Jails **SPOTLIGHT**

MEETING CLIENTS WHERE THEY'RE AT:

Conducting Transitional Care Coordination in challenging physical and community environments.

From outreach in underground tunnels on the Las Vegas Strip, to Uber Health rides for medical appointments, learn how the Southern Nevada Health District saw opportunities in their physical and community environments to help clients living with HIV during and after release from jail.

SUMMARY

This project spotlight profiles the Southern Nevada Health District's experience implementing the Transitional Care Coordination model (TCC). The TCC model strengthens connections between community and jail health care providers to improve HIV care for people recently released from jail. This replication project is part of the Dissemination of Evidence-Informed Interventions, a program funded for five years (2015 - 2020) by the Health Resources and Service Administration (HRSA), HIV/AIDS Bureau (HAB), Special Projects of National Significance (SPNS).

The Southern Nevada Health District's TCC program seeks to reduce individual barriers for clients engaging or reengaging with HIV care after incarceration. The program employs two care coordinators who begin working with clients while they are incarcerated in the Clark County Detention Center. They create relationships, identify resources, and draft a transitional care plan to guide clients after release from jail.

DISSEMINATION OF **EVIDENCE-INFORMED** INTERVENTIONS

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

Southern Nevada Health District

WHY THIS SPOTLIGHT?

Transitional Care Coordination (TCC) facilitates linkage and re-engagement with the health care system for people living with HIV following incarceration. TCC programs, like the one implemented at the Southern Nevada Health District, identify and engage clients during their time in jail and link them to appropriate community and jail-based services. Clients work with trained care coordinators to plan for life when they return to the community, a time when they may be especially at risk for unstable housing, lack of healthcare, lack of social support, and an exacerbation of mental health conditions. Whereas jail stays may be often brief and discharge dates sometimes uncertain, programs can meet changing needs most effectively when they have a strong partner network and institutional support already in place.

CONTRIBUTORS

Experts from the Southern Nevada Health District interviewed for this spotlight include:

- Elizabeth Adelman, Project Manager
- Kathryn Barker, Principal Investigator

Care coordinators follow clients for a maximum of four months' post incarceration. During this time, they help clients reconnect with community HIV primary care, address challenges such housing insecurity, lack of transportation, and finding a job. They may also schedule medical appointments and attend visits upon request. Finally, they connect clients with HIV case managers who can provide longer term support.

CHALLENGE

The Southern Nevada Health District identified several barriers affecting their intervention. Many of their clients report substance use disorders, in particular, methamphetamine addiction. As a result of their felony convictions, clients may not qualify for some community services, limiting options among already strained resources. Often their clients cannot return to the communities where they lived prior to incarceration, and many lack transportation to attend healthcare appointments. Consequently, the majority of their clients are transient, living in poverty, or chronically homeless.

Homelessness presents unique challenges in the desert climate of Southern Nevada. Some clients seek shelter outside of the city in remote areas that are difficult to locate. Other clients may move underground, creating makeshift encampments in rain tunnels underneath the Las Vegas strip. For someone seeking shelter, the tunnels appear to offer a cool, secure, and shaded environment, but they are extremely dangerous.

During a storm, the tunnels divert water away from the city creating flash floods that could drown or seriously injure someone residing inside. Even during dry weather, the tunnels capture standing water that may contain pathogens and environmental pollutants. Such harsh and unsanitary conditions are especially perilous for someone living with HIV. It also makes finding clients extremely challenging for care coordinators and other outreach workers.

KEY TIPS & TAKEAWAYS

- *Go where the clients are.* For the Southern Nevada Health District, their clients are often found in tunnels under Las Vegas or encampments in the desert. Even if it's an unconventional area, meet your clients where they live.
- *If you can't offer a service, meet that need through a community partnership.* The health district couldn't directly offer transportation to clients, so they worked with a community partner who uses Uber Health to arrange rides to medical appointments.
- *Recognize the importance of identification.* It is nearly impossible to qualify for social support services without identification—something all too common for those coming out of corrections and struggling with homelessness. The Southern Nevada Health District participates in the Clarity Card program, which provides ID cards to that can be used to access food, shelter, and other community services.
- *Meet face-to-face when possible.* In-person meetings offer opportunities for collaboration and resource sharing. This intervention used roundtable discussions to maintain momentum and commitment among partners.
- *Consider alternatives to incarceration.* Through the use of court advocates and strong relationships with the Clark County Detention Center, care coordinators could identify candidates who may otherwise have been overlooked for alternatives to incarceration.

