Virtual Capacity-building Sessions for Correctional Linkage to Care (CLTC)

Session 1

ta4si
TECHNICAL ASSISTANCE
FOR SERVICE INTEGRATION

JSI RESEARCH & TRAINING INSTITUTE, INC.

Navigating Zoom

Can you hear us?

The audio is being shared via your computer speakers/headset. If you can't hear the audio, make sure your computer audio is turned on.

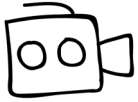
If you'd prefer to call in:

Call-in number: 646-558-8656
Webinar ID: 918 2690 6911
Password: 709346

If you're still having problems or you have a question, use the chat box at the lower-left of your screen to chat with the presenter.

Navigating Zoom

Audio



Video

Chat

Annotate

Breakouts

Technical problems?
Send a message to
Molly Rafferty or email
molly_rafferty@jsi.com

WELCOME!

Introductions

- Your name and pronouns (e.g., she, he, they)
- Your organization
- Your role in CLTC services

Poll Questions

- What is your beverage of choice in the morning?
- What is your role in the HOC?
- Are you allowed into the HOC at this time or are COVID restrictions still in place?

Background

- MDPH Bureau of Infectious Disease & Laboratory Sciences has long history of working in county and state correctional facilities
  - Infectious Disease Coordinator and ID nurses in Dept of Corrections
  - HIV Coordinators in county Houses of Corrections (HOCs)
  - Services for people with HIV leaving HOCs
  - Assessment of Infectious Disease Services in HOCs
  - Correctional Linkage to Care
  - Infectious Disease Coordinator in Suffolk County

Assessment of ID Services

- Numbers of HIV + individuals declined
- Delivered assessment to all county HOCs to understand impact of defunding coordinators, and understand ID testing, treatment, and release planning needs
- Major findings from majority of HOCs
  - Need for transition/release planning and support
  - Need for services for people with HCV
  - Needs of people with substance use disorder

ID Coordinator

- CDC Ending the HIV Epidemic (EHE) funds allocated to support Infectious Disease Coordinator to provide additional prevention and care support at Suffolk County HOC in both facilities
- ID Coordinator will add capacity to optimize prevention and care services for incarcerated individuals living with or at risk of HIV and HCV, and those preparing to reenter the community including individuals diagnosed with substance use disorder

Correctional Linkage to Care

- Short term intensive service for individuals transitioning out of county HOCS
- Eligibility includes people living with HIV and/or HCV (prioritizing those with current or past SUD)
- Services support individuals to successfully link to medical care and other essential health supports in the community
- Integrated ID testing is not component of CLTC but is supported in HOCs either through MDPH out-posting or through HOC

CLTC

- 12 weeks *prior to* estimated date of release
  - Intake/assessment
  - Health education (HIV/HCV/STI/TB)
  - Identification of providers and appointment scheduling
  - Health insurance
- 12 weeks *following* release
  - Linkage to harm reduction (MAT, SSP, OEND)
  - Linkage to medical care (HIV, HCV, PrEP)
  - Linkage to other support services (e.g. MCM, housing, etc.)

CLTC Model

- Community-based agencies funded to outpost linkage staff in HOCs
- Most agencies also funded for integrated testing (although some HOCs do their own)
- Referral from either testing staff or HOC staff
- Prior to release: intake/assessment, education, medical appointments, insurance enrollment
- Following release: linkage to harm reduction, medical care, and other support services
- Accompaniment to appointments and/or reminders

Questions and Clarifications

Referral and Enrollment Models

Referral from agency testing staff

Benefits:

Confirmed diagnosis

Confirmed interest in service

Challenges:

Unknown release date

Referral from HOC staff

Benefits:

