Session 119: Correctional Health is Public Health is Community Health: Collaboration is Essential

This presentation will begin soon. Please join us at e2polls.com Access Code: NCCHCS22

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Thomas Lincoln MD CCHP-P FASAM

Jesse Thomas

Monday, April 11, 2022, 2:15 PM - 3:45 PM

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NCCHC NATIONAL COMMISSION ON CORRECTIONAL HEALTH CARE

Disclosure and Disclaimer

We do not have any relevant financial relationships with any commercial interests.

Alison O Jordan represents the American Public Health Association on the NCCHC Board and serves on the APHA Governing Council and editorial board of the Journal of Correctional Health Care.

Tom Lincoln is a long-standing member of the American College of Correctional Physicians, serves on the JCHC editorial board and is the American College of Physicians 2021 recipient of the W. Lester Henry Award for Diversity and Access to Care.

Jesse Thomas and RDE systems have provided HIT support to key collaborative projects in NYC, Paterson and Puerto Rico.

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Acknowledgement / Disclaimer

Views our own.

Several of these projects are / were supported by the Health Resources and Services Administration (HRSA)) of the U.S. Department of Health and Human Services (HHS):

- Enhancing Linkages to HIV Primary Care and Services in Jail Settings, 2007-2012
- Culturally Appropriate Interventions of Outreach, Access and Retention among Latino(a) Populations, 2013-2018
- System-level Workforce Capacity Building for Integrating HIV Primary Care in Community Health Care Settings, 2014-2018
- The HIV Housing & Employment Project, 2017-2021

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Transitions
A Public
Health
Model
Assessment
Populations
Warm
Community
Coordination
Assessment
SPNS
Correctional
Healthcare
Disparities
Camden
ACOJA
Education
Jail
Clinic
Prison
Vulnerable
NYC
Baystate
Collaborative
Hampden County
DEII
Raleigh
LVNV
Network
Continuity
Employment
Transitional
Housing
Reentry
Planning
Equity
Access
Engagement
http://www.edwordle.net/index.htm
Care
Coordination

ACOJA Consulting

ACOJA Consulting LLC owners created, implemented and adapted Transitional Care Coordination, an evidence-informed intervention that facilitates correction to community linkages through collaborations.

Skilled in strategic planning and guidance for health and human services, public health research, and government programs.

Alison O Jordan & Jackie Cruzado

Tom Lincoln

Baystate Health

baystatehealth.com

Thomas Lincoln MD, CCHP-P, FASAM

- Associate Professor of Medicine at University of Massachusetts Medical School – Baystate
- Primary care physician at Baystate Brightwood Health Center in Springfield, MA
- Medical director for the Hampden County Correctional Centers
- Longstanding commitment to integrating community and correctional health care, HIV care, and addiction treatment.

Learning Objectives

1. **Identify facilitators** and barriers to correction to community collaborations from the perspective of each discipline

2. **Apply Implementation Science** methodology to address barriers from the perspective of each discipline

3. **Examine the impact** key outcomes for people with criminal / legal system involvement

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Introductions

What is your role in Correctional Health Services? Where are you located? What is the type of work setting?

Overview

Correctional, public health and community collaborations are essential to address the myriad health and social needs of people entering and exiting U. S. correctional facilities:

- High rates of chronic and communicable diseases, including COVID-19
- Socioeconomic and racial disparities

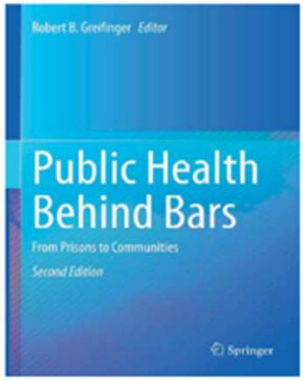
Collaborations Essential: approaches to and benefits of establishing strong corrections, correctional health, public health, and community health and social service collaborations

Evidence-informed interventions using integrative approaches include:

- A Community/Public Health Model of Correctional Health Care
- Transitional Care Coordination

Teamwork: Physicians, nurses, social workers and case managers, based in both correctional and community settings, facilitate continuity of care and services

- "Warm Transition" approach for people returning home after incarceration.
- Functional Assessment Tool to identify gaps and align local practices with proven approaches



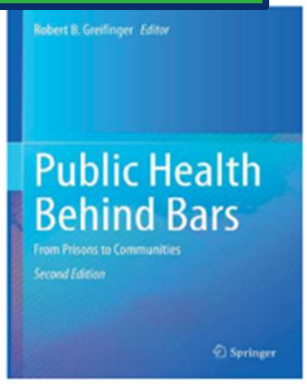
Learning Objective 1: Facilitators & Barriers

From your perspective: What barriers exist to correction to community collaboration? What facilitators exist to support correction to community collaborations? What do you think are the greatest barriers to successful correctional and community health collaborations?

Correctional Health is Public Health is Community Health*

- U.S. has the world's highest incarceration rate.
- Disproportionately impacts the poor, people of color, and those with behavioral health problems.
- Inconsistent scope and quality of care - often directed by security leadership, not health professionals.
- Vital information needed to coordinate care with community providers / consider alternatives to incarceration.

Programs make safer correctional facilities and communities at large through partnerships with key stakeholders.



*Collaboration is Essential

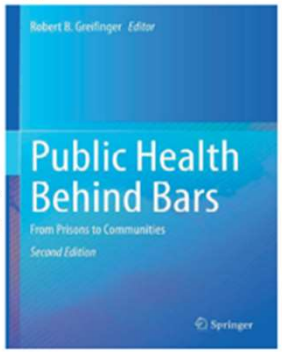
POPULATION HEALTH DISPARITIES

Table 33.1 Incarceration Rates by Race and Ethnicity based on U.S. 2010 Census.

Race/Ethnicity	% of U.S. population[2]	% of U.S. incarcerated population[2]	National incarceration rate (per 100,000)[2]
White (non-Hispanic)[1]	64%	39%	450 per 100,000
Hispanic	16%	19%	831 per 100,000
Black	13%	40%	2,306 per 100,000

1. *"Whites" refers to white non-Hispanics throughout this report and the accompanying figures. Because the Census Bureau does not publish non-Hispanic data for any other race in correctional or detention facilities, all other racial categories in this report are that race alone without distinguishing ethnicity.*
2. *Figures calculated with Census 2010 SF-1 table P42 and the PCT20 table series*

Reprinted/adapted with permission from Prison Policy Initiative https://www.prisonpolicy.org/reports/rates.html



A Community Problem Needs a Community Solution

The Opioid Crisis Affects Everyone. Where to Start?

Identify Key Stakeholders and Champions in your Community!

Criminal / Legal Partners:

- Police
- Courts (District Attorney, Bar Association, Judges)
- Probate and Family Court
- Community Corrections (Probation, Parole, etc.)
- Jail & Prison Leadership
- Reentry Support
- Alternatives to Incarceration / Sentencing

Primary Care & Treatment:

- Hospitals
- Community Health Centers
- Behavioral Health Clinics
- Opioid Treatment Programs
- Outpatient Treatment
- Harm Reduction Agencies
- Recovery Homes

Community Services:

- Peer Recovery Centers
- Social Service Programs
- Concerned community / family members
- K-12 and post-secondary schools

Courtesy of Ed Hayes, Sheriff's Department, Franklin County, MA

Public Health Services

Ten Essential Public Health Services

1. Assess and monitor population health status, factors that influence health, and community needs and assets
2. Investigate, diagnose, and address health problems and hazards affecting the population
3. Communicate effectively to inform and educate people about health, factors that influence it, and how to improve it
4. Strengthen, support, and mobilize communities and partnerships to improve health
5. Create, champion, and implement policies, plans, and laws that impact health
6. Utilize legal and regulatory actions designed to improve and protect the public's health
7. Assure an effective system that enables equitable access to the individual services and care needed to be healthy
8. Build and support a diverse and skilled public health workforce
9. Improve and innovate public health functions through ongoing evaluation, research, and continuous quality improvement
10. Build and maintain a strong organizational infrastructure for public health

https://www.cdc.gov/publichealthgateway/publichealthservices/essentialhealthservices.html

Population Based Approach

Determine:

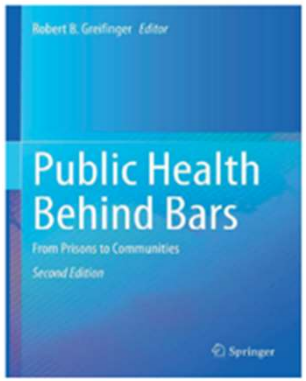
- Health-specific risks
- Perceived lowest safety-risk
- Survival needs (food, transport…)
- Critical services/programs needs (housing gaps)
- Case management/navigation
- Criminal / legal alternatives

Educate:

- Leadership and staff
- Health education

Community Collaborations:

- Leadership and planning
- Implementation cycle
- Share best practices / lessons learned



CORRECTIONAL HEALTH LEADERSHIP

"with the highest incarceration rate in the world – where persons of color are disproportionately represented and have a higher incidence of chronic and communicable diseases, and where the recidivism rate is unacceptably high – are we successfully accomplishing the ostensible social goals of punishment or rehabilitation?"

Correctional Health Care, Carmona 2018

INFECTIOUS DISEASES

(STI TB HCV HBV HIV COVID19)

Opportunity for Public Health & Correctional Health Collaborations

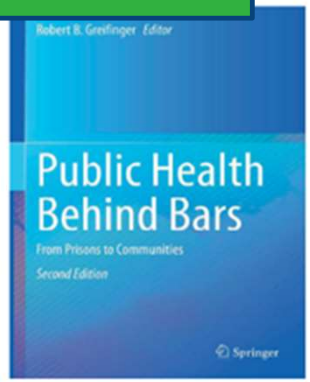
Surveillance:

- screening = identification
- identification = treatment
- treatment w/o insurance payer = cost shift to Correctional Health

Public Health benefits:

- Reduces community viremia and cost to treat
- Epidemiology requires
- Import to those with pre-existing conditions (MI, SU)
- Disease progression costs mitigated through early identification & treatment

Consider stationing Public Health Agency Disease Investigators / Surveillance staff at jail medical intake.



