Session 111
Health Information Technology Supports Reentry Programs & Community Collaborations

This presentation will begin soon. Please join us at e2polls.com Access Code: NCCHC S21

e2Polls.com
Code: NCCHC S21

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Disclosure and Disclaimer

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

Alison O Jordan represents the American Public Health Association on the NCCHC Board, serves as their representative to the Academy of Correctional Health Professionals, and serves on the editorial board of Journal of Correctional Health Care.

Tom Lincoln is a long-standing member of the American College of Correctional Physicians and serves on the editorial board of Journal of Correctional Health Care.

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

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Educational Objectives

1. Identify facilitators to adopting community collaborations in order to enhance collaborations from the perspectives of correction administrators, correctional health staff, community clinics, service organizations and participants
2. Understand barriers created by lack of national coordination of correctional public health and potential strategies for universal healthcare access
3. Use translational research to facilitate fidelity and penetration of community collaborations
4. Understand / leverage collaborations to achieve key outcomes for people with recent criminal / legal system involvement; and
5. Understand and use data-driven methodology in the planning and design of targeted interventions and utilize data dashboards and other technology tools to produce actionable data.

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Acknowledgement / Disclaimer

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

This information or content and conclusions are those of the authors and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, OMH, HHS or the U.S. Government.

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ACOJA Consulting - Who We Are

ACOJA Consulting LLC is a NYC-certified M/WBE and internationally recognized team skilled in strategic planning and guidance for health and human services, public health research, and government programs.

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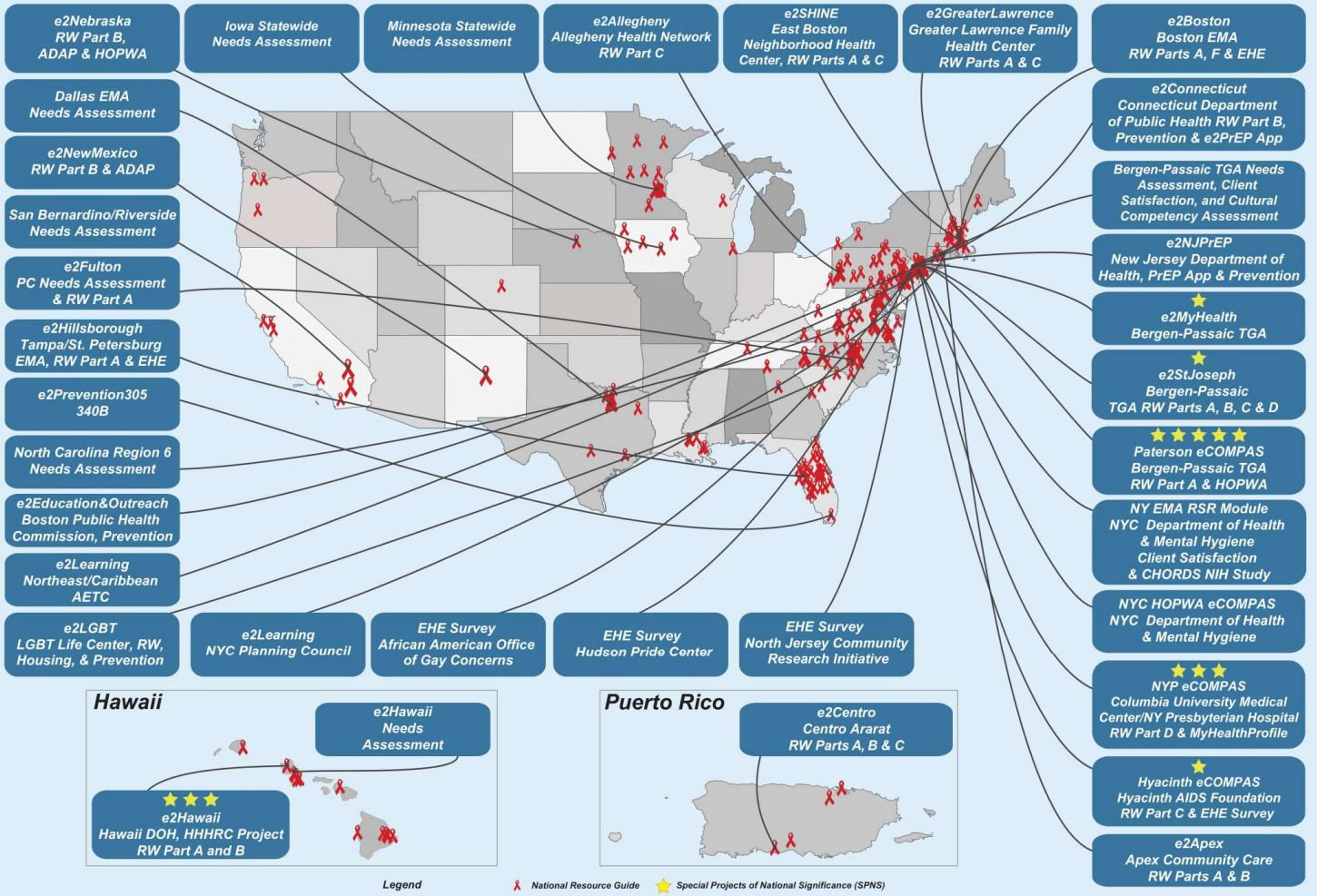
eCOMPAS and e2Community Success Stories



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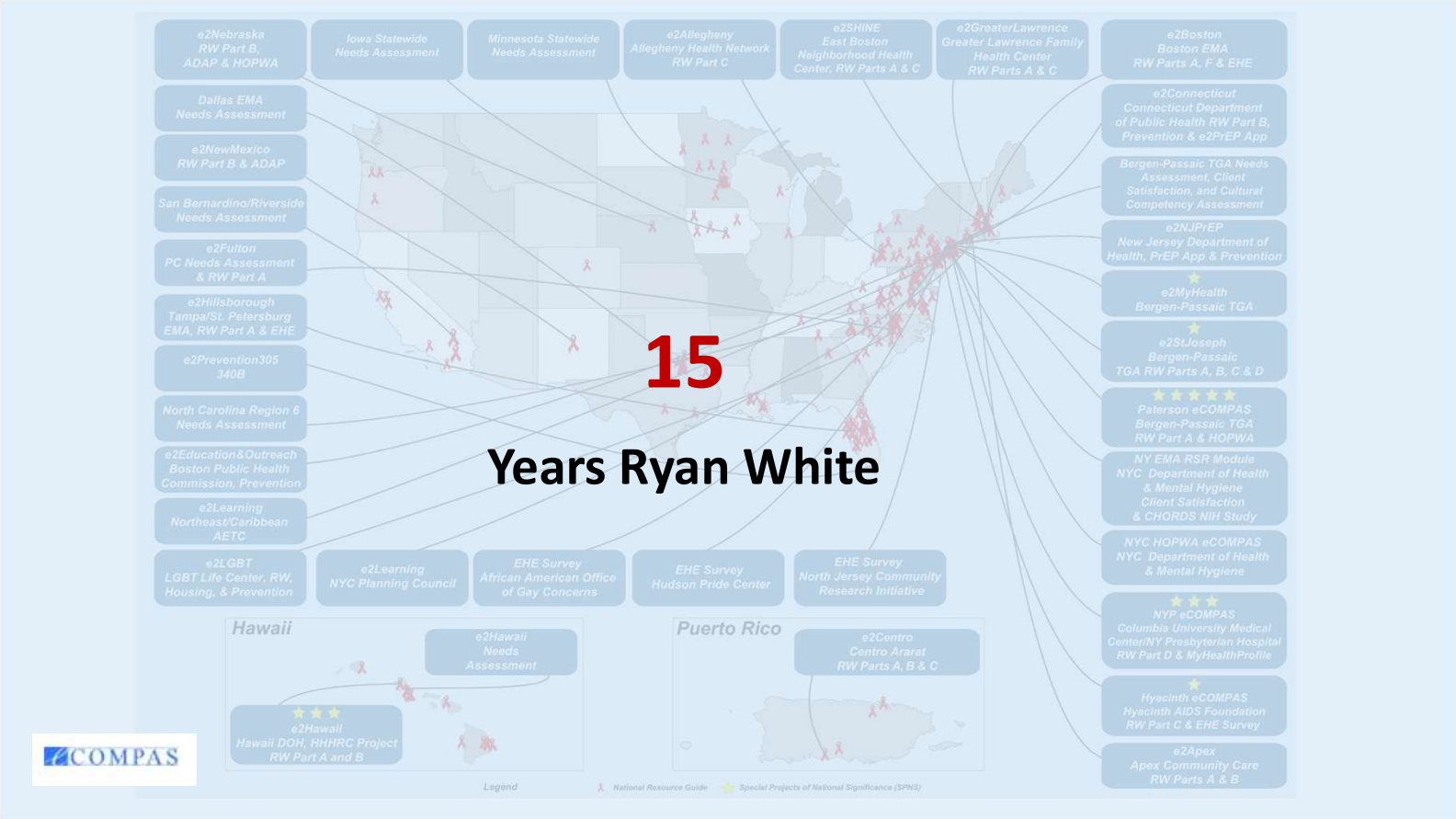

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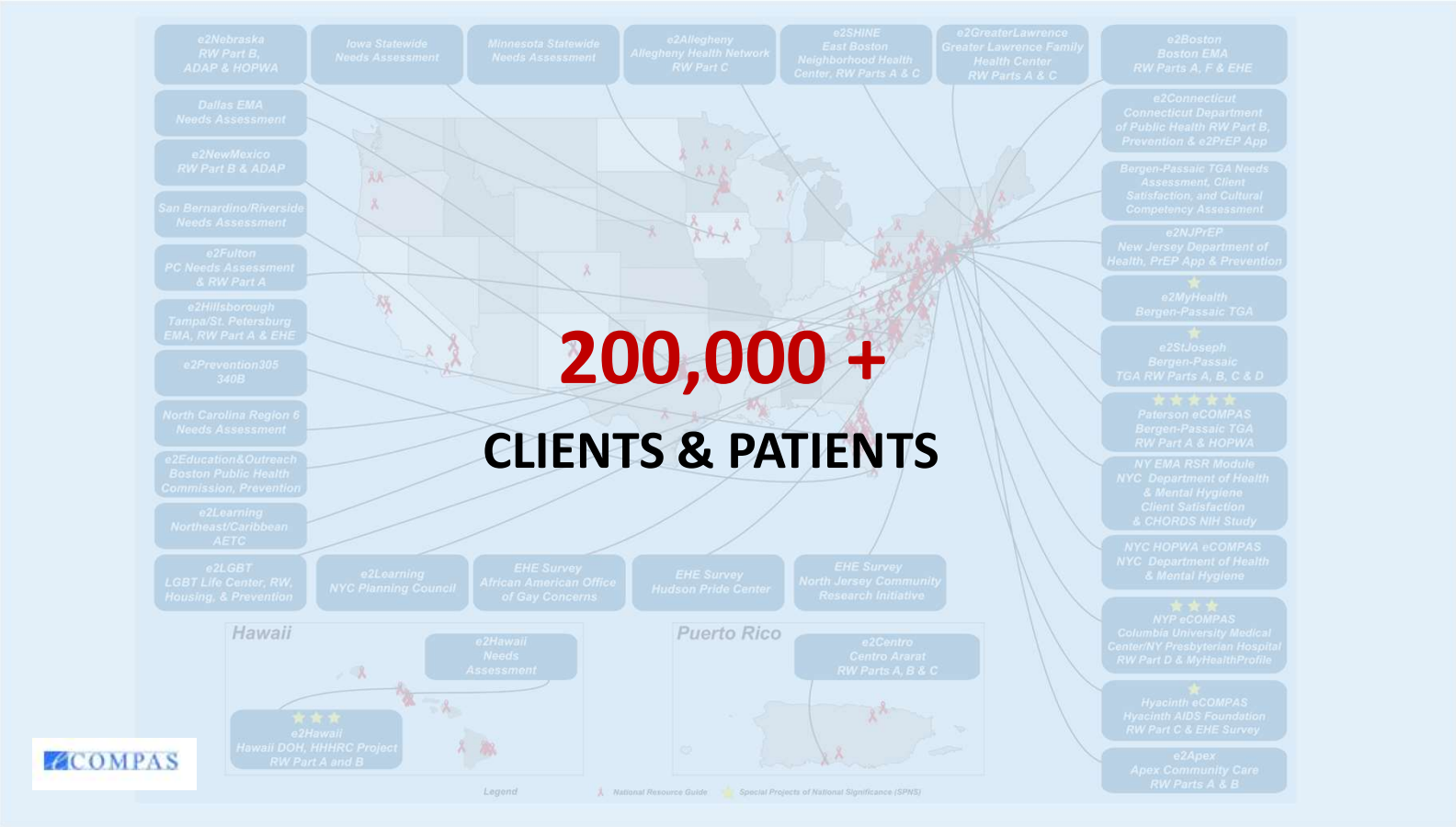

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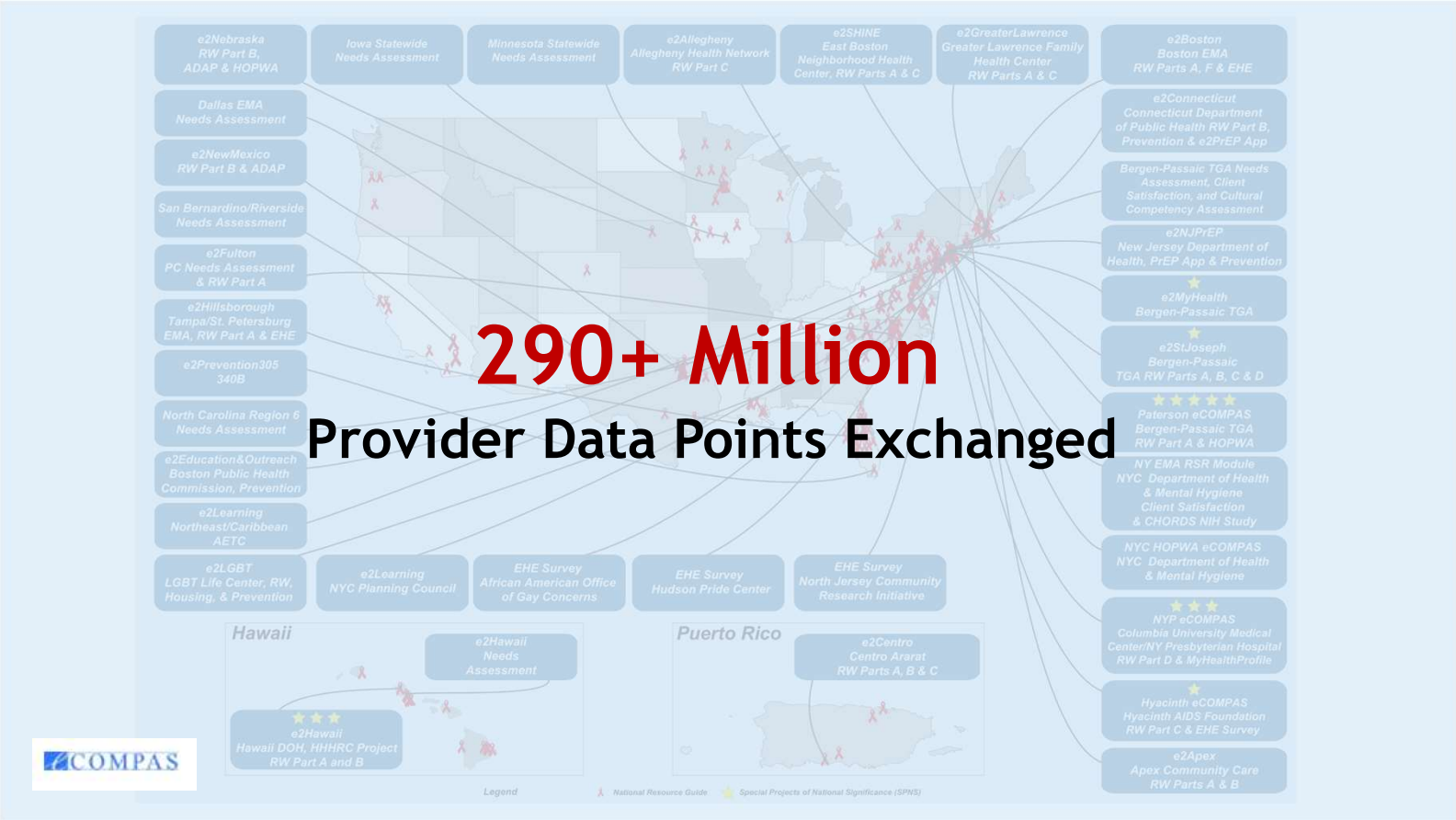

290+ Million

Provider Data Points Exchanged

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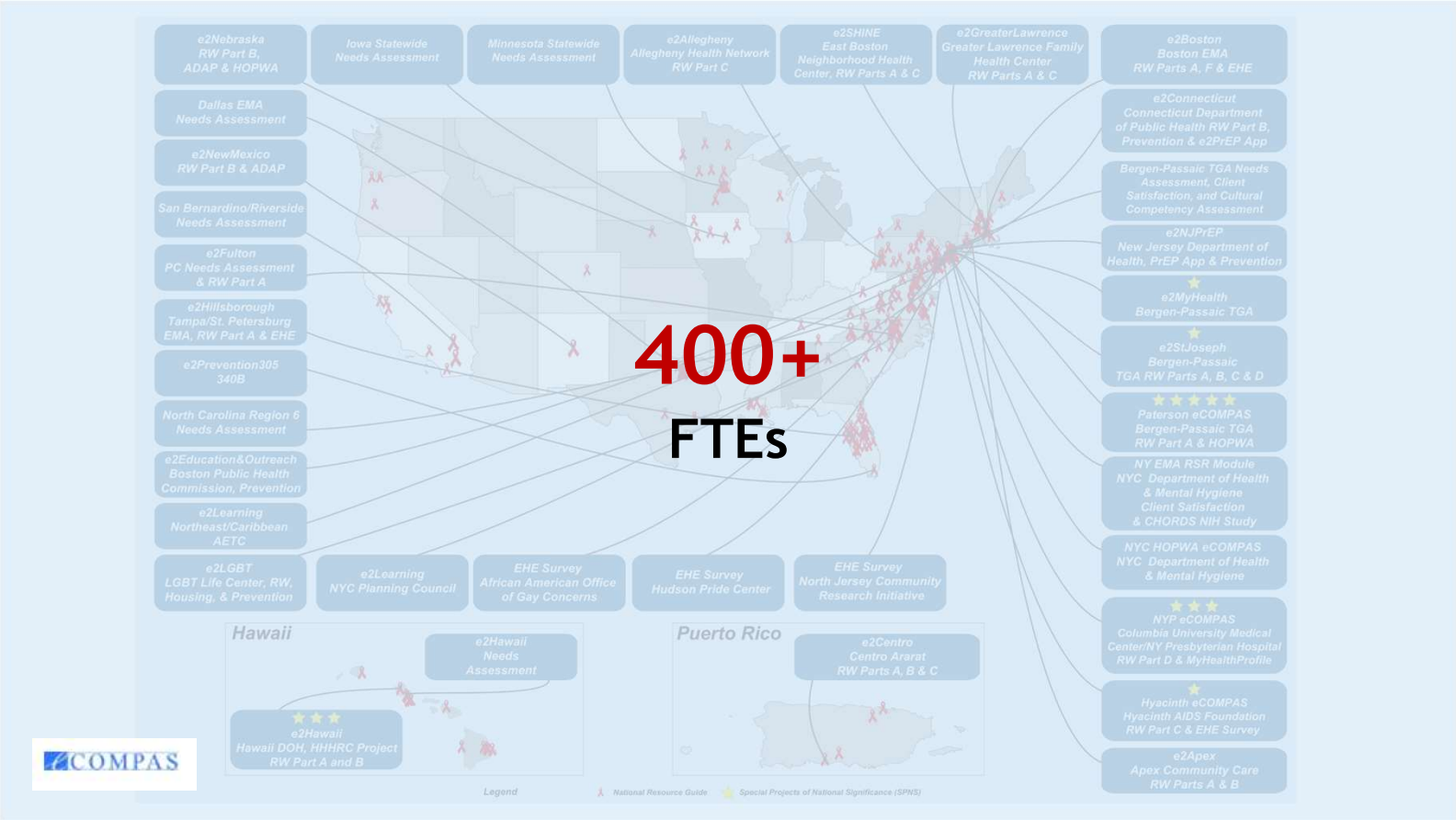