STRATEGY/ACTIVITIES

Adapt to Circumstances
Leverage existing knowledge and experience.

Staff from TCC Program first sought mentorship and training from their colleagues in the health district's disease investigation unit. Disease investigators are trained to find people and share sensitive information like positive test results for sexually transmitted infections. Their skills, experience, and familiarity with the city's underground tunnels provided a valuable in-house consultancy.

The TCC Program also partners with a non-profit group called Help of Southern Nevada that works with the area's homeless community. The organizations have a Memorandum of Understanding (MOU), which allows them to share basic client information. Outreach workers with Help of Southern Nevada often know clients who are lost to follow-up and can recognize them during tunnel walkthroughs. Their regular on-the-ground presence and a non-judgmental approach has earned trust among the area's homeless community. They provide a critical link to connect clients with TCC care coordinators.

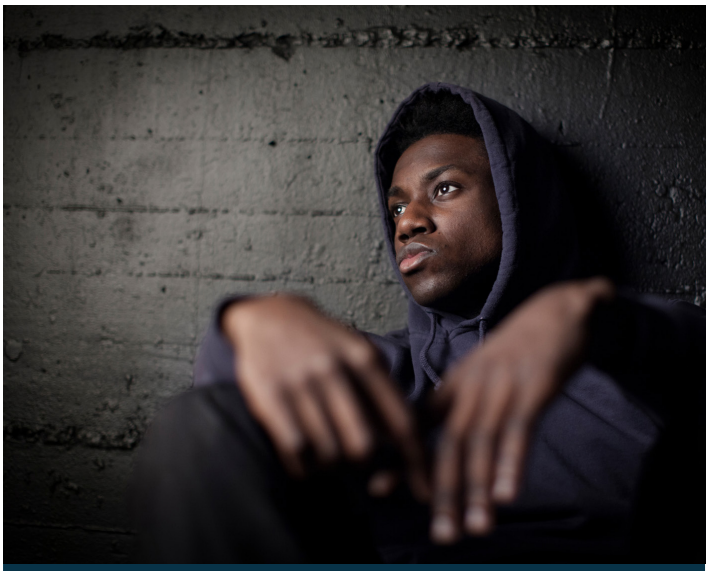
Workers from Help of Southern of Nevada also model the client-centered approach that has become the hallmark of this intervention. Care coordinators first meet their clients at the Clark County Detention Center and have time to build trust before they return to the community. Care coordinators also emphasize harm reduction and a willingness to support clients without expectations. "It's not about trying to push them into something they don't want", explains Elizabeth Adelman of the Southern Nevada Health District. Care coordinators do not force housing or drug treatment but are ready to assist when clients are ready.

The primary goal is "trying to at least get them stabilized with care", says Elizabeth Adelman. "That's where they choose to be in the tunnel, but how can we get them to the medical appointment?"

Improve identification and tracking.

Medical providers, like many community organizations, frequently require some form of identification to access services. People who are homeless or just leaving jail often lack these documents. The Clarity Card solves this problem. It serves as a valid form of identification for people who are homeless or living in poverty and need the support of food banks, housing programs, and other community services. Clarity Cards do not replace an official government ID, but they do fill a critical gap for clients seeking assistance with immediate survival needs.

The Clarity Card also establishes a client's identity in a central tracking system known as the Homeless Management Information System (HMIS). This system records demographic data and qualitative details, like which tunnels clients use or where they go for meals. The Clarity Card and HMIS connect all agencies in Southern Nevada who assist homeless clients. Care coordinators can log into HMIS, search for clients' names, and view where they used their Clarity Cards. Care coordinators can then contact those agencies and ask for additional details to help them locate clients.



