c   VLRJ clients may also be referred to CC by CHARLI Coordinators, ID Clinics, ADAP Coordinators at LHDs, CBOs, PNs, ADAP Operations Technicians or other referral sources.

    d   CC will need to obtain the authorization to exchange and disclose health information (Attachment #2) or signed ADAP application to enroll a client into Care Coordination services.

    e   CC will enter all new referrals into the STD/ADAP Data base.

    f   CC will initiate medication access and linkage to care before release if possible or immediately upon release.

B. Processing New Client Referrals from Other Sources:

1.   Comprehensive HIV/AIDS Resources and Linkages for Inmates program

    a   Program Structure and Organization

       i.   The CHARLI program is divided into 5 health regions and covers the entire state of Virginia.

- Northwest - Thomas Jefferson Health District
- Northern Region - Inova Juniper Program
- Southwest - Council of Community Services
- Central - Fan Free Clinic
- Eastern - Minority Support Services

      ii.   The CHARLI program provides a continuum of services for HIV/AIDS-positive inmates and recently incarcerated individuals including: pre-release HIV/AIDS STD education

in correctional facilities, pre-release and post- release discharge planning, and CMCM for 18 months after release from incarceration.

 iii. CHARLI Coordinators are trained to facilitate care in both VADOCs and VLRJs.

 iv. The CHARLI program has access to bus tickets, food pantry, Goodwill vouchers, transportation funds and housing assistance and other incentives to engage client to care.

b Shared Referrals between CC and CHARLI

 i. CHARLI will refer all clients to CC after initial intake.

- CHARLI will notify CC via phone or secure fax regarding HIV positive released inmate.
- CC will provide Care Coordination services for clients that have been released from incarceration up to 12 months prior referral.
- CHARLI will fax consent and all other documentation to CC via secure fax.

 ii. CC will refer all clients to CHARLI upon initial referral

- CC will identify which CHARLI coordinator works in clients jurisdiction.
- CC will notify CHARLI coordinator of new client referral via phone.
- CC will secure fax all documentation to CHARLI coordinator.

c Partner Collaboration

 i. CC and CHARLI coordinators will visit new VRLJs in efforts to expand both programs statewide.

 ii. CC will meet monthly with CHARLI contract monitor to discuss any pertinent program information.

 iii. CC will speak on CHARLI conference calls as needed to inform the coordinators of updates and new information.

 iv. CC and CHARLI contract monitor will organize yearly partner collaboration meetings/trainings with guest speakers and incentives to grow relationships and show appreciation and program success.

 v. CC and CHARLI will actively built relationships with VADOC medical teams and participating VRLJs through monthly communication, site visits, trainings, presentations and education.

2. Case Management/Patient Navigation/ADAP coordinators at LHD/ADAP Technicians

a CC will actively build relationships with all current and prospective partners to ensure program success and expansion.

    i. This can be accomplished through phone calls, emails, meetings, presentations and trainings.

b   Referrals from CM and PN

    i. CC can actively receive referrals referral sources who inmate intake with clients who need HIV services and indicate that they have been released from incarceration with the past 12 months.

    ii. Once CC receives, a consent form CC will actively obtain any missing information needed to provide Care Coordination services. The consent form that the referral sources uses is valid for client enrollment into Care Coordination program.

    iii. If the client is not enrolled into direct ADAP, CC will actively try to obtain medication list and most recent labs from their previous facility in efforts to coordinate Care Coordination medication and Expedited Enrollment.

    iv. CC will refer clients to CM if needed and provide 12 months of Care Coordination services.

3. Referrals from ADAP coordinators at LHD and ADAP technicians

a   LHD ADAP coordinators

    i. LHD ADAP coordinator will send the ADAP application or consent form to CC.

    ii. Once CC receives, a consent form CC will actively obtain any missing information needed to provide Care Coordination services. The consent form that the referral sources uses is valid for client enrollment into Care Coordination program.

    iii. If the client is not enrolled into direct ADAP, CC will actively try to obtain medication list and most recent labs from their previous facility in efforts to coordinate Care Coordination medication and Expedited Enrollment.

    iv. CC will refer clients to CM if needed and provide 12 months of Care Coordination services.

b   ADAP Technicians

    i. The ADAP technician will refer new ADAP applications that arrive that have indicated that client has been recently released.

    ii. ADAP technicians will actively notify CC of clients who are found to be incarcerated during the recertification process.

    iii. CC will identify where client is house through VINELINK and notify CHARLI coordinator of client's current incarceration status.

    iv. CHARLI will work towards a pre-release intake with client and notify CC of client release date.