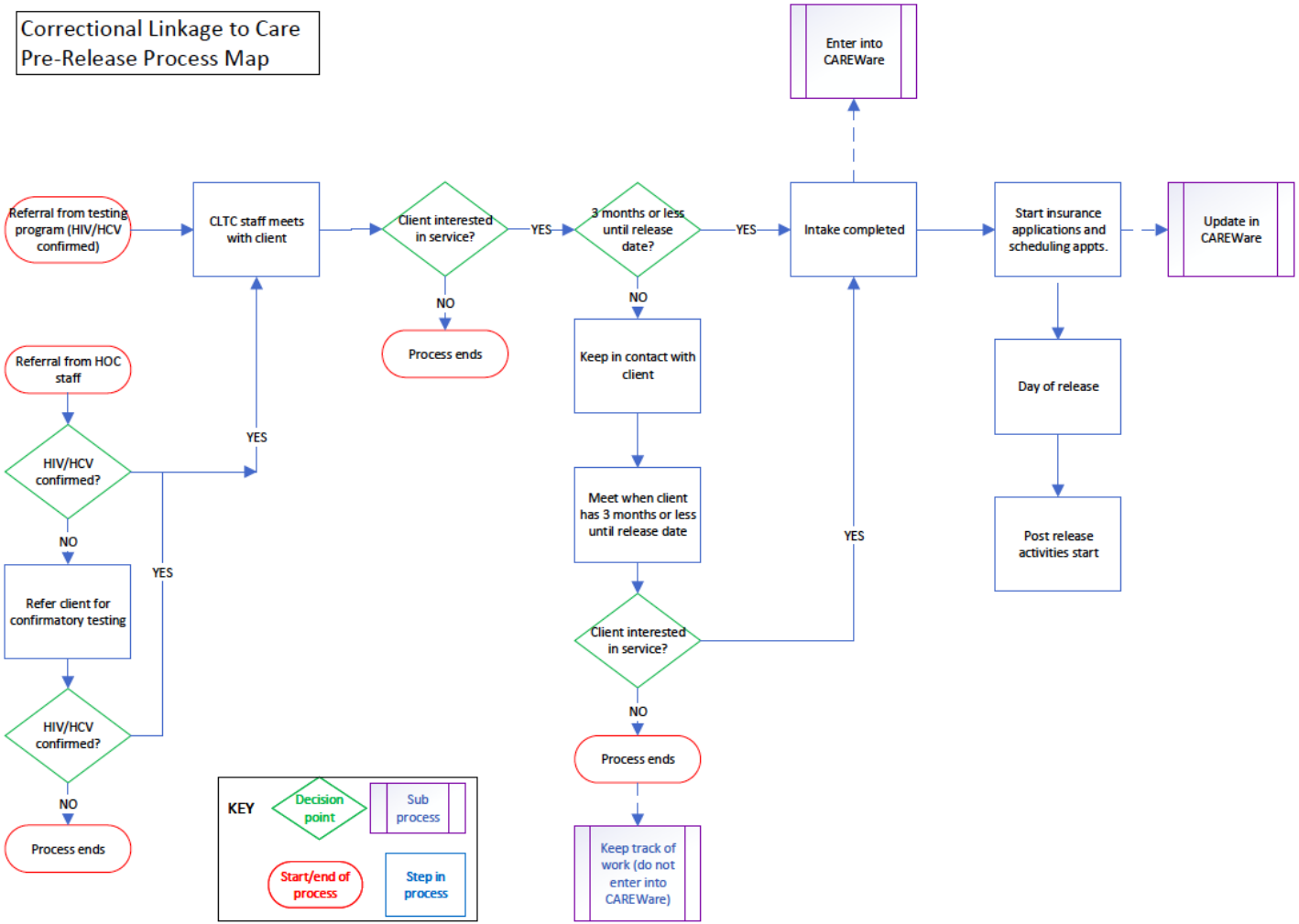
Confirmed release date

Challenges:

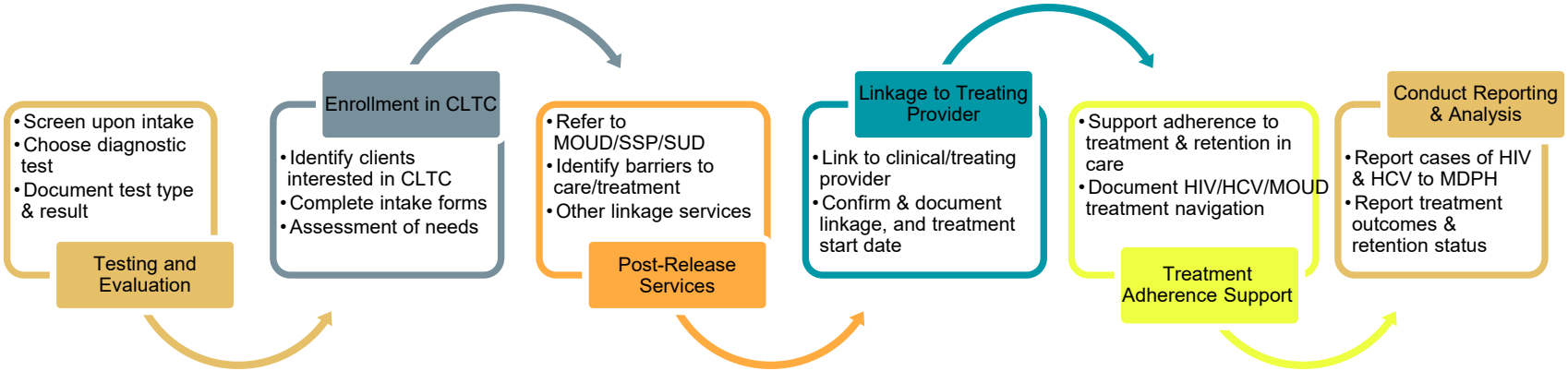
Diagnosis not confirmed

Lack of CLTC information

Correctional Linkage to Care Pre-Release Process Map



CLTC Indicators – Components of Service



CLTC Indicators – Broad Overview

No.	Steps for Testing and Treatment	Process Indicators (Required indicators are in bold)			Outcome Indicators (Care Cascade) (Required indicators are in bold)		
		No.	Indicator	Comment	No.	Indicator	Comment
1	Testing and Evaluation: -Screen upon intake (clients are screened for eligibility by means of confirmed HIV and/or HCV diagnosis) -Choose appropriate diagnostic test -Document test type and result	a.	# HCV-antibody tests conducted	Required	c.	#/% Clients tested for HCV (among all screened)	Required
		b.	# Confirmatory HCV RNA tests conducted	Required	d.	#/% NAT positive clients (among those tested)	Required
					e.	#/% Clients with positive HCV-antibody test and negative HCV RNA result (among those tested)	Required
2	Enrollment in Correctional Linkage to Care (CLTC) Service: -Identify clients who may be interested in CLTC services -Complete intake forms to enroll clients in the service -Perform assessment of needs	a.	# Clients referred to CLTC Stratification by correctional referral type (e.g., out-posted testing staff, HOCV staff, etc.)	Required	c.	#/% Clients enrolled in CTLC	Required
		b.	# CLTC intake forms completed	Required			
3	Post-Release Services -Refer clients to Medication Opiod Use Disorder (MOUD) and/or SSP/OEND/SUD support services -Identify client barriers to care/treatment -Other linkage services (e.g., transportation assistance, housing, benefits advocacy, etc.)	a.	# Clients referred to MOUD/SSP/SUD support services Stratification by referral type	Recommended	b.	# Clients linked to MOUD/SSP/SUD service provider(s) Stratification by linkage type	Required
					c.	# Clients linked to MOUD/SSP/SUD support services within 30 days (*linkage to MOUD should be done within 7 days)	Required
4	Linkage to Medical Care: -Link to clinical/treating provider post-release -Confirm and document linkage to treatment -Document treatment start date	a.	# Clients referred to care through CLTC services	Required	d.	#/% HCV+ who initiate HCV treatment (among all NAT positives)	Required
		b.	# HCV+ Clients who attend initial visit with treating provider, post-release	Required	e.	#/% Clients who initiate HCV treatment within 30 days of release (among all NAT positives)	Required
		c.	# HIV+ Clients who attend initial visit with treating provider, post-release	Required	f.	#/% HIV+ clients linked to medical/treating provider (among all HIV positives)	Required
					g.	#/% Clients linked to HIV medical care within 30 days of release (among all HIV positives)	Required
5	Treatment Adherence Support: -Support adherence to treatment and retention in care -Document HIV & HCV treatment navigation activities	a.	# Vistis with medical/treating provider Stratification by disease type (e.g., HIV or HCV)	Recommended	d.	#/% Clients who have completed treatment (among all NAT positives)	Required
					e.	#/% Clients retained in care (among all NAT positives) Stratification by type of adherence support provided	Required
