

**WEBINAR VIDEO TRANSCRIPT**  
**SPNS Workforce Capacity Building Initiative**  
**Correctional Health Services**

17 July 2019

SHELLY KOWALCZYK: Hi, everyone. My name is Shelly Kowalczyk and I will be moderating today's webinar on Improving Health Outcomes—Moving Patients Along the HIV Care Continuum. This is our final webinar in our series being brought to you by the HRSA HIV/AIDS Bureau's Special Project of National Significance Program.

So today I will provide a very brief overview about those Special Projects of National Significance, or the SPNS program, and the Integrating HIV Innovative Practices, or IHIP project. We'll then hear from our presenter, Alison Jordan with New York City Health and Hospitals, who will discuss her Workforce Initiative intervention.

Alison Jordan is a nationally recognized public health professional with more than 20 years of senior government and health system management experience, including 15 years designing and developing reentry and continuity services for New York City Correctional Health Services. Ms. Jordan oversees activities in coordinating medical discharge planning and providing education, services, and linkages to community care after incarceration in New York City jails.

Alison has extensive experience working with underserved communities, particularly those with a history of incarceration, and designing and implementing large-scale, culturally sensitive direct service health care programs. Jordan received her master's degree in social work from the City University of New York in our college School of Social Work.

The SPNS program is funded through part F of the Ryan White HIV/AIDS Program and provides opportunities for developing, implementing, and assessing innovations designed to meet national goals to end the HIV epidemic and address emerging issues in HIV care and populations most affected by HIV.

In order to most effectively promote dissemination and replication of successful SPNS models, the SPNS program developed the Integrating HIV Innovative Practices, or the IHIP project. Through the IHIP project, SPNS effectively promotes, markets, and disseminates strategies to support optimal implementation of these models.

So these strategies include developing tools and resources such as implementation manuals, intervention guides, and fact sheets that are used to encourage replication of these models, engaging stakeholders to increase reach of these tools and resources, supporting peer-to-peer sharing of information through the provision of capacity-building assistance, and then

disseminating information via an e-newsletter to market promote tools and upcoming webinars. So at this point, I'm going to turn things over to Allison for her presentation. Allison?

ALISON JORDAN: Thank you so much, Shelly. And welcome to—I see a number of friends and some new names on our screen there, and I'm looking forward to having a bit of a conversation as we go through this. And we'll take questions at the end.

Big thank you to Jacqueline [? Cusado, ?] who is the instigator supreme of most of this work, and Janet Wiersema who helped us count for the Workforce Initiative, to Paul Teixeira who helped us with health outcomes, and also for a cost study analysis. Carmen Cosme-Pitre who oversaw the One Stop Career Center's component to this initiative. And Carlos Rodriguez-Diaz, my co-PI and evaluator on the Puerto Rico site.

And then, of course, our support from Jesse and the team at RBE from impact marketing. And Sarah and Shelly and MayaTech for putting this together. Disclaimer is, all conclusions are those of mine. And we are very grateful to the SPNS team for their support, for their funding, and for their continued promotion and dissemination of this work.

So we're going to have six topic areas. We're going to do a little overview. We're going to talk about why we say correctional health is public health. About our intervention, which is now evidence-informed, and is being replicated through SPNS. Dissemination of evidence, informed interventions, transitional care information, also known as the Jails Initiative or Correctional Health Linkages Project.

And the Pay It Forward Project that we did in Puerto Rico to implement the transitional care coordination and other strategies in Puerto Rico. We'll talk about challenges, lessons learned, and things that we think might be helpful to you going forward.

Just as a way of starting this conversation, know that we had started doing what we call transitional health care coordination at the time in New York City jails. And it was a chronic care discharge planning component that was enhanced with some additional Ryan White funding that we used six weeks' worth of pilot data to share what we had been doing and to enhance that.

Because we found a lot of folks who were here were here because their legal cases couldn't be resolved, or for reasons that we thought we could impact through court advocacy, which we did. And then the second initiative through that original Jails Linkages Initiative, we found that our Latino populations—particularly Latina—were not as well maintained in care as the population as a whole. So we wanted to do a deeper dive on that.