CARE COORDINATION

C. Procedure for Coordinating Care Coordination Medications

1. Virginia Department of Corrections Clients

   a 30 days prior to release the CC will fax Care Coordination Medication Request and Approval (Attachment #4) to Central Pharmacy to indicate that client is a Care Coordination client and to be aware of incoming prescriptions.

   b CC will fax the Care Coordination Medication Request and Approval form (Attachment #4) to VCUHS/MCV and VADOC providers to initiate Care Coordination medication request.

   c The VCUHS/MCV medical providers will order HIV medications via e-prescriptions to the Central Pharmacy to release Care Coordination medications.

   d VADOC provider faxes non-HIV ADAP medication prescriptions to Central Pharmacy for Care Coordination medications.

   e CC will fax Care Coordination Medication Request and Approval form (Attachment #4) and the Discharge Summary Package to the LHD in the jurisdiction where the client plans to reside and the corresponding CHARLI case manager.

   f CC will wait up to 3 days for VCHUS/MCV to return the CC Medication Request and Approval form with a physician signature. This confirms that medications were sent to Central Pharmacy. After three days, the VDH CC will resend paperwork or call VCHUS/MCV contact. If client does not pick up medication from LHD within 3 weeks

   g after release, the CC will contact the client's CM or client to confirm awareness of medication pick up hours of operation and location.

   h CC will address any barriers that are preventing client from picking up Care Coordination medications, communicating needs to the CM and providing support to both the client and the CM.

   i CC will follow up weekly with either client or client CM until Care Coordination medication pick up is confirmed.

   j CC will document Care Coordination date of pick up in STP/ADAP database.

   k All medications that have not been picked up by client will be returned to the Central Pharmacy by the LHD after 60 days.

   l If a client remains out of care, the VDH CC will forward their information to PN for additional support in locating client.

   m If PN is unable to re-engage client back into care then CC will refer client to DIS for assistance to bring client back into care.

   n CC will send a letter to client's last known address in an attempt to make contact.

CARE COORDINATION

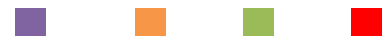2. Virginia Regional and Local Jail Clients

    a   Pending the short notice of the referral the CC will complete and approve Care Coordination Medication Request and Approval form (Attachment #4) prior or immediately after release.

    b   CC will fax the Care Coordination Medication Request and Approval form (Attachment #4) and Discharge Summary Package to the VDH Central Pharmacy to notify that client is with the Care Coordination program and to be aware of incoming prescriptions.

    c   CC will fax the Care Coordination Medication Request and Approval form (Attachment #4), the VLRJ Discharge Summary (Attachment #3) and signed consent form to the LHD in the jurisdiction where the inmate plans to reside at time of approval.

    d   CC will request the VRLJ provider to fax all prescriptions that match the ADAP formulary to Central Pharmacy.

    e   A VRLJ client can also be referred to Care Coordination by CHARLI Coordinators, ADAP Coordinators at LHDs, CBOs, PNs, ADAP Operations Technicians or other referral sources.

        i.   CC will need to obtain the authorization to exchange and disclose health information (Attachment #2) or signed ADAP application to request medication list and most recent lab results.

        ii.   CC can try to obtain prescriptions to be sent to Central Pharmacy from the prescribing jail physician if the jail is participating in the Care Coordination program.

        iii.   If the jail does not participate in the Care Coordination program then CC can release the labs and medication list to the client's future provider and request that provider send scripts to Central Pharmacy to release Care Coordination medications.

        iv.   If client is active and enrolled into ADAP then Care Coordination medications will not be dispensed, however client will remain in the Care Coordination program.

    f   If client does not pick up Care Coordination medication from the LHD within 3 weeks of release, the VDH CC will contact the client or client's CM to confirm awareness of medication pick up hours of operation and location.

    g   CC will address any barriers that are preventing client from picking up Care Coordination medications, communicating needs to the CM and providing support to both the client and the CM.

    h   CC will follow up weekly with either client or client CM until Care Coordination medication pick up is confirmed.

    i   CC will document Care Coordination date of pick up in STP/ADAP database.

  j All medications that have not been picked up by client will be returned to the VDH Central Pharmacy by the LHD after 60 days.

  k If a client remains out of care, the VDH CC will forward their information to PN for additional support in locating client.

  l If PN is unable to re-engage client back into care then VDH CC will refer client to DIS for assistance to bring client back into care.

  m CC will send a letter to client's last known address in an attempt to make contact.

 D. Procedure for Expedited ADAP Enrollment

  1. Time Frame

   a CC will Expedite ADAP Enrollment for all VADOC clients within 30 days of release.

   b CC will Expedite ADAP Enrollment for all VRLJ clients within 48 hours of release.

  2. Signature and Consent for EEP approval

   a The ADAP application is completed and signed by a client or the client's case manager.

   b If there is not an ADAP application sent to the CC then the CC can fill out the ADAP application on behalf of the client. The CC will sign the signature page and attach a copy of the client's signed consent form located within the client's Discharge Summary Package.

  3. All ADAP applications will have current lab values with a CD4 count/viral load and date

   a The values can be found in the Discharge Summary Package. If there is no value available, the CC can verbally receive the information from the facility or clinic.

   b Lab values must be within the last 6 months for EEP provisional approval.

   c CC needs to attach a copy of the Discharge Summary (Page 2) of Discharge Summary Package behind the ADAP signature page. (The values will be highlighted).

  4. Financial Documentation or Proof of Income (POI)

   a Being recently incarcerated and unemployed, the POI is not needed for the client to be EEP approved. However, the client will be required to provide financial documentation at the time of recertification.

  5. Provider Information

   a The date and time of the scheduled medical appointment is located in the Discharge Summary (Page 1).

   b If the physician of the client is unknown than the CC may put "Pending Provider" in the ADAP Eligibility Checklist.