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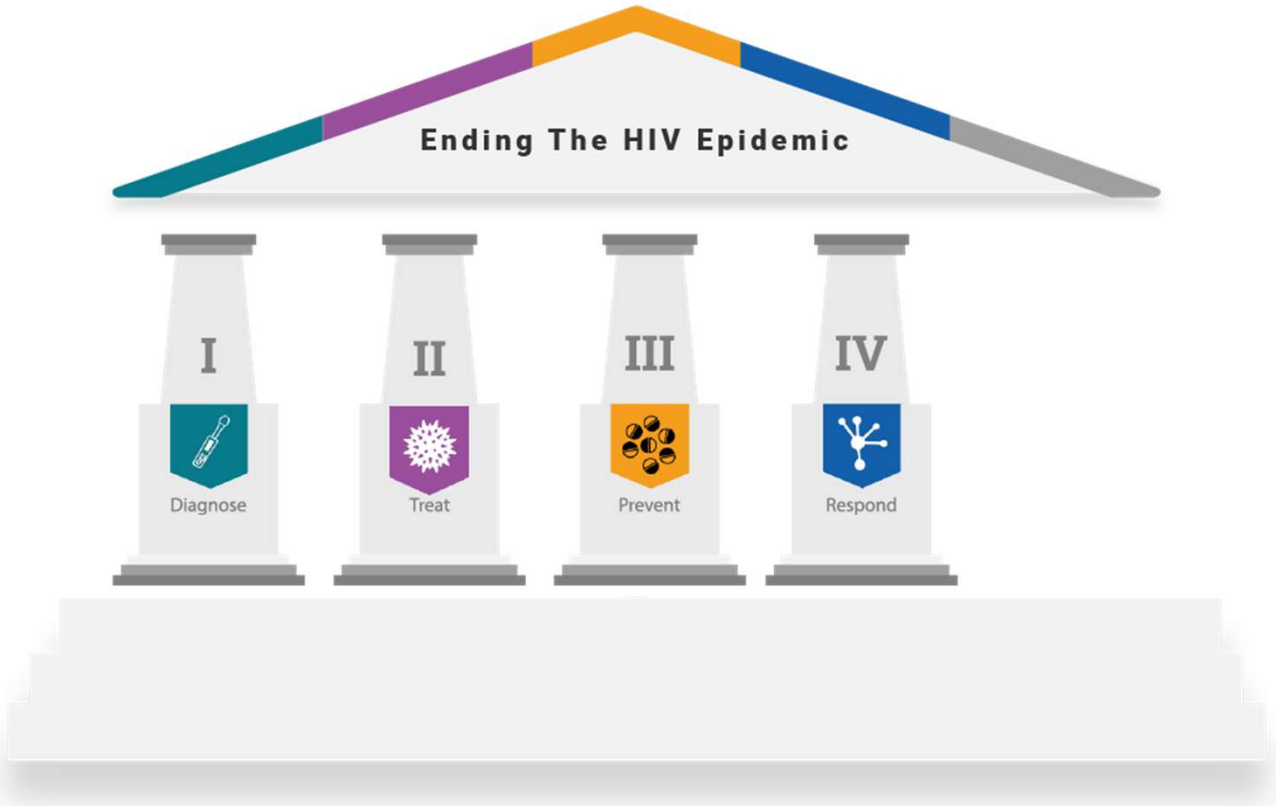
30 Years of Innovating Care, Optimizing Public Health, Ending the HIV Epidemic



Source: Four Pillars: Ending the HIV Epidemic: A Plan for America, HIV.gov

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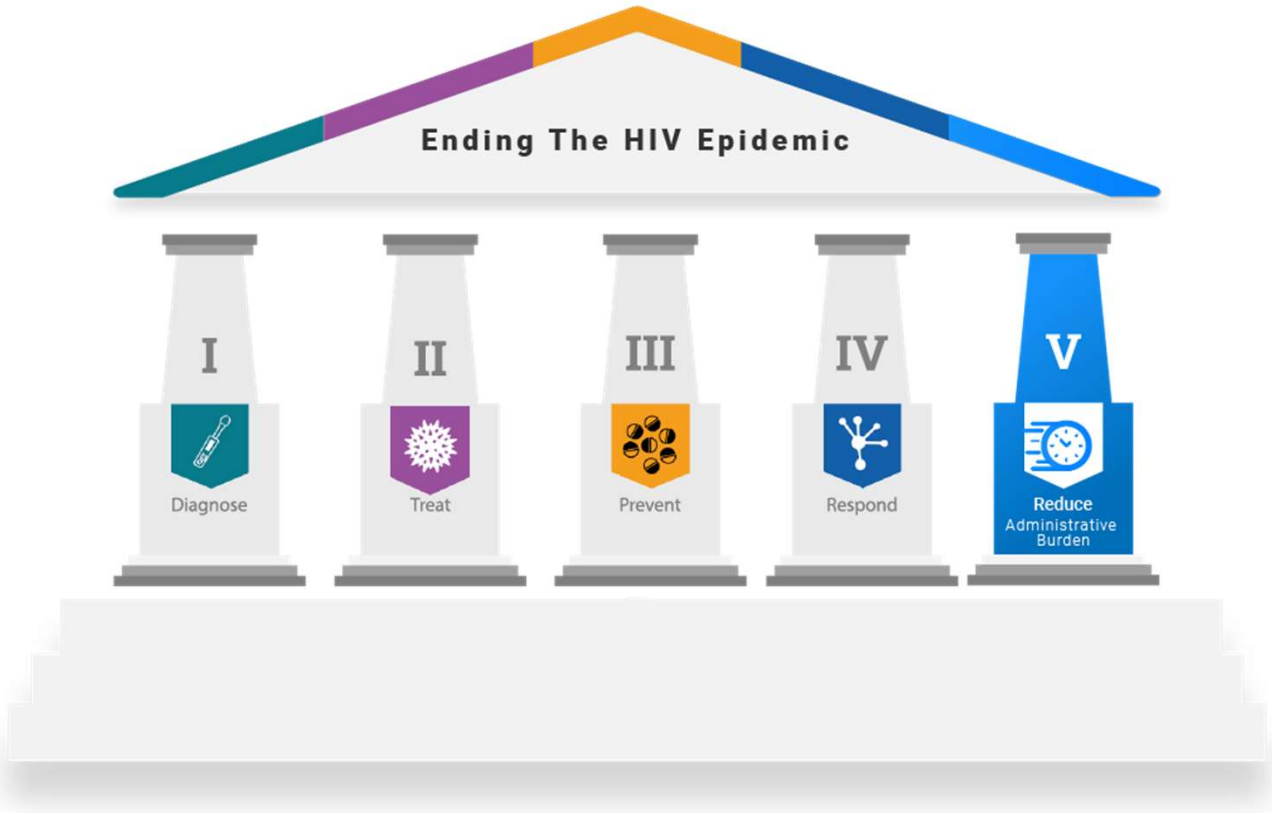

Source: Four Pillars: Ending the HIV Epidemic: A Plan for America, HIV.gov

Reducing Administrative Burden

- Time is our finite resource
- Reduce staff stress, burnout, and turnover
- Burden → empowerment

Right Data & Right Tools

- Quality
- Actionable
- Useful + Usable

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Who are you?

An interactive poll

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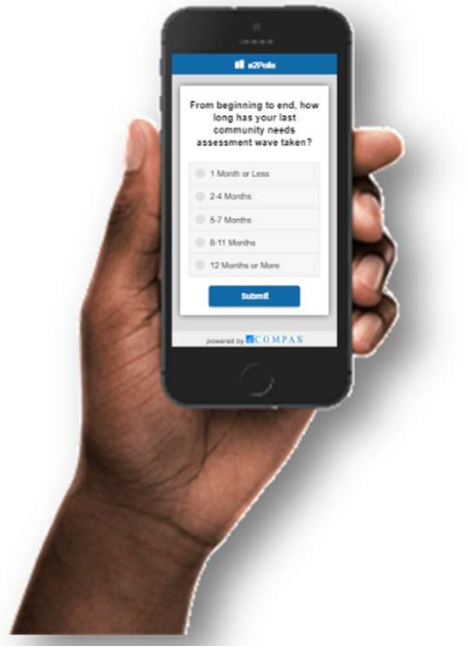
Interactive Poll

e2Polls.com
Code: **NCCHC S21**



Welcome! Please introduce yourself?
Who are you? What is your role in Correctional Health? What interested you in this session?

Role: clinical pharmacist, substance use treatment, Quality Management, Mental health; public health liaison to local county jail; Healthcare / Health Services Administrator; Operations and technology, EMRA; Dir of Pharmacy; social worker; Medical Discharge Planner; Sheriff's office; psychiatrist; Physician; psychiatrist; Consultant; former Regional Director, current NCCHC surveyor, psych social worker; LCSW; specialist for VA hospital; Discharge planner.

Locations: California, Florida, Massachusetts, New Jersey, New York & Wyoming

Interests: passion is criminal justice and reentry; reentry needs; learning more about reentry programs; reentry services; hoping to be more involved in re-entry services; Interested in finding out ways to support reintegration, divert frequent users. re-entry and transitions;
re-entry programming addressing high utilizers;
expanding pharmacy service to continue treatment management after incarceration; Working on re-entry programs as related to pharmacy;
General information; data analytics to support ISUDT; health information and advancement of health outcomes in corrections; interested in reentry data; healthcare for recently incarcerated.

PURPOSE

- High rates of chronic and communicable disease among people in jails and prisons mirror the rates in the areas of greatest need in local communities.

- This is attributable to health disparities found in communities with the lowest socioeconomic status overrepresented by Black, Indigenous and People of Color (BIPOC) with the highest rates of incarceration, especially in local jails.

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METHODS

- Several correctional demonstration projects across the United States, including the islands of Puerto Rico have implemented public health approaches to community collaborations among agencies and service organizations that serve people involved with the criminal legal system.

- Collaborators may include correctional facilities, community corrections, health and hospital networks, housing and employment services organizations and care management programs.

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Approach

- Reentry activities require collaborations across systems including legal, correctional and community health providers.
- Collecting, sharing and reporting key outcome measures across systems helped sustain, enhance and increase funding for evidence-informed interventions
- A Public Health Model for Correctional Health (PHMCH) calls for Community Integrated Correctional Health Care
- Transitional Care Coordination (TCC) emphasizes correctional and community collaboration
- To successfully adapt, implement and replicate these models:
  - Collect key data
  - Share information among stakeholders
  - Use data to support the collaboration and continued funding

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Diverse Locations / Providers

Hampden County MA since 1992	New York City since 2004	Puerto Rico since 2015	Paterson, NJ since 2019
Mid-sized City / sub-urban (Population: 466k)	Large Urban City (Population: 8.34m)	Large city; Rural territory (13% outside San Juan)	Mid-sized city (Population: 145k)
• Integrated community and Correctional Health Service under agreement between Sheriff's Dept and mix of contracted local health providers • Coordinate with State / Local Health Agency (LHA)	• Led by NYC Correctional Health Services • Health + Hospitals (H+H) now direct provider • Department of Correction (DOC) oversees custody • NYC LHA oversight	• Led by Housing & Employment agency push social services • DOC part of PR government oversees hybrid custody • Contracted FP health services • Coordinate w/ LHA	• LHA outreach to DOC • DOC oversees custody and health • Contracted FP health service • Push in reentry service provider
• Mass Health Enhanced • RW Part A, B, C	• NYC H+H Options • RW Part A	• Medicare for All • RW Part F	• New Jersey Family Care • RW Part A
• 2 correctional centers	• 10 jails	• 10 hybrid facilities	• 1 downtown jail

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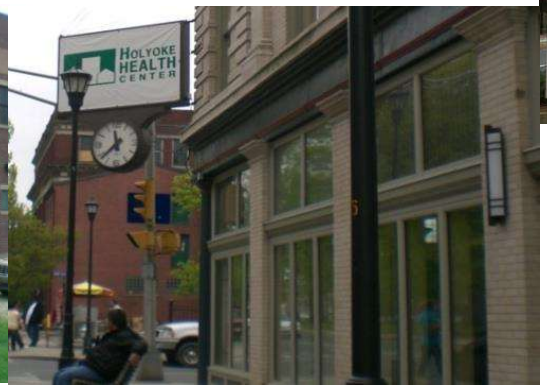
Hampden County Correctional Center
Ludlow, MA

Correctional Centers

Western Mass Regional Women's
Correctional Center Chicopee, MA

HAMPDEN COUNTY, MA

Community Health Centers



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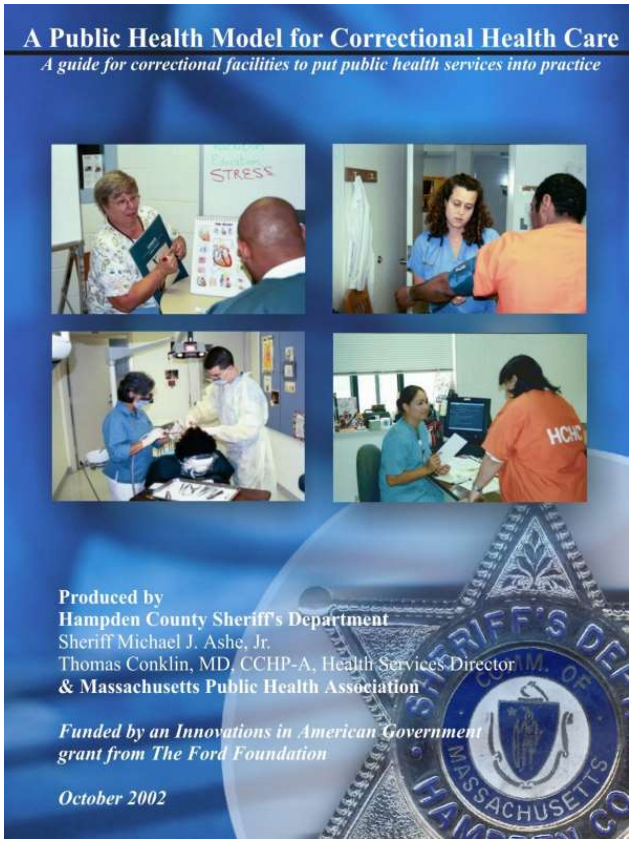
Hampden County:

A Public Health Model for Correctional Health Care



- Education
- Prevention
- Early detection
- Treatment
- Continuity of care --
- Data

Community-integrated model

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Hampden County

Community Integrated Correctional Health Care

1992… Dually-based care for chronic health conditions: hepatitis c, asthma, hypertension, HIV, depression, other

- 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.”

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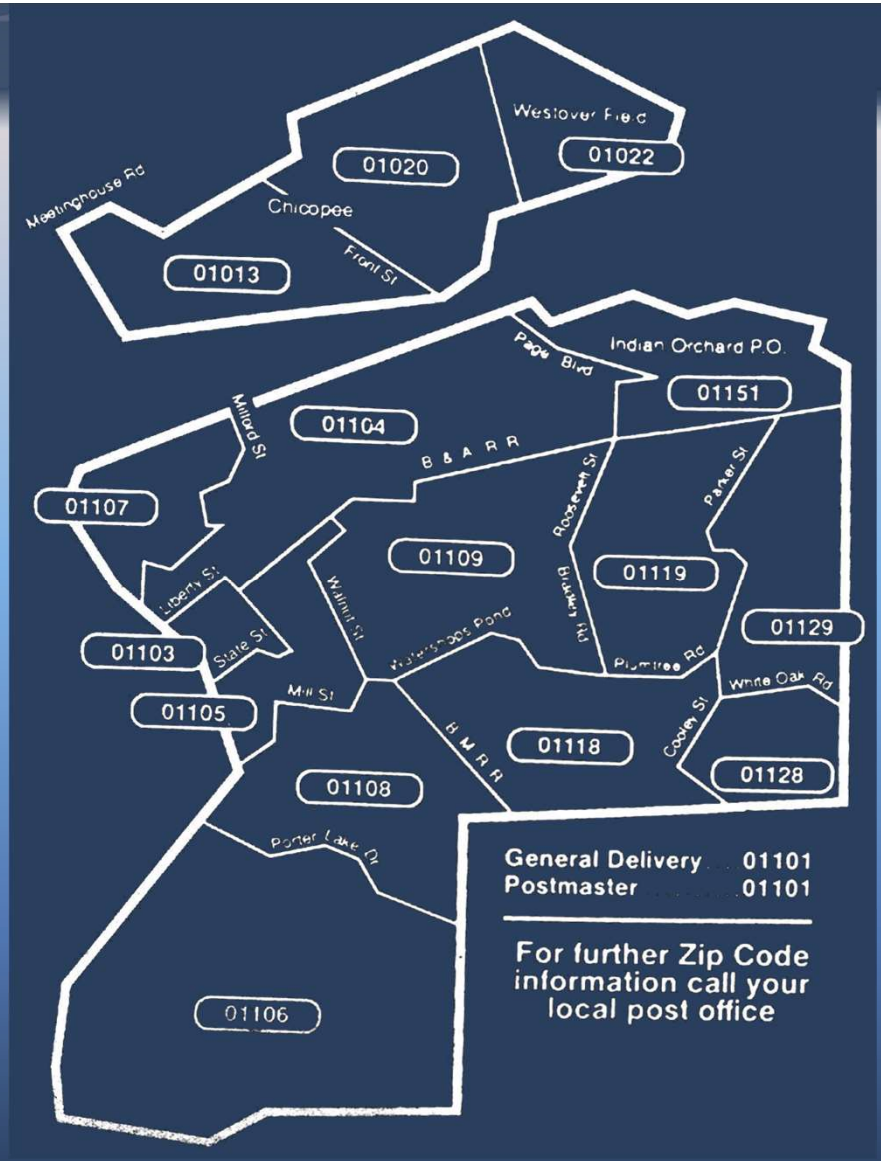
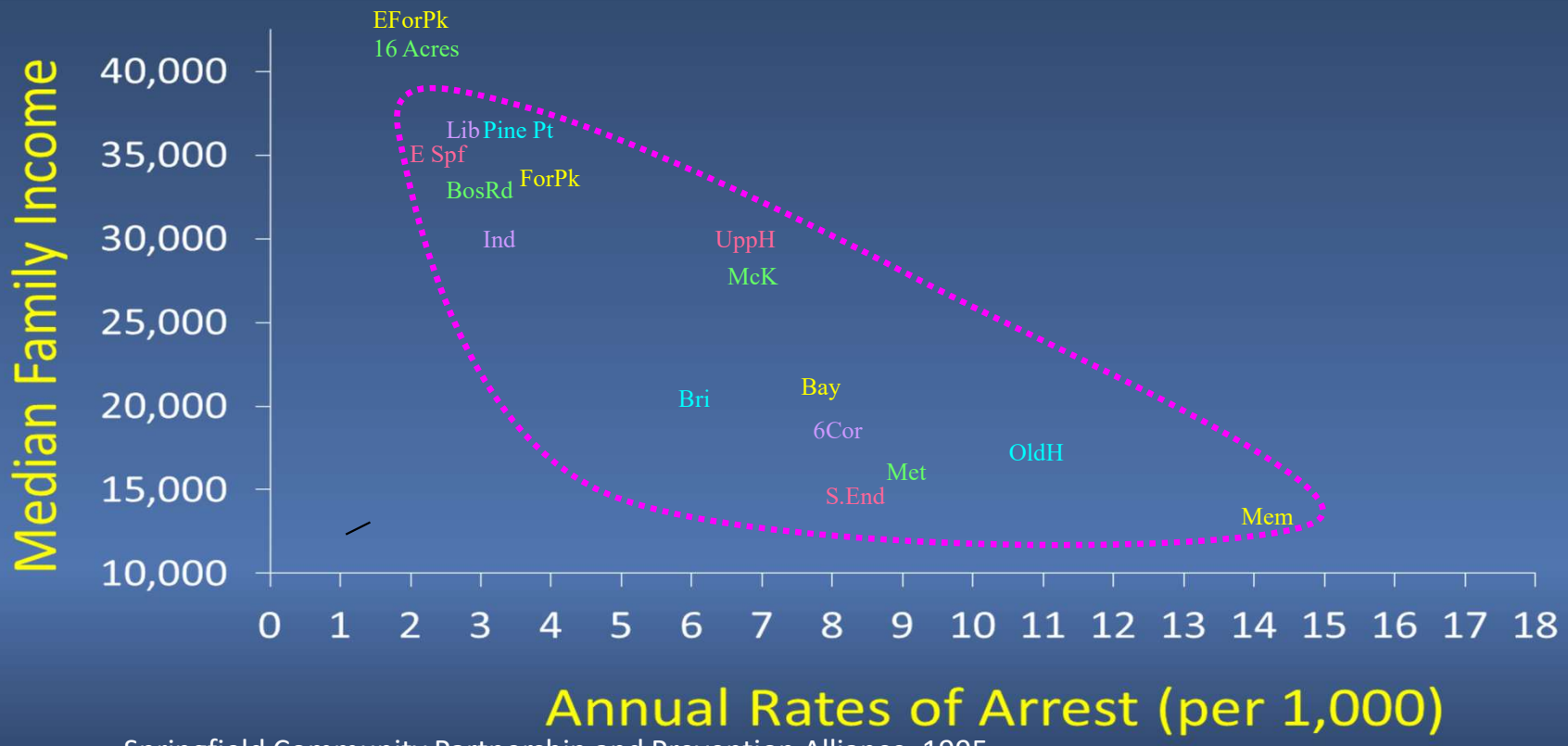
COMMUNITY INTEGRATED
CORRECTIONAL HEALTH CARE