RYAN WHITE FUNDING

Policy Clarification Notice #18-02: The Use of Ryan White HIV/AIDS Program Funds for Core Medical Services and Support Services for People Living with HIV Who Are Incarcerated and Justice Involved

Core medical and support services to support only the HIV-related needs of eligible individuals on a:

1) transitional basis to people living with HIV (PLWH) who are incarcerated in Federal and State prison systems;
2) short-term and/or transitional basis to PLWH who are
   - incarcerated in other correctional systems (e.g., local prisons and jails) or
   - under community supervision (e.g., parole or home detention).

Provider of last resort applies.

COVID-19 Health Equity Task Force

OASH / OMH Subcommittee Interim Recommendation May 28, 2021

PROBLEM STATEMENT 5

The health outcomes of people in jails, prisons and other carceral settings are not tracked or addressed in real time or by our public health agencies and structures, contributing to preventable death. This failure to measure the health and health outcomes of incarcerated people is a potent and harmful example of racism in health.

1. The CDC and State Departments of Health should establish efforts to track and report in real time, the health and health outcomes of incarcerated people, and develop evidence-based programs to protect and improve their health.

2. The federal government should promote research on the effectiveness of interventions to prevent death in carceral settings during COVID-19, such as early release.

Data, Analytics, and Research: Chair: Joneigh Khaldoun
Attendees: James Hildreth, Andy Imparato, Victor Joseph, Homer Venters
Staff: Josephine Nguyen, Martha Okafor, Catie Pennington, Minh Wendt

https://www.minorityhealth.hhs.gov/Assets/PDF/May%20COVID%2019%20HETF%20Subcommittees'%20Recommendations_Discrimination%20and%20Xenophobia_final.pdf

NCCHC: Use of Humanizing Language

February 3, 2021: NCCHC Board approves position statement

"We encourage adding:

'use person-first language such as person/people/individuals experiencing incarceration, incarcerated person/people/ individuals, the incarcerated, person living with HIV, person with substance use disorder.'

to your protocols along with:

'greet your patient with a warm smile and a handshake or bow.'" (or masked nod during COVID-19 pandemic).

https://www.ncchc.org/use-of-humanizing-language-in-correctional-health-care

Take away messages:

- Person-first approaches set the stage for a therapeutic relationship
- Mutual objectives are achievable despite the setting.
- Using person-affirming language creates a more positive environment for you and your team.

https://www.ncchc.org/blog/language-matters-ncchcs-new-position-statement-on-use-of-humanizing-language-in-correctional-health-care

Words Matter

USE: Person, People or Individual	AVOID:	POPULATION-BASED ALTERNATIVES:
experiencing incarceration	Offender, Inmate, Felon, Criminal, Convict, Prisoner, Offender, Delinquent	The incarcerated
with incarceration history; prior criminal / legal system involvement; previously incarcerated;	ex-inmate, ex-offender, ex-convict, ex-prisoner, ex-felon, "incarceritis"	Formerly incarcerated; Incarceration history
under judicial supervision; detained	detainee	Held pending a hearing
supervised by parole or probation; under parole or probation supervision	parolee, probationer,	Under supervision
with sex offenses conviction; history of sex offense charges	Sex Offender	Formerly incarcerated; incarceration history
with mental health needs; history of mental illness	Mentally Ill, psychotic	Receiving mental health services
currently or previously experiencing homelessness; unstably housed	Homeless	Unstably housed; houselessness
Person with HIV; person with with diabetes	HIV/AIDS patient; HIV/AIDS infected; diabetic	People with diagnosed HIV
with a history of substance use or substance use disorder (if known); living on the substance use spectrum; who used / uses substances	Substance abuser; addict; drug user, illicit drug use	Substance use spectrum
USE: Young Person / Young Adult	**AVOID:**	**POPULATION-BASED ALTERNATIVES:**
with criminal / legal system involvement; impacted by the criminal / legal system; under criminal / legal supervision; detained	Juvenile Offender, Juvenile Delinquent	Held pending a hearing; Under legal supervision

Health Information Technology

Purpose: Managing by data is critical for both public health and correctional health systems.

Facilitators:

- Collaborations between corrections, health and community
- Information sharing: patient-level and population-wide
- Electronic health records: correctional and community providers virtually share patients.

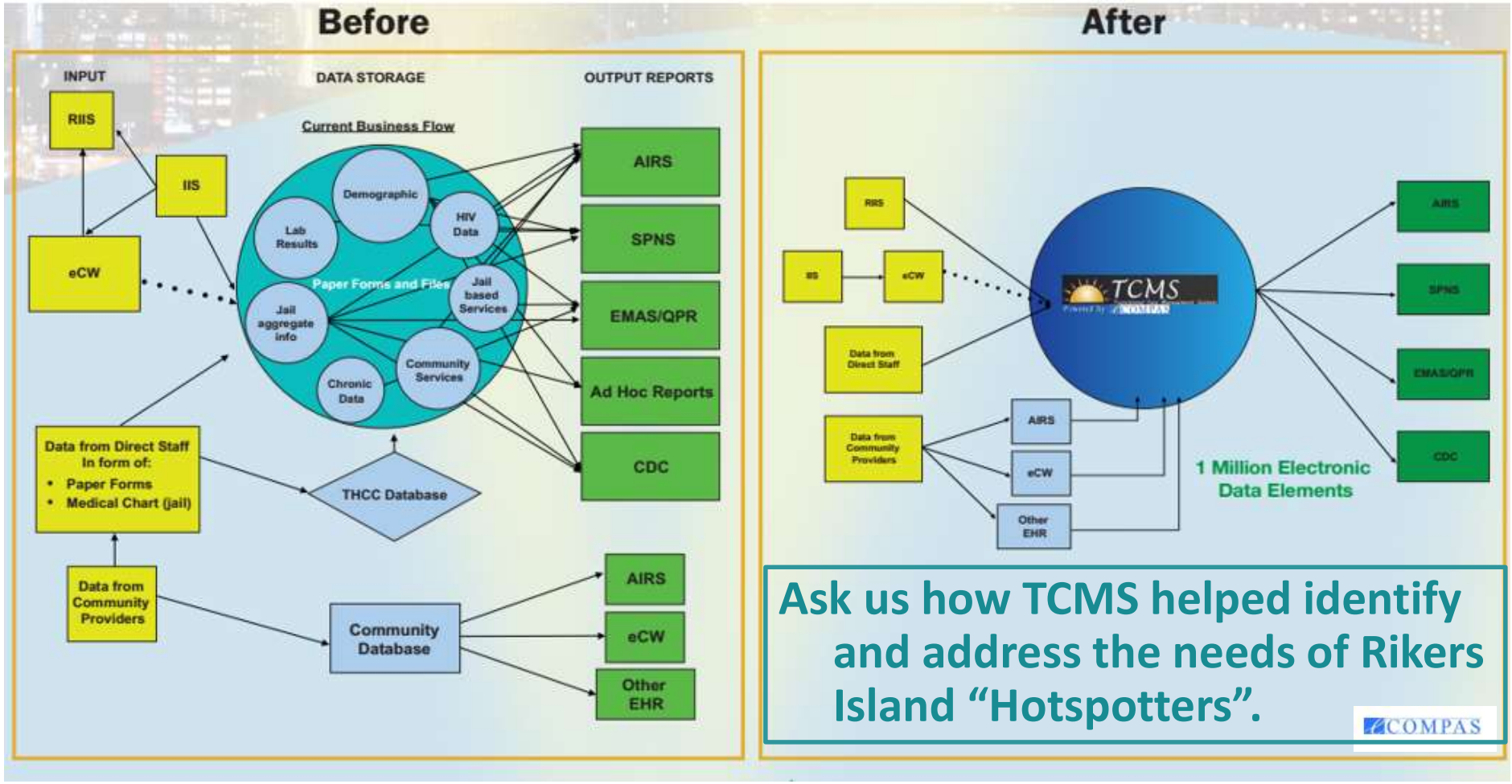
Smart Care Management:

- Cross-matching zip codes to which people return after incarceration helped identify community service providers for appropriate linkages to care
- Health, housing and employment agencies share care plans