  6. Health Department Information

    a   The client's LHD will be listed in the Discharge Summary Package and will receive a faxed copy of the EEP provisional approval letter (Attachment #5) and ADAP application.

7. Pre EEP Approval Requirements

    a   CC will request a provider signed Medical Certification Form to be sent within 90 days for continued ADAP approval.

    b   The requested information is located on the fax cover sheet and within the approval letter (Attachment #5).

    c   Fax cover sheets will be sent to Central Pharmacy, LHD, Medical Provider/ID Clinic, and to the client's case manager.

    d   The EEP provisional approval letter (Attachment #5) is submitted to ADAP Coordinator or designee for approval signature to be mailed to the client or case manager if there is not a known address.

    e   A confidential envelope will have the client's address and name printed on the front.

    f   CC will make a note in the notes section that the client is EEP provisional approved for Direct ADAP for 90 days.

8. Post EEP Approval Requirements

    a   CC will fax the copy of the signed EEP provisional approval letter (Attachment #5) along with the ADAP application, lab values and medication list to Central pharmacy, LHD and case manager.

    b   CC will make a note in the Seamless Database that the client was approved for ADAP under the 90 days of EEP provisional approval.

    c   CC will create a corresponding Follow-Up Action in the Seamless database to date the end of the 90 days.

9. Data

    a   CC will submit the file to the Data Team, with a request that the file be returned after its entry. This request is indicated and highlighted in the note section of the ADAP file.

    b   Once returned, CC will place ADAP file in the top drawer of the Care Coordination cabinet in the corresponding month of when the client's EEP provisional approval ends.

    c   CC will note that file is stored in the Care Coordination cabinet in the note section of the ADAP database.

    d   CC will actively follow up on completion of ADAP approval.

10. ADAP Approval

    a   In order for a client to be ADAP approved, their medical provider will submit a Medical Certification Form with the client's most recent CD4 count and viral load. This will be

completed within the 90 days of the EEP provisional approval. Lab values must be dated within the last 6 months.

b   Once the provider signed Medical Certification Form arrives, CC places the document in the ADAP file that is housed in the Care Coordination cabinet.

c   CC will note in the client's ADAP file that the Medical Certification Form has been received and that the client is ADAP Approved on the notes document.

d   CC will also note any changes to the client's Provider, Insurance Status and LHD on the notes document if present.

e   The ADAP Approval Letter will be drafted and submitted for signature by the ADAP Coordinator or designee.

f   After the ADAP Approval Letter is signed, the letter will be sent to Central Pharmacy, LHD, Medical Provider/ID Clinic and the client.

g   CC will submit the file to the data team for completion.

11. Denial

a   If the CC does not receive a completed and provider signed Medical Certification Form within the 90 days of the EEP provisional approval then CC will issue an ADAP Denial letter to the client.

b   The ADAP Denial letter will be signed and faxed to Central Pharmacy, LHD, Medical Provider/ID clinic, and case manager.

c   A copy of the ADAP Denial letter will be placed in the client's file, and the original will be mailed out to the client.

d   The updated ADAP file will be submitted to data for processing.

e   Upon denial, the client can start the process to be re-enrolled into ADAP however the client is no longer eligible for EEP approval.

E.   Procedure for Confirming Medication Adherence

1.   Resources Used to track Medication

a   Direct ADAP Clients

i.   Send secure faxes on the first day of each month to individual LHDs that serve Care Coordination clients. Each fax contains the client's name, date of birth and a space for the LHD ADAP Coordinator to write in client's last medication pick up date. The LHD ADAP Coordinator then returns completed information to CC through secure fax.

ii.   Call the LHD ADAP Coordinator monthly to inquire medication pick up dates.

        iii.   Use the internal ADAP medication database to look up the date of a refill request to Central Pharmacy by the LHD.

        iv.   Review the Virginia Medication Assistance Registry System (VMARS) to obtain the most current date of client's medication fill.

        v.   Review VACRS for medication pick up which shows CHARLI data.

  b   For clients that are enrolled ADAP insurance programs

        i.   CC can obtain access to the RAMSELL database, which shows medication pick up dates at local pharmacies. CC is currently unable to see pick up dates after client has reached their Maximum out of Pocket.

  c   All other Care Coordination Clients

        i.   The VDH CC is unable to confirm medication pick up for clients who have other forms of public insurance, including Medicaid and Veteran's Administration. However**,** the CC is able to confirm medication compliance through verbal affirmation from the CM or the client.

2. Initial Care Coordination or Medication Pick-up/Fills

  a   CC will prioritize the first medication fill or pick up for client as this is a relevant marker for continued client engagement into care.

  b   CC will document the date of the first Medication Pick-up or Fill in the STP/ADAP database.

3. Continued Medication Pick-Up/Fills

  a   CC will continue to follow medical appointments, tracking made appointments and inputting appointments into the STP/ADAP database.