Hampden County:
A Public Health Model for
Correctional Health

2-3%



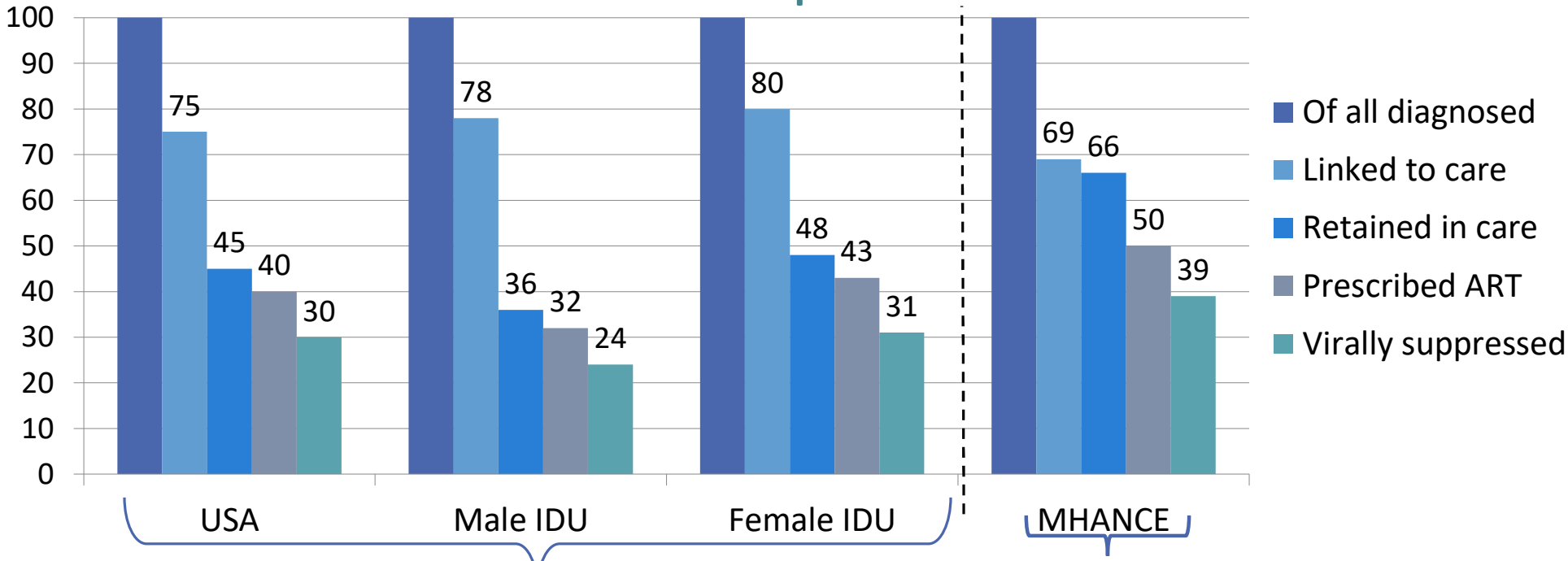
Drug-Related Arrests of Persons Residing in Specific Neighborhoods



Springfield Community Partnership and Prevention Alliance, 1995

SPNS CHLI: Baystate Local Evaluation

HIV Care Cascade: Comparison with National



CDC 2012

Linked to care = 30d care accessed
Retained = Has HIV provider at 6mo
Prescribed ART = On HIV med at 6mo
Virally suppressed = HIV RNA <400 6mo

Missing assigned negative value

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Hampden County
Electronic Medical Records

Jail EMR

- Homegrown (Visual Basic, SQL server)
- Interchanges with Jail Management System, jail case management system, OTP Assistant
- Orphaned, but supported

Health Center & community MH provider EMRs

- Remote access permission to jail or onsite staff

Labs for jail and most health centers accessible through hospital system

INFORMATION EXCHANGE SYSTEMS

Still planning interfaces with:

- Pioneer Valley Information Exchange (PVIX)
- Massachusetts Immunization Information System (MIIS)

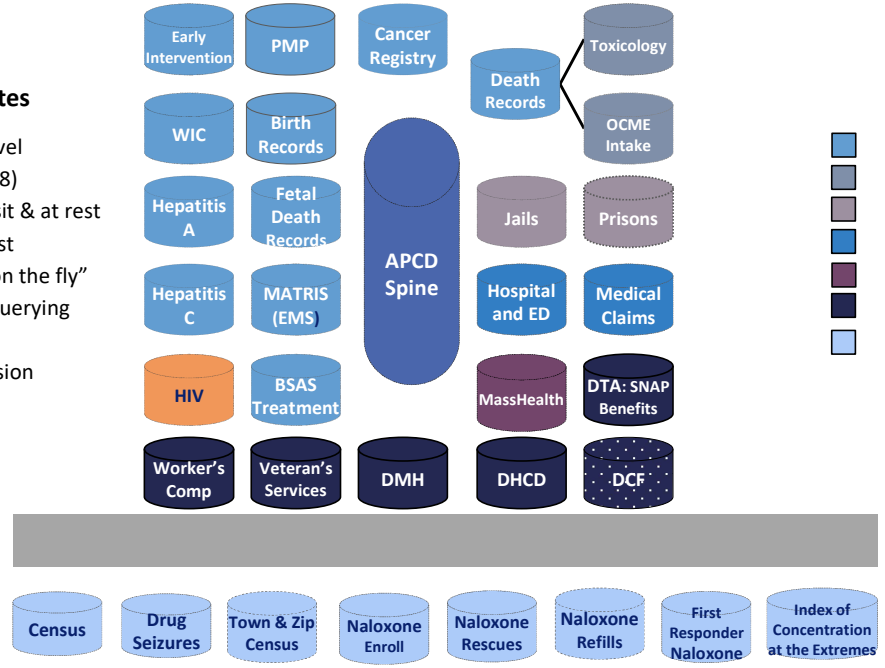
- Manually fax to community sites
- Manual entry into MIIS

HAMPDEN COUNTY
PUBLIC HEALTH DATA WAREHOUSE (PHD) 2.0

Proposed Data Structure

System Attributes

- Linkage at individual level
- Longitudinal (2011-2018)
- Data encrypted in transit & at rest
- Datasets unlinked at rest
- Linking and analytics "on the fly"
- No residual files after querying
- Analysts can't see data
- Automatic cell suppression



Data Sources

- Public Health
- Public Safety
- Criminal Justice
- Medical Claims & Hospital
- MassHealth (Medicaid)
- Other State Agencies
- Aggregate

Note: *dotted "buckets" represent datasets that we are pursuing*

SPNS CHLI: Local Study Design

Baystate	NYC CHS
Project Staff	
Dually-based Program Manager/HIV Coordinator, physicians, case management, mental health clinicians and re-integration specialists	NYC CHS Patient Care Coordinators (PCC) in jails; Community reentry providers' dually-based transitional counselors; home visit team
Case managers and mental health clinicians trained by Allies in Recovery Evaluation Team	PCC and counselors trained by Yale site & Emory Evaluation Team
Program Focus	
Mental Health Needs	Population-based approach
Doses of Case Management	Linkage to Care within 30d of release
Program Enhancements	
Linkage to HIV Primary Care w/ Mental Health	Health Liaison to the Courts

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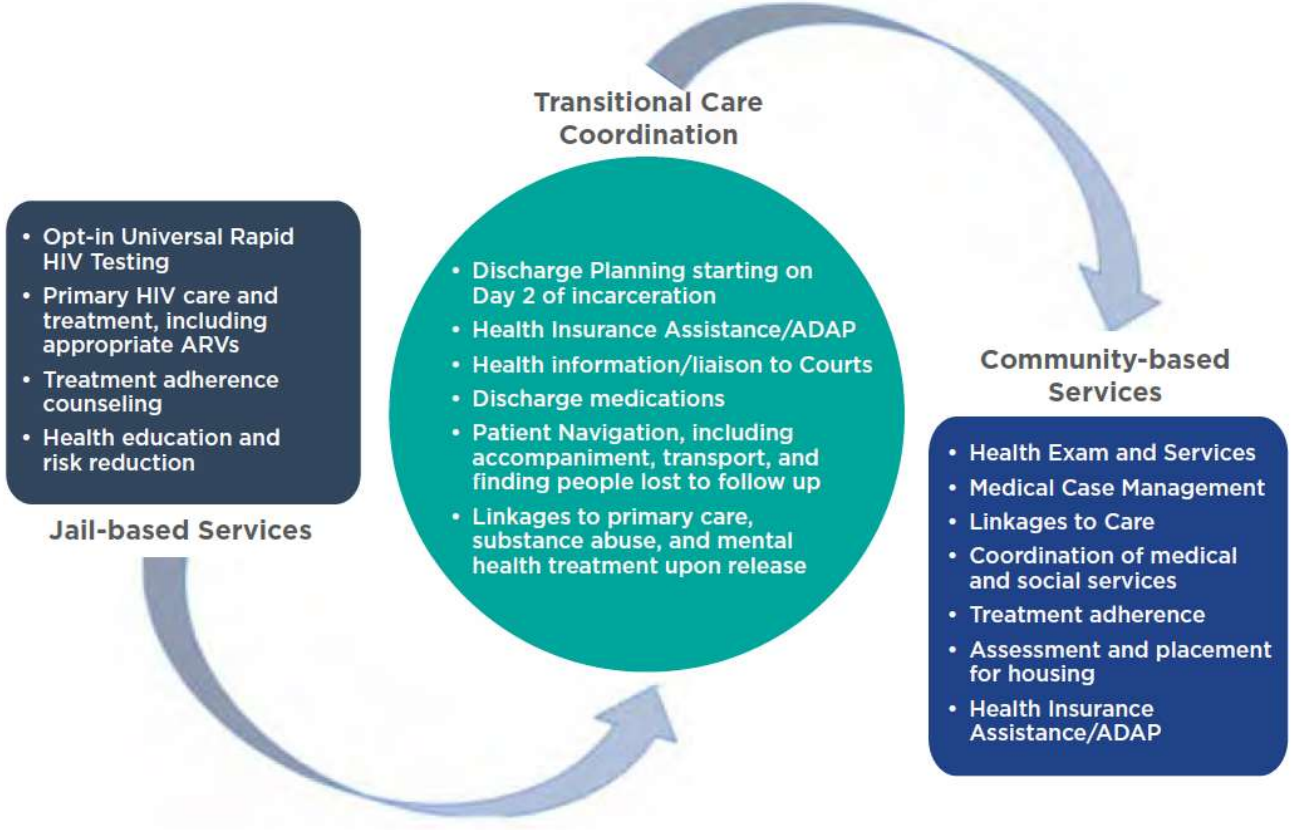
Transitional Care Coordination



https://www.acojaconsulting.com/providing-transitional-care-coordination-handbook

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Transitional care coordination in New York City jails: facilitating linkages to care for people with HIV returning home from Rikers Island.

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NYC Jail System

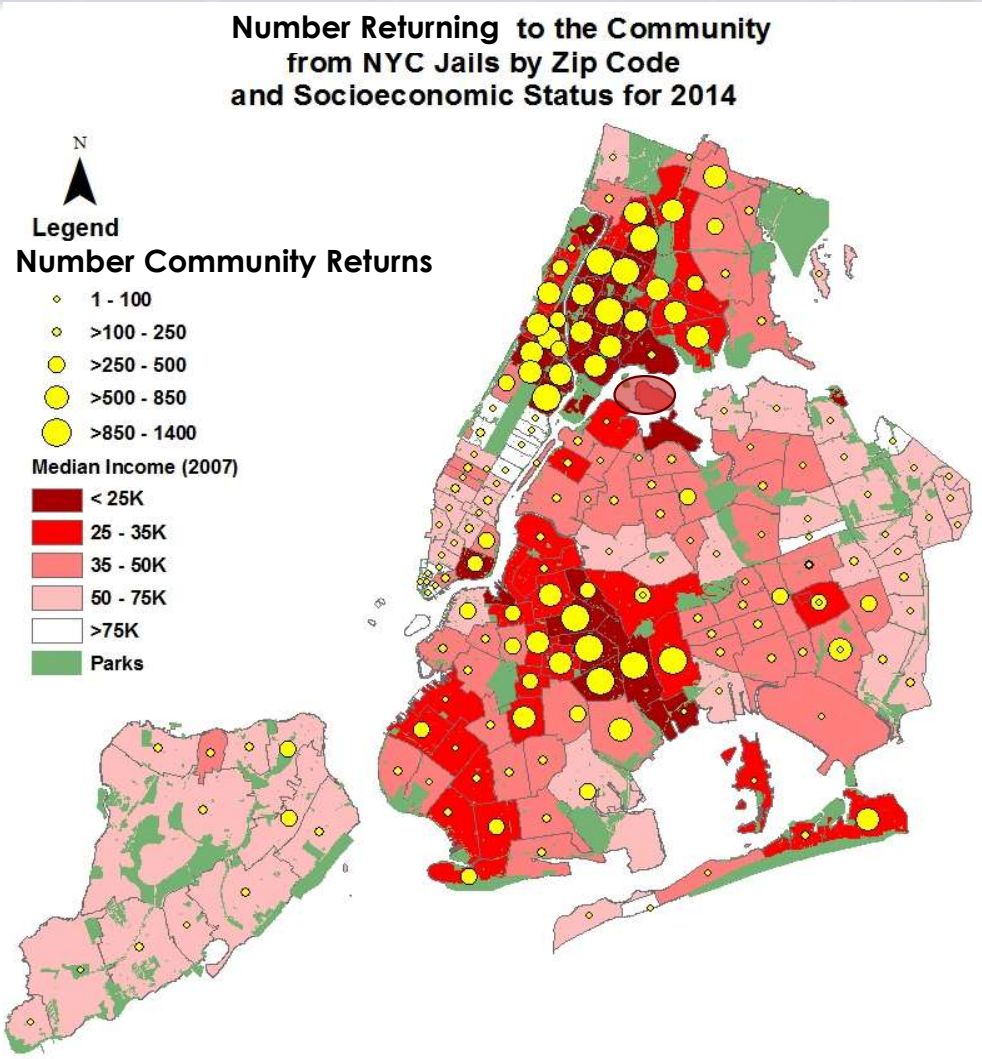
NYC CHS
T1. Operations
T2. Mental Health
T 3. IT support

Manhattan Detention Center

Brooklyn Detention Center (currently closed)

NYC CHS
T4. Medical Care
T5. Reentry & Continuity Services
Transitional Care Coordination

CORRECTIONAL HEALTH IS PUBLIC HEALTH IS COMMUNITY HEALTH



Over 70% return to communities with lowest socioeconomic status

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NYC CHS Transitional Care Coordination

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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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It can take just one individual to initiate improvement and one team to sustain it.

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Improving Health Outcomes

NYC Transitional Care Coordination Results:

- 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.

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Community Integration Strategies

non-medical strategies to facilitate access to care

- Case conferencing prerelease
- Medical summary / medications
- Accompaniment / transport
- Community case manager
- Directly Observed Connections
- Patient Navigator / Care Coordinator

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COMMUNITY COLLABORATORS

- Along with primary medical care, Jail Linkages clients were also connected to:
  - Medical case management (53%)
  - Substance abuse 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 known to be linked to care were found through community outreach; 30% re-incarcerated.

"An ideal community partner offers a 'one-stop' model of coordinated care in which primary medical care is linked with medical case management, housing assistance, substance abuse and mental health treatment, and employment and social services."

– Alison O Jordan, LCSW &
Lawrence Ouellet, PhD

http://chip.sph.emory.edu/EnhanceLink/documents/Transitional_Care_Coordination--Fall2010.pdf

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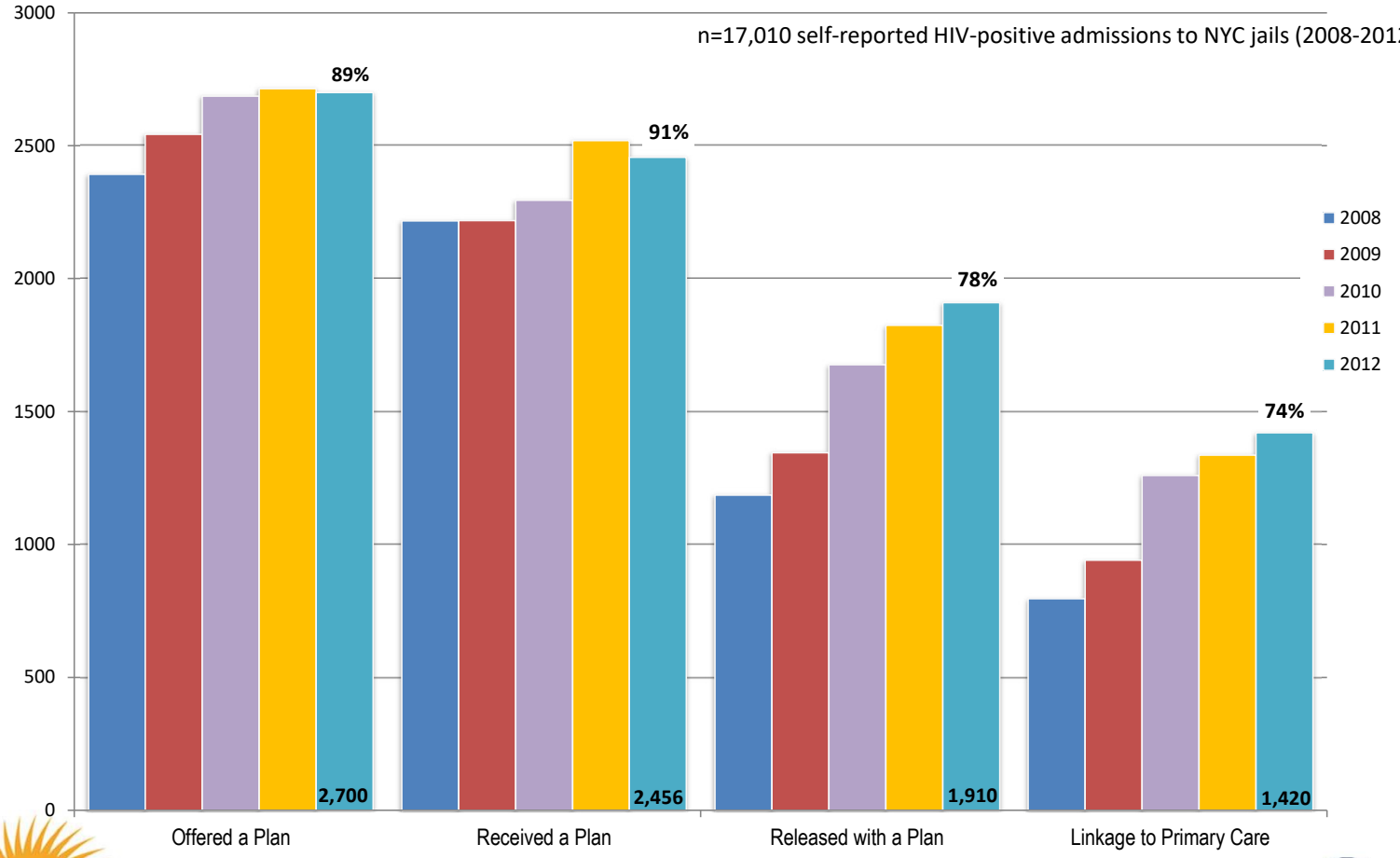
SPNS Correctional Health Linkages Initiative Community Outcomes

From Prior to Incarceration to 6 months after Community Return

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%)
79% of those released with a plan linked to HIV primary care		
# 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%)

Improved community outcomes & reduced costs

SPNS CHLI – NYC TCC Program Outcomes



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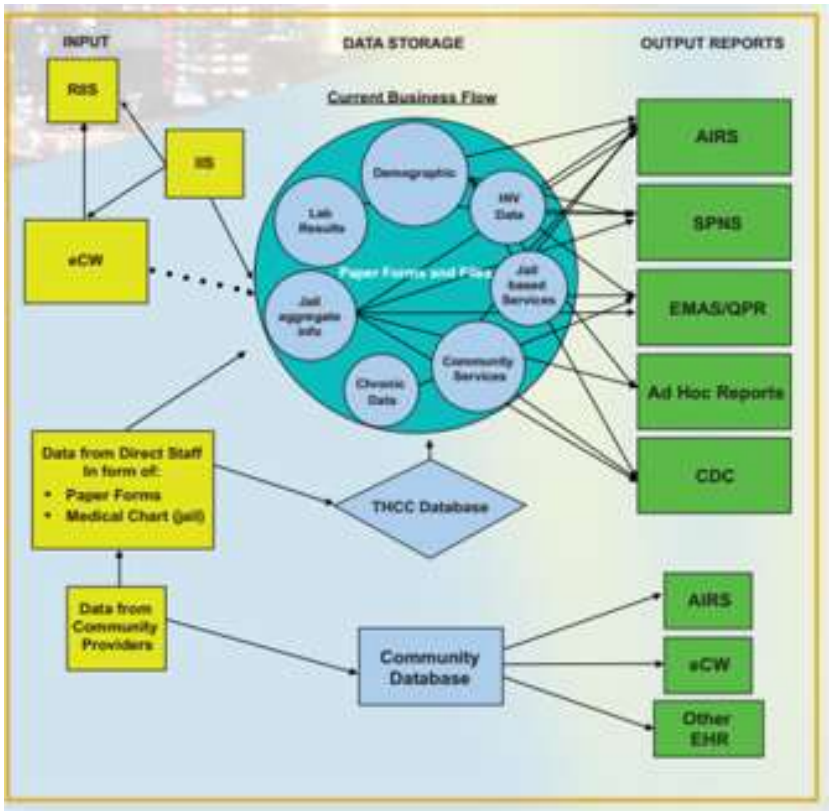
SPNS CHLI – NYC TCC DATA MANAGEMENT



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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 and linkages to care
  - Visitor Outreach & Education
  - Young Adult Initiatives
- Legal & Social Services
  - Housing & Employment Services
  - Alternatives to Incarceration
  - Leveraging networks of care + collaboration (law enforcement, correction agencies, community health and social service agencies, employers, landlords…)
- SPNS Latino Cultural Appropriateness Initiative
- Other Jurisdictions:

  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

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SPNS Latino Initiative Training

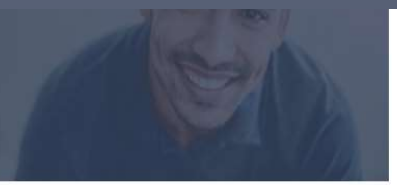
Key Topic Areas

- Transnationalism
- Puerto Rican & Latino Culture
- Cultural Competency
- Strategies for Improving Care
- Also: Interactive activities

Free Resources!