And while we were developing our Latino Initiative, we had started to build capacity in Puerto Rico, because we wanted to make sure that we had places—in case folks were in New York and wanted to go to Puerto Rico after incarceration—that we had the resources for them in Puerto Rico. So we started to build those resources as we went forward.

And then, about a year into the Latino Initiative, we applied with the One Stop Career Center for the Workforce Capacity Initiative to not only continue those collaborations, but also to then integrate the transitional care coordination intervention. And all of that is kind of what we were looking at on a systems level.

But at the same time, just know that there was a patient of ours, a trans woman, who we were struggling to help serve in New York while her mother was continuing to call Jackie—it seems hourly, though she promised me to get it down to once a week—to inquire about how her "son" was doing in Rikers Island.

And so both the individual client trajectory and the trajectory of initiative happened in a parallel path. So I just want you to keep in mind that this is a systems intervention that impacted individuals in very profound ways.

Why correctional health is public health? Many of you on the call have seen this slide before, but to me, it really illustrates structural racism. And that is because the areas of greatest need are the ones with the greatest socioeconomic health disparities and racial disparities in the city of New York. And they're exactly the same places that our population is returning after incarceration.

At the same time, we have—a good proportion of our population are from Puerto Rico. They are similarly impacted by HIV, incarceration, and income disparities, particularly folks coming home after incarceration who often need assistance—housing, transportation outside of San Juan is very limited—and to access HIV care in Puerto Rico.

And having been in a number of the facilities in Puerto Rico, it may not be a racial/ethnic disparity, but I promise you that the folks who are out on the beach have lighter skin tone than the folks who are incarcerated in the facility. So those color issues come up, as well.

So this is a depiction of the transitional care coordination model. We talk about the two institutions being the boxes on the left and on the right—I don't know if you can see my cursor—and then the circle in the middle being the hub. And if you think of the swirls that are connecting the jail-based service to the community based services being kind of two arms and the hug in the middle, you'll get an idea of how we think of implementing this intervention.

Through the Latino Initiative, which very much, I think, helped our understanding of what we might be facing in Puerto Rico, we developed a provider training. And just know that that provider training is available online. It's 2.5 to 2.7 continuing education credits, depending on your discipline.

And thanks for those who are helping with getting the continuing education credits approved for free through the CDC. If you ever want to know how to go about doing that, Chantal, who's sitting with me, has all the documents. It's a process, but know that we have some lessons learned from that that we won't talk about today, but it is a process.

And as a result, though, you all can get free continuing education credits and learn more about people who are incarcerated, particularly Latinos who are incarcerated, and particularly people of Puerto Rican ancestry and origin as a case study, and really looking at transnationalism as well as Latino culture.

This is a little bit about our partner that I talked about earlier, One Stop Career Center of Puerto Rico. One Stop Career Center is the housing and employment services entity for the island of Puerto Rico. So they're not just serving folks in the San Juan region. They have two offices.

And they're not just providing employment, they're also providing housing assistance. They do eviction prevention. They help people negotiate with their banks so that they can continue to stay housed. And they were already pushing into the jails and prisons before we met them. And they were the only respondent to my plea for, can someone help us navigate how to identify resources for our folks in New York City who might want to access care and treatment in Puerto Rico?

I mean, even this morning, we're talking about someone who was started out on hepatitis C treatment in New York City Jail who will be going Puerto Rico, and will he have enough medication to continue to be stable in treating his hep C while he's there, and what resources might we have? And so this is an ongoing conversation. We were very grateful for the partnership with One Stop.

We had steps to the implementation. We used implementation science. We give a shout out to UCSF, and Wayne, and the team, who really helped us look at this from a very scientific way so that we were measuring all the steps along the way, and teased out what was a pretty complex model. And we were the one thing that didn't look like the others, a systems intervention that had very individual-level components to it.

So we identified the staff, Jackie, and the Department of Health in Puerto Rico, trained and certified the counselors. There was a little van that was purchased by One Stop through external sources that was a government surplus vehicle, and they won the bid.