4. Addressing Inconsistent Medication Pick-up/Fills

  a   If a client does not pick up medications within 1 month of the last pick up date, the CC will notify the CM and call the client to determine barriers to care and assess unmet needs.

  b   If CM is unable to engage clients into care within 3 months of notification then CC will refer clients to PN. This action is always in mutual agreement with case managers. PN will have 3 months to re-engage clients into care. If the CC and the CM are unable to

  c   locate the client, the VDH CC will search the statewide registry for re-incarceration.

  d   CC will use the Lexis Nexis to search for updated demographic information and share new information for CM or new referral sources.

  e   If PN is able to re-engage, the client can choose to keep PN as their CM or be reinstated into their original case manager.
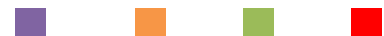
f   If PN is unable to re-engage client back into care then CC will refer client to DIS for assistance to bring client back into care.

g   If DIS is able to bring client back into care then CC contacts client to inquire where they would like to receive case management services.

h   If DIS is unable to bring client back to care then CC will send the client a contact letter (Attachment #6) in the mail and dis-enroll client from Care Coordination Services.

F.   Procedures for Confirming Medical Appointments

   1.   Initial Medical Appointment

      a   The VADOC or CHARLI Coordinators will schedule the first medical appointment for released clients. This information is located on the Discharge Summary Package.

      b   CC will schedule appointments for clients who have not received help from VADOC or CHARLI coordinators.

      c   CC will document if the client went to their first appointment in the STP/ADAP database and input their upcoming appointment to run medical appointment queries.

      d   If a client misses their first appointment, that client will become a priority on the CC caseload. CC will work with CM and client and other referral sources as necessary to engage client into care.

   2.   Continued Medical Appointments:

      a   CC will continue to follow medical appointments, tracking made appointments and inputting appointments into the STP/ADAP database.

   3.   Process for Missed Medical Appointments:

      a   CC will contact CM or clients when three consecutive appointments are missed.

      b   CC will contact CM if client has gone 6 months without a lab appointment.

      c   If CM is unable to engage clients into care within 3 months of notification then CC will refer clients to PN. This action is always in mutual agreement with case managers. PN will have 3 months to re-engage clients into care.

      d   If the CC and the CM are unable to locate the client, the VDH CC will search the statewide registry for re-incarceration.

      e   CC will use the Lexis Nexis to search for updated demographic information and share new information for CM or new referral sources.

      f   If PN is able to re-engage, the client can choose to keep PN as their CM or be reinstated into their original case manager.

      g   If PN is unable to re-engage client back into care then CC will refer client to DIS for assistance to bring client back into care.

h   If DIS is able to bring client back into care then CC contacts client to inquire where they would like to receive case management services.

i   If DIS is unable to bring client back to care then CC will send the client a contact letter (Attachment #6) in the mail and dis-enroll client from Care Coordination Services.

G. Procedures for client Follow-up/Engagement

1. Adherent Clients

a   Defined as: Clients who attend medical appointments within 1 month of recommended appointment times as requested by their physician, pick up their medications monthly, complete ADAP enrollment if needed, and are responsive to case manager and/or CC calls and requests.

i. CC will contact the CM or client for the following reasons:

- Refer client to CM upon processing into Care Coordination program.
- Client does not have pertinent information on Discharge Summary Package.
- Approval or Non-Approval for Care Coordination medications.
- Approval or Non-Approval for EEP.
- Assistance for Marketplace enrollment.
- Pending ADAP documentation for continued ADAP approval.
- Client has reached 12 months of Care Coordination has successfully graduated from Care Coordination program.

ii. Frequency:

- Clients who are engaged into care do not need frequent contact with CM because they are actively picking up or filling medications and attending appointments.

2. Non-compliant Clients

a   Defined as clients who do not attend medical appointments or have labs every six months, do not pick up medications monthly, do not complete the ADAP enrollment package if needed, and/or have not had contact with the CM or CC.

i. CC will contact the CM or client for the following reasons:

- Client has been released for three weeks without picking up Care Coordination medications.
- Client has missed first medical appointment.
- Client went to first medical appointment but missed three or more consecutive appointments.
- Client has not been to an appointment in six or more months.

- Client has not picked up medication and is out of medication.
- Client needs to be referred to PN for re-engagement into care.
- Client needs to be referred to DIS for assistance to bring client back into care.
- Client has reached 12 months of Care Coordination services and has not consistently met their care markers therefore needing a 6-month extension.

    ii. Frequency:
- Clients who are not engaged into care will require weekly communication, as it is the goal of Care Coordination for retention to care, reduced recidivism and program success.
- There is not a maximum amount of times that a CC can have a client service encounter until client is re-engaged back to care.

H. Procedures for Graduating Client from Care Coordination

    1. Twelve Month Care Coordination Program

        a   12 months is an important HIV/AIDS care retention measure to indicate that a client has successfully linked and retained in HIV/AIDS care.

        b   12 months allows adequate time for the CC to track medical appointments and medication pickups and address barriers to retention or medication pickup.

        c   CC work actively during those 12 months in collaboration with a CM, CHARLI program, PN and/or DIS to communicate missed appointments and medication pickups to address client needs.

    2. Graduation from Care Coordination Program

        a   Client can graduate early from services if they have met two care markers and have requested to graduate from program.

        b   Clients who have not consistently met their care markers can remain on Care Coordination for an additional 6 months.

        c   Client who have successfully met all care markers can continue CM services and additional referrals can be made if client is not self managed.

        i.   CC will notify CM to inquire if they agree that client is ready to graduation from Care Coordination services.
- If CM agrees that client can graduate then CC will enter all necessary information into STP/ADAP database.
- If CM believes that client needs addition CC support then CC will retain client for an additional 6 months. This can be an ongoing process until CC and CM mutually agree that client is ready to graduate.

