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

Dissemination of Evidence Informed Interventions
Boston University School of Public Health
AIDS United
Health Resources and Services Administration (HRSA) Special Programs of National Significance
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Background

The central aim of the Transitional Care Coordination (TCC) intervention is to facilitate the linkage of a client living with HIV to community-based HIV primary care and treatment services after incarceration. Intervention activities include identifying and engaging people living with HIV (PLWH) during their jail stay, identifying “right fit” community resources, developing a client plan for their time during and post-incarceration, and coordinating activities needed to facilitate linkage to care after incarceration. These activities need to be initiated in the jail soon after an individual is incarcerated (ideally within 48 hours) because jail stays are often brief and the uncertainty around discharge dates and times presents a shorter window of opportunity to provide intervention services.

There are three main resources that will facilitate a successful implementation of this intervention. The Implementation and Technical Assistance Center (ITAC) at AIDS United, the Dissemination and Evaluation Center (DEC) at Boston University, and the Health Resources and Services Administration (HRSA) have collaborated to create the following:

1. Training Manual
2. Implementation Manual
3. Evaluation Protocol

This Implementation Manual is the road map for the implementation process. It follows the intervention’s logic model (Appendix A) and 3 year work plan (Appendix C). This manual complements the training provided by the ITAC, and is not meant to serve as a substitution for any training components provided by the ITAC. If your site feels as though it needs additional training on any of the content or activities addressed in this manual, contact the ITAC:

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All evaluation activities, protocols, and tools are included in the evaluation protocol. For all evaluation related questions or technical assistance needs, contact the DEC:

- Jane Fox
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- Alexis Marbach
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Pre-implementation activities

The following are programmatic requirements that need to be addressed prior to implementation of intervention activities and client enrollment, and will be handled by clinic administration (in conjunction with intervention team once hired or identified) unless otherwise noted.

☑️ Strengthen relationships with jail leadership (local jail, sheriff’s office, and/or other entity overseeing jail system) to ensure ongoing cooperation and support throughout implementation. During this relationship building process, clinic administration and jail leadership will address the following logistical issues that may impact implementation of intervention activities:

- Access to necessary office equipment and materials.
- Appropriate work space to conduct intervention activities within the jail while maintaining client confidentiality.
- A process for providing client participation incentives (i.e. putting funds in commissary accountant for select items).
- Access to a telephone for case conferences with community-based organizations and the client during the client’s jail stay (to facilitate a warm transition).

☑️ Formalize logistical commitments and develop mutual Memorandum of Understanding (MOU) Linkage Agreement with the jail. This MOU will include:

- Explicit permission to conduct intervention activities as outlined in this manual.
- A commitment to provide intervention staff with access to the jail-based record system(s) to monitor client transfers and client health information.
- A commitment to provide access and security training for jail-based intervention staff.
- A commitment for correctional officers to provide escort services (i.e. dedicated jail security staff and correctional officers are assigned to partner with the intervention team).
- A commitment for the jail to provide the clinic administration and the intervention staff an annual jail-specific security briefing.
- A list of the materials and resources that are or are not permissible within the jail and adapt the implementation of intervention activities accordingly (for example, some jails do not allow laptops inside).
- Data on the average length of stay and what percent of those admitted are released within 72 hours and within a week.
  - During the process of developing the MOU, the jail should also provide information on the facility’s release plan (the time of day when people are typically released, if people are provided with an ID upon release, if the facility provides transportation upon release, etc.). This information will help inform work done to prepare a client for release.

☑️ Assess existing jail-based health services.

- Determine if jail-based medical health screenings, mental health screenings, and physical exams, (including voluntary universal offer of a rapid HIV test and ART) are provided in accord with CDC recommendations (http://www.cdc.gov/hiv/pdf/risk_correctional_settings_guidelines.pdf).
- Determine who is providing the medical and mental health services.
- Determine how HIV care is managed (i.e. if there is a jail-based medical provider or an outside contractor that is brought in to manage HIV care).
- Determine how the care coordinator will gain access to medical records both during and after incarceration.