Jesse Thomas

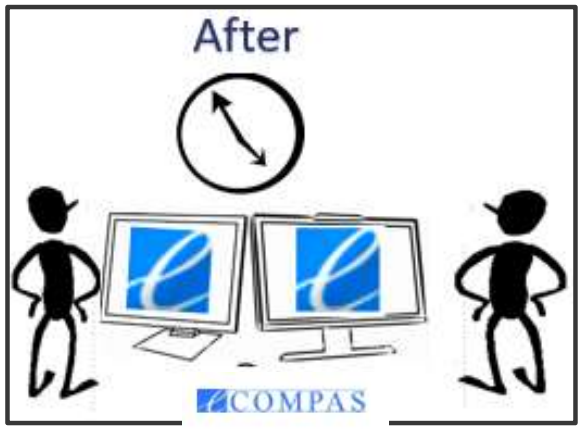
Manager
RDE System Support Group LLC

TRANSITIONAL CARE MANAGEMENT SYSTEM

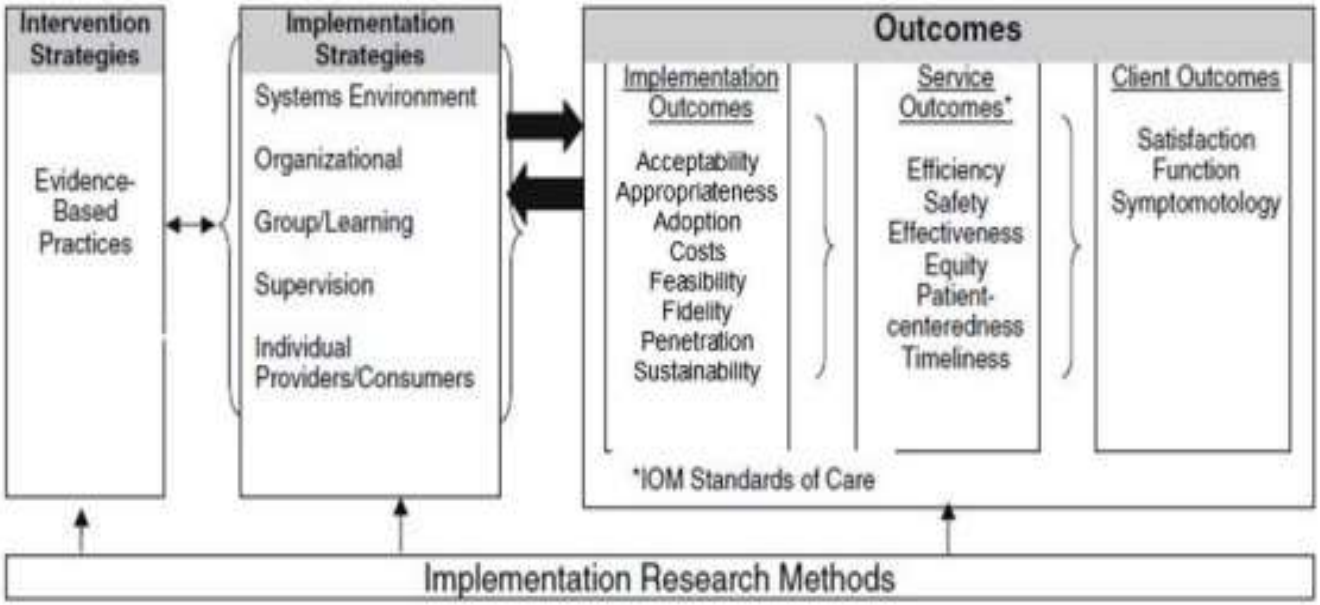


HEALTH IT SOLUTIONS

1. Save time, reducing double key entry and maintaining data consistency
2. Support Quality Improvement and ensure compliance with federal program and grant requirements
3. Streamline care coordination and facilitate continuity of care
4. Provide patient portals and alerts



Implementation Science Approach: Proctor Model



Courtesy of Alexi Marbach, Jane Fox Abt Associates, 2018 National Ryan White Conference on HIV Care & Treatment

Proctor Model Implementation Outcome Domains

acceptability – To what degree are site providers, staff, and leadership willing and able to take on the full terms of the intervention?

appropriateness – To what degree does the provider think the intervention is the appropriate intervention for the target population?

adoption – To what degree are providers and staff willing to implement the intervention by following the protocol outlined in the implementation plan?

cost – What does it cost to implement the intervention?

feasibility – What are the barriers and facilitators to effective implementation of the intervention?

fidelity – To what degree is the intervention being implemented as outlined in the implementation plan?

integration – To what degree do sites integrate the intervention into their other ongoing efforts to improve outcomes along the HIV Care Continuum? (*note – this is a merger of penetration and sustainability

Courtesy of Alexi Marbach, Jane Fox Abt Associates, 2018 National Ryan White Conference on HIV Care & Treatment

Learning Objective 2: Using Implementation Science

Which correction to community collaborative approaches have you heard about?

Hampden County
Community Integrated Correctional Health Care

Since 1992…

Dually-based care for chronic health conditions: hepatitis c, asthma, hypertension, HIV, depression, SUD and more

- Patients: assigned to one of four healthcare teams by residential zip code or health center primary care during jail stay.
- Team staff: a primary nurse, a physician, a nurse practitioner or physician assistant, and a case manager.
- Physicians and case managers are “dually-based.”