IV   Contingencies:

    A.   Care Coordinator Commitment

        1.   The CC always commits to the goal of the program, which is to **"To provide a Care Coordination Services for recently incarcerated HIV/AIDS-positive clients in regards to related Care Coordination medications, EEP enrollment, ADAP enrollment and linkage to care for 12 months."**

        2.   Prior to action to any circumstance that is not listed on this protocol, the CC will communicate any special circumstances to his/her supervisor within the ADAP program.

V   Content of Care Coordination Documents**:**

    A.   VADOC Discharge Summary Package:

        1.   *VADOC Discharge Summary* to include client demographics, date of diagnosis, dates of other infectious diseases, all current medications, all pertinent laboratory values and dates of test/s. Also included, is the client's future medical provider, scheduled appointment date and location of LHD chosen by offender for EEP medication pickup. (Attachment #1)

        2.   *Authorization to Exchange and Disclose Health Information* which provides client consent to share their health information with VDH in order to coordinate services such as medical care, medication access, housing, and transportation, Marketplace enrollment and other support services. (Attachment #2)

    B.   VRLJ Discharge Summary Package:

        1.   *VRLJ Discharge Summary* to include client demographics, date of diagnosis, dates of other infectious diseases, all current medications, all pertinent laboratory values and date of tests. Also, included is the client's future medical provider, scheduled appointment date and location of LHD chosen by offender for EEP medication pickup. (Attachment #3)

        2.   *VDH Authorization to Exchange and Disclose Health Information* which provides client consent to share their health information with VDH in order to coordinate services such as medical care, medication access, housing, and transportation, Marketplace enrollment and other support services. (Attachment #2)

    C.   Care Coordination Medication Request and Approval Form:

        1.   This form is used by VDH to request a prescription for a client to provide an additional 30 day supply of ADAP medications through the VDH Central pharmacy for both VADOC and VRLJ clients. (Attachment #4)

    D.   EEP Provisional Approval Letter:

1. This letter is used to communicate the EEP Provisional enrollment approval, dates of service and documentation pending and sent to Central Pharmacy, LHD, ID/Medical provider and CM. (Attachment #5)

E. Contact Letter
   1. This letter is used to contact client via mail when the client is unable to be reach through other methods. (Attachment #6)

F. ADAP Eligibility Guidelines**:**
   1. An overall description of ADAP guidelines and parameters for eligibility and program enrollment.. (Attachment #7)

G. Partnership Collaboration Flow Chart:
   1. A flow chart depicting the flow of the Relationships and Partnerships involved in the Care Coordination Program. (Attachment #8)

Review and Revision

The protocol is reviewed annually by CC, ADAP Leadership, Central Pharmacy, LHD, VCU/MCV provider, VADOC Head Epidemiology Nurse and Health Service Administrators Directors at VRLJ.

Definitions

ADAP: Virginia AIDS Drug Assistance Program

CAC: Certified Application Counselors

CC: Care Coordinator

CHARLI: Comprehensive HIV/AIDS Resources and Linkages for Inmates

DDP: Department of Disease Prevention

DIS: Disease Intervention Specialist

EEP: Expedited Enrollment Program

HCS: HIV/AIDS Care Services

ID: Infectious Disease

LHD: Local Health Department

LIC: Lost in Care

POI: Proof of Income

STP: Seamless Transition Program

VACRS: Virginia AIDS Client Reporting System

CARE COORDINATION

Attachments/Forms

1. VADOC Discharge Summary

2. VDH Authorization to Exchange and Disclose Health Information

3. VRLJ Discharge Summary

4. Care Coordination Medication Request & Approval Form

5. EEP Approval Form

6. VDH Contact Letter

7. ADAP Eligibility Guidelines

8. Partnership Collaboration Flow Chart

Attachment 1. VADOC Medical Discharge Summary

VIRGINIA DEPARTMENT OF CORRECTIONS

INFECTIOUS DISEASE DISCHARGE SUMMARY **Page 1 of 2**

Fax copy: VDH HIV Care Coordinator at (804) 864-8050
Send original to: Epidemiology Nurse, Dept. of Corrections: 6900 Atmore Drive, Room 2095 Richmond VA 23225

CLIENT INFORMATION		
Name:	**DOB:**	**ID Number:**
DOC/JAIL Facility NAME:	**SSN:**	**Race:**
Ethnicity: Non-Hispanic ☐ Hispanic/Latino ☐ Unknown ☐	**Gender:** Male ☐ Female ☐ Transgender ☐	**Release Date:**
Home Address:	**Phone Number:**	

DISCHARGE INFORMATION	
Medical Provider Name:	**Phone Number:**
Medical Provider Address:	**Scheduled Appointment Date/Time:**
Case Manager Name:	**Phone Number:**
Health Department where client wants to pick up medications upon release:	

LINKAGE TO CARE AND SERVICES			
List special counseling or treatment programs that client may need upon release. (i.e. Substance Abuse/Mental Health)	1. 2. 3.		
Has stable housing for first night of release?	YES	NO	Unknown
Is client currently adherent to drug regimen?	YES	NO	Unknown
Is client currently blind or disabled?	YES	NO	