☑ Conduct a jail workflow analysis.
  - Walk through the health services unit and other relevant spaces to learn where services are delivered and identify space that will work for delivering the intervention and the evaluation activities.
  - Consider intervention's impact on jail processes (i.e., the potential need for additional consent forms, prescreening procedures, and escort restrictions) and address any impacts the intervention may have on existing jail processes with jail leadership.
  - Assess medication distribution methods.

☑ Assess points of integration between intervention activities and the local HIV continuum of care.
  - Identify existing jail, transitional and community programs and policies that could dovetail with or impact implementation of National HIV Strategy, local health agency policies and practices, corrections’ security protocols, corrections’ access, national and local substance use and mental health care policies ongoing thereafter (i.e. with introduction of new programs).
  - Assess the jail’s existing relationships with community health service systems (providers of health care, housing, treatment and other social services).
  - Identify potential areas where service delivery could be streamlined or strengthened.

☑ Strengthen relationships with community partners and referral resources.
  - Assess organizational capacity within community partnerships to accept clients referred through this intervention (i.e. the number of clients they can work with at any given time, any restrictions on the clients that they are able to work with).
  - Determine which community partners are able to provide consistent transitional care and social supports that demonstrate cultural sensitivity and trauma informed care.
  - Determine number of referrals the partner can reasonably accept into their program and within what timeframe.
  - Establish protocols defining roles and responsibilities for staff at community partner settings and intervention team members related to working with clients referred through this intervention.
  - Establish protocols for ongoing communication between staff and community-based service providers regarding intervention operations and expectations for documenting linkages to and maintenance in care.
  - Establish data sharing protocols to facilitate continuity of care and data sharing agreements across community partner organizations.
  - Formalize logistical commitments and develop mutual Memoranda of Understanding (MOU) including Linkage / Data Sharing Agreement with each community partner that includes a commitment to provide access for jail-based staff (care coordinator and data manager) to data that verifies linkage to care (see sample attached).
  - Streamline the process for coordination among service providers to avoid duplication or omission of service provision to each client (to remain consistent with the client’s transitional care plan).
  - Organize a quarterly meeting between community partners and referral resources to continue throughout the intervention.
Hire or identify intervention staff members.
- Post job descriptions, interview candidates, and hire staff (utilizing job descriptions in Appendix B) for the following positions on the intervention team:
  - Project Manager
  - Care Coordinators
  - Data Manager
- Identify clinical supervisor: clinical supervisor to be identified from within existing resources, as an external consultant, or added to job description of Project Manager if the person identified to fill that role has the necessary skills and qualifications.

Train staff members on intervention principles, intervention activities, and evaluation protocols.
- The ITAC will provide training on how to implement the intervention. The ITAC will work with the clinic administration to train interventionists and cross train back-up staff. Clinic administration will arrange for back up staff to cover duties of interventionists due to absences. These trainings will occur prior to implementation and as new staff come on board (or in the event of staff turnover).
- The DEC will provide training on conducting evaluation activities. All intervention team members will participate in training provided by the DEC.

Develop and document the protocol to identify eligible clients.
- The protocol will specify that eligible clients will be seen in the jail within 48 hours after the jail health service process for determining HIV status.
- Inclusion criteria:
  - HIV/AIDS diagnosis - Acceptable documentation of HIV infection includes:
    - Positive HIV antibody test results
    - Documentation of detectable HIV viral load results
    - Physician (M.D., N.P., P.A.) signed/written statements/progress notes
    - Photocopy of enrollment card for the AIDS Drug Assistance Program (ADAP)
    - Photocopy of enrollment card for an HIV Specialty Care program
    - Other medical form documenting HIV status.
    - Client Self-report (due to the transient nature of the client population, services are initiated pending HIV/AIDS diagnosis documentation.)
  - Client is incarcerated in a local jail
  - Client is 18 years or older
- Exclusion criteria:
  - Individuals who do not have an HIV/AIDS diagnosis.
  - Individuals who are no longer incarcerated (and did not start intervention activities prior to release).