		b.	# HCV RNA tests of cure conducted Stratification by ordering provider if applicable	Required	f.	#/% Clients who interrupt HCV treatment due to re-encarceration	Recommended
					g.	#/% Clients who are virally suppressed, or in continuous care for 12 or more months ith a CD4 cell count >350 cells/mm^3 or viral load of <200 copies/mL (among all HIV+ cases)	Required
		c.	# Clients who are out-of-care, or have failed to engage in medical care necessary to treat and/or cure disease Stratification by testing facility	Required	h.	#/% Clients retained in care (i.e., with up-to-date viral loads and/or CD4 counts, and 2 or more visits per year with a medical provider for routine HIV medical care)	Required
					i.	#/% Patients with active ART prescriptions (among HIV+ clients who initiated treatment) Stratification by whether adherence support was received or not	Required
6	Conduct Reporting and Analysis -Report cases of HIV & HCV to Massachusetts Department of Public Health (MDPH) -Report treatment outcomes, including date and treatment retention status -Report clients who are out-of-care, or clients who require treatment re-engagement	a.	# HCV cases reported	Required	d.	#/% Cases reported on-time to MDPH	Recommended
		b.	# HIV cases reported	Required			
		c.	# Cases engaged in care (i.e., undergoing treatment, and/or receiving treatment adherence support)	Required			

Enrollment in CLTC

Component	Type of Indicator	Indicator	Data for this indicator is required to be reported or recommended to be collected?	Where to record this data
Enrollment in Correctional Linkage to Care (CLTC)	Process Indicator	# Clients referred to CLTC	Required	CAREWare
	Process Indicator	# CLTC intake forms completed	Required	CAREWare
	Outcome Indicator	#/% Clients enrolled in CLTC	Required	CAREWare

Interview with Health Imperatives

Interview with Cambridge Health Alliance

Question & Answer

BREAK

Poll Questions

Are you using a form to document referrals into CLTC?

(Yes/No/Don’t know)

Are you using the DPH CLTC intake/assessment tool?

(Yes/No/Don’t know)

Does your CLTC program get referrals from facility MOUD program?

(Yes/No/Not applicable)

Group Discussion

Referral and Enrollment

What is working well with referral and enrollment? What barriers is your program facing?

How has your program dealt with the challenge of identifying clients with three months or less to serve on their sentence?

One agency suggested posting a flyer with information about CLTC for clients to see. Is that something that would be helpful? Would you be allowed to do that? What about a video?

Thank you!

Please Complete the Evaluation!

- Your feedback in the evaluation helps us plan future sessions and address your TA needs.
- Your feedback is appreciated!

Click the eval link in the chat or in the follow-up email you receive in order to complete the evaluation.

ta4si
TECHNICAL ASSISTANCE
FOR SERVICE INTEGRATION

Contact Us

TA4SI@jsi.com

JSI

Implemented by JSI under contract # INTF4971M04500824092 with the Massachusetts Department of Public Health, Bureau of Infectious Diseases and Laboratory Sciences.