Additional Notes: _____
_____
_____

VADOC Medical Discharge Summary (Page 2)

INFECTIOUS DISEASE DISCHARGE SUMMARY **Page 2 of 2**

CLIENT NAME:	DOB:

CURRENT LAB VALUES		
CURRENT DISEASE STATUS:		
☐HIV Positive, not AIDS ☐HIV Positive, AIDS status unknown ☐CDC-defined AIDS ☐Pediatric		
Most Current CD4 Count:		DATE:
Most Current CD4 Percentage:		DATE:
Most Current HIV Viral Load:		DATE:

INFECTIOUS DISEASE HISTORY			
INFECTIOUS DISEASE:	**YES**	**NO**	**DATE DIAGNOSED**
HIV/AIDS:			
HEPATITIS C:			
HEPATITIS B:			

CURRENT MEDICATIONS		
Name of HIV-Related Medication/s:	**Released with Medication upon release:**	**Amount of Medication supply provided at release: (total # of days)**
1.	Yes No	
2.	Yes No	
3.	Yes No	
4.	Yes No	
5.	Yes No	
Name of other Current Medications		
1.	Yes No	
2.	Yes No	
3.	Yes No	
4.	Yes No	
5.	Yes No	
6.	Yes No	
7.	Yes No	
8.	Yes No	
9.	Yes No	

FORM COMPLETED BY:

Printed Name:	Direct Phone:	Extension:
Signature:	Business Cell:	Fax:

Attachment 2. VDH Authorization to Exchange & Disclose Health Information

AUTHORIZATION TO EXCHANGE AND DISCLOSE HEALTH INFORMATION

I understand that different agencies provide different services and benefits and that each agency must have specific information to provide those services and benefits.   By signing this form, I allow agencies to use and exchange certain information, so it will be easier for them to work together efficiently to provide or coordinate these services or benefits.

_____   _____
PRINT INMATE'S FULL NAME   DOB (MM/DD/YYY)

I want the following confidential information to be exchanged (Please check all that apply):

☐   Benefits/Services Needed Planned, and/or Received   ☐   Medical Records

☐   Contact Information After Discharge   ☐   Mental Health Diagnosis

☐   Criminal Justice Records   ☐   Psychological Records

☐   Laboratory Results   ☐   Substance Use History and Treatment

☐   Medical Diagnosis   ☐   All of the Above

To receive services, resources and/or additional assistance through the Virginia Department of Health, community agencies or medical facilities (Please check all that apply):

COMPREHENSIVE HIV/AIDS RESOURCE AND LINKAGES FOR INMATES (CHARLI) PROGRAM:

☐   Thomas Jefferson Health District - Charlottesville, VA

☐   Council of Community Services - Roanoke, VA

☐   Fan Free Clinic - Richmond, VA

☐   Minority AIDS Support Services - Newport News, VA

☐   Inova Juniper – Northern VA

PATIENT NAVIGATION:

☐   Carilion, Infectious Disease Clinic - Roanoke, VA

☐   Virginia Commonwealth University, Infectious Disease

      Clinic - Richmond, VA

OTHER:

☐   Virginia Department of Health - Richmond, VA

☐   _____
      (PRINT THE AGENCY AND/OR PROGRAM IF IT IS NOT LISTED ABOVE)

This authorization is good until   ☐   My service case is closed.   ☐   Other _____

I can withdraw this authorization at any time by telling the referring agency.   The listed agencies must stop sharing information after they know my authorization has been withdrawn.   I have the right to know what information about me has been shared, and why, when, and with whom it was shared.   If I ask, each agency will show me this information.   I want all agencies to accept a copy of this form as valid authorization to share information.   If I do not sign this form, information will not be shared and I will have to contact each agency individually to give information about me that is needed.   However, I understand that treatment and services cannot be conditioned upon whether I sign this authorization.   There is potential for information disclosed pursuant to this authorization to be re-disclosed by the recipient and not be subject to the HIPAA Privacy Rule.

Signature(s): _____   _____
                                     (AUTHORIZATION PERSON OR PERSONS)   *(DATE)*

Person Explaining Form: _____   _____   _____
                                               (NAME)   *(CORRECTIONAL FACILITY)*   *(PHONE NUMBER)*

Witness (If Required): _____   _____   _____
                                         (SIGNATURE)   *(ADDRESS)*   *(PHONE NUMBER)*

Attachment 3. VRLJ Medical Discharge Summary

Virginia's Local and Regional Jails

INFECTIOUS DISEASE DISCHARGE SUMMARY **Page 1 of 2**

Fax copy: VDH HIV Care Coordinator at (804) 864-8050
Send original to: Epidemiology Nurse, Dept. of Corrections: 6900 Atmore Drive, Room 2095 Richmond VA 23225

CLIENT INFORMATION		
Name:	**DOB:**	**ID Number:**
DOC/JAIL Facility NAME:	**SSN:**	**Race:**
Ethnicity: Non-Hispanic ☐ **Hispanic/Latino** ☐ **Unknown** ☐	**Gender:** **Male** ☐ **Female** ☐ **Transgender** ☐	**Release Date:**
Home Address:	**Phone Number:**	