Some folks think it wasn't such a great idea that we won the bid, because the cost of gas and fuel for the car and the repairs have been something to contend with. But the folks who were transported across the island, and the staff who worked on the project, were really grateful for the "little van that could."

And then, of course, coordinating with corrections, which One Stop had a little bit of a leg up on that. Access to patient records was challenging and had a lot of twists and turns along the journey. And then engaging the key stakeholders and establishing a consortium, which piggybacked on the Latino Initiative, where we had identified resources and then we were looking to have linkage agreements with them, as well as with those who were being served, to get their input.

Building on the Latino Initiative to enhance these collaborations among the organizations was really training One Stop's interventionists, two or three over time—they were two at any given time, but they did transition over the three years of the project. And they already knew how to engage folks. They were already working in the jail and prison facilities—13 of the 30-something facilities across Puerto Rico they already had a presence in.

But one of the ways that I measure the success of this project was that, in the beginning, before they were taught about HIV and understanding it, the folks who were coming into One Stop to receive employment and housing services but were living with HIV, the interventionists were kind of saying, oh, indito, poor baby, they're living with HIV. It's such a shame, tisk, tisk, kind of thing.

And then at the end I asked them, at our closeout site visit. So you said in the beginning, oh, indito. How do you feel now? She goes, oh, yeah, HIV. Yeah. Well, diabetes people get stuff, but life goes on. And so the attitude changed from when we first met with them—I think was one of the really important things for you all to understand about how important training people about living with HIV can really be.

So this is 60 MOUs. I have looked, in preparation for our targets, some of our earlier maps. There were many maps that looked in many colors that were actually hand-colored by Robin Casey, god love her, in Paintbrush—no kidding.

And it goes from the whole mountain region, that aqua and teal there, is really through one of the corporations of primary care services. Really, they go hiking in the mountains to see the patients. Filled in a lot of that space. And then, toward the end, there were additional resources that were getting to some of the islands at Calabria and Biagasto. So it was an evolutionary process. It did not happen overnight.

We could not have done it without our federal partners, both in Ryan White and the US Department of Justice, without the Puerto Rico Departments of Correction, as well as Department of Health, and all the community providers and government partners that came together. This was not done overnight, and it was definitely a collaborative partnership among many different entities, some who had never met each other. They knew of each other, but they had never met.

So we talked about the 13 out of 32 facilities. And so they had been, and continue to provide, health education risk reduction sessions at the jail orientation sessions. And that was one way that we identified people who just self-reported as a result of those sessions. So at the end of orientation—this is how Jackie started in Rikers. So we just replicated that.

She was going to orientation sessions, doing health education, risk reduction, how to wear a condom, into all the jail intake areas. And then she'd say, well, afterwards, if anybody would like to know more, speak further with me. We'll stay behind and then have one-on-one

conversations in that same moment. And people would self-report through that process. And One Stop did replicate that process.

There were also some—over some portions of time of the enrollment period, there were linkage agreements that were in place between the correctional health agency that was under contract to the State of Puerto Rico Health Department, and then other times where that administration changed and then all those agreements had to be redone. And so we would ebb and flow between having really easy ways of getting the information and then the more challenging ones over the course of the project.

But at the end of the day, 58% returned to the community after incarceration and 54% of them were linked to primary care. That's of the folks that were enrolled in the study. And all 10 of the pilot participants that we had started with before the IRB process had gone through, just to check out the model, all 10 of those pilot participants were linked to care.

And while they were at it—because, as it turns out—well, we joke about this and we say, we think going to the doctor would be something folks would do maybe 10th on a good day. And a good day is when they feel crappy, right? And so there's lots of competing priorities, even for folks who are very motivated during the jail stay, that life is very complicated for.

So they don't have a permanent place to live. They need a roof over their head tonight. They need food today. They need to know how they're going to get home, how they're going to get to their parole or probation officer. And so there's all these other things happening.

And I think one of the reasons why this particular model was so successful, and actually more successful than our original jail linkages, both in New York and in the other nine sites, is because of the relationships that were built around helping folks find housing and employment.