"That's where they choose to be in the tunnel, but how can we get them to the medical appointment?"

Engage a wide range of community partners.

The Clarity Card and HMIS exemplify the Southern Nevada Health District's strong community partnerships. Early on, they researched local groups that could lower barriers for clients seeking to engage or reengage in HIV care. One partner, for example, offers employment assistance and training. Another connects people with housing. The health department signed MOUs with several partners and can now make referrals based on their clients' needs.

The health district also knew their partners had more to offer than just contractual relationships. From the beginning, they sought in-person feedback and collaboration. They host regular roundtable discussions to maintain the project's momentum and their partners' engagement. Their first meeting included an overview of the TCC model and its history as a HRSA funded intervention. This background offered partners the broader context for their contributions. Today, roundtable discussions focus on how to improve outcomes for their shared client population, conversations made livelier and more dynamic because of its in-person format.

While the TCC program enjoys strong support, some community providers expressed worry about working with clients who they perceived as challenging. In addition, some programs have strict eligibility requirements that would disqualify anyone with a criminal record. Staff from the TCC program addressed this feedback with honest conversations. They acknowledged their partners' concerns and affirmed that clients can present with difficult behaviors and circumstances. Being honest and non-judgmental nurtured relationships and improved collaboration.

Look for unique partner resources.

Strong partnerships offered the health district an innovative solution to a persistent barrier to care. Even clients with housing often lack transportation to attend healthcare appointments. Through this intervention, the Southern Nevada Health District now collaborates with a partner who uses Uber Health to schedule pick up and return rides for medical visits. Uber Health is a HIPAA (Health Insurance Portability and Accountability Act) compliant service that allows organizations to arrange rides using a web-based scheduling platform. The cost is equivalent to most Uber rides, and often less expensive than maintaining an in-house transportation program.

The partner organization schedules the rides through their account. Clients receiving rides do not need a smart phone, but they must provide a phone number to confirm their location and time of pick up. (Another

community partner helps with phones to minimize this barrier.) The Uber Health website can track when clients were picked up and delivered to their appointments. The partner organization then shares the information with TCC care coordinators. Uber Health has reduced the rate of missed appointments and improved customer service. Clients have expressed great enthusiasm and appreciation for Uber Health rides.

Advance jail-based services.

In addition to community partners, the TCC program formed strong relationships within the Clark County Detention Center. Care coordinators work with the public defender's office to connect the health department with the court system. They meet with jail leadership, collaborate with medical staff, and when appropriate attend court dates with their clients. Care coordinators emphasize the need to respect jail leadership and acknowledge they are visiting workers in a unique and highly structured environment.

At the beginning of the intervention, the health district leadership met with decision-makers at the jail and allowed them to introduce the TCC Program to their staff. When discussing the program, the health district shared outcomes from other successful interventions and highlighted data that would be compelling to jail leadership, such as fewer emergency room visits, reduction of recidivism, and demonstrable cost savings. As the TCC program has matured, care coordinators maintain strong relationships by staying respectful, sharing data, and facilitating the use of alternatives to incarceration for eligible clients.

Often known as "drug courts", alternatives to incarceration provides a multi-discipline approach to assist clients with substance abuse disorders. The program is effective, but the need often outstrips the judicial system's resources to identify and enroll appropriate candidates. TCC care coordinators realized they were in a unique position to identify candidates that might otherwise be overlooked.

With support from jail leadership, they now assist judicial social workers with making referrals to the program. They also use a detailed transitional care plan to support requests. A judge may respond more favorably if applicants can demonstrate an existing plan for housing and medical care upon release from jail. The health district's participation in alternative incarceration is a direct outgrowth of their ability to embed in the jail, create relationships, and demonstrate the value of transitional care coordination.