NEW RESOURCE

Culturally appropriate engagement with Latinos/as to enhance linkage and retention to HIV care



A webinar series about Culturally Appropriate Engagement and Service Delivery with Latino/as to Enhance Linkage and Retention to HIV Primary Care – including a Transnational Case Study for Puerto Ricans is now available for health and social service professionals! This Continuing Education activity is for physicians, nurses and Certified Health Educators, as well as other health and social service professionals. Accreditation for physicians, nurses, and Certified Health Educators as well as general CE is available (CME, CNE, CHEC and CEU).

This curriculum explains how to use four key frameworks which, when integrated, allow for the development of a provider-level strategy to improve the HIV primary care patient outcomes for Latinos/as who are incarcerated or have a history of incarceration. The case study provides a sub-analysis of transnationalism among Puerto Ricans.

These frameworks include:

1. **Cultural Formulation,** which analyzes cultural factors that affect clinical encounters, especially when the healthcare provider does not share the same cultural background as the patient.
2. **Transnationalism,** which represents the process by which immigrants forge and sustain multi-stranded social relations with their country/place of origin. It affect the social field of individuals, which includes their group identity, daily activities, neighborhoods/communities, economic opportunities, and social and political behaviors.
3. **DECIDE**, a six-step process for decision making.
4. **Shared Decision Making**, a strategy where patients and providers build a consensus on the treatment plan and agree on the steps necessary to implement it.

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Opiate Overdose Prevention Training

2014:
Piloted nation's first Opiate Overdose Prevention program for jail visitors.

4/14 to 1/19:
37,000 doses distributed to 29,000 NYC jail visitors.

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Community Outcomes:

Visitor Opiate Overdose Prevention Training

Witnessed overdoses and naloxone use among visitors to Rikers Island jails trained in overdose rescue

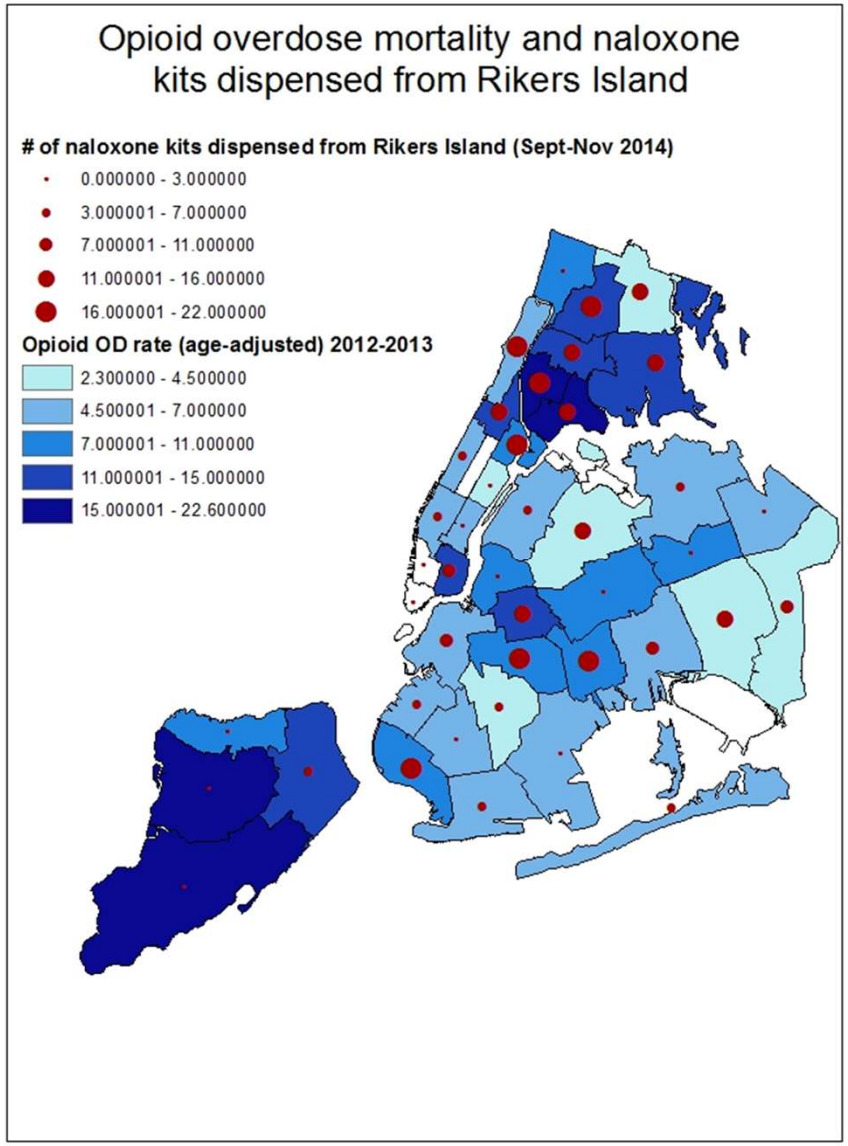
Zina Huxley-Reicher[a,*,1], Lara Maldjian[a], Emily Winkelstein[a], Anne Siegler[b], Denise Paone[a], Ellenie Tuazon[a], Michelle L. Nolan[a], Alison Jordan[b], Ross MacDonald[b], Hillary V. Kunins[a]

[a] *New York City Department of Health and Mental Hygiene, 42-09 28th Street, 19th Floor, Long Island City, NY 11101, United States*
[b] *New York City Health + Hospitals, 55 Water Street, 18th floor, New York, NY 10014, United States*

HIGHLIGHTS

- A 6-month prospective study of NYC jail visitors to Rikers Island trained in naloxone.
- Of the 283 participants enrolled, 14% witnessed at least one overdose.
- Of the 283 participants enrolled, 10% administered naloxone at least once.
- The naloxone use is comparable to similar interventions for high-risk populations.
- Training jail visitors is effective at reaching a population at risk of overdose.

https://doi.org/10.1016/j.addbeh.2017.11.029



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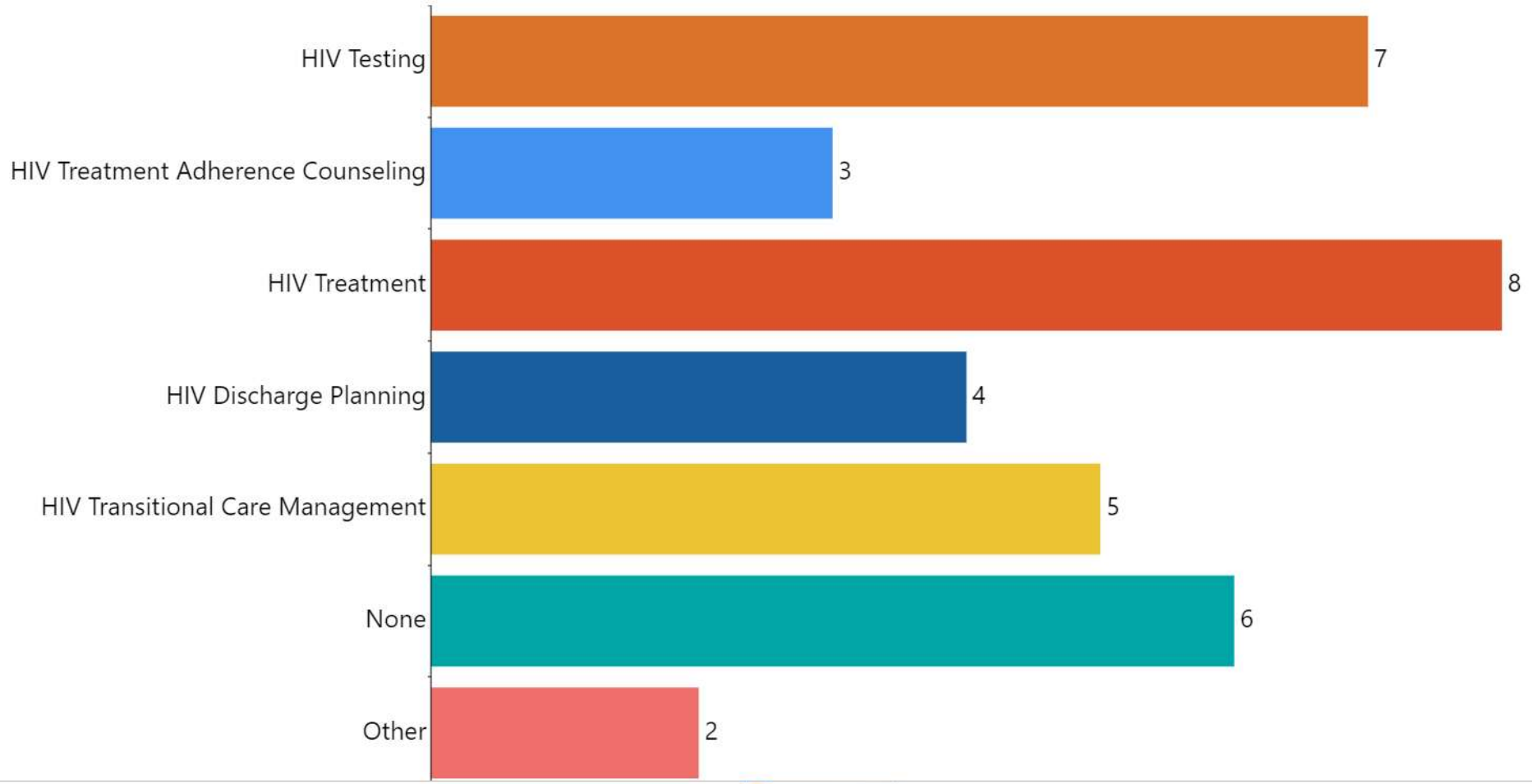
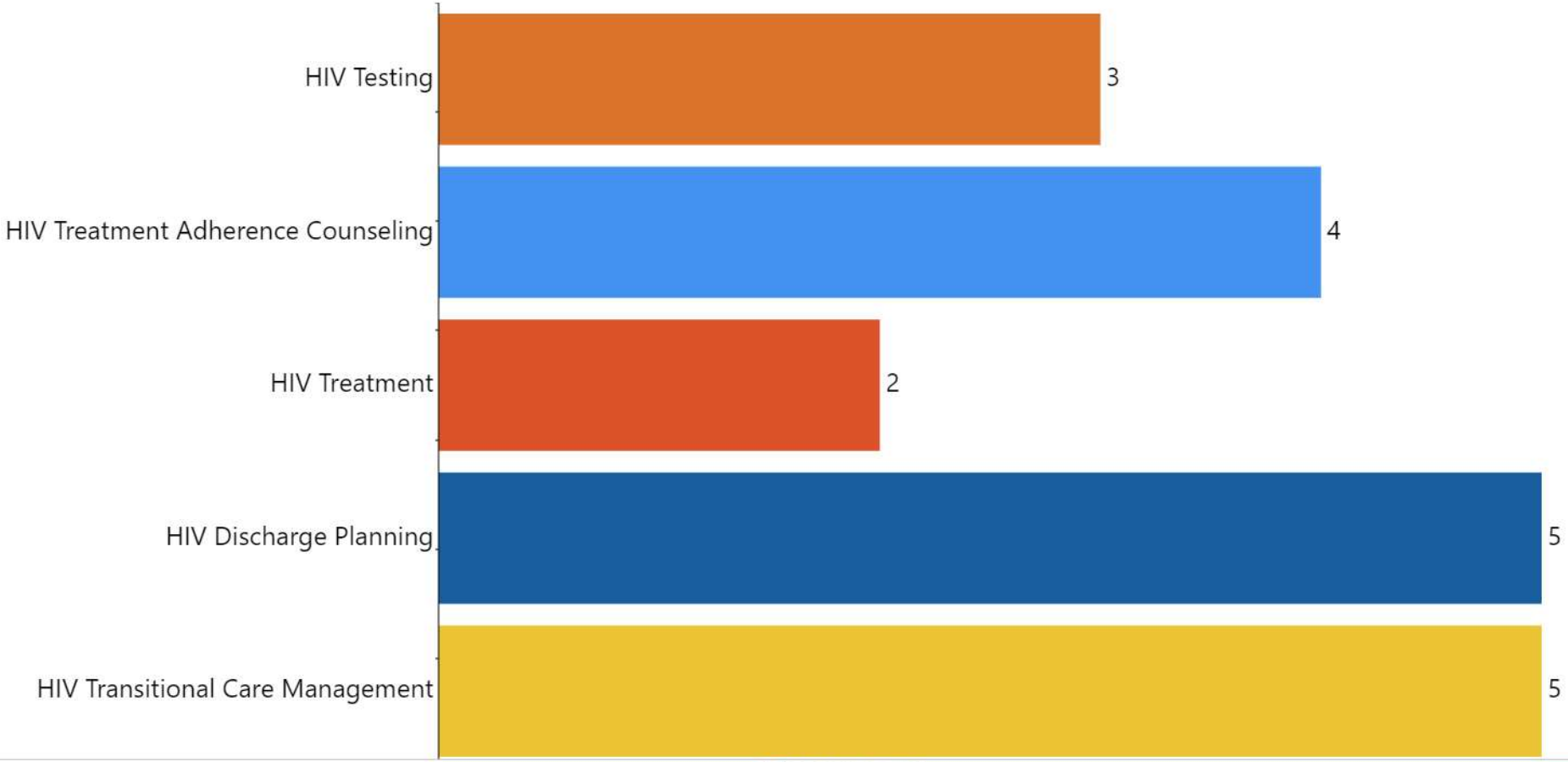
Indicate each HIV Service your system provides by leveraging Ryan White funding



Indicate each HIV Service your system does not provide and might enhance with Ryan White funding.



Funding Sources

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, including Hampden County MA and NYC
- Workforce Capacity and Latino Initiatives in NYC and Puerto Rico
- 14 Housing & Employment demonstration site (Paterson NJ; Chicago site)
- 3 Dissemination of Evidence Informed Intervention TCC sites (Camden, Raleigh, Las Vegas)

HRSA Ryan White (RW) Part A:

NYC Correctional Health Service [NYC CHS] Transitional Care Coordination model

NYC CHS HIV testing enhancements seeded by foundations (ELJ, MACAIDS, Robin Hood)

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

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LOCATIONS


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

Who We Are

One Stop Career Center of Puerto Rico, Inc. (OSCCPR) is a private non-profit organization (501) (c) (3), incorporated in November 2000, with state and federal tax exemption. We offer services to young people and adults across the island with a commitment to develop and help strengthen community structures.

Our initiatives aim to impact the areas of greatest need of the population such as housing, education, employment, health and legal services. Offering service programs that can integrate and offer alternatives to communities in need.

In addition, we believe in the importance of collaborations between organizations, with the aim of bringing more and better services to the participants.

ONE STOP Career Center of Puerto Rico, Inc.

Ayudando a Forjar Caminos

What We Do

ONE STOP
HOUSING AGENCY

Advisory Agency and Financial Capacity

Advice for first purchase, prevention of loss and reverse mortgages.

ONE STOP
JOB PLACEMENT

Job Placement and Retention

Training in social and labour integration and job placement for persons who have had problems with the justice system or have been displaced. The removal of criminal records, if it qualifies.

HIV

HEALTH

Case Management Services and connection to health services for people who have committed a crime and are HIV patients.

LEGAL SERVICES

LEGAL SERVICES

Legal advice and representation for people over 50 years of age who are in the process of losing their home or at risk of losing their home.

ONE STOP
Career Center of Puerto Rico, Inc.
Ayudando a Forjar Caminos

TRAINING

Short-term workshops and training

HOUSING COUNSELING
PROGRAM

One Stop Career Center of PR in coordination with the Department of Housing of Puerto Rico provides advisory services to people affected by hurricanes Irma and/or Maria.