http://hcsdma.org/public-resources/public-health-model/

Baystate Health
baystatehealth.com

Hampden County Correctional Center
Ludlow, MA

Correctional Centers

Western Mass Regional Women's
Correctional Center Chicopee, MA

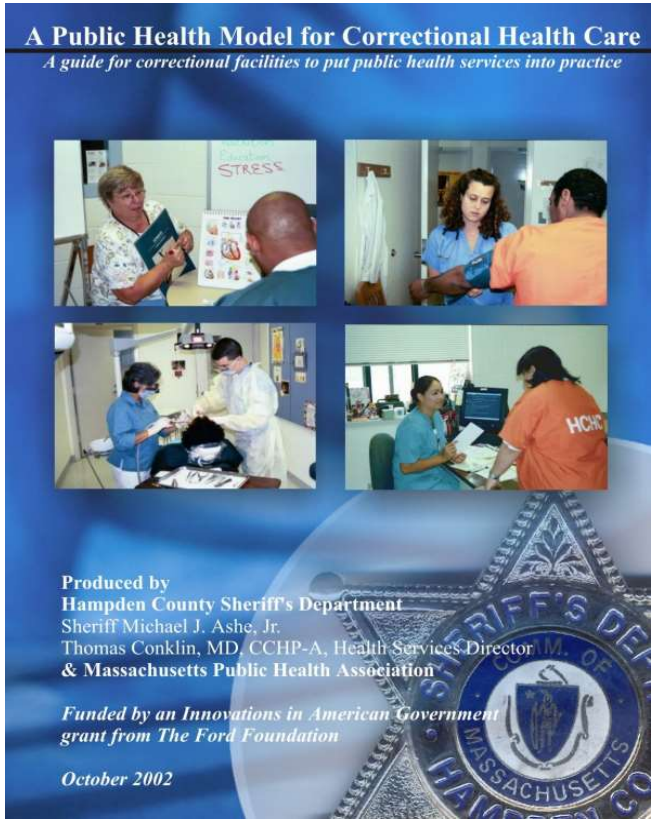
HAMPDEN COUNTY, MA

Community Health Centers

Baystate Health

baystatehealth.com

HAMPDEN COUNTY:
A PUBLIC HEALTH MODEL FOR CORRECTIONAL HEALTH



OCTOBER 2002

1. Education
2. Prevention
3. Early detection
4. Treatment
5. Continuity of care →
6. Data

Community-integrated model

http://hcsdma.org/public-resources/public-health-model/

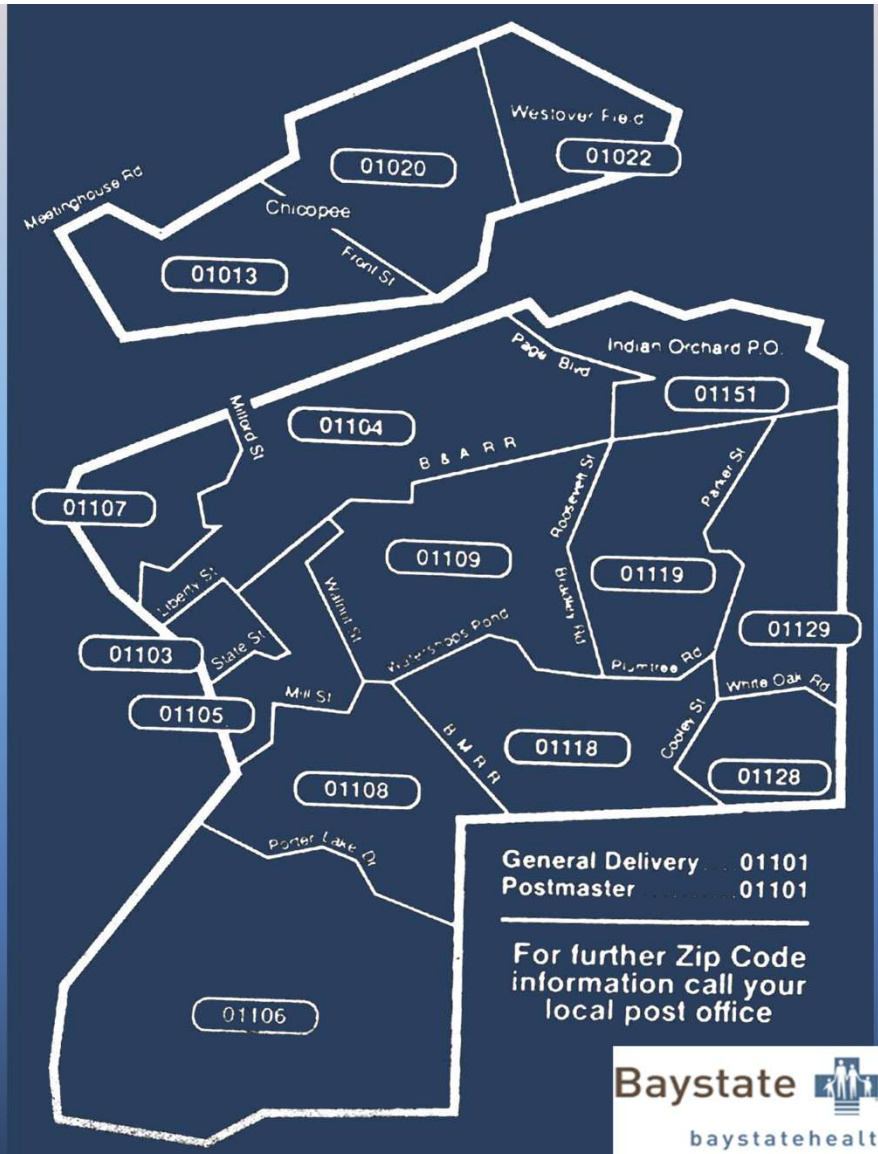
Baystate Health
baystatehealth.com

Community Integrated Correctional Health Care

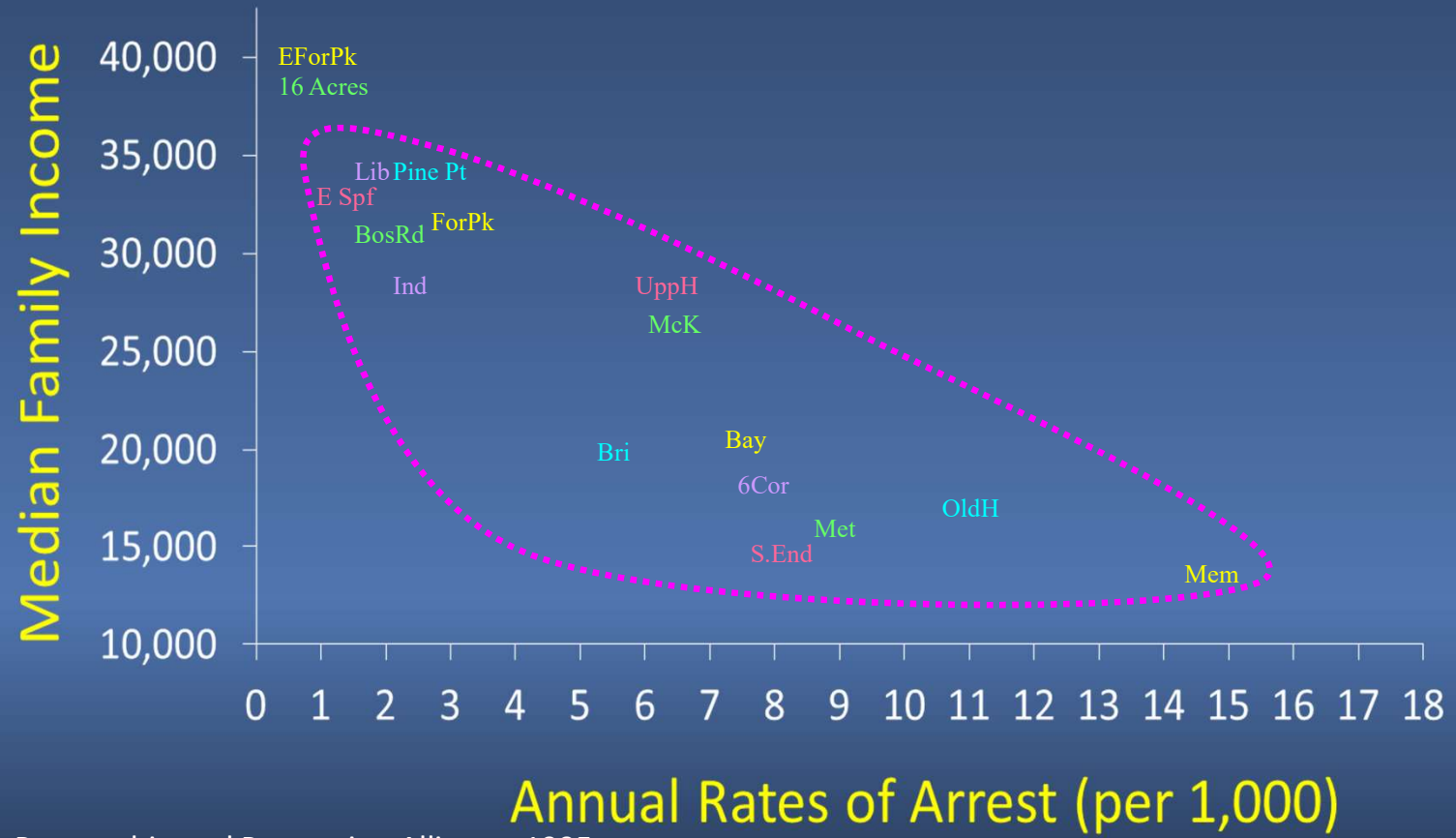
Hampden County MA: A Public Health Model for Correctional Health

2-3%

http://hcsdma.org/public-resources/public-health-model/



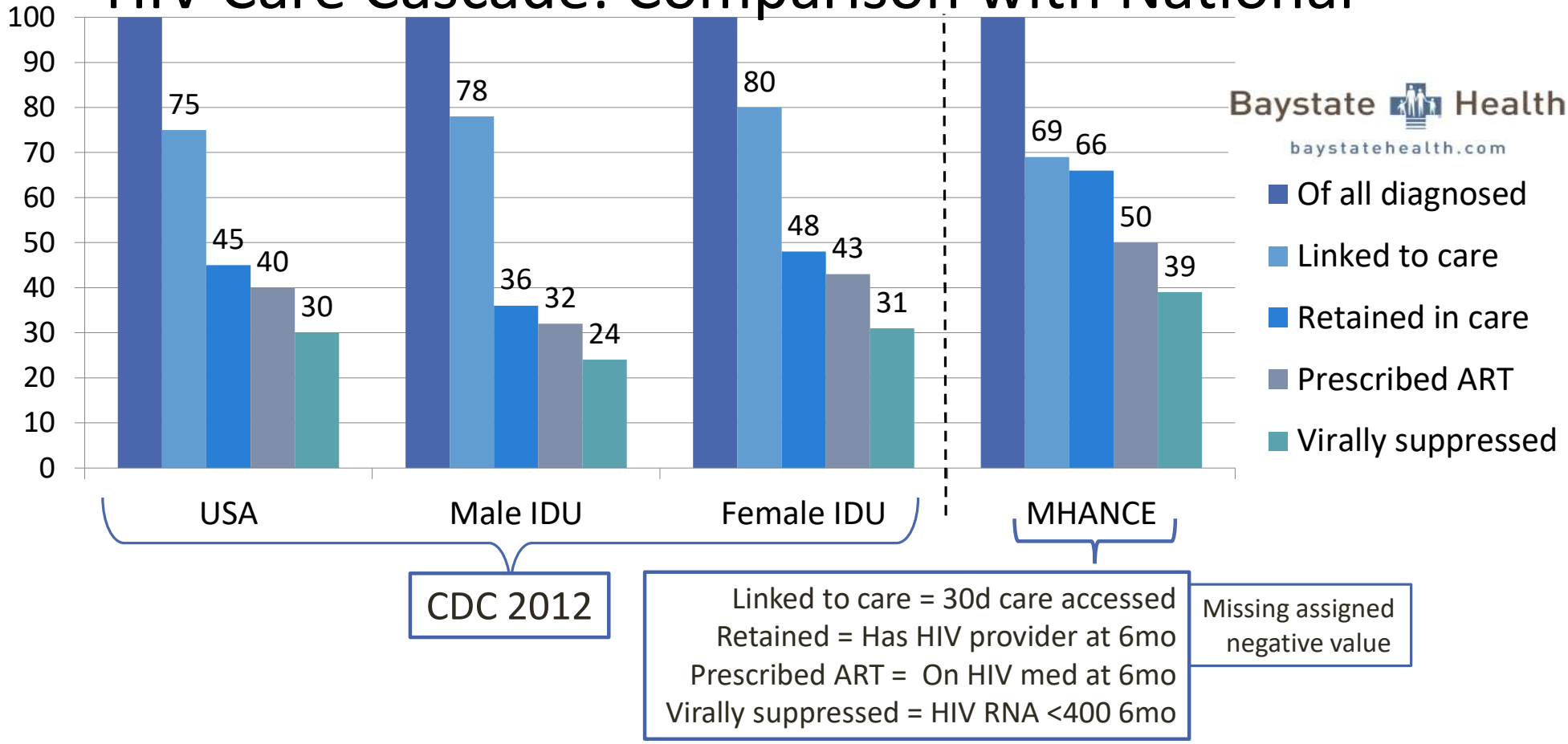
Drug-Related Arrests of Persons Residing in Specific Neighborhoods



Springfield Community Partnership and Prevention Alliance, 1995

SPNS CHLI: Baystate Local Evaluation

HIV Care Cascade: Comparison with National



Creating a Jail Linkages Program

Expect the Unexpected

Client Level:

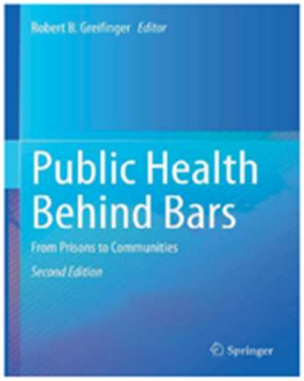
- Begin Where the Client is; harm reduction approach
- Plan for both options: Stay or Go; treat each session as last

Program Level:

- Train staff: Motivational Interviewing & stages of engagement in care
- Hire those who care AND
  - Meet correction agency requirements (no community supervision, no recent charges)
  - Demonstrate cultural competency and understanding of system impact
  - Use humanizing language; clients' primary language, when possible

Systems Level:

- Track outcomes (linkage to care and follow up after incarceration)
- Arrange transitional services (continuity of medication, after care letter, medical summary, lab reports, transportation, and accompaniment)
- Ask community health centers to help; set aside walk-in hours



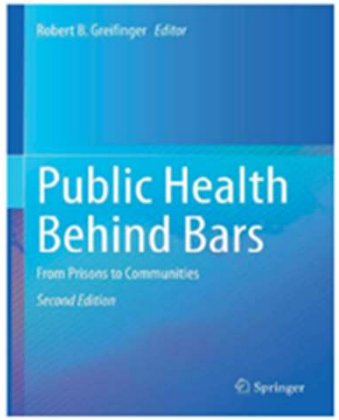
Ask the Audience:

What do you think are the greatest barriers to successful correction and community health collaborations? What community partners have helped support your work?
How might collaborations with organizations outside your workplace improve your day?