Here's the Transitional Care Cascade for One Stop Career Center. You can see 99% accepted service. One would go into prison, you didn't have any way of thinking about going home after incarceration. 100% of the folks who wanted to receive the service did get a plan.

So that means that we had good relationships with the jailer, because they had the time and space to have auditory privacy and a one-on-one conversation. 86% returned to the community. And 94%—that's including the 10% from the pilot and the 69% from the vocal evaluation—were linked to care. With here we say, my goodness, ring the bell.

These are the places where folks were linked. Most of them were linked to care at Ryan White Part B and C Clinics. Others were followed through with Allied Qualified Health Centers. And that included the doctors.

I think of them as the mountain men who were climbing to see patients, making home visits, house calls, whatever they have to do, all through the mountain region—from migrant health and Prim-Ed, and all those doctors that are running to make sure that their clients continue to

get access to care and treatment. And so that was all across Puerto Rico. And you can see the population dots are where folks are found.

I looked—just so you know, I wanted to do a similar map like we had in New York showing the socioeconomic disparities with the darker red shades for folks who are living in areas that are socioeconomically disadvantaged. But Puerto Rico, when you go and look, is 100% dark red with a very tiny little crook of downtown San Juan where the tourists go being the only exception of that. And so everyone who went was going to an area that was socioeconomically disadvantaged.

So this guide is one of, I think, the outcomes of the initiative, and really will help sustain Puerto Rico's ongoing collaboratives and access to resources. So this guide is available at no cost to the network providers.

And if anyone on the call or anyone you know is in need of it, we can get access. If you pull it up through the link that's on the screen, that [nrg.econference.com/puertorico](http://nrg.econference.com/puertorico), you'll get a production version of it. So you can see it, but it will flash funny.

But just email me and we'll make sure that you get access. And in case Jesse or anyone from RD is on the line, I've committed to sharing that link with our navigators over at the health department, who are looking to link that gentleman we were talking about just earlier to KR in Puerto Rico and make sure it's—continuity in medication. So, yeah, it's very cool.

And each of the services is designated based on these little—I don't know how big your screen, is but there's a little briefcase for employment, and there's a little house for housing, and then there's various icons that depict the type of services that are available at the different locations. And you can see the island is—there's resources everywhere.

So that original client that we were talking about at the beginning, we thought maybe, after she left, she'd want to go home to Puerto Rico. And everybody's like, oh, no, you can't. There's no services in Puerto Rico. And our Latino initiative actually—similarly, people thought the service availability in New York and the services available to people with HIV in New York was superior to that which is available in Puerto Rico.

And I can tell you, because Jackie has a very high bar, that no one providing services or who's in this Resource Directory was put on the list if they weren't vetted by her and Carmen. And Jackie's bar for a provider going on the list is, would I have sent my sister here? And so just know that the locations that are here were visited in person by Jackie and Carmen and the team, and that they didn't get on the list if the clinic didn't pass that bar, that standard.

And this summer, Carlos Rodriguez-Diaz and the team at UPR are going to be doing culturally appropriate training for people with histories of incarceration in Puerto Rico. And we hope to collaborate with them to provide flags, pink or blue or rainbow, depending on your

certifications, in LGBT and trans-friendly locations so that folks will know where they are. But if you do have a trans person or someone who needs that

Culturally appropriate care in Puerto Rico, I can tell you that I can think of five offhand. And depending on where they're located, I'm certain that the resources now that we didn't know of at the time we started this for our clients, I could definitely answer that affirmatively.

And it would be something that would be regionally available across Puerto Rico. And the clinics are very fine, and the providers there really care. So there are resources in Puerto Rico, you just—maybe getting the word out was the problem.

So identifying right fit programs in Puerto Rico was challenging. And I think some of that is very cultural. So people were very much about, who do I know? Can I trust them? Is this an organization or a person that I know is going to pay on time? Is this is an organization that I know is going to deliver on their promises? Is this someone I have a history with that I can trust?

And that came first. So if you had—even the formal relationships, even a letter from the commissioner of health, was not something that persuaded people to do business with you or to work with you. That was a big lesson for us. And it meant that more time than one might think would be necessary—because just your letters, or that you're funded by the federal government, or any of those things by itself was not sufficient to gain respect.