OSCC-PR Partners

citi
CitiCommunityDevelopment.com

UNIDOSUS
AFFILIATE

EQUAL HOUSING OPPORTUNITY

GOBIERNO DE PUERTO RICO

U.S. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF PRISONS

ELTON JOHN
AIDS FOUNDATION

DEPARTMENT OF LABOR
UNITED STATES OF AMERICA

FUNDACIÓN
FONDO DE ACCESO A LA JUSTICIA, INC.

hispanicfederation

Estadisticas.pr

cfpb Oficina para la Protección Financiera del Consumidor

FEDERAL TRADE COMMISSION · UNITED STATES OF AMERICA · MCMXV

FUNDACIÓN COMUNITARIA
DE PUERTO RICO

HIV & Incarceration in PR

- Puerto Rico (PR) has the 5th highest rate of new HIV diagnoses in the U.S.[1]
- PR has the 3rd highest rate of people living with HIV[1]
- PR has a high prison population rate (303 per 100,000):[2]
  - Over 11,000 incarcerated individuals
  - 98% are men in 7 correctional centers
  - 6.9% of people incarcerated in PR are living with HIV
- Puerto Ricans living with HIV and coming home after incarceration often need assistance, including housing, employment and transportation, to access available HIV care in Puerto Rico

1. *CDC HIV Surveillance Report 2014, excludes DC (rates are per 100,000)*
2. *Rodriquez-Diaz CE, Rivera-Negron RM, Clatts MC, Myers JJ. 2014. Health Care Practices and Associated Service Needs in a Sample of HIV-Positive Incarcerated Men in Puerto Rico: Implications for Retention in Care. J Int Assoc Provid AIDS Care.*

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SPNS Workforce Capacity

One Stop Career Center of Puerto Rico (OSCC)

- Partnership with PR Department of Correction Supports individuals coming home after incarceration
  - Job training and placement
  - Clear criminal records
  - Case management
  - Housing assistance
  - Eviction prevention
  - Life skills training

Workforce Capacity Expansion

- HIV outreach and education in jails / prisons
- Transitional Care Coordination
- Mapping linkages to care
- Interactive Resource Guide

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Steps to Implementation

Identify staff:

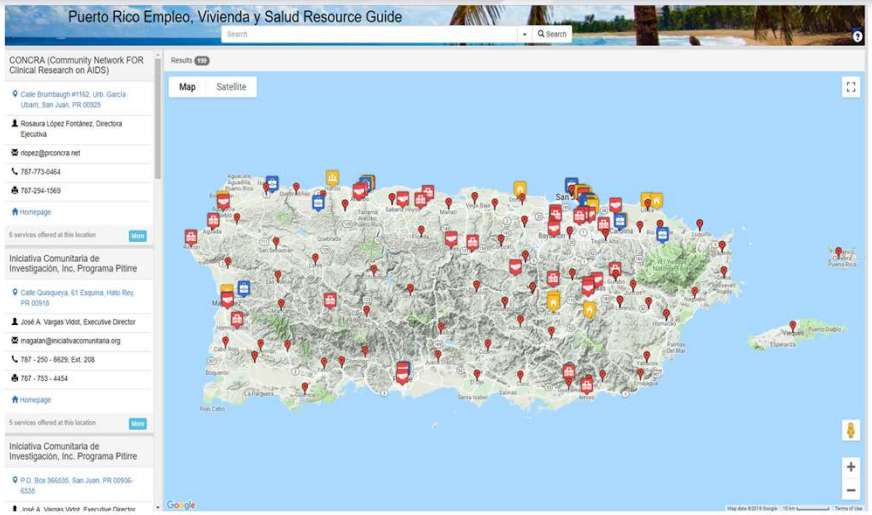
- ✓ Train staff in TCC
- ✓ State certified HIV counselors

Transportation:

- ✓ Transportation Service
- ✓ Identify sustainable funding

Coordinate with Corrections:

- ✓ Access to correctional facilities
- ✓ Patient health records



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Engage Key Stakeholders:

- ✓ Establish Linkage Agreements and a Consortium
- ✓ Sustain using Resource Guide

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Workforce Capacity Building

- Build on SPNS Latino Initiative to enhance collaboration and coordination among providers
- Train employment and housing specialists in Transitional Care Coordination
  - HIV education and risk reduction
  - Outreach & engagement
  - Transitional care planning
  - Coordination with service providers
  - Patient navigation after incarceration
- Conduct SPNS local evaluation
- Secure reliable transportation for clients
- Sustain collaborative and service delivery

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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

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Program Outcomes

- OSCC staff working in 13/32 correctional facilities in PR
- Prevention education/risk reduction sessions provided at jail orientations to identify potential clients (n=360)
- 69 enrolled and completed baseline
  - All received transitional care coordination
  - 10 additional served as part of pilot
- 58 returned to community after incarceration
  - 54 of 58 eligible (93%) linked to HIV primary care and other services after incarceration
  - All 10 (100%) pilot participants linked to care

Housing & Employment

Housing: 22
- 19 transitional
- 5 permanent

Job readiness: 15
- 12 employed;
- 1 volunteer;
- 2 seeking employment

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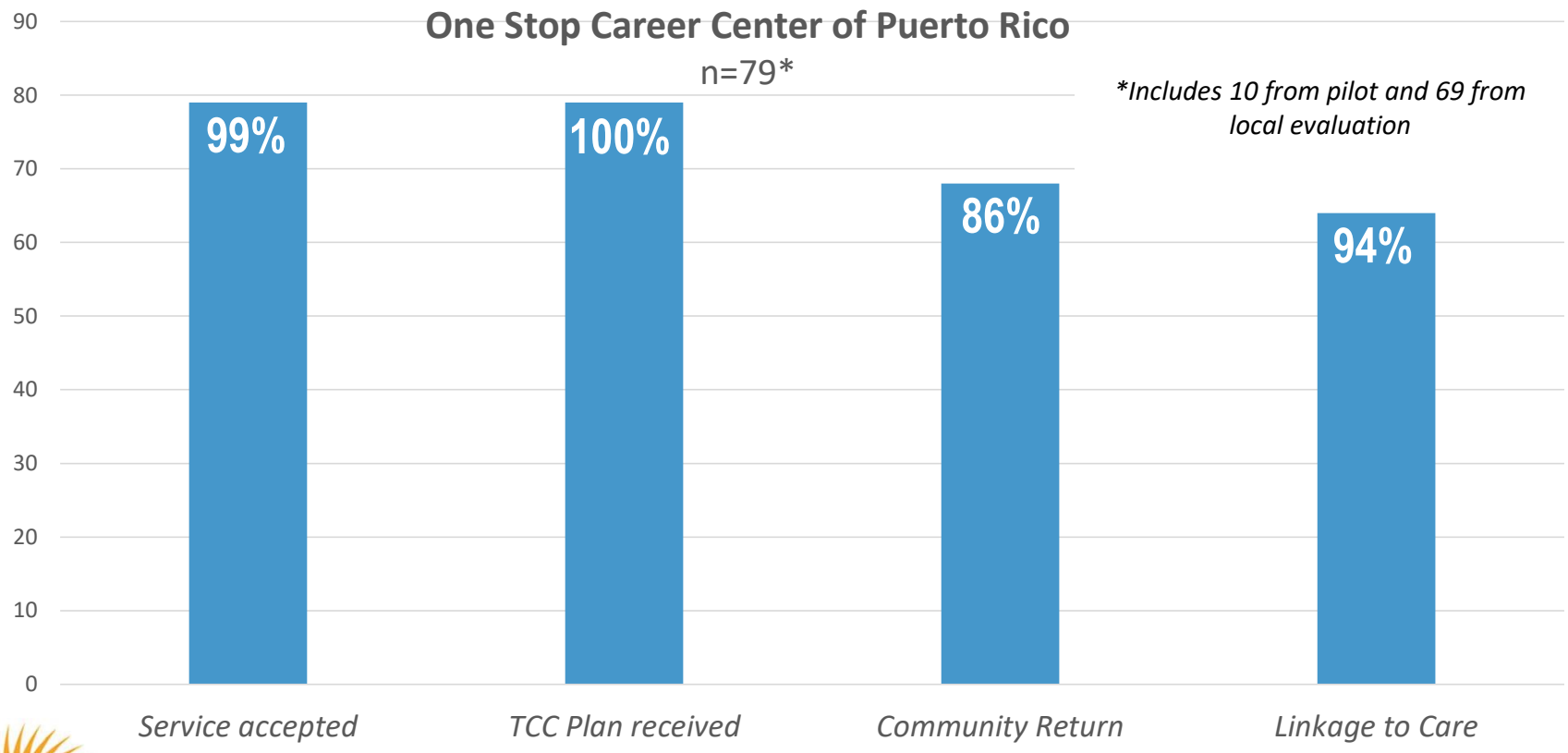
Transitional Care Coordination Cascade



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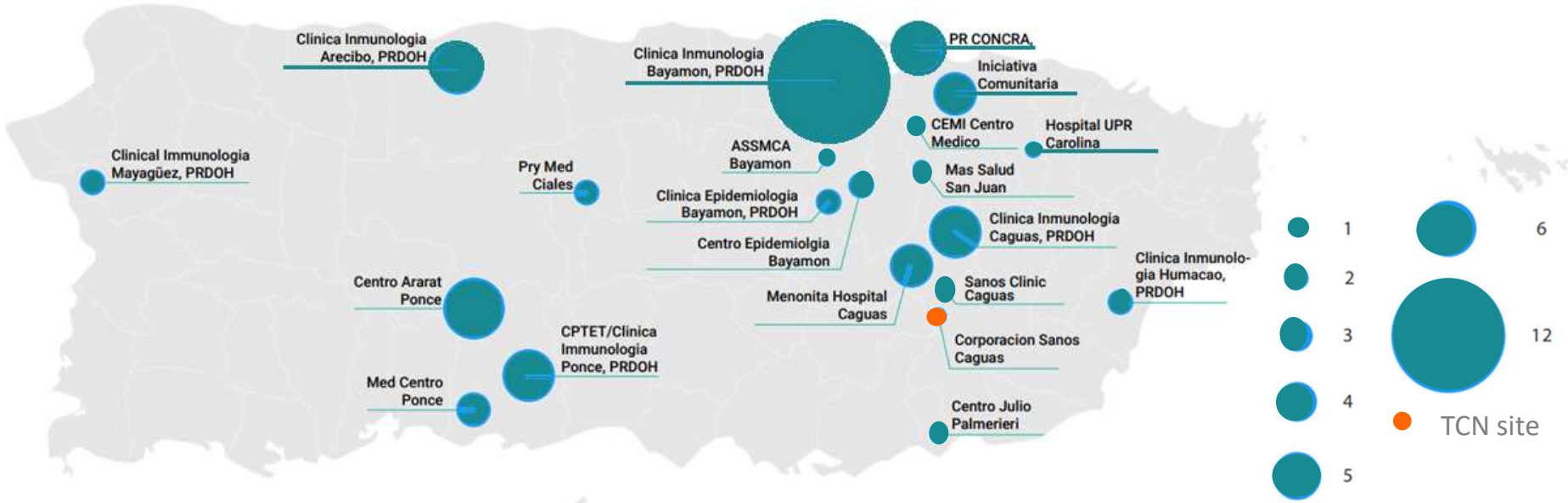
Mapping Linkages to Care in Puerto Rico



94% of people returning home with a transitional care plan linked to care after incarceration (n=80).

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Implementation Challenges

- Identifying right fit programs: personal relationships v. formal expertise
- Proposal evaluation methodology favors existing programs
- Formal authority/documents from predecessors insufficient to gain buy-in
- Culture of corrections varies by location/jurisdiction
- Opening/closing of programs absent formal communication system
- Frequent turnover and changes in local government leadership
- Poor local economy, lack of affordable housing/shelters
- Hurricane Maria…

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Hurricane Maria Relief Efforts

OSCC received hurricane relief funding and found clients after Hurricane Maria to assess need and arrange for:

- Medications
- Housing
- Food, drinking water, clothes and other needs
- Assistance with FEMA application
- Placement in transitional housing / treatment

OSCC Executive Director and staff secure & distribute food and essentials

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Overcoming Challenges

Manati

After Hurricane Maria

Brenda Rosario

February 2019

Alison O Jordan

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Lessons Learned & Recommendations

1. Networking with other agencies & jurisdictions identified core organizations and champions
2. Local community/ faith-based organization (CBO) leadership pooled resources + worked with government staff to establish best practices to facilitate continuity of care
3. Coordination & collaboration between Ryan White service network and local CBOs improved access for those out of care.
4. Pre-established relationships led to formal agreements & created synergy among medical and support service providers (housing, employment, substance use)
5. OSCC participation on HIV Planning Council facilitated coordination with key stakeholders
6. Annual convening of stakeholders helped create strategies to address population needs
7. Maintain relationships and linkage agreements
8. Transitional Consortium maintained core leadership, supported relationships & leveraged resources to coordinate care
9. Engaging client during incarceration fosters relationships to endure after incarceration
10. Transportation access ensures linkage to care after incarceration

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Thank you

Jesse Thomas

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SPNS DEII

DISSEMINATION OF
EVIDENCE-INFORMED
INTERVENTIONS

FUNDING STATEMENT

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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

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HIT SUPPORTS COLLABORATIONS

- Data sharing
- System Mapping
- Gap analytics
- Shared health information
- Leverages shared resources

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Benefits of Health IT

1. Free up time better spent on client care and quality improvement through interactive use of mobile audience engagement tools.
2. Implement web-based resources to achieve federal and local compliance and improved quality management.
3. Avoid pitfalls and realize benefits of implementing a web-based collection and reporting system for tracking and reporting of patients and quality improvement programs.

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Health Information Technology

Hampden MA	New York City	Puerto Rico	Paterson, NJ
• Homegrown eHR data fed by Jail system (99% one way door). • 3 of 5 Community Health Centers' EHR are accessible from jail. • CHC EHRs diminishing capacity, staffing, access to care. • HIE read-only access • New interchange: need funding • RDE Red Suite	• Customized Centricity eHR (formerly eCW) data fed by DOC system (one way door); Transitional Care added 5/21/13. • Limited Health Information Exchange (HIE) access; Statewide Health Home patient record access with consent; Citywide benefits information • Transitional Care Management system with community provider sharing capacity • Health & Hospital system networking capacity	• Linkages to Care Mapping • Electronic Resource Guide	• eCOMPAS • SMART Care Management system with community provider sharing capacity (community-based) • RDE Red Suite

Baystate Health
baystatehealth.com

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What HIT solutions are you using to support service integration, linkages to care or other community collaborations?

Previously wrote a reentry curriculum... Sadly, our jail did not have anyone to do case management, and we were too busy... So, used it as I could.

None currently

Looking at making contracts available to other states when completed

Emr

I championed a few sites in CO to use HIE

NA

Utilize facility EMR and dashboards

Currently restricted in this way; our facility utilizes public disclosure unit which adds several barriers

Cerner

Na

Background

NYC Health+Hospitals:

- Largest public health care delivery system in the nation
- Widely recognized for its quality and culturally responsive services

Division of Correctional Health Services (CHS):

- Provides comprehensive health care services and discharge planning services to the NYC jail population
- Transitional Care Coordination intervention under CHS' Ryan White (RW) Part A Non-Medical Case Management for the Incarcerated population category requires collaboration and data sharing with:
  - CHS' medical providers, reentry and continuity of services case managers
  - Between CHS case managers and RW Part A community partners

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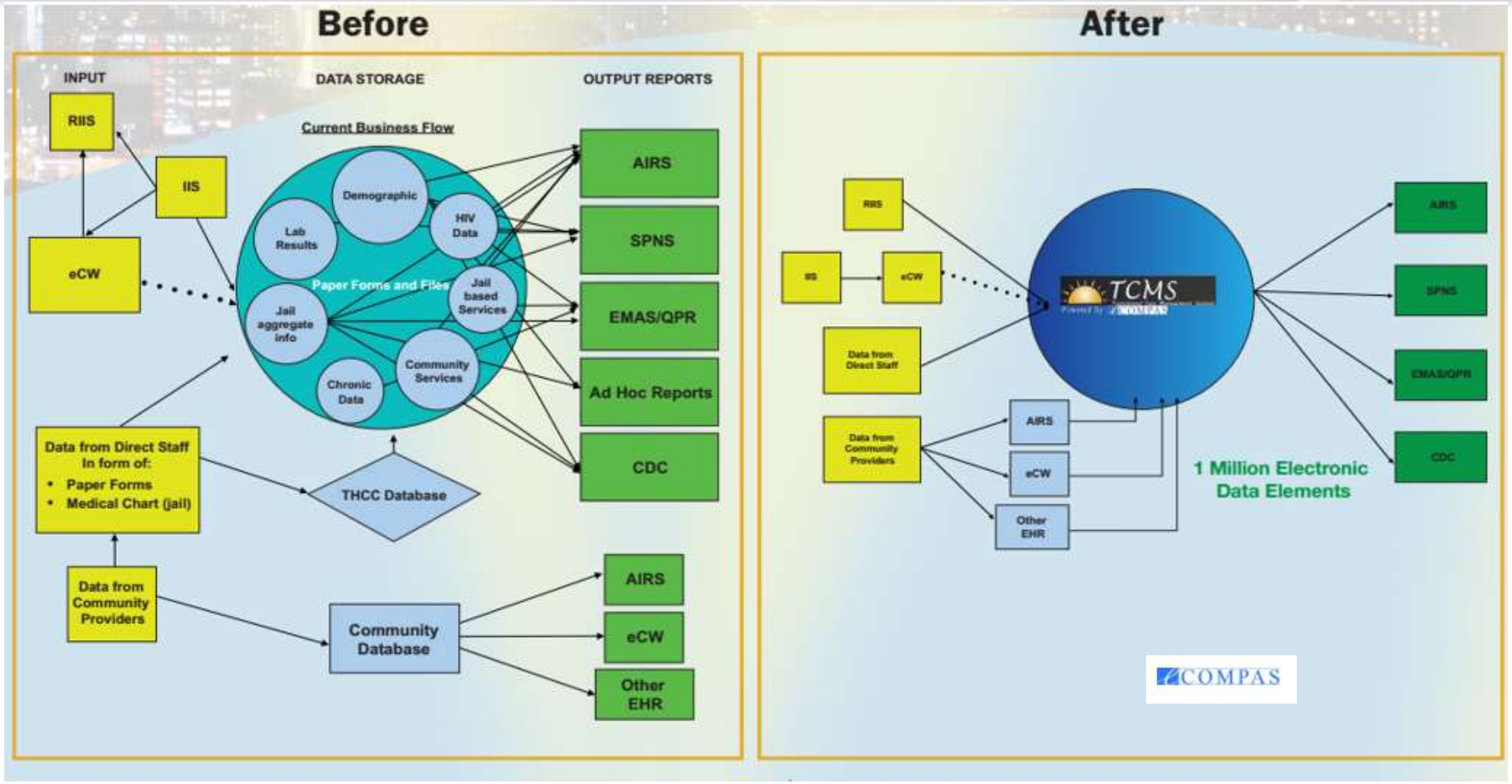

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Transitional Care Management System (TCMS)

Challenges

- ✗ Time spent on entering data into multiple excel sheets hence less effective and lower efficiency
- ✗ Time spent on cleaning up errors in multiple excel sheets
- ✗ Double data entry
- ✗ Communication back and forth on data clean up
- ✗ No ability to monitor real time activities

Solutions

- ✓ No more paper/excel sheets thus improved effectiveness and efficiency
- ✓ Work smarter and not harder
- ✓ Projected to redirect 10-15% from admin to direct service delivery
- ✓ Partners can access information with consent on file
- ✓ No more double data entry, direct data integration from EMR
- ✓ Instant access to management reports
- ✓ Accountability of community partners

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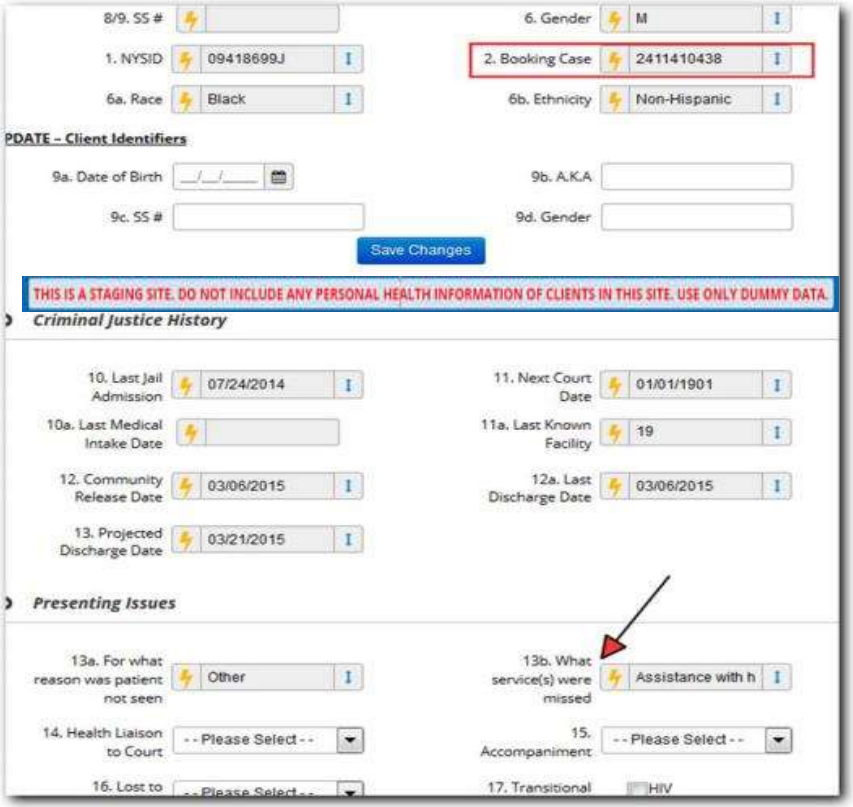
The Whoosh! … eHR to eCOMPAS data flow

Every lightning bolt represents a data element that is "Whooshed" from NYC CHS electronic health record (EHR) into TCMS



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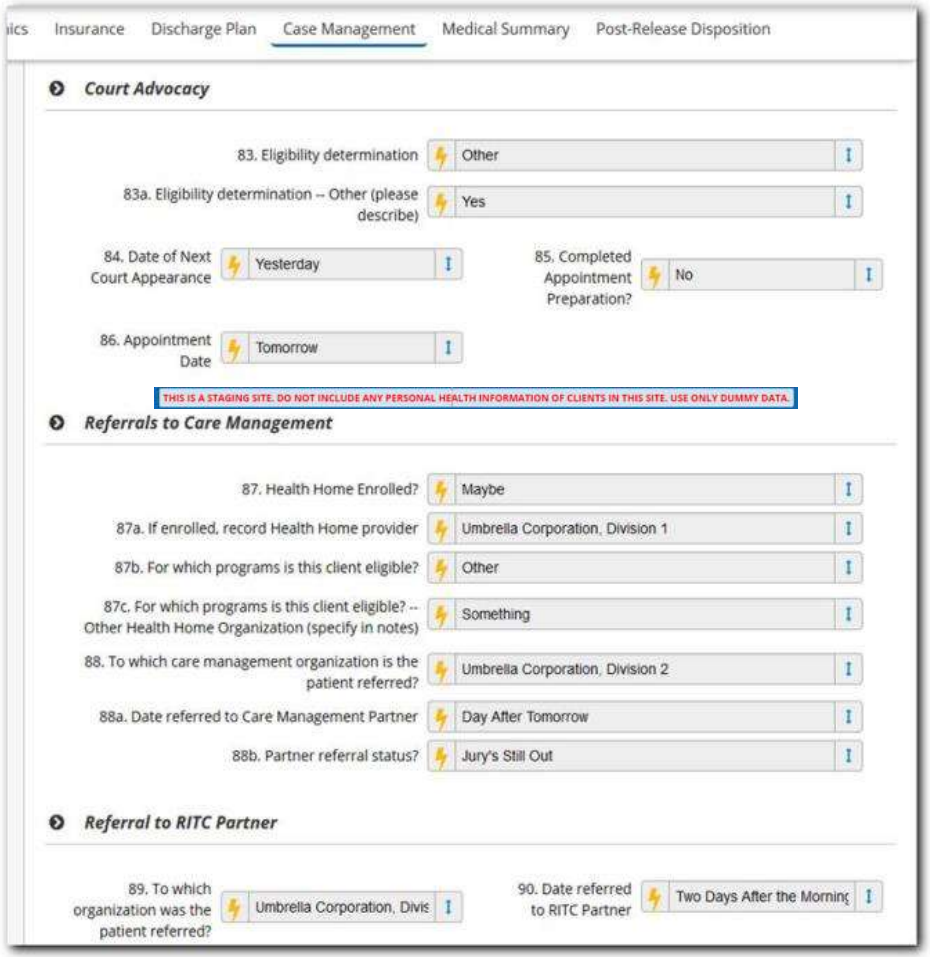
The Whoosh! … eHR to eCOMPAS data flow

TCMS collects data and, through an interface, imports meaningful data points for the end user.