DISCHARGE INFORMATION	
Medical Provider Name:	**Phone Number:**
Medical Provider Address:	**Scheduled Appointment Date/Time:**
Case Manager Name:	**Phone Number:**
Health Department where client wants to pick up medications upon release:	

LINKAGE TO CARE AND SERVICES			
List special counseling or treatment programs that client may need upon release. (i.e. Substance Abuse/Mental Health)	1. 2. 3.		
Has stable housing for first night of release?	YES	NO	Unknown
Is client currently adherent to drug regimen?	YES	NO	Unknown
Is client currently blind or disabled?	YES	NO	

Additional Notes: _____
_____
_____

INFECTIOUS DISEASE DISCHARGE SUMMARY **Page 2 of 2**

CLIENT NAME:	DOB:

CURRENT LAB VALUES		
CURRENT DISEASE STATUS:		
☐HIV Positive, not AIDS ☐HIV Positive, AIDS status unknown ☐CDC-defined AIDS ☐Pediatric		
Most Current CD4 Count:	DATE:	
Most Current CD4 Percentage:	DATE:	
Most Current HIV Viral Load:	DATE:	

INFECTIOUS DISEASE HISTORY			
INFECTIOUS DISEASE:	**YES**	**NO**	**DATE DIAGNOSED**
HIV/AIDS:			
HEPATITIS C:			
HEPATITIS B:			

CURRENT MEDICATIONS *Please attach labs and medications list if possible		
Name of HIV-Related Medication/s:	**Released with Medication upon release:**	**Amount of Medication supply provided at release: (total # of days)**
1.	Yes No	
2.	Yes No	
3.	Yes No	
4.	Yes No	
5.	Yes No	
Name of other Current Medications		
1.	Yes No	
2.	Yes No	
3.	Yes No	
4.	Yes No	
5.	Yes No	
6.	Yes No	
7.	Yes No	
8.	Yes No	
9.	Yes No	

FORM COMPLETED BY:

Printed Name:	Direct Phone:	Extension:
Signature:	Business Cell:	Fax:

Attachment 4. Care Coordination Medication Request & Approval Form

Care Coordination Medication Request and Approval Form

Date: ___August 19, 2015___

To: ___ID Nurse___   _____
        VCUHS/MCV   Signature
        Phone: (804) 828-6165
        Fax: (804) 828-2338

From: <u>SEAMLESS/VDH CARE COORDINATORS</u>

     [ ] ___Misty Johnson___   [ ] _____

VDH requests medications on behalf of:
Name:_____
Address:_____Phone:_____

Local Health Department pick-up site:
Local Health Department: _____
ADAP Coordinator/LHD Designee: _____
Address: _____
Phone: _____   Fax: _____

VDH Care Coordinator is authorizing Central Pharmacy to fill prescriptions ordered by VCU/MCV. <u>Exception form must be completed for the following medications</u>: Intelence, Edurant, Fuzeon, Aptivus, Selzentry, Deltasone, and VFEND.

See Attached Medication List Provided by Virginia Department of Corrections or Virginia Local and Regional Jail.

Please verify and order medications, sign form & fax back to (804) 864a-8050
Attention: Care Coordinators/SEAMLESS.

If you have any questions, please contact us at (804) 864-7919 or (804) 864-7219.
Eligibility Hotline (855) 362-0658

VDH VIRGINIA DEPARTMENT OF HEALTH
Protecting You and Your Environment

Attachment 5. EEP Provisional Approval Letter

COMMONWEALTH of VIRGINIA
Department of Health

MARISSA J. LEVINE, MD, MPH, FAAFP	PO BOX 2448	TTY 7-1-1 OR
STATE HEALTH COMMISSIONER	RICHMOND, VA 23218	1-800-828-1120

August 12, 2015

Dear:

    You are enrolled in the drug assistance program under <u>provisionary approval</u>. You will be able to get your medications at a local health department site from   until   Please be mindful that in order to remain enrolled in the drug assistance program your medical physician must provide us updated medical certification form by fax. This will be provided to us after attending your upcoming medical appointment.

    To get your medications, please call your doctor to get new prescriptions. Take your prescriptions to the person listed below. He/she will order them for you. They will be ready in 3 days for you to pick up.

    A copy of this letter was also sent to the health department as well as your doctor. If you have questions, please call the Hotline at 1-855-362-0658.

Client Name:

Effective Date:

Health Department:

Contact Name:

Phone number:

Sincerely,

Carrie Rhodes
Medication Access Coordinator
Virginia Department of Health

Attachment 6. VDH Contact Letter

COMMONWEALTH of VIRGINIA
Department of Health

CYNTHIA C. ROMERO, MD, FAAFP	PO BOX 2448	TTY 7-1-1 OR
STATE HEALTH COMMISSIONER	RICHMOND, VA 23218	1-800-828-1120

Dear: _____

I have attempted to contact you to assist with helping you get your medications and scheduling a doctor's appointment. Unfortunately, I have not been able to reach you.

If I am not able to speak to you, I cannot continue to provide services that you may need such as transportation, clothing, food pantry, housing assistance and more.

If you would like assistance, I would need to speak to you directly. Please call me at 804-864-7919 and leave a voicemail with contact information if I am not available.

If I hear back from you within 30 days I will re-enroll back into the Care Coordination program and link you to Case Management and other necessary services.