And then the formal authority from the predecessors, because of that, does not transfer over. So if you have a linkage agreement with an organization and it's signed by their CEO and the CEO leaves for whatever reason, or the head of the government agency isn't there anymore, or the head of the corrections department, or whichever the head is that signed the documents, in New York, that becomes grandfathered in by whoever is the successor.

In Puerto Rico, you have to start all over. So as the head of corrections changed, the head of the health department changed, the governor changed—any time you had any change in leadership, you had to start over with your linkage agreement. And work stopped until such time as those relationships were formed, the agreements were put in place, and you could get the buy-in from the new leadership.

And then, when you look at those maps earlier, you'll see there's 78 different jurisdictions in Puerto Rico. And those of you who are local, so that would be like having 78 towns, maybe, on Long Island—which they do—and then 78 school districts, and 78 mayors, and 78 towns.

In an area, though, where you don't have the top 5% of income in the country, you have the bottom 5%. Don't quote me on that. But I'm saying the, poverty is great but the local control is also in place in ways that make change challenging because of the turnover.



And then you couple that with these personal relationships and the need to form them, and then every time you turn around, every time there's an election or there's other reasons that people leave office then you have to start those relationships all over again.

And then, of course, the lack of affordable housing and shelters. And then, while they're in the middle of this project, there were three hurricanes, including Hurricane Maria. So those of you who've done studies before and you have challenges in the middle and you want to keep tracking folks, I just refer you back to 95% linkage to care, and then we follow those folks one year out.

The way that happened was through the relief efforts of One Stop Career Center, who actually got relief funding and were taking medication to folks, making sure they had places to live, clean water. Walgreen's gift cards, I think, paid for more water than I can think of.

They also, because of the housing assistance, helped with the FEMA applications and placement in temporary housing, as well as making sure that folks had continuity of treatment. And keeping track of which places were open, and which ones moved, and where they went. Because frankly, some of the buildings were demolished and then they had to go around the corner. And all of that was word of mouth that One Stop came in touch with.

Just to see one example of this, if you look at Manati, after Hurricane Maria, one of our staff, who's Puerto Rican took this picture of Manati—that's her hometown. It was Brenda Rosario who took the picture. And then, this past February, I took a vacation to Puerto Rico and did a little—what do they call that? Busman's holiday, going over to Manati because I wanted to see if the road had been repaired.

And as you can see, it was. If you look really closely in the picture on the right, you'll see that not all the telephone and electric poles are standing completely upright. So we're not sure how much of that infrastructure was completely fixed, but it looks good in the picture. So they were doing better.

I did wander into the mayor's office. Because they had a restroom there, and so I wound up—I guess gringo walks into mayor's office in Manati and the mayor comes out of his office to see what that is about.

And so he did introduce himself to me and said, oh no, that street's fixed and we're doing better. But when you look at this storefront, most of them are still closed. The businesses haven't come back. They're still struggling. So I told them I'd share the picture with you all.

Lots of lessons learned. I tried to pick the top 10, and working backwards. So the transportation access was, I think, definitely necessary, even if it wasn't cost-effective. Engaging the clients during incarceration, I think, is true no matter where you go. If someone meets you when you're incarcerated and then you see them on the outside, there's something very profound about that, and enduring.

The transitional care consortium was able to maintain a core leadership and relationships. We are not sure if they're going to have the funding to have the annual meeting that we had together. And hopefully there will be funding opportunities for that to happen. But they do maintain the relationships and the linkage agreements, which continues to be a work. It's a job.

And it was great to know that—there was a lawyer that we had working with Maria Cardona, who really had a lot of street cred with all the organizations in Puerto Rico. She's someone that exudes, really, confidence and also competence. And I think that that was appealing to the leadership that we were reaching out to.

And then those established relationships had to come before the formal one. And then was able to create the synergy. So having an organization that was providing housing, employment, and substance use was really very helpful in getting access to the social determinants of health that were so critical to people to improve HIV care and treatment.