TCMS facilitates coordinated care management with multiple service providers and facilitates cross-system collaboration.

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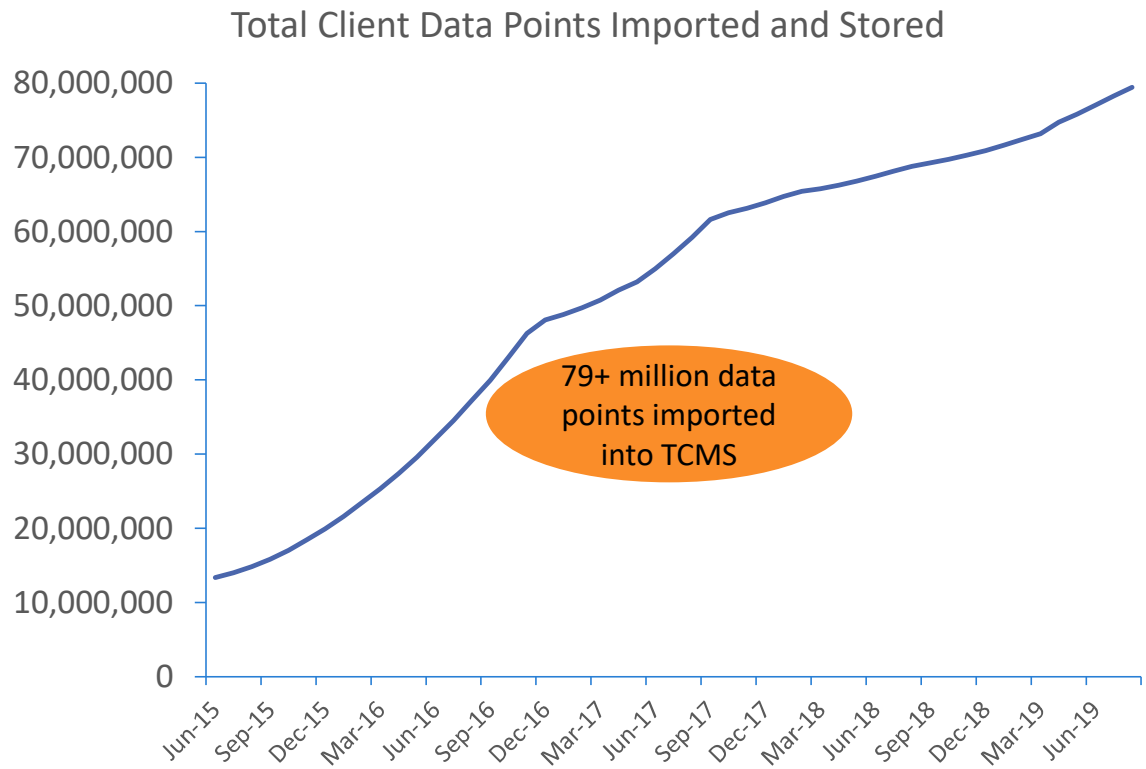
Process Outcome: TCMS Data Feeds (The Whoosh!)



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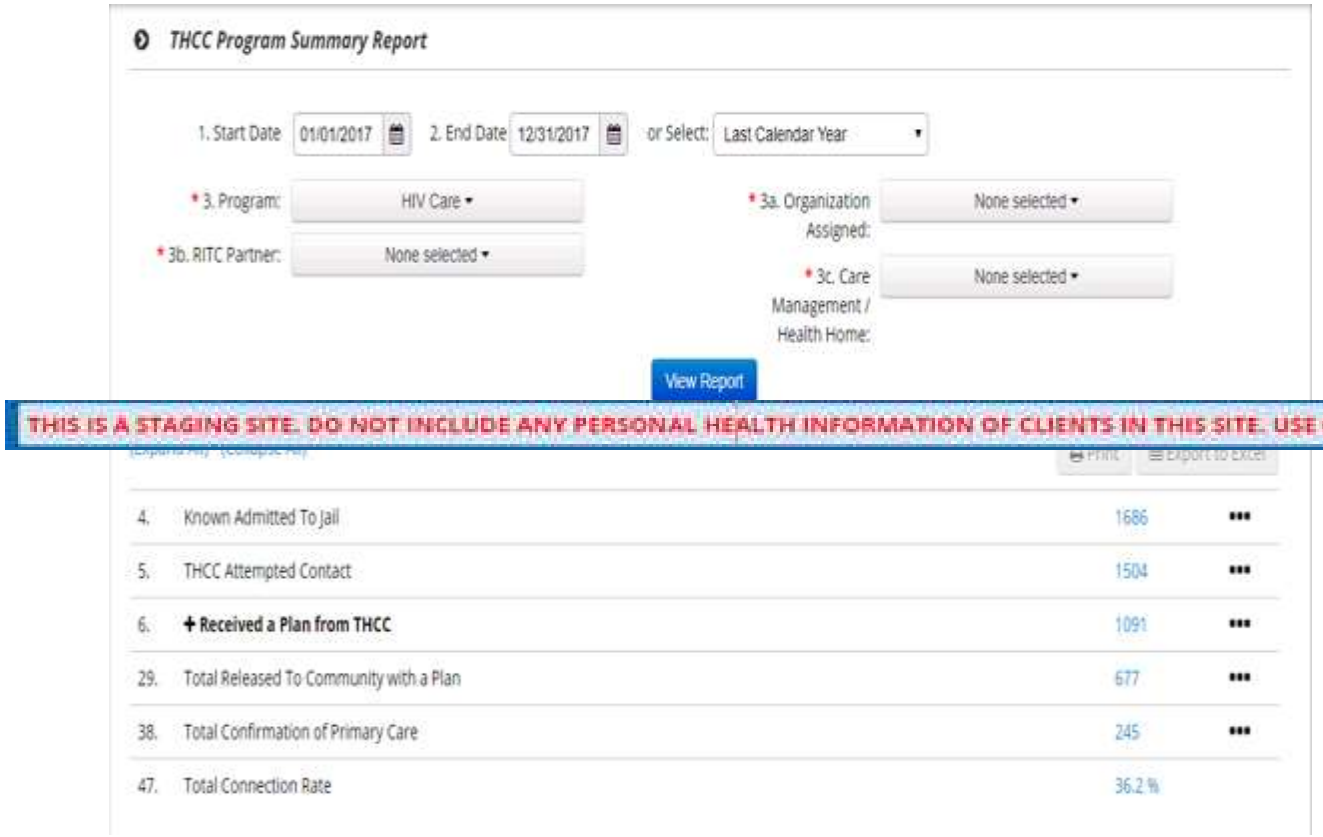
Results: Program Management Summary Report



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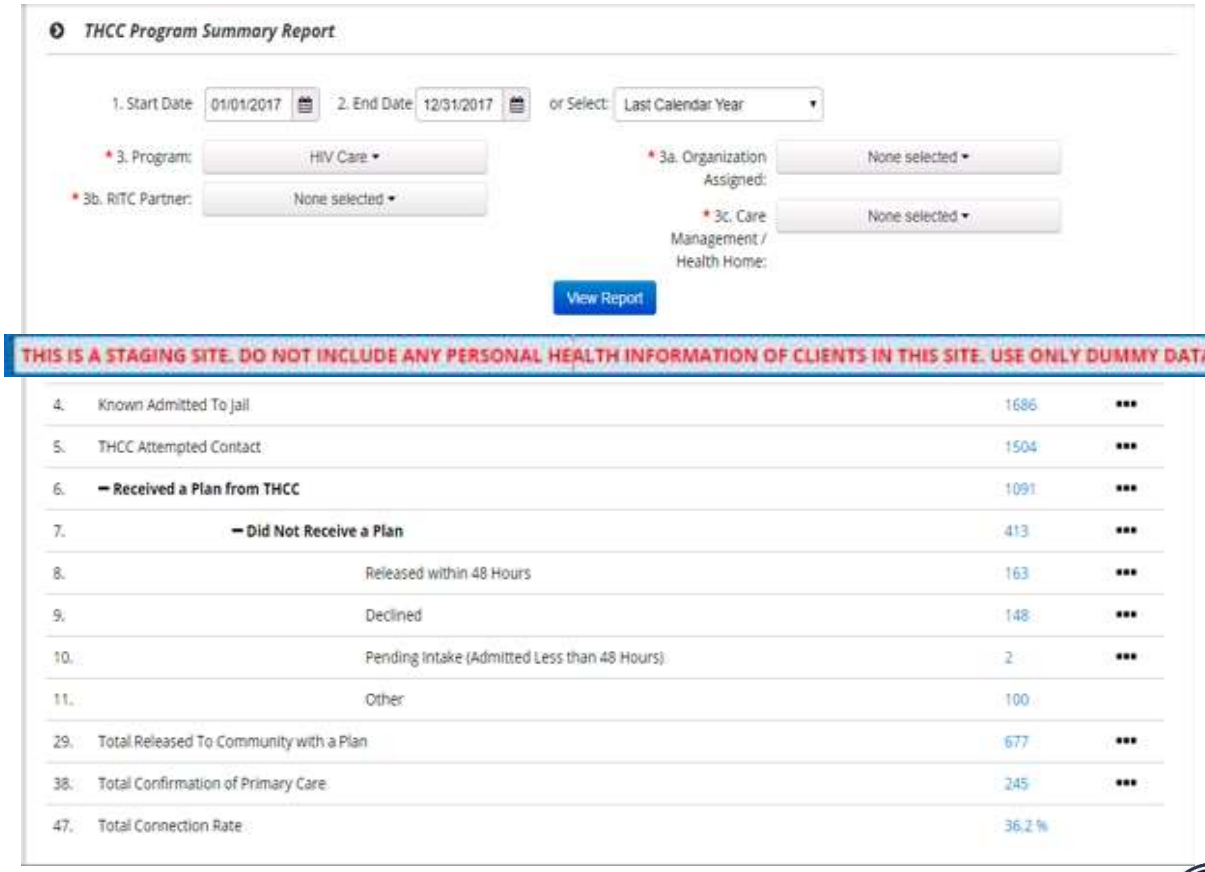
Quality Improvement: Collapse-expand feature



THCC Program Summary Report

1. Start Date 01/01/2017 | 2. End Date 12/31/2017 | or Select: Last Calendar Year

* 3. Program: HIV Care
* 3a. Organization Assigned: None selected
* 3b. RITC Partner: None selected
* 3c. Care Management / Health Home: None selected

View Report

THIS IS A STAGING SITE. DO NOT INCLUDE ANY PERSONAL HEALTH INFORMATION OF CLIENTS IN THIS SITE. USE ONLY DUMMY DATA.

4.	Known Admitted To Jail	1686	•••
5.	THCC Attempted Contact	1504	•••
6.	**– Received a Plan from THCC**	1091	•••
7.	**– Did Not Receive a Plan**	413	•••
8.	Released within 48 Hours	163	•••
9.	Declined	148	•••
10.	Pending Intake (Admitted Less than 48 Hours)	2	•••
11.	Other	100	
29.	Total Released To Community with a Plan	677	•••
38.	Total Confirmation of Primary Care	245	•••
47.	Total Connection Rate	36.2 %	

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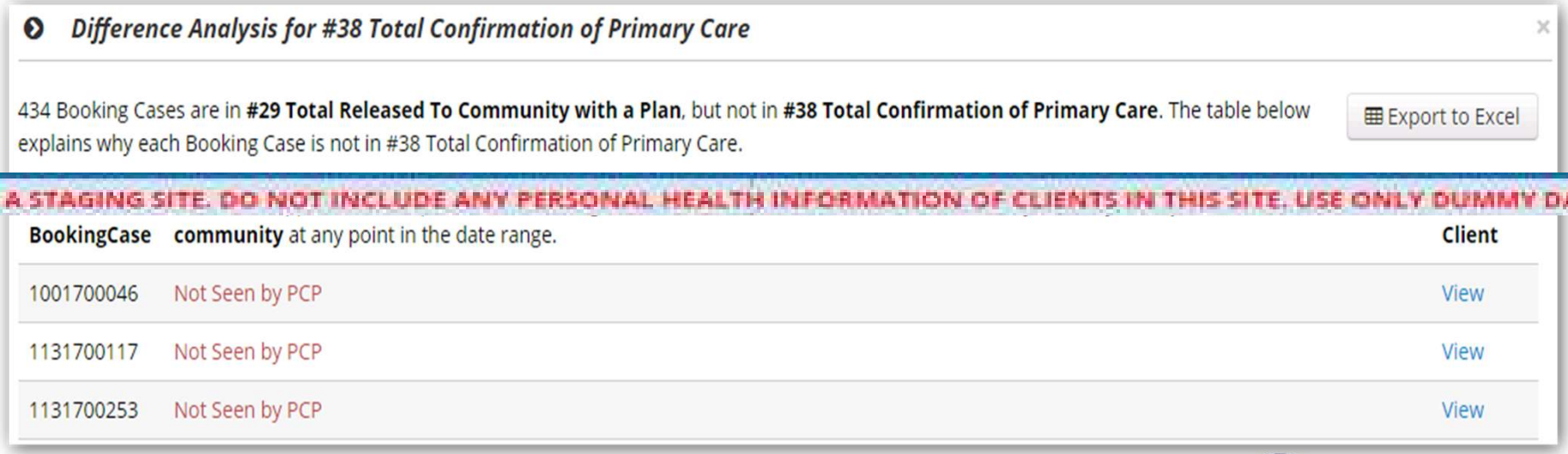
Actionable Data: Exceptions Report

TCMS Exceptions Report helps NYC CHS easily find list of clients NOT in the indicator. Reasons are listed so next steps can be taken to document community access to care:



Difference Analysis for #38 Total Confirmation of Primary Care

434 Booking Cases are in **#29 Total Released To Community with a Plan**, but not in **#38 Total Confirmation of Primary Care**. The table below explains why each Booking Case is not in #38 Total Confirmation of Primary Care.

Export to Excel

THIS IS A STAGING SITE. DO NOT INCLUDE ANY PERSONAL HEALTH INFORMATION OF CLIENTS IN THIS SITE. USE ONLY DUMMY DATA.

BookingCase	**community** at any point in the date range.	Client
1001700046	Not Seen by PCP	View
1131700117	Not Seen by PCP	View
1131700253	Not Seen by PCP	View

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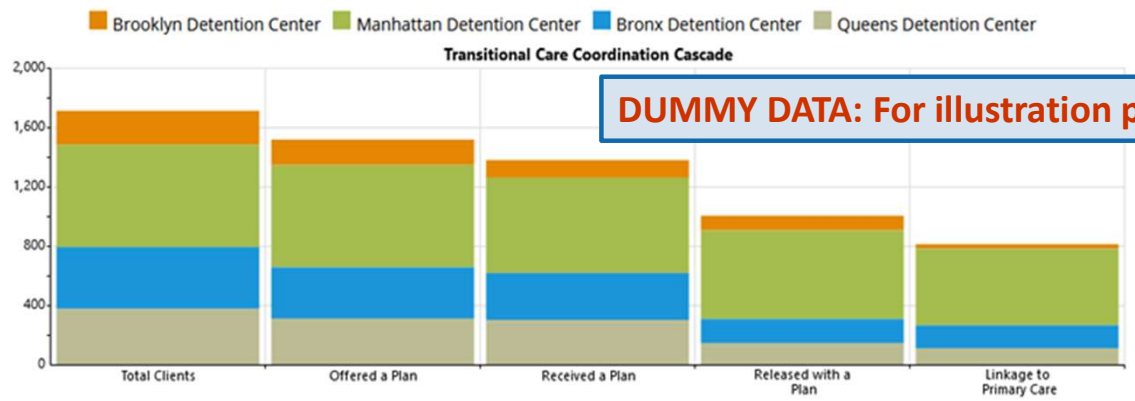
Dashboard Tool

Transitional Care Coordination Cascade



DUMMY DATA: For illustration purposes only

Facility	Total Clients	Offered a Plan	Received a Plan	Released with a Plan	Linkage to Primary Care
Brooklyn Detention Center	228	172 (-56)	119 (-53)	99 (-20)	30 (-69)
Manhattan Detention Center	691	689 (-2)	643 (-46)	598 (-45)	517 (-81)
Bronx Detention Center	415	346 (-69)	316 (-30)	163 (-153)	155 (-8)
Queens Detention Center	380	313 (-67)	304 (-9)	147 (-157)	113 (-34)
Total	1713	1520	1383	1006	815

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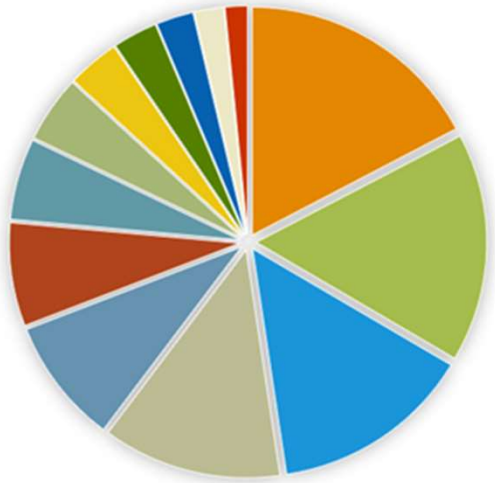
Dashboard Tool

Linkage to Care Locations

DUMMY DATA: For illustration purposes only

Linkage to Care Locations



Community Clinic	Gap	Percentage
Staten Island University Hospital	33	17%
Brightpoint Healthcare	31	16%
Community Healthcare Network	27	14%
Queens Hospital Center	24	13%
Fortune Society	17	9%
Kings County Hospital	14	7%
Institute for Advanced Medicine	11	6%
Montefiore Medical Center	9	5%
Bellevue Hospital Center	7	4%
Housing Works	6	3%
Mt Sinai Health Coming Home Program	5	3%
Bronx Lebanon Healthcare Network	4	2%
Elmhurst General Health	3	2%
Total Gap	191	100%

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The Whoosh!

*"RDE has been a **great partner, providing excellent support, proactive problem-solving, and being responsive** to our IT needs… **RDE has worked seamlessly with IT operations across organizations** to facilitate a smooth migration and uninterrupted operation and data feeds. **RDE is a knowledgeable, competent, and responsive HIT partner**."*

Jeffrey Herrera
Senior Director
Information Technology

NYC Correctional Health Services

Thank you RDE, we can hear The Whoosh!