DISCUSSION

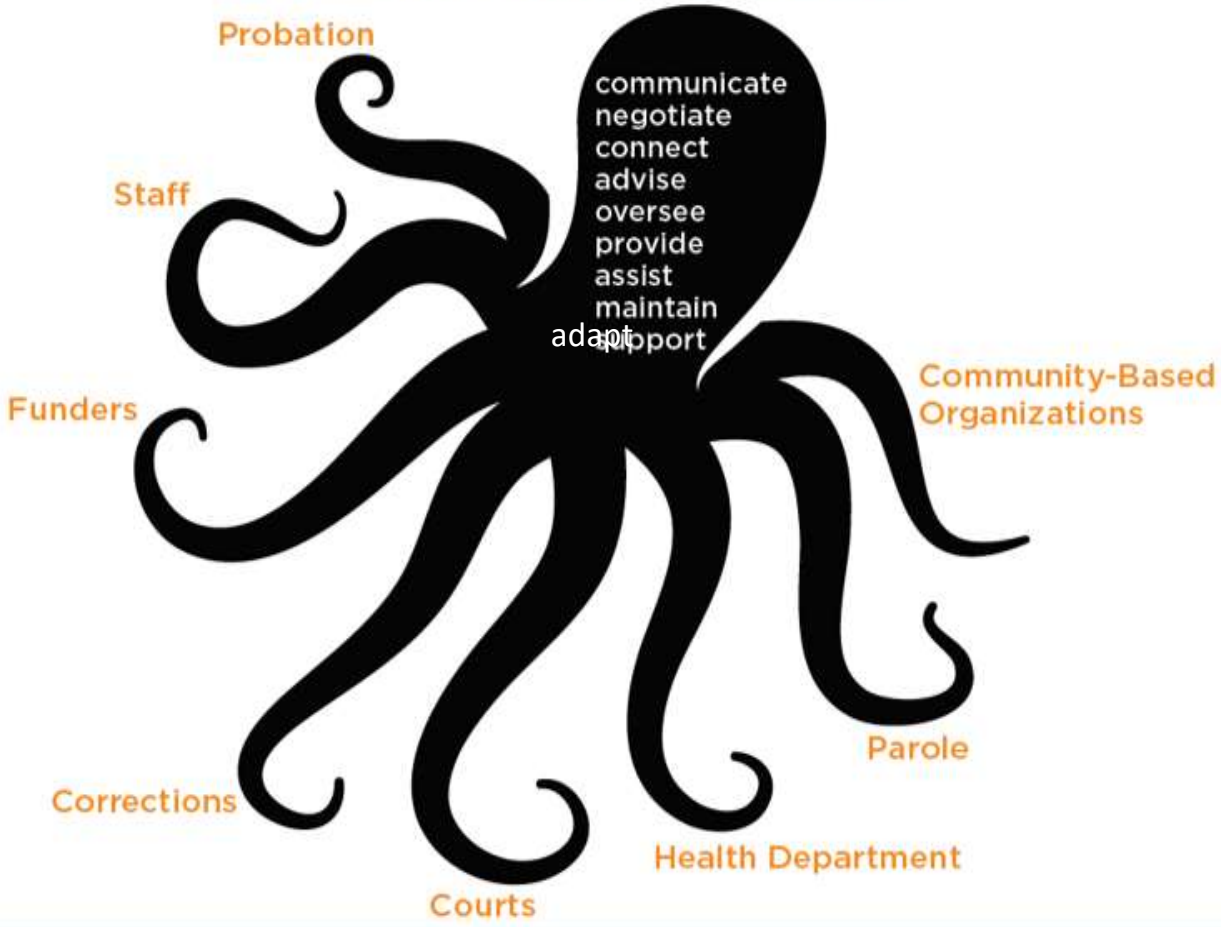
Reentry planning, discharge planning and continuity of care collaborations involve:

- people with criminal legal system involvement
- correctional and community health providers – nurses, social workers, providers
- legal representatives – defenders; treatment courts; district attorneys
- Correctional and community medical, substance use and mental health treatment providers
- Housing, employment and social service – reentry teams and service providers
- Skilled nursing facilities – correctional, hospital, facility NURSES!
- treatment courts and care management teams



Resources: Evidence-informed public health approaches include a Public Health Model for Correctional Health (PHMCH) and Transitional Care Coordination (TCC) which have been successfully adapted, implemented and replicated using translational science.

CRITICAL SKILLS



COMMUNICATE | NEGOTIATE | CONNECT | ADVISE | OVERSEE | PROVIDE | ASSIST | MAINTAIN | SUPPORT

TOOLS + TIPS FOR PROVIDING TRANSITIONAL CARE COORDINATION

HANDBOOK

Synthesizes program planning, implementation, and lessons learned, offering strategic approaches to:

- implement, expand, and refine care coordination work.
- negotiate and form partnerships to improve health outcomes.
- identify medical alternatives to incarceration.
- improve continuity from jail to community healthcare.
- benefit health and hospital care, public health, HIV services, substance use and mental health, and jail health.

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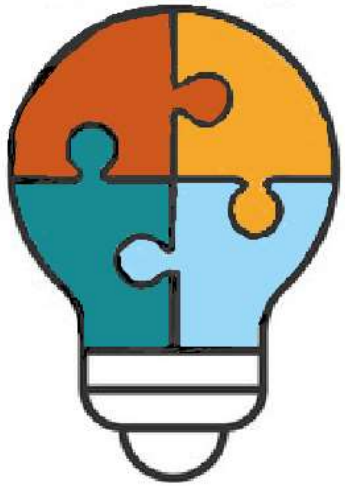
Benefits of Collaborations Across Systems

Achieve Mutual Objectives

- Leadership required
- Health IT solutions
- Cost saving on a societal level

Improve health outcomes

- Vulnerable Populations
- Reduce housing instability
- Address mental health and SUD



Requires Ongoing Support

- Training, Technical Assistance
- Guidance
- Collaborators

Education & Awareness

- Overdose Prevention
- Peer leadership
- Visitor Outreach

Funding Sources

Since the 1980s…

federal, state and local agencies as well as foundations have supported:

- **Hampden County MA:** Public Health Model for Correctional Health (PHMCH)
  - led to **Community Oriented Correction Health Services (COCHS)** adaptions in other areas

HRSA Special Projects of National Significance (SPNS):

- 10 Correctional Health Linkage Initiatives (CHLI) sites (**Hampden County MA, NYC …**)
- Workforce Capacity and Latino Initiatives (**NYC and Puerto Rico**)
- 14 Housing & Employment demonstration sites (**Chicago; Paterson NJ**)
- 3 Dissemination of Evidence Informed Intervention TCC sites (**Camden, Raleigh, Las Vegas**)

Other federal and Foundation funding

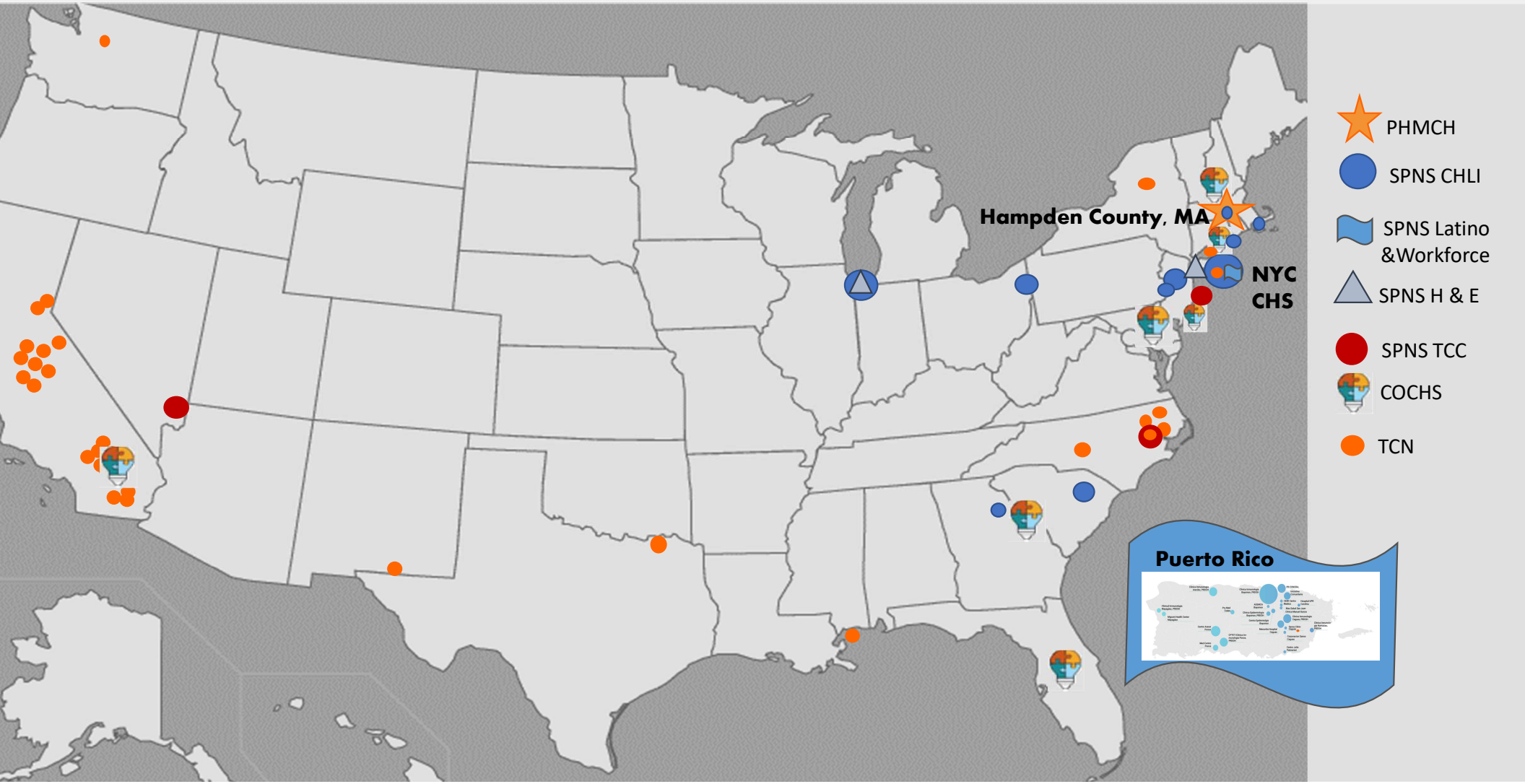
HIV Prevention: Health Education / Risk Reduction & Condom Distribution (**CDC**)