Currently, the TCC program is working on an initiative that would require applicants for alternative to incarceration to complete training in opioid overdose reversal. This training would also be available to friends and family of applicants. The program is still in development, but it exemplifies the possibilities that can occur when the health department and judiciary have positive working relationships.

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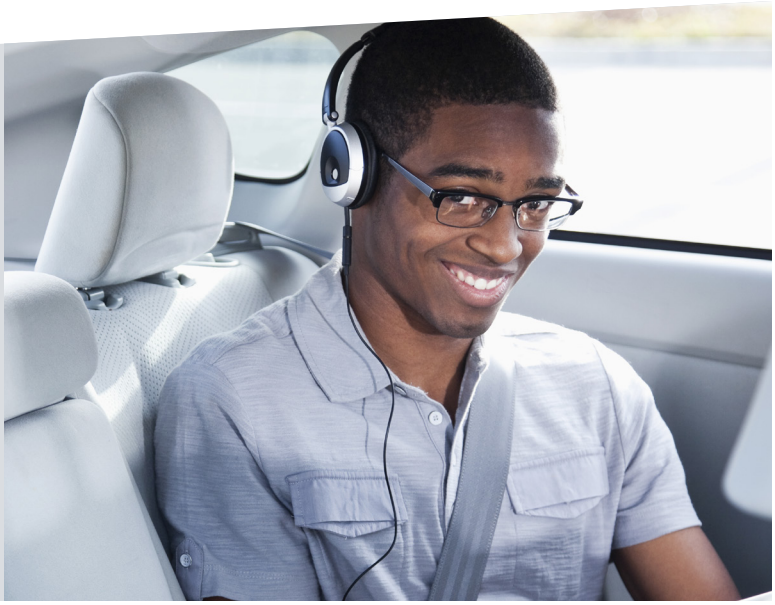


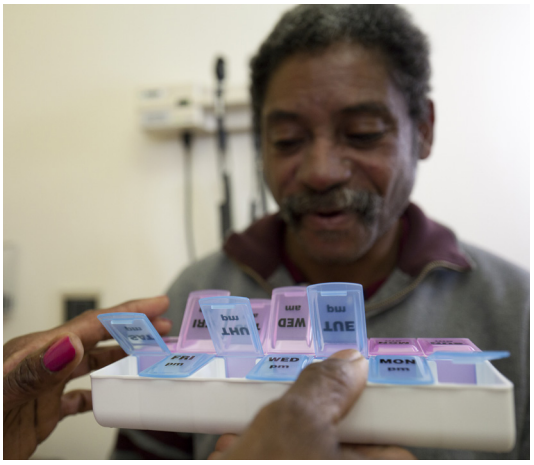
EARLY IMPACT

The Southern Nevada Health District Transitional Care Program is ongoing, but early qualitative reports suggest it has made a positive impact for clients and staff. Program staff report that the TCC model has expanded their toolbox and given them a tested intervention to implement with confidence. They also stress the importance of having dedicated and well-trained staff with knowledge and experience with the target population.

Participating in this Dissemination of Evidence-Informed Interventions funded project has increased their staff's training opportunities and refined their professional skills. They have connected with other intervention sites to share strategies for enhancing services. They also have access to experts in the field for consultation and mentoring. They point to Boston University, AIDS United, and HRSA as being particularly helpful.

Care coordinators also share they often get heartfelt emails, phone calls, and letters from grateful clients. Clients express appreciation that someone helped them have a second chance to improve their health and quality of life. **"It's always rewarding and exciting when we get to know our clients,"** explains Kathryn Barker, Principal Investigator. "We know their needs and how difficult their situations are . . . and then we see them not just making it to their appointments, but getting healthy, getting a job."

Seeing the changes in clients' lives can be a profoundly moving experience for the program's staff. **"Believing in someone while they're in jail, in a situation where not a lot of people are believing in them or giving them a second chance,"** says Kathryn Barker, "and going in there and turning things around . . . I would say that is huge."



FIND OUT MORE

To learn more about the initiative and access additional project resources, visit:
https://nextlevel.targethiv.org

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