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Results

1. eCOMPAS connects to the eHR to “whoosh” data from the EMR to TCMS every day
2. Saves time, reducing double key entry and maintaining data consistency
3. Program implementation and Quality Management reports developed in TCMS eCOMPAS support Quality Improvement and ensure compliance with federal program and grant requirements
4. CHS and its community partners access the data system that contains the "whooshed" information, simplifying coordination, tracking efforts and facilitating a Warm Transition to continuity of care after incarceration
5. Data systems integration helps improve care coordination, data reporting & quality management

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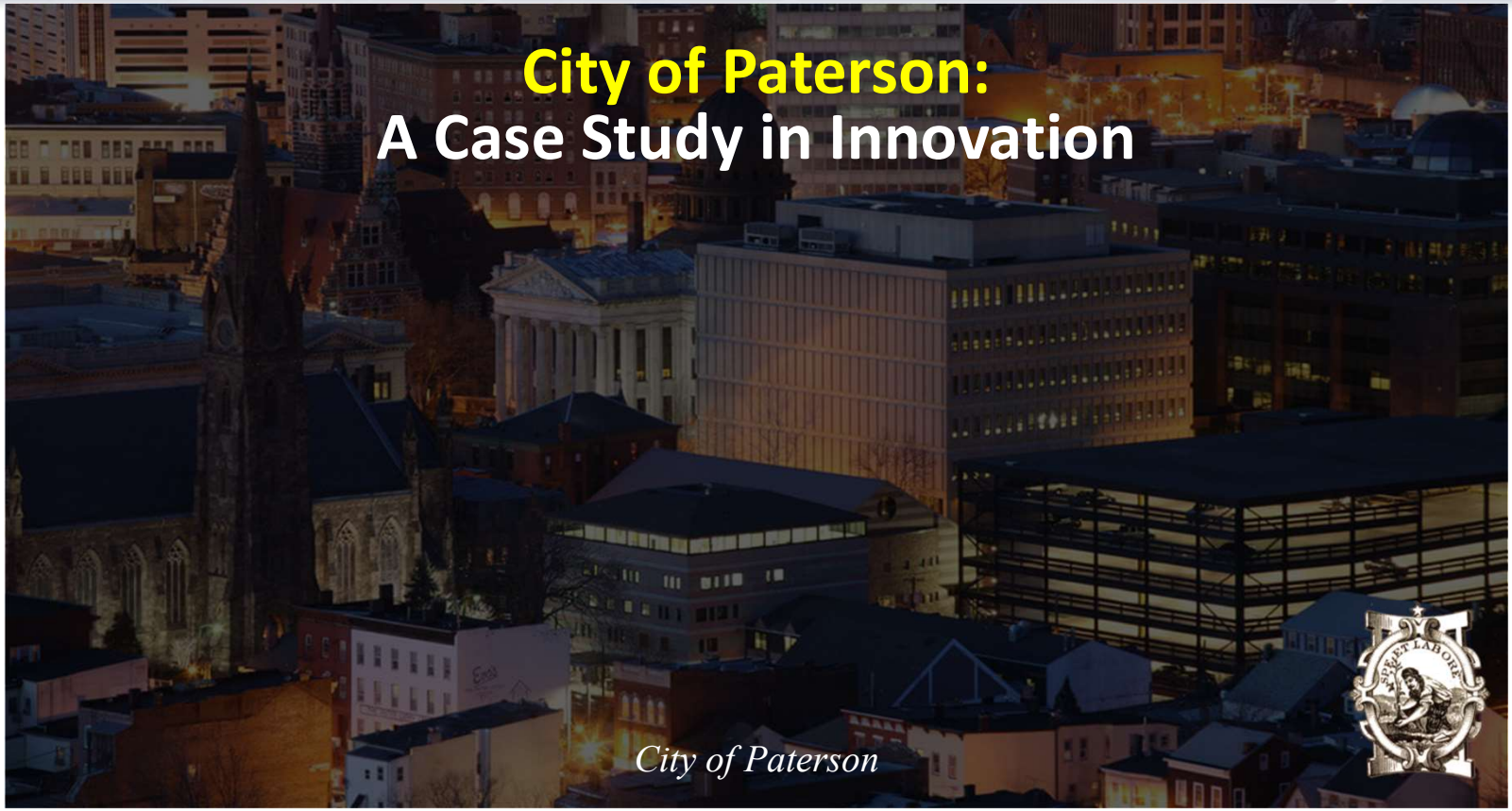
City of Paterson:
A Case Study in Innovation



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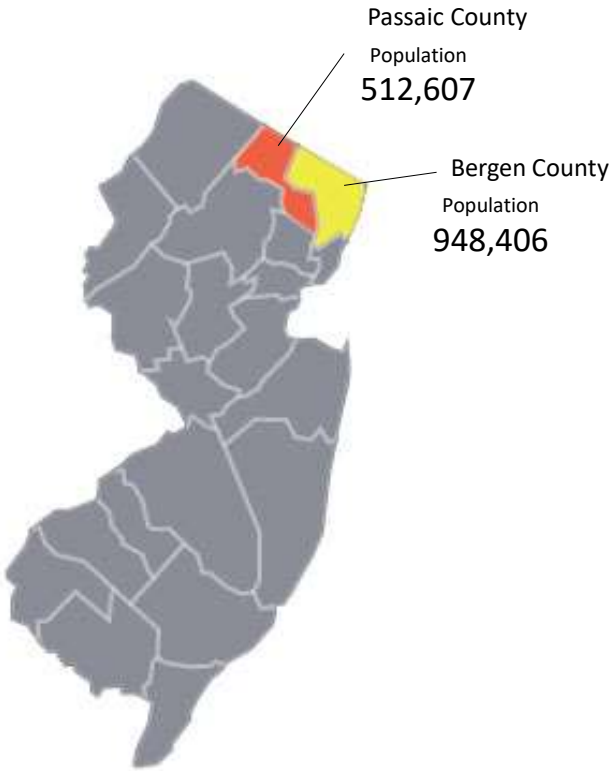
Introduction to Paterson Case Study



Coordinating systems through eHIE

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SPNS Improving HIV Health Outcomes through the Coordination of Supportive Employment and Housing Services

2017-2020

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IN A NUTSHELL

We are enhancing Housing and Employment services, workflows, tracking and coordination within the Bergen-Passaic TGA for improved client outcomes.

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Bergen-Passaic Housing and Employment SPNS: Changing Lives – A Client Story

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Big Picture Themes

- The Power and Challenge of electronic coordination, monitoring, and tracking.
- Partnership: Being flexible and creative, transforming barriers into win-win arrangements.
- Smart Care Management

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Leveraging Technology and Data

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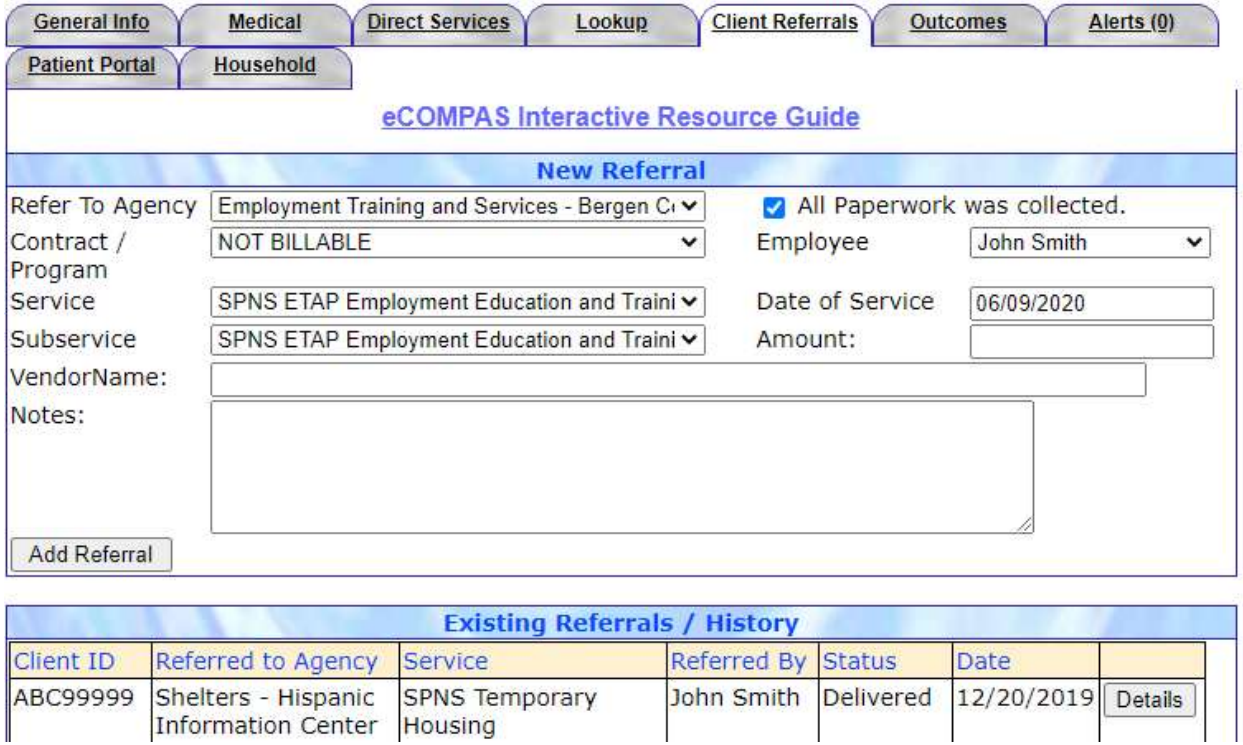
Electronic Referrals in e2



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12,000

Referrals Made in eCOMPAS

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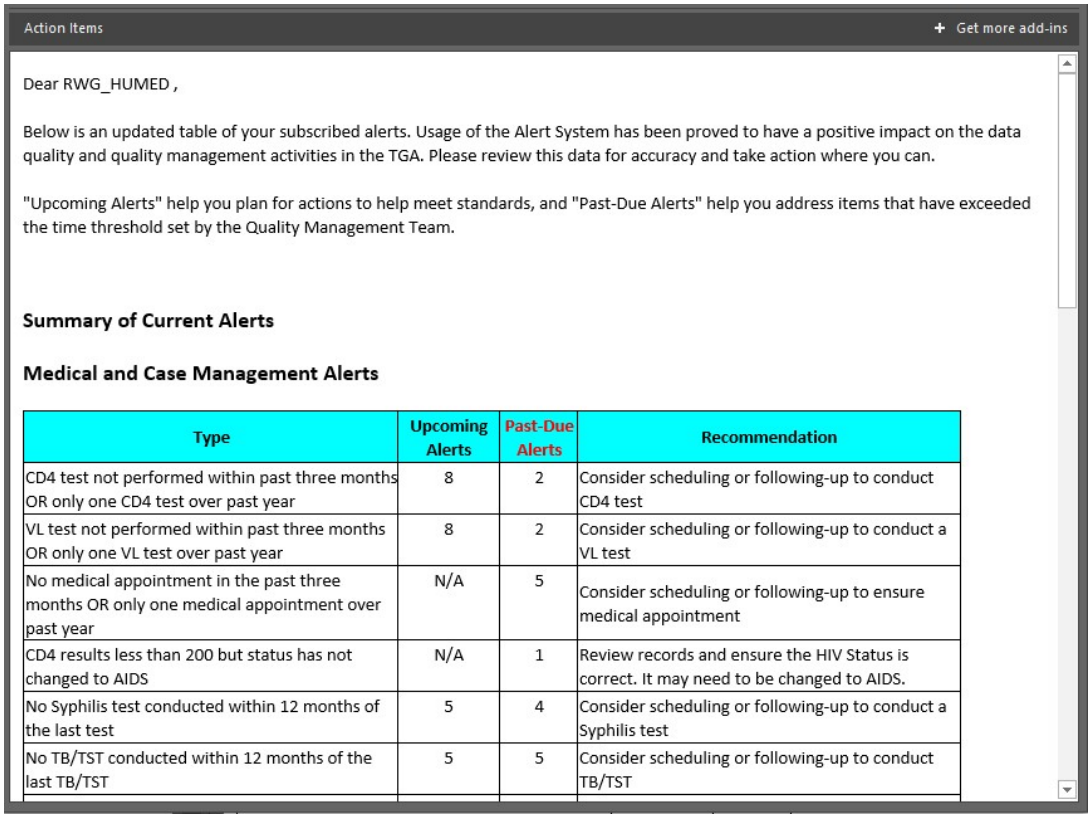
Proactive Weekly Email Alerts



Action Items + Get more add-ins

Dear RWG_HUMED ,

Below is an updated table of your subscribed alerts. Usage of the Alert System has been proved to have a positive impact on the data quality and quality management activities in the TGA. Please review this data for accuracy and take action where you can.

"Upcoming Alerts" help you plan for actions to help meet standards, and "Past-Due Alerts" help you address items that have exceeded the time threshold set by the Quality Management Team.

Summary of Current Alerts

Medical and Case Management Alerts

Type	Upcoming Alerts	Past-Due Alerts	Recommendation
CD4 test not performed within past three months OR only one CD4 test over past year	8	2	Consider scheduling or following-up to conduct CD4 test
VL test not performed within past three months OR only one VL test over past year	8	2	Consider scheduling or following-up to conduct a VL test
No medical appointment in the past three months OR only one medical appointment over past year	N/A	5	Consider scheduling or following-up to ensure medical appointment
CD4 results less than 200 but status has not changed to AIDS	N/A	1	Review records and ensure the HIV Status is correct. It may need to be changed to AIDS.
No Syphilis test conducted within 12 months of the last test	5	4	Consider scheduling or following-up to conduct a Syphilis test
No TB/TST conducted within 12 months of the last TB/TST	5	5	Consider scheduling or following-up to conduct TB/TST

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11,370

Alerts module was accessed in eCOMPAS

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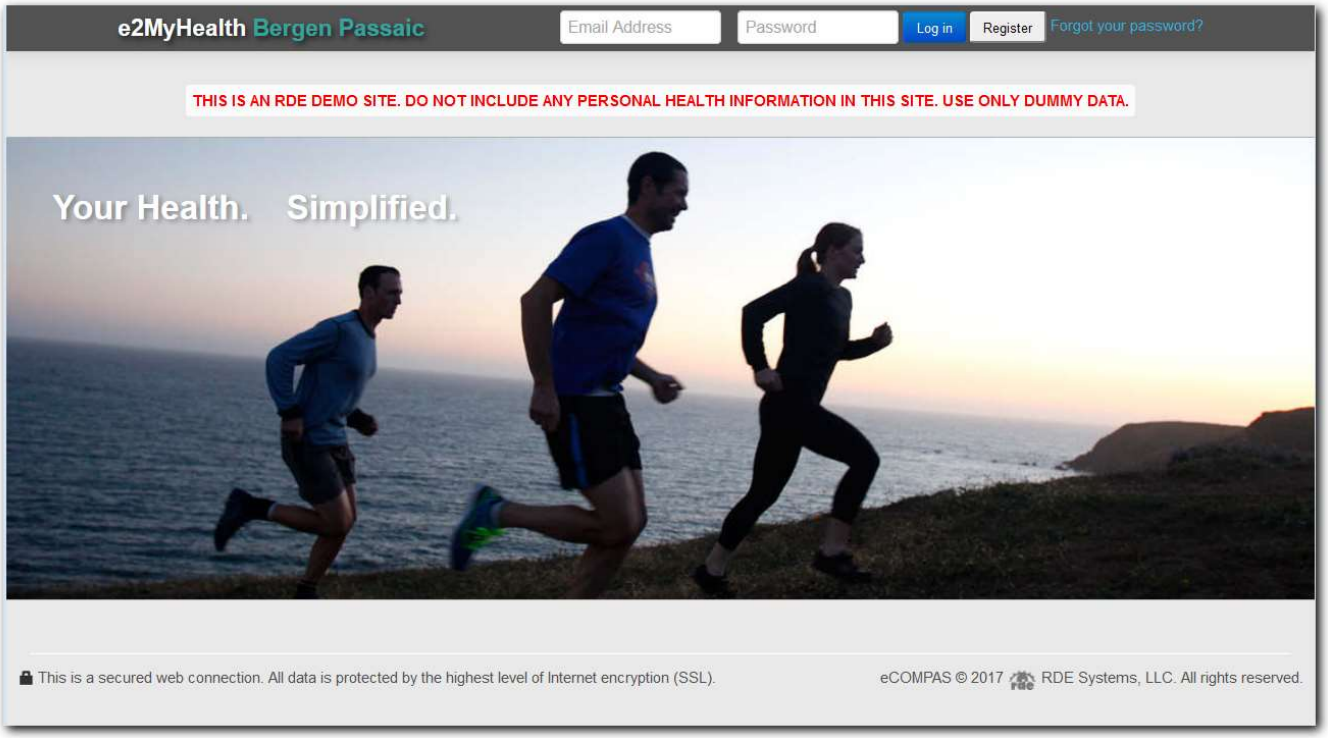
Bergen Passaic e2MyHealth



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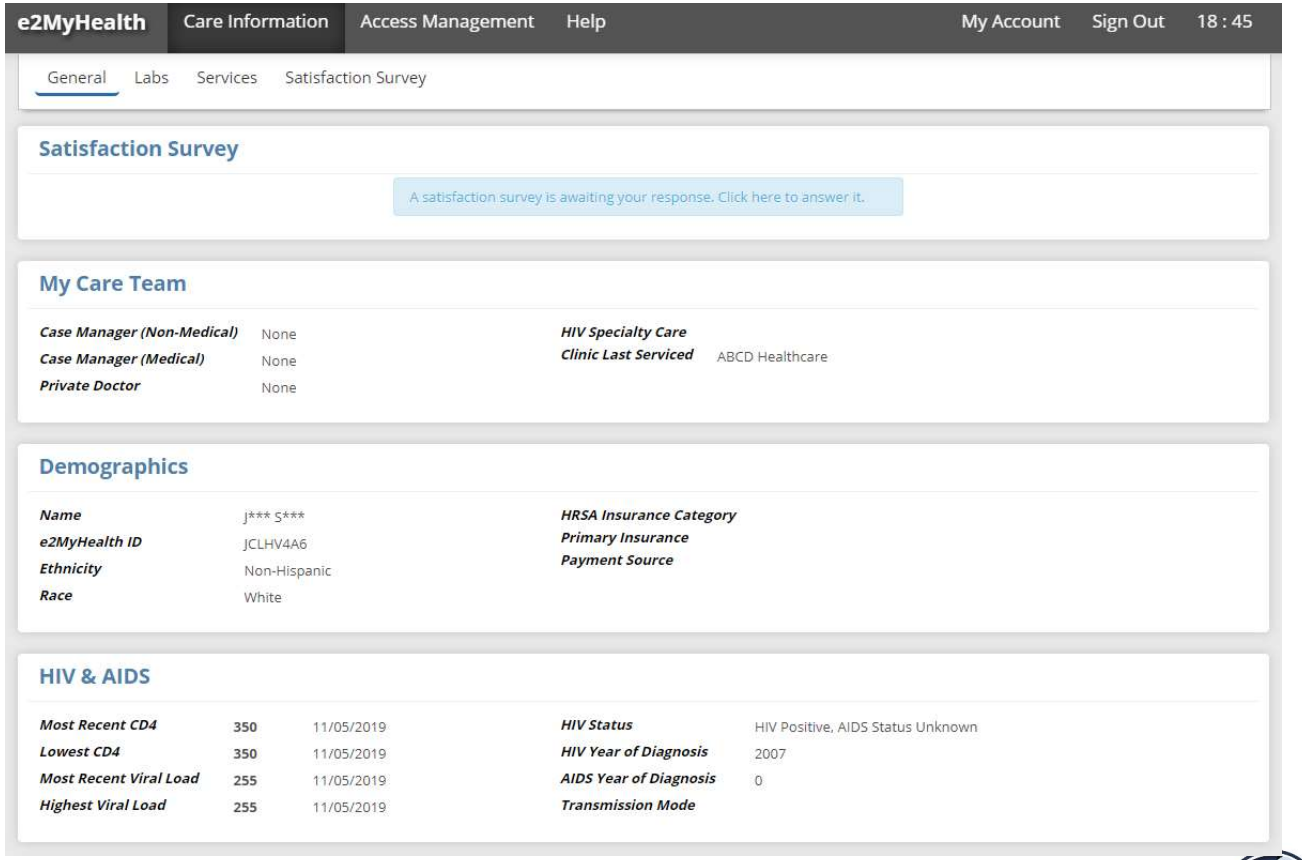
e2MyHealth



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HIV Care Continuum

HIV Care Continuum Dashboard

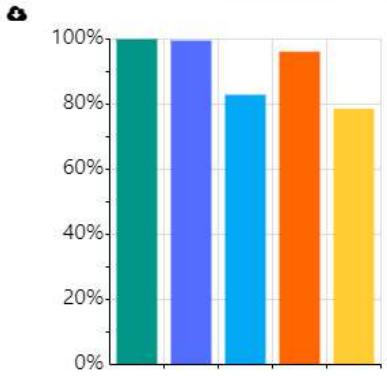
End Date: 12/31/2019 | Report Type: SPNS ETAP | Run Report

Measurement Year: 01/01/2019 - 12/31/2019
24-Month Measurement Period: 01/01/2018 - 12/31/2019

This is the latest version of the CCT Dashboard
Click Here to see the previous version of this report

Summary | Graphical View | Tabular View

Bergen-Passaic Ryan White Part A (3 clinics) HIV Care Measures



Summary Table		[?]
Enrolled	234	100.00%
Linked to Care	233	99.57%
Retained in Care	194	82.91%
Rx of ARV Therapies	225	96.15%
VL Suppressed	184	78.63%

Bergen-Passaic Ryan White Part A (3 clinics) HIV Care Measures: by Service

	Enrolled		Linked to Care		Retained in Care		Rx of ARV Therapies		VL Suppressed	
Outpatient/Ambulatory Health Services	234	100.00%	233	99.57%	194	82.91%	225	96.15%	184	78.63%
Medical Case Management	118	100.00%	118	100.00%	104	88.14%	115	97.46%	98	83.05%
Mental Health Services	6	100.00%	6	100.00%	5	83.33%	3	50.00%	3	50.00%
Oral Health Care	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%
Early Intervention Services (EIS)	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%