NYC Correctional Health Service [NYC CHS] Transitional Care Coordination model (**CDC/RW**)

NYC HIV testing model adapted from **Project Start** seeded by (**ELJ, MACAIDS, Robin Hood**)

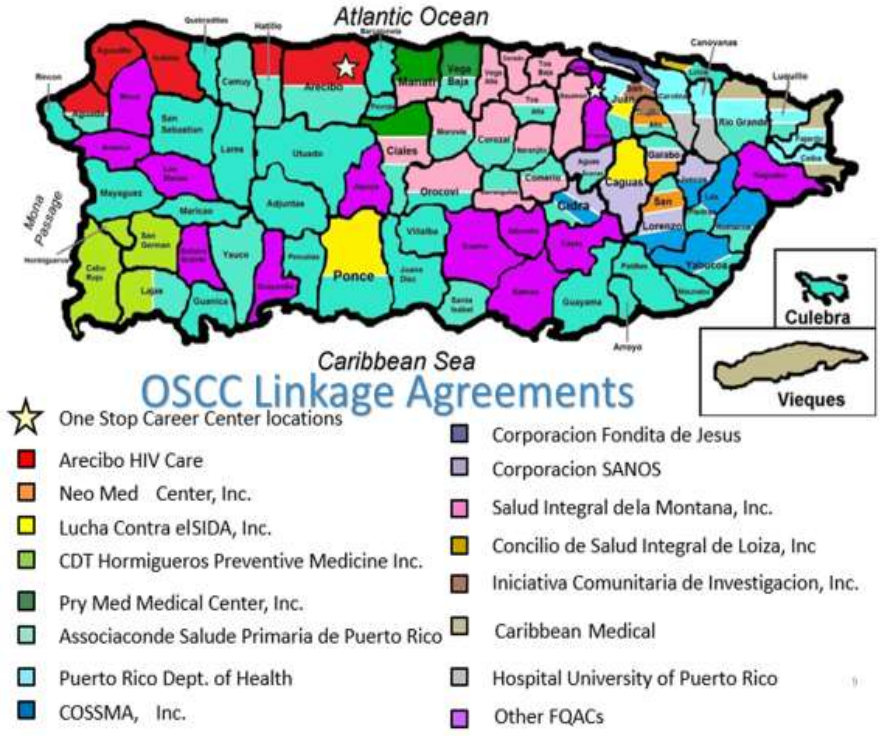
- **Transitions Clinic Network (TCN):** over 30 community health centers; collaborate with **TCC**

Locations


Hampden County, MA
NYC
CHS
Puerto Rico
PHMCH
SPNS CHLI
SPNS Latino
&Workforce
SPNS H & E
SPNS TCC
COCHS
TCN

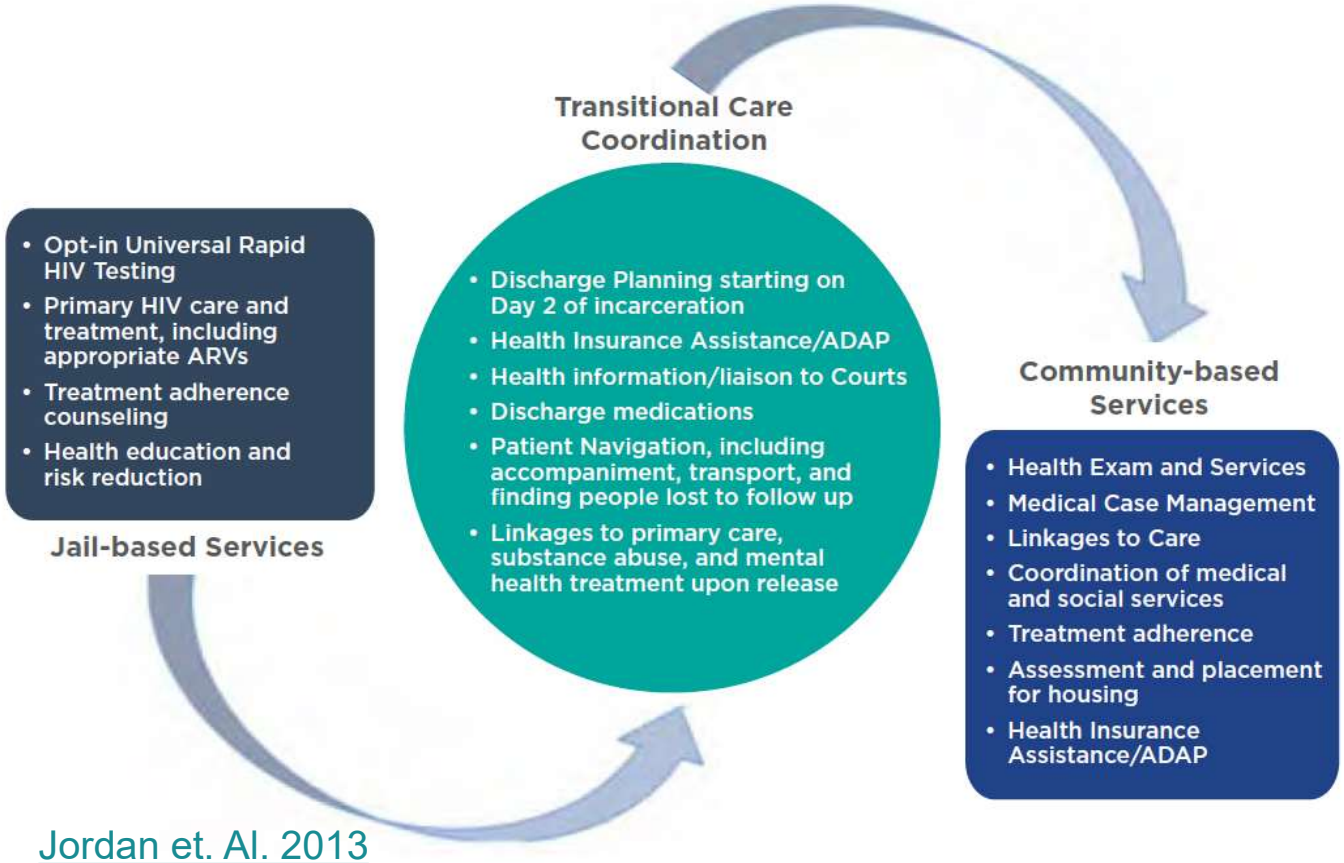
Collaboration Outcomes

- Over **60 MOUs** with service providers across PR to address housing, primary care, employment, and other social services
- Government and community partners launched Island-wide consortium to address needs of HIV+ clients transitioning to community after incarceration
  - **Community providers** – medical care, including HIV Primary Care, housing, substance use treatment, syringe exchange, support services, care management.
  - **Federal agencies** – Ryan White, US DOJ
  - **PR Department of Correction and Rehabilitation**



HIV Primary Care in PR

NYC Transitional Care Coordination



Jordan et. Al. 2013

Free download available at: https://targethiv.org/ihip/tools-tips-providing-transitional-care-coordination

"It can take just one individual to initiate improvement and one team to sustain it," Jackie Cruzado

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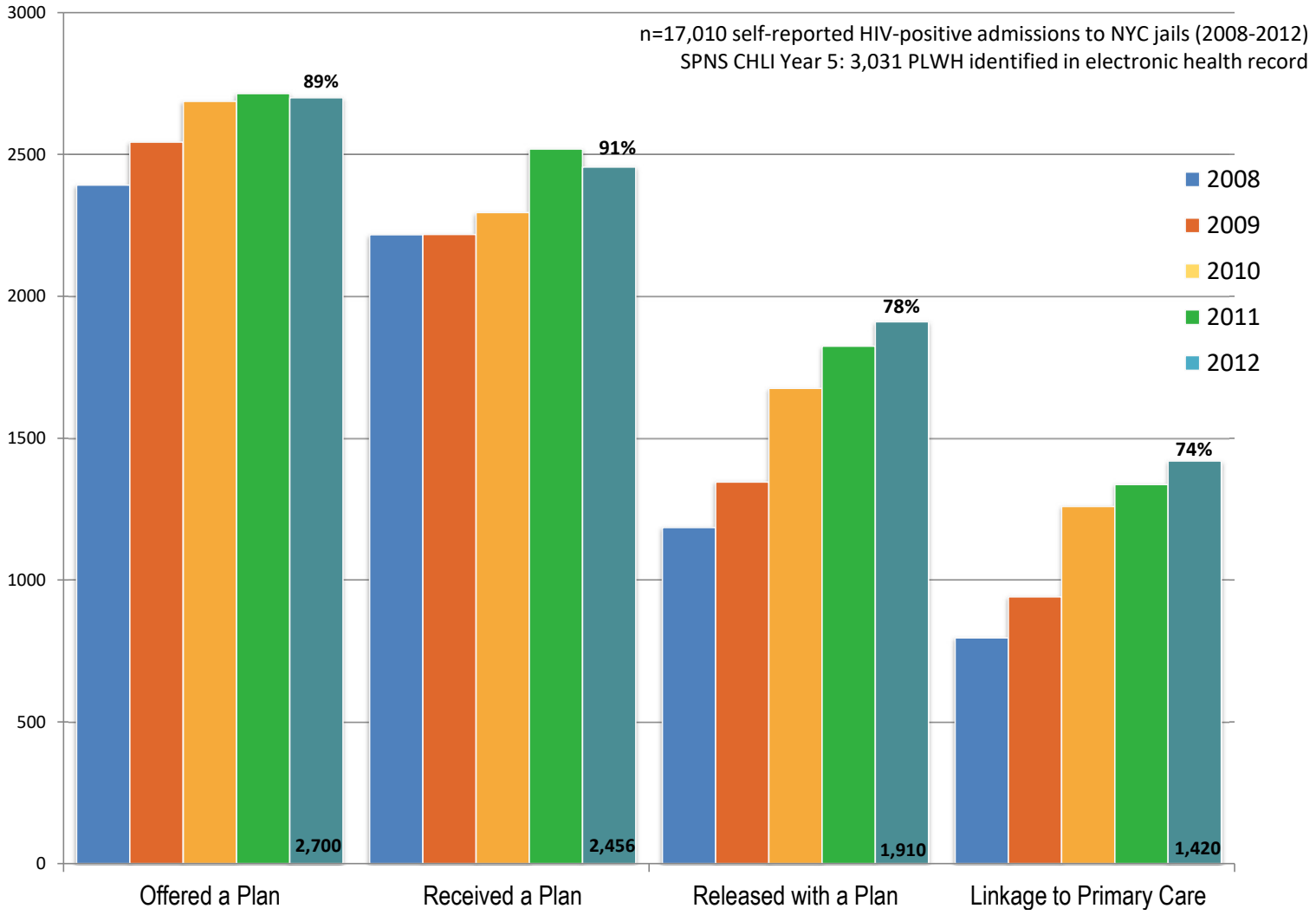
OPENING DOORS... MAKING A DIFFERENCE