And the coordination between the CBOs and the Ryan White Service Network is something that, I think, was definitely improved through these initiatives. And the local faith-based organizations and leadership really pooled their resources and wanted to work with government to really establish best practices.

And found that the networking with other agencies—and also, across jurisdictions, people would be in the room saying, oh, I know of your work but I have never met you, and how do you do this? And really problem-solving as they came together—was, I think, a real benefit of this intervention.

And this is the folks that came together. You can see there were over—I wrote this down somewhere, over 100 or so people and 60 organizations that each of the convenings. My thanks to Jesse for the picture, because he has a way of doing this "everybody in the room" kind of photo.

And the folks who were [INAUDIBLE] table on the right. I'm standing up on the left. And then there was an interpreter that was doing English-Spanish translation. So folks would have headsets depending on who was speaking live, which I think was very helpful.

The meeting was attended by representatives from the Puerto Rico governor's office, from corrections, from health, federal correction, state and local, from the health department, from the health providers, from the FQHEs, from housing and employment services organizations and providers, including the homeless services organizations.

And then we went and joined them from New York City correctional health and the folks here. And then we also had guest speakers, including Jesse Thomas from RDE, who helped solve—I think three problems the day of this convening for folks who had either Ryan White data exchange problems, where their system was being grandfathered out and they had to reserve their data.

And then also for the Day Initiative, where there was an organization who wanted to implement buprenorphine that identified there. And we were able to work for them and were successful in getting that ground. As well as from the Fortune Society. And those of you know Stanley Richards know what a powerful speaker he is. But he did come and address the group and told his story in, I think, the most powerful way.

And so for a group of folks that included law enforcement, parole probation, health—and folks who are incarcerated are seen as "less than" by folks in Puerto Rico. And so he stood before them as an authority, in a suit, with a badge—because he's on the New York City Board of Correction—and told the story of his other self, who spent so many years incarcerated and who came out and found out that he was smart.

And when he came to the community, was able to better himself and to identify as a professional person who's now on the board of correction and a chief operating officer of a major organization. And the whole room was both in tears and stood to their feet and gave him a standing ovation.

And I think it was a big highlight for me throughout the conference—again, not so much because Stanley's such a powerful speaker, and he is, but because of the mindset change that you could feel happening in the room of folks thinking of the incarcerated as those people, and seeing that they're us. And that is where this stops. And I guess next steps would be for you guys to ask questions or let us know if there's any other information you'd like us to share.

SHELLY KOWALCZYK: All right. Thank you so much, Alison. We appreciate hearing about this wonderful model. Before we do open up the lines for Q&A, I do want to provide quickly here some information about staying connected.

If you have questions about the information shared today or anything related to the SPNS program, you can send your inquiries to [spns.hrsa.gov](mailto:spns.hrsa.gov). We can also relay information if you have questions for Alison that arise afterwards. You can also email that and we'll ensure that Alison gets the question.

And then for information about the tools and resources that I mentioned earlier that we've been developing over the last several years, you can join the IHIP listserv by visiting [targethiv.org/ihip](http://targethiv.org/ihip).

And then, lastly, to stay connected, of course, with HRSA, you can visit [hrsa.gov](http://hrsa.gov). This is the link to the online feedback form that I mentioned at the beginning. So if you have a minute to complete that, I'd appreciate it. But again, anyone who registered for the webinar, we will also send this link via email.

Any questions, you can use, again, the chat feature on your screen by typing in any question that you might have for Alison. And also, operator, can we open up the lines for anyone who wants to speak their questions?

ALISON JORDAN: I had a question from one of my staff. They were like, well, what kinds of training did you do to teach folks how to do this? And so I can just give you a little—there's red, but the Puerto Rico Department of Health provided certification and training in HIV 101, HIV prevention, basic principles on rapid testing, STI 101, crisis intervention, and HIV/AIDS stigma.

And then we provided the transitional care coordination, clinical skills on collaboration, and then the Puerto Rico Department—Carlos provided the ACOCCA survey administration and really how to evaluate, how to conduct an evaluation. And we also shared about our health court liaison.