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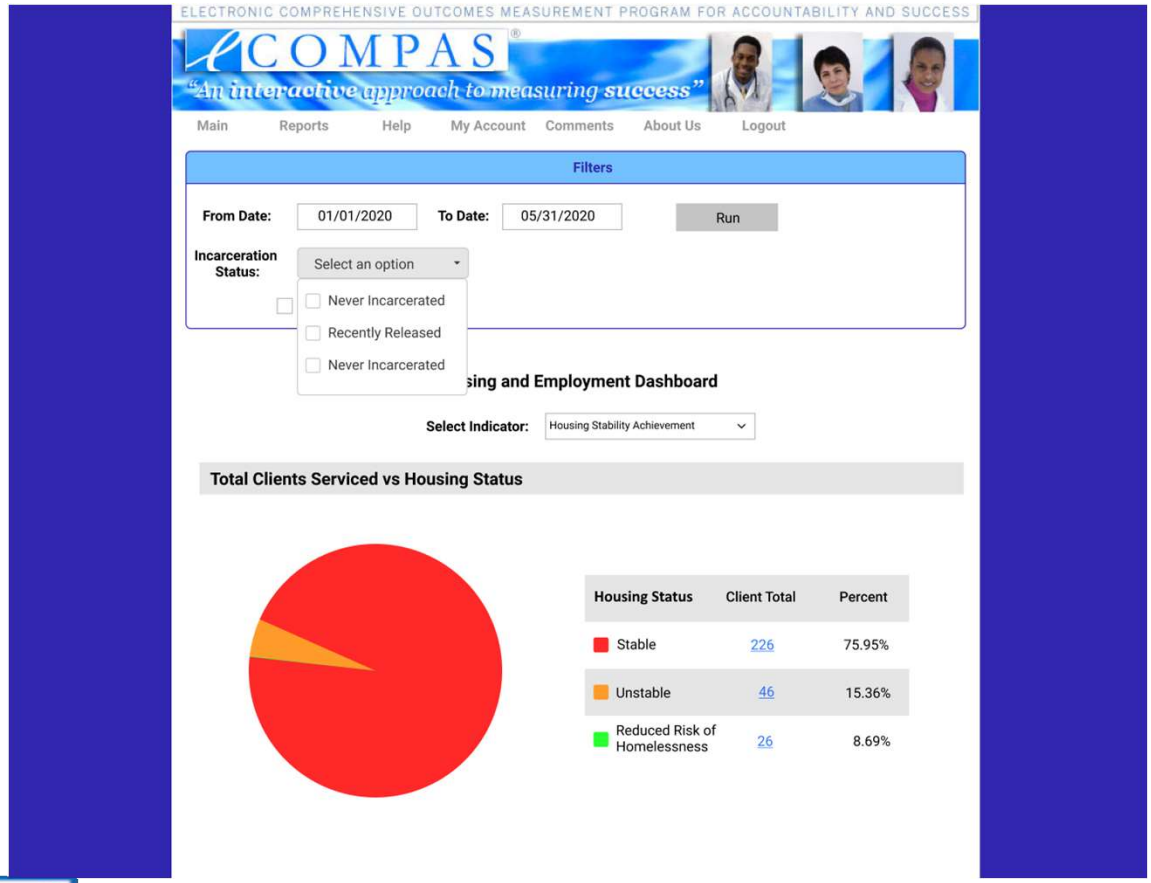
Future Vision – Housing Dashboard



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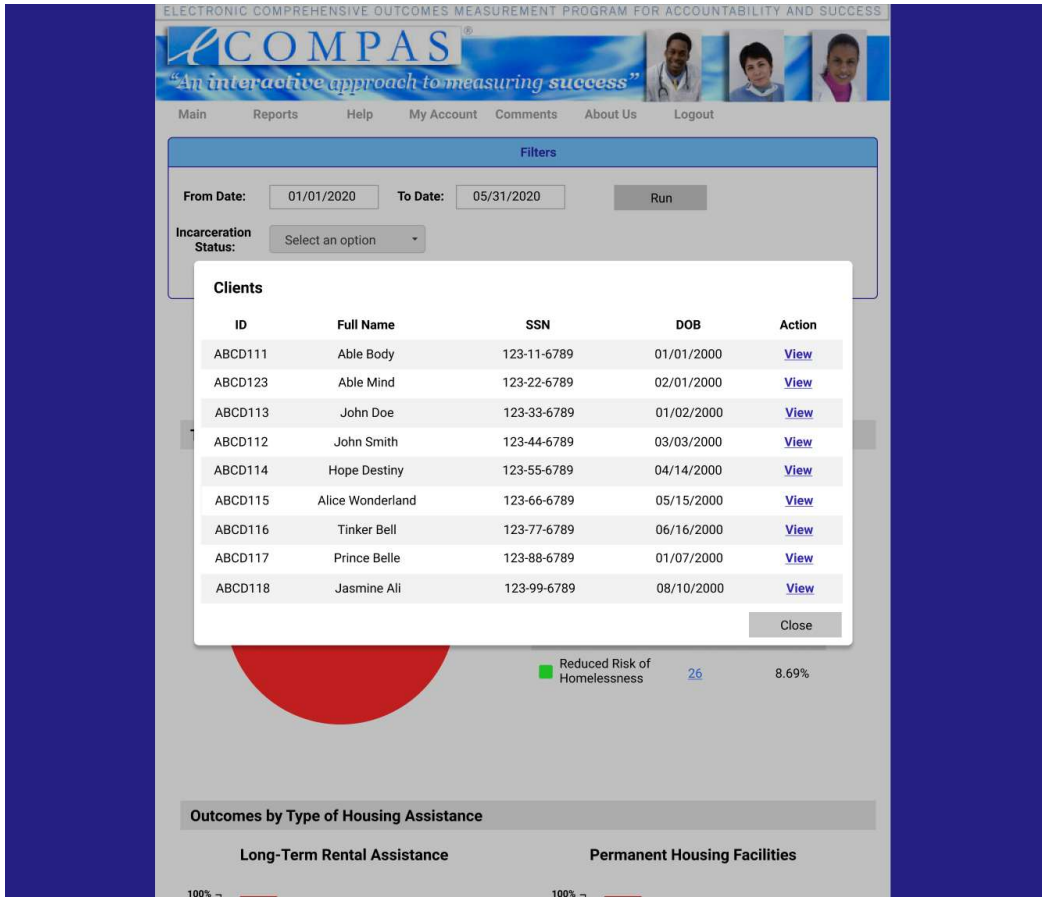
Future Vision – Housing Dashboard Drilldown



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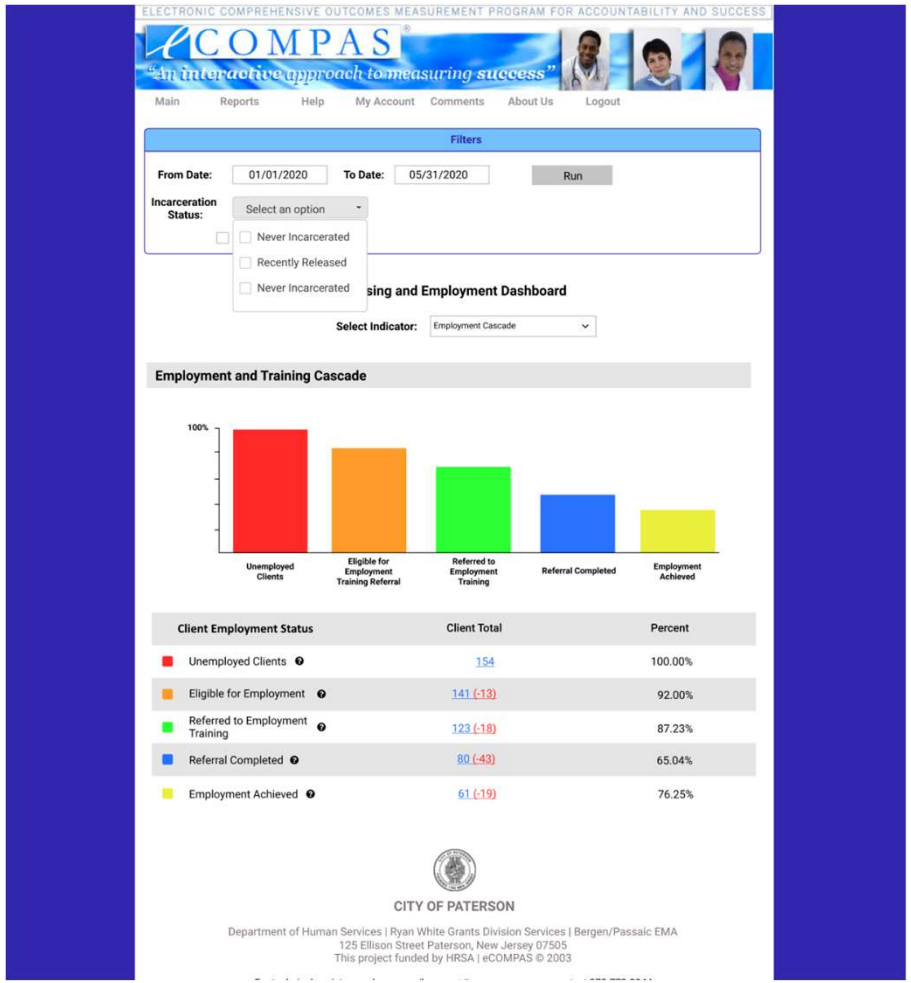
Future Vision – Employment Dashboard



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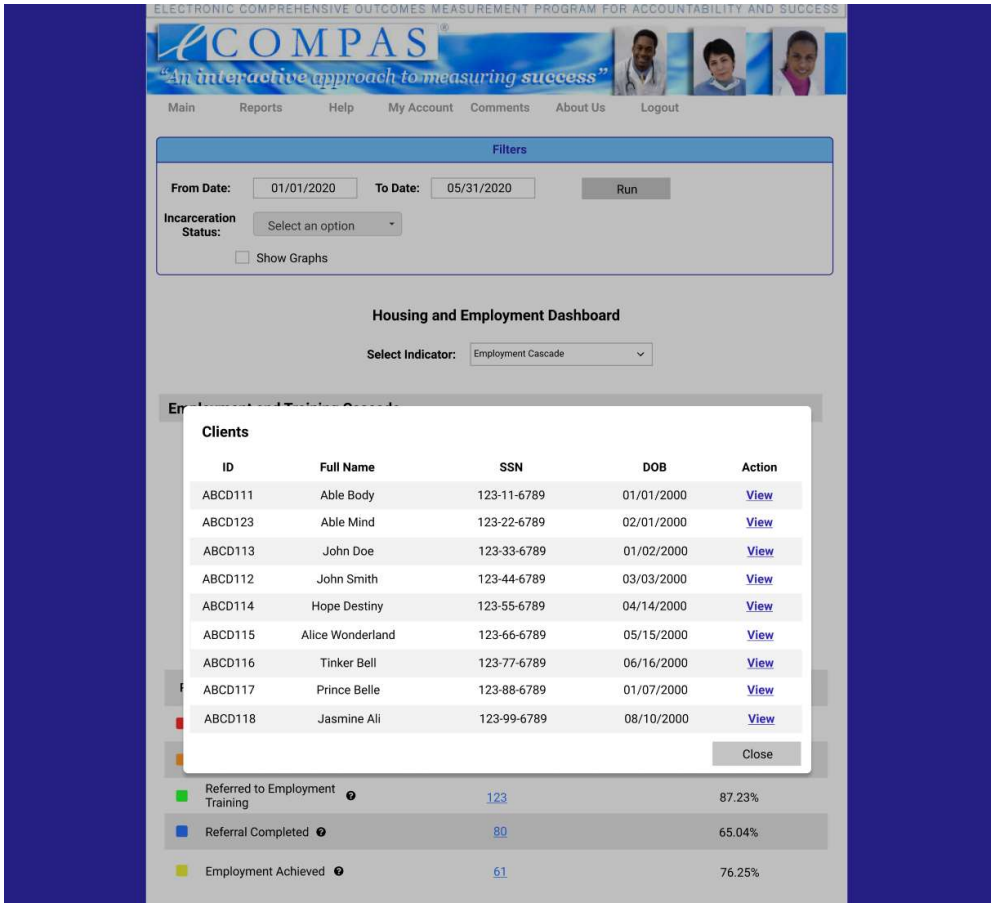
Future Vision – Employment Dashboard Drilldown



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Case Manager Experience

- **Experience with the housing and employment SPNS project**
  - **It was enlightening** finding services for clients
  - We provided job services
  - Barriers such as COVID-19 and client drug addiction was challenging

- **Success Stories**
  - One client was homeless and is now doing quite well
  - Got **over 12 people housed**
  - Had a plan for clients to be self-sufficient
  - Leveraging the City's HOPWA program was a strength and benefit

- **Working with the SPNS Team (Recipient, RDE, and Partners)**
  - It is a good experience
  - Team work - **we did the best we can**
  - This will be a sustainable program

Tisa Nicole Smith
Medical Case Manager
CAPCO Resource Inc.

CAPCO

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Conclusions

- System Innovations – Cross-program integration, electronic referral expansion, visual dashboards with drill downs
- Partnership – Flexibility, Win-Win, Patience
- Impact – Consumers and those that serve them deserve the best
- Feasibility – You Can Do it!
- Sustainability – Through strategic systems capacity development and unwavering leadership, administrative burden can be reduced to sustain.

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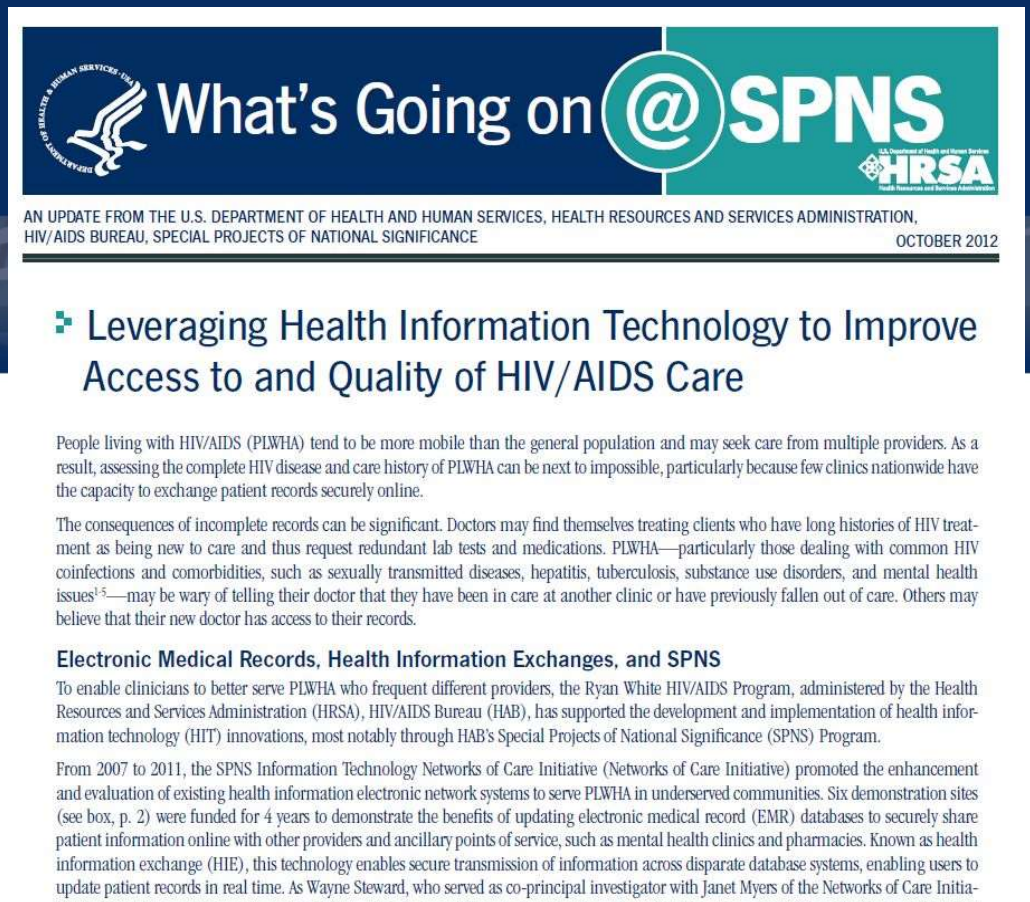
A heartfelt thanks…..



What's Going on @SPNS

AN UPDATE FROM THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, HEALTH RESOURCES AND SERVICES ADMINISTRATION, HIV/AIDS BUREAU, SPECIAL PROJECTS OF NATIONAL SIGNIFICANCE

OCTOBER 2012

Leveraging Health Information Technology to Improve Access to and Quality of HIV/AIDS Care

People living with HIV/AIDS (PLWHA) tend to be more mobile than the general population and may seek care from multiple providers. As a result, assessing the complete HIV disease and care history of PLWHA can be next to impossible, particularly because few clinics nationwide have the capacity to exchange patient records securely online.

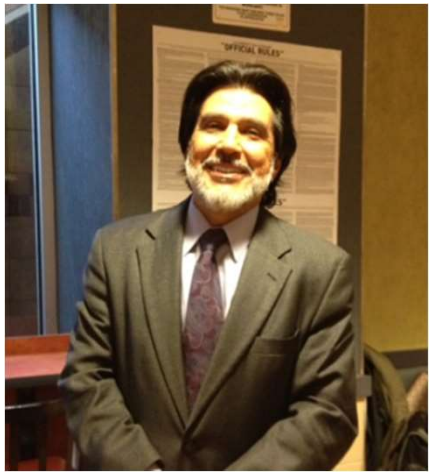
The consequences of incomplete records can be significant. Doctors may find themselves treating clients who have long histories of HIV treatment as being new to care and thus request redundant lab tests and medications. PLWHA—particularly those dealing with common HIV coinfections and comorbidities, such as sexually transmitted diseases, hepatitis, tuberculosis, substance use disorders, and mental health issues[1-5]—may be wary of telling their doctor that they have been in care at another clinic or have previously fallen out of care. Others may believe that their new doctor has access to their records.

Electronic Medical Records, Health Information Exchanges, and SPNS

To enable clinicians to better serve PLWHA who frequent different providers, the Ryan White HIV/AIDS Program, administered by the Health Resources and Services Administration (HRSA), HIV/AIDS Bureau (HAB), has supported the development and implementation of health information technology (HIT) innovations, most notably through HAB's Special Projects of National Significance (SPNS) Program.

From 2007 to 2011, the SPNS Information Technology Networks of Care Initiative (Networks of Care Initiative) promoted the enhancement and evaluation of existing health information electronic network systems to serve PLWHA in underserved communities. Six demonstration sites (see box, p. 2) were funded for 4 years to demonstrate the benefits of updating electronic medical record (EMR) databases to securely share patient information online with other providers and ancillary points of service, such as mental health clinics and pharmacies. Known as health information exchange (HIE), this technology enables secure transmission of information across disparate database systems, enabling users to update patient records in real time. As Wayne Steward, who served as co-principal investigator with Janet Myers of the Networks of Care Initiative's Evaluation and Support Center, explains, each site used different customizations to achieve the same result: "The Initiative helped bolster the operations of existing systems so that providers could communicate electronically across locations, hence the idea of health information

Especially,
Adan Cajina
Chief, Demonstration and Evaluation Branch



ACOJA CONSULTING
OPENING DOORS … MAKING A DIFFERENCE

Baystate Health
baystatehealth.com

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Findings

- Reentry planning, discharge planning and continuity of care activities involve
  - people with criminal legal system involvement,
  - correctional and community health providers,
  - legal representatives,
  - medical,
  - substance use and mental health treatment providers,
  - skilled nursing facilities,
  - treatment courts and
  - care management programs.
- Evidence-informed public health approaches include a Public Health Model for Correctional Health (PHMCH) and Transitional Care Coordination (TCC) which have been adapted, implemented and replicated using translational science.

Inform and inspire:

- ❑ Best practices
- ❑ Cost analyses

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What's next? Please share what interested you in this session. What other information or resources would you like to know about at the intersection of corrections and community health? HIT Support? Discharge Planning? Transitional Care Management? Correctional / Community collaboratives? Other?

- just collecting collaborative ideas at this point. :)
- Info on all noted would be helpful; it can be difficult to coordinate care without ability to transfer records and info.
- Discharge planning
- Transitional care
- Transitional Care

[WHITEBOARD] Please list all your comments, reactions, questions, and ideas here as you participate in this workshop.

- love the resources! always helpful to see what other people are doing. :) Strength in numbers. :D ty
- I'm not currently working in corrections, hence my answers stating other or none

How can we accomplish ambitious goals?

How can we accomplish ambitious goals?

One bite at a time.

Thank you for your time!

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Jesse Thomas
Jesse@rdesystems.com

Free and innovative resources to end the epidemic

www.RDE.org/Red

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