NYC Transitional Care Coordination Cascade



SPNS Correctional Health Linkages Initiative

NYC Program Outcomes

- Along with primary medical care, NYC CHLI clients were also connected to:
  - Medical case management (53%)
  - Substance use treatment (52%)
  - Housing services (29%)
  - Court advocacy (18%)
- Approximately 65% of clients accept the offer of accompaniment and / or transport to their medical appointment.
- 85% of those who were not initially known to be linked to care were found through community outreach; 30% re-incarcerated.

Health Liaison to Courts

1. Obtain participant consent to contact defender.
2. Call during lunch or off tours.
3. Discussed planned approach.
4. Collaborate on the right first step – then stay in touch.

SPNS CHLI Outcomes

From 6m Prior to Incarceration to 6m Post Release

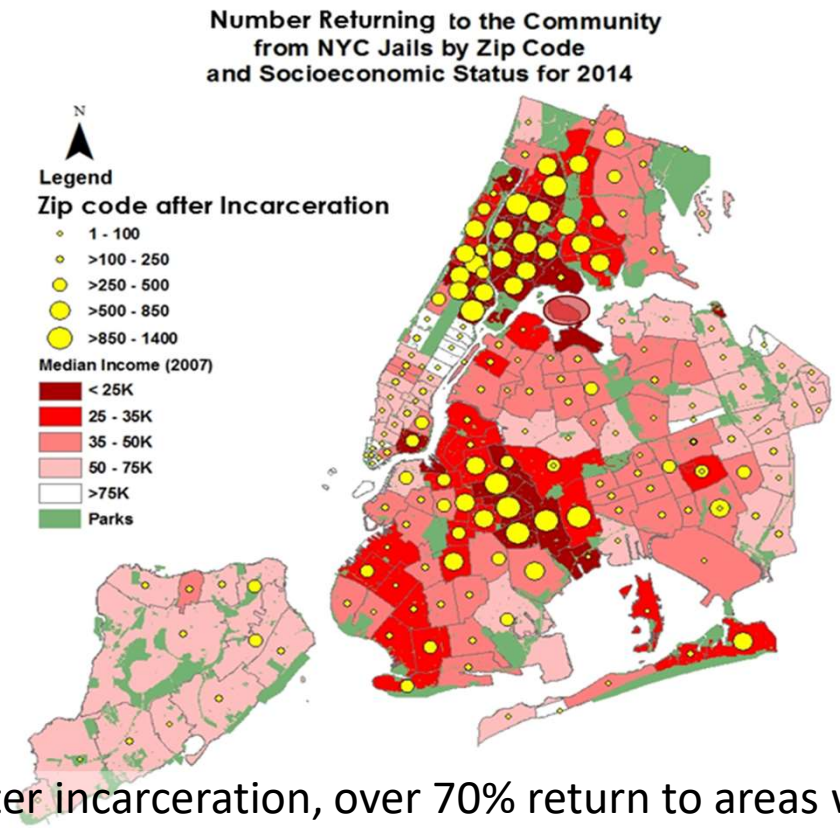
Indicator		NYC		All Sites
Clinical Care				
CD 4 (mean)	↑	(372 to 419)	↑	(416 to 439)
vL (mean)	↓	(52,313 to 14,044)	↓	(39,642 to 15,607)
Undetectable vL	↑	(11% to 22%)	↑	(9.9% to 21.1%)
1,021 (79%) linked to HIV primary care after incarceration*				
# Taking ART	↑	(62% to 98%)	↑	(57% to 89%)
ART Adherence	↑	(86% to 95%)	↑	(68% to 90%)
Avg. # ED visits p/p	↓	(.60 to .2)	↓	(1.1 to .59)
Survival Needs				
Homeless	↓	(23% to 4.5%)	↓	(36.2% to 19.2%)
Hungry	↓	(20.5% to 1.75%)	↓	(37.4% to 14.1%)

Improve community outcomes & reduce costs

**Linkage to HIV primary care measured at 30d after incarceration*

Making a Difference

New York, NY



After incarceration, over 70% return to areas with lowest socioeconomic status. (Jordan et al 2013)

NYC Transitional Care Coordination Outcomes:

- Fewer visits to the emergency department, from 0.60 per person in the 6 months prior to baseline to .20 visits at follow-up
- Housing instability and food insecurity decreased from over 20% at baseline to less than 5% at follow-up.
- Individuals also self-reported feeling in better general health.

(Teixeira et al 2015)

Enhancements / Expansions

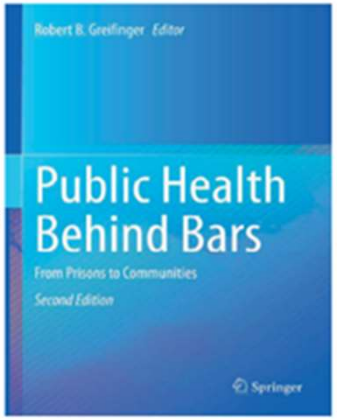
Evidence based outcomes led community integrated correctional health collaboratives to expand / enhance approaches to include:

- Other populations:
  - Substance use disorders including MOUD
  - Geriatric & Complex Care
  - Chronic and communicable disease interventions
  - Universal HCV screening, treatment and linkages
  - Visitor Outreach & Education
  - Young Adult Initiatives
- Legal & Social Services
  - Housing & Employment Services
  - Alternatives to Incarceration
  - Leveraging networks of care + collaborations
  - SPNS Latino Cultural Appropriateness Curricula

- Other locations:

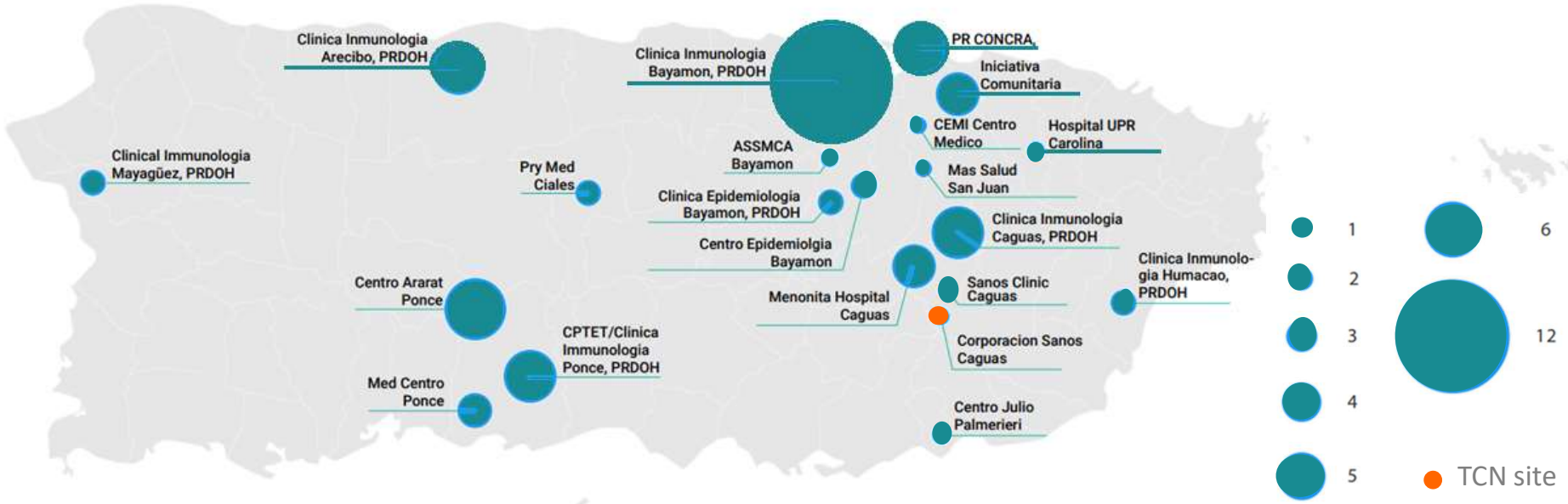
From Hampden County to
- 10 SPNS CHLI sites
- COCHS sites
- Transitions Clinic Network

From NYC CHS to
- OSCC-PR
- 3 SPNS DEII sites
- 14 Housing & Employment sites



SPNS Latino Initiative Training

Mapping Linkages to Care in Puerto Rico



94% of people returning home with a transitional care plan linked to care after incarceration (n=79).