And then the AETC provided training on HIV and incarceration, as well as the You Are the Tool to Achieve Equity Resource. Obviously, they got their human subject research through CITI.

And then the University of Puerto Rico provided a lot of technical support and guidance around program planning and program evaluation, and how to make sure that you collect data in a way that it can then be read by the evaluators. So you can see it was pretty robust training.

SHELLY KOWALCZYK: Thank you. Alison, I had a quick question for you in thinking about—which, of course, is common with all the turnover that occurs. And you are speaking about the changes in leadership, in government and different organizations. Which I can imagine might get discouraging and frustrating, to know that these signed documents have to be re-signed, and building those relationships again.

So I wondered if there were any particular steps that you had taken, or if you sort of figured out a way, after this happened several times, to sort of go to the right people. Or were you approaching people within those organizations to help you influence the new leadership?

ALISON JORDAN: Right. So thank you for asking this question. So really, what we learned is that the informal authority was really the most important authority to have, because even when the administration changed—

I, myself, being one of the bureaucrats, or the people who've been around forever, or the opinion leaders of the organization, and figuring out who those folks were and having the relationships with them greatly helped to facilitate, then, the subsequent thing. So because everything's about personal relationships, you need to develop personal relationships with the people that are seen as the opinion leaders.

And actually, we should have known this, because when we were doing peer educator training in the jails, we went to the warden. We said, we want to work with an inmate council. Because we thought, if anybody was going to take an HIV test or wear a condom, they would they would be more likely to do it if we had the folks who had been voted into the main council as their identified leadership.

Unfortunately—well, then the warden said, well, so you want me to take all the gang leaders and put them in a room together? So that became a little bit funny. But at the end of the day, he did wind up helping us to collaborate, and had all of the gang leaders in the room together. And then he was able to house them in different areas so that, then, they could kind of spread the word.

And so I think if we would have used that approach earlier, it might have gone better the first time around. Because we really did not know that once you have an MOU signed, that it's not going to be honored by the incoming organization until it happened.

And so I would say, if you have the relationships with the informal authority, and start with the informal authority, and have those relationships with them, and then go to whoever the whoever is the person in charge de jure rather than going top-down, I think you would be better off. And that may be not just in Puerto Rico.

SHELLY KOWALCZYK: Great. Thank you. All right, one last call for any questions.

ALISON JORDAN: Hi, Cheryl.

CHERYL: Hey, Ally. How are you?

ALISON JORDAN: Good.

CHERYL: I just wanted to build on relationship-building and let everyone know that it's imperative. I'm calling from a site that was part of the recent jail linkage, and we have a huge binder full of MOEs with multiple organizations, and once we started to implement this project, unbeknownst to us, we realized that we had a lot of work to do. So definitely look to see who your key partners are.

ALISON JORDAN: So thank you so much. So Cheryl is with Cooper Health, and they're one of the three sites that are replicating transitional care coordination intervention through the SPNS Dissemination of Evidence Informed Intervention services. And she actually was a big catalyst there for developing the right fit programs.

Because they did have—when you're working as a health organization, very often, the community-based organizations are good at pushing into you and getting your help, but then at the end of the day, what Cheryl needed were the organizations that weren't health service organizations, that weren't the ones that they were helping.

It was the ones that they needed help from, that she needed relationships with. So the housing providers, the employment services providers, the drug treatment program, the halfway houses. All of the community resources that Cheryl needed were not really part of the Cooper portfolio even though they had a very extensive community resource planning council, all those kinds of traditional health linkages.

She got them the old-fashioned way, knocking on doors and making relationships and finding out, well, then, if you want me to help you with this, or you can help me, who needs to sign? And really going about that in, I think, a very productive and helpful way from the client's perspective.

SHELLY KOWALCZYK: OK. Well, thank you again, Alison. And for those of you on the line, the slide deck, along with the archived recording, again, will be available on [targethiv.org](http://targethiv.org) in about three to four weeks. And as we mentioned, for this year, this is the last webinar in our series. And on behalf of HRSA, I want to thank you very much for your participation. And this concludes our SPNS/IHIP webinar session. Thank you, everyone.