Your health is very important to me. If there is anything that I can do to assist you, please call the above number to speak to your personal Care Coordinator.

Sincerely,

Misty Johnson
Care Coordinator
Virginia Department of Health
109 Governor Street
Richmond, VA 23218-2448

Attachment 7. ADAP Eligibility Guidelines

ADAP ELIGIBILITY GUIDELINES

Purpose: To provide clear parameters for eligibility and program enrollment.

Objective: To ensure ADAP eligible clients are referred to the appropriate service option.

To be eligible for one of the programs supported by Virginia AIDS Drug Assistance Program (ADAP) applicants/clients must:

1. Live in Virginia
2. Apply through Virginia Department of Health (VDH) Central Office or through Virginia Commonwealth University Health Systems (VCUHS) Financial Services.
3. Have an individual or family income at or below 400% of the Federal Poverty Level
4. Have documented CD4 count(s) and Viral Load(s) within the last six months
5. Not qualify or have Medicaid
6. Provide proof of income, changes in insurance coverage or any changes in residency every six months for recertification
7. Agree to participate in the service option that best meets the client' needs and resources, and for which the applicant/client is eligible.

Central Office Staff will determine the program for which an applicant/client is eligible based on review of the application and submitted documentation. The following programs are available through Virginia ADAP:

1. Health Insurance Marketplace Program (HIMAP) – If a client has insurance through a VDH approved Affordable Care Act (ACA) plan, he/she must access medications through Ramsell. This program is used to purchase insurance for clients who are eligible to enroll into specific VDH approved plans via the Health Insurance Marketplace. VDH will pay for monthly insurance premiums, as well as all medication copayments and deductibles approved by the primary insurance. Clients access medications at retail pharmacies within an approved network.

2. Insurance Continuation Assistance Program (ICAP) – If a client has private insurance, that has approved program medication benefits; he/she must access medications through ICAP. This program assists clients with certain private insurance with medication benefits. The program allows ADAP to assist those with limited income to access medication at retail pharmacies within an approved network.   VDH will pay for medication copayments and deductibles on the ADAP and Ryan White Part B non-ADAP formularies.
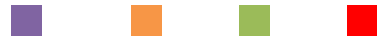
3. Medicare Part D Assistance Program (MPAP) – If a client has Medicare they must enroll in a Part D prescription drug plan and, he/she must access medications through MPAP. This program assists clients who are on, or eligible for, Medicare Part D. VDH will pay for monthly Medicare Part D premiums, as well as all medication copayments and deductibles for medications that are approved by the Part D plan. Clients access medications at retail pharmacies within an approved network.

4. Direct ADAP – This program assists clients who are not eligible for any other coverage (including insurance or Medicare Part D) for HIV/AIDS medications. Medications on the ADAP formulary are ordered and picked up through any Local Health Department or other medication access site.

Attachment 8. Partnership Collaboration Flow Chart

REFERRAL SOURCES

-DEPARTMENT OF CORRECTIONS (DOCs)
-VIRGINIA REGIONAL AND LOCAL JAILS (VRLJs)
-COMMUNITY PARTNERS
-ADAP TECHNICIANS
-LOCAL HEALTH DEPARTMENTS

VDH
CARE COORDINATION (CC)
PROGRAM
Misty Johnson
and
Nicole Gore

CARE COORDINATION
MEDICATIONS

DOCs

WORKS WITH TELEMEDICINE AND
DOC PROVIDER TO REQUEST Rx

VRLJs

WORKS WITH VRLJ PROVIDERS
TO REQUEST Rx

CENTRAL PHARMACY

WORKS WITH CENTRAL
PHARMACY TO APPROVE CARE
COORDINATION Rx

MEDICAL CARE

ID CLINICS/PROVIDERS

COORDINATES ACCES TO
CARE BY MAKING OR
CONFIRMING APPOINTMENTS

**CC TRACKS MEDICAL
APPOINTMENTS FOR 12
MONTHS**

CARE COORDINATION
LINKAGE PARTNERS

COMMUNITY RESOUCES AND
OTHER SUPPORT SERVICES

CASE MANAGEMENT
CC COMMUNICATES COMPLIANCE AND
ADHERENCE TO CLIENT'S CASE MANAGER
• CHARLI
• COMMUNITY BASED
  ORGANIZATIONS
• ID CLINICS
• ADAP COORDINATORS

PATIENT NAVIGATION (PN)

(TO HELP RE-ENGAGE CLIENTS AS
NEEDED IF CLIENT FALLS OUT OF CARE)

DISEASE INTERVENTION SPECIALIST (DIS)

AT LOCAL HEALTH DEPARTMENTS FOR
CLIENTS WHO BECOME LOST TO CARE

ADAP

**ADAP COORDINATORS/ADAP
TECHNICIANS**
FACILITATES ADAP
ENROLLMENT THROUGH
EXPEDITED ENROLLMENT
PROGRAM (EEP) FOR ALL
ELIGIBLE CLIENTS

**CC FOLLOWS MONTHLY ADAP
PICKUPS AND ACA MEDICATION
FILLS FOR 12 MONTHS**

ENROLL Virginia

REFER ALL ELIGIBLE CLIENTS TO
BECOME ENROLLED INTO
MARKETPLACE/INSURANCE