Powered by: COMPAS

DISSEMINATION OF
EVIDENCE-INFORMED
INTERVENTIONS

SPNS Dissemination of Evidence-Informed Interventions: Transitional Care Coordination

Implementation in Camden, Raleigh & Las Vegas

AIDS United & Boston University

Training/Technical Assistance & Translational Research

2015-2020

n=268 identified; 229 community return

Patient Outcomes

180d after incarceration:

- 53% linked to care
- 76% virally suppressed

Suggested citation: Dissemination of Evidence-Informed Interventions. Transitional Care Coordination: From Jail Intake to Community HIV Primary Care (2020).
Available at: https://targethiv.org/deii/deii-transitional-care

Ask the Audience

What lessons do you think were learned using Implementation Science to replicate Transitional Care Coordination in Camden NJ, Raleigh NC and Clark County (LVNV)?

Learning Objective 3: Key Outcomes

Which outcomes do you think helped sustain these interventions?

TRANSITIONAL CARE COORDINATION

Functional Assessment Instructions

- Assess roles and responsibilities for each function associated with the five **CORE ELEMENTS.**
- Determine role / organization that will perform each function and adjust font colors on each listed function using the Functional Assessment Tool to reflect:
  - Position / Performance Site
  - Position / Performance Site Partners
  - Community Standard of Care
  - To be determined
- Identify gaps as well as inconsistencies and any strategic adjustments that may facilitate:
  - Start up
  - Integration of model
  - Maintenance of model
- Use Goal Setting Tool to reflect changes or updates that are needed for Implementation

DISSEMINATION OF EVIDENCE-INFORMED INTERVENTIONS

TRANSITIONAL CARE COORDINATION

KEY:
Position / Performance Site
Position / Performance Site Partners
Community Standard of Care
To be determined

Functional Assessment Tool
[Your Site]

CORE ELEMENTS

- ❑ Medical Intake (Day 0)
  - ○ ID Screening
- ❑ Primary care and treatment
- ❑ Treatment counseling

1. INITIAL CLIENT CONTACT

- ❑ Intake Assessment
- ❑ Health Insurance Assistance
- ❑ Health education and risk reduction

2. TRANSITIONAL CARE PLAN

- ❑ Health Liaison to Court
- ❑ Identify community resources to meet identified needs

Prepare for community return

Transition

3. FACILITATE A WARM TRANSITION

- ❑ Discharge medication|ePrescribing
- ❑ Accompaniment / transport
- ❑ Verify linkages to:
  - ○ primary care,
  - ○ treatment (substance use/mental health)
  - ○ housing & employment

Linkage and follow up

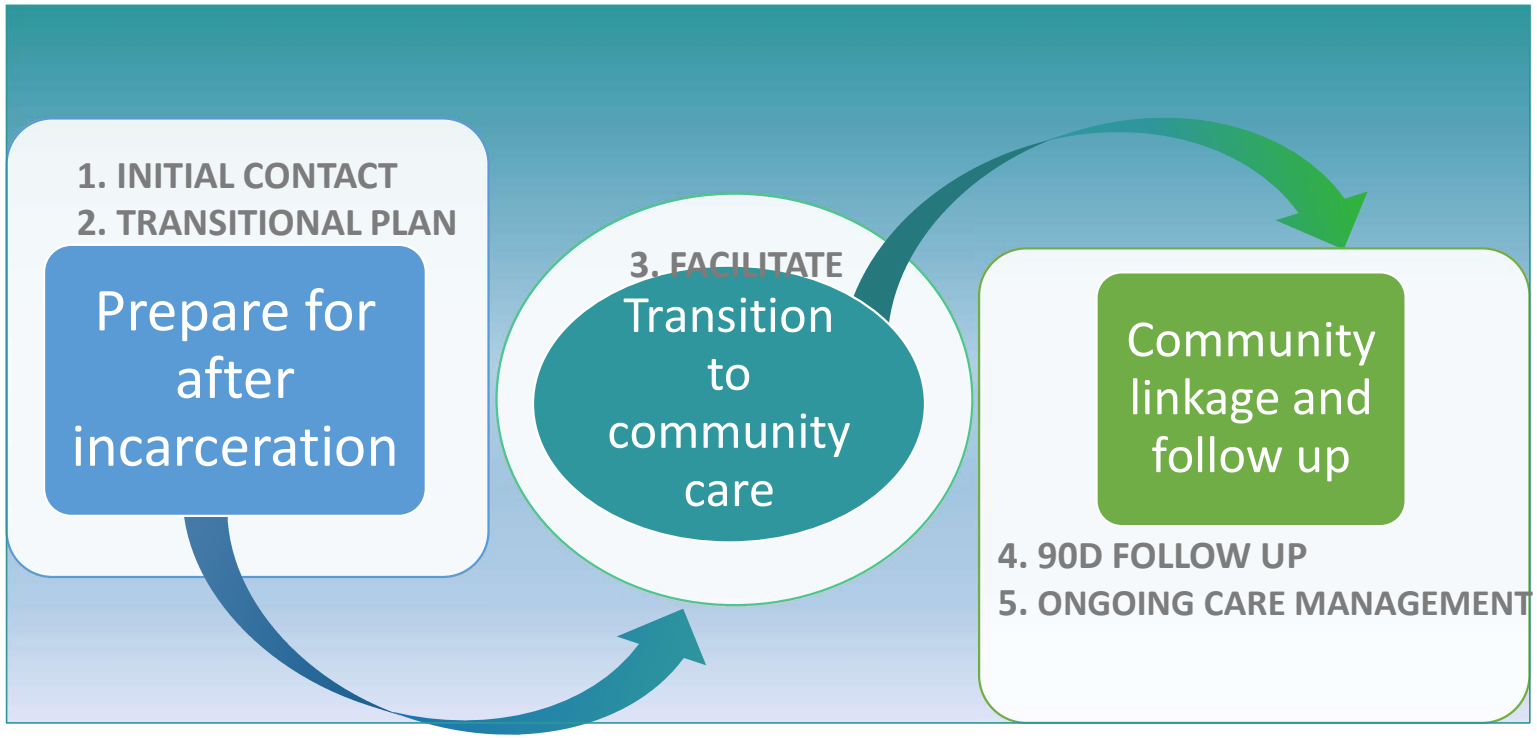
4. FOLLOW UP AFTER LINKAGE TO CARE

- ❑ Implement Transitional Care Plan (TCP)
- ❑ Linkages to care and services
- ❑ Care & Treatment
- ❑ Wellness / Health promotion
- ❑ Housing / Employment assistance
- ❑ Health Insurance Assistance
- ❑ Patient Navigation:
  - ○ accompaniment,
  - ○ home visits, and
  - ○ re-engagement in care

5. ONGOING CASE MANAGEMENT 90+ DAYS AFTER LINKAGE TO CARE

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

Three Phases: Five Core Components



DISSEMINATION OF EVIDENCE-INFORMED INTERVENTIONS

Implementation Readiness Assessment

Functional Assessment for Five Core Components

What's Next?

What gaps did you identify?

How might we help?

e2Polls.com
Code: NCCHCS22

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NCCHC
National Commission on Correctional Health Care

SELECT REFERENCES

Carmona, R. H. (2018). Foreword for symposium on correctional health care. Journal of Health and Human Services Administration, 41(3), 281-284. https://www.questia.com/library/journal/1G1-623173150/foreword-for-symposium-on-correctional-health-care Accessed 1 March 2020.

Centers for Disease Control and Prevention. (2020). The public health system & the 10 essential public health services. https://www.cdc.gov/publichealthgateway/publichealthservices/essentialhealthservices.html Accessed 1 August 2020.

Conklin, T., Lincoln, T., Flanigan, T. P. (1998). A public health model to connect correctional health care with communities. *American Journal of Public Health, 88*(8), 1249-1250.

Conklin, T., Lincoln, T., Wilson, R. (2002). A public health manual for correctional health care. Ludlow, Massachusetts: Hampden County Sheriff's Department. October 2002 http://hcsdma.org/wp-content/uploads/2015/03/Public-Health-Model-2002-Archive.pdf. Accessed 1 March 2020.

Cruzado-Quinones, J., Jordan, A. O., & Cagey, R. (2016) *Tools + Tips for Providing Transitional Care Coordination: Handbook*, Health Resources Services Administration Integrating HIV Innovative Practices. targethiv.org/ihip/tools-tips-providing-transitional-care-coordination Accessed 30 December 2020.

Fox, J., Marback, A., Nortrup, E. & Bryant, H. (2017). Session 3148.0: Transitional Care Coordination: Implementation in Three Cities Across the United States. APHA annual meeting. November 6, 2017.

Health Resources and Services Administration. (2020). Dissemination of Evidence-Informed Interventions. https://targethiv.org/deii Accessed 27 December 2020.

Jordan, A. O., Cohen, L. R., Harriman, G., Teixeira, P. A., Cruzado, J., & Venters, H. (2013). Transitional care coordination in New York City jails: Facilitating linkages to care for people with HIV returning home from Rikers Island. *AIDS and Behavior, 17,* 212–219.

Jordan, A. O., Cruzado-Quinones, J., Sinnreich, R., Hane, L., MacDonald, R., Rosner, Z., & Venters, H. (2015). Abstract 326511: Medical Alternatives to Incarceration: Health Liaison to the Court Advocates for Community Health and Health in all Policies. Presented at APHA annual meeting. November 3, 2015.

Macmadu A, Goedel WC, Adams JW, Brinkley-Rubinstein L, Green TA, Clarke JG, et. al. Estimating the impact of wide scale uptake of screening and medications for opioid use disorder in US prisons and jails. Drug Alcohol Depend. 2020, https://doi.org/10.1016/j.drugalcdep.2020.107858

Teixeira, P. A., Jordan, A. O., Zaller, N., Shah, D., Venters, H. (2014) Health outcomes for HIV-infected persons released from the New York City jail system with a transitional-care-coordination plan. *American Journal of Public Health,* 105, 351-357. doi: 10.2105/AJPH.2014.302234

Thank you!

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