Develop a grievance procedure: The grievance procedure provides a structured process through which clients can report problems in accessing or receiving services with documented acknowledgement of receipt. The procedure will include information on how to file agency-level grievances to funders including if the client’s complaint cannot be resolved. Filed agency grievances must be maintained by Project Manager and available for audit and must include problem presentation, issue resolution, and evaluation of client satisfaction.
Develop a health liaison to the court procedure (sample provided in Appendix F):

- Identify existing court advocacy programs and current processes for arranging Alternative to Incarceration (ATI) services, jail diversion, and compassionate release.
- Develop procedures for integrating health liaison to the courts with existing practices.
- Develop mutual Memorandum of Understanding (MOU) Linkage Agreement with each justice system partner including Treatment Accountably for Safer Communities (TASC), defenders, prosecutors and courts.

Obtain necessary materials to conduct intervention activities.

- Ordering and obtaining personal care items, commissary incentives, gift cards, public transit tokens/cards.
- Prepare any necessary client education materials (including information on community resources).

Prepare to conduct evaluation activities.

- The clinic administration will work with the intervention team to obtain Institutional Review Board Sub-Part C (IRB approval). Intervention team members will need to complete the Human Subjects Training (if they have not already done so).

The intervention team will schedule regular meetings with the ITAC and the DEC (ongoing throughout the funding period).
Supervision activities
Implementation activities related to supervision include:

☑️ The project manager will provide weekly administrative supervision of the care coordinators and the data manager.

☑️ The clinical supervisor will provide 1 hour, monthly clinical supervision of the care coordinators and monthly group supervision as needed.

☑️ The intervention team will participate in weekly case conferencing meetings to provide an opportunity to discuss pertinent individual, intervention, and systems issues. These meeting agendas may address discharge planning status, referral outcomes for all persons connected to care post-incarceration, agency updates, best practices, expectations of leadership, training collaborations, funding opportunities, unnecessary emergency department visits or hospitalizations, and client clinical health outcomes.
Intervention Implementation Activities: Workflow

The following are ongoing activities that happen throughout the client’s time in jail:
- CC updates post-release linkage appointment if necessary
- CC provides education, advocacy, and support service (specific to client needs and client release date)
- CC collaborates with client to update TCP
- CC prepares client for linkage activities post-release and supports clients with any meeting any

After the client is released:
- CC works to link the client to HIV primary care within 48 hours of release
- Client links to care
- Client does not link to care
- CC provides emotional and practical support, connects client to community resources for 90 days post-release (continually updating TCP)
- CC works to connect the client to care for up to 90 days post-release

After 90 days, the CC, client, and case manager at local clinic determine if the client is ready to transition to the standard of care (or more intensive services if appropriate)
**Intervention Implementation Activities: Core Elements**

The aim of this intervention is to establish a linkage program for PLWH to support their engagement in HIV primary care and necessary support services post-incarceration and as they re-enter the community.

The core elements of the intervention that cannot be modified, adapted, or changed are:

<table>
<thead>
<tr>
<th>Core Element</th>
<th>Evidence that the core element was implemented with fidelity to the model (covered in the training manual)</th>
<th>Data collection method (covered in the evaluation manual)</th>
</tr>
</thead>
</table>
| Care coordinator (CC) initiates contact with eligible potential clients in jail. | Intake form and client assessment completed  
CC demonstrates ability to leave space for questions and answer questions appropriately  
CC demonstrates familiarity with and comfort when working in a jail setting.  
CC asserts timeline of the intervention, the role of the CC, and the goals of the intervention  
CC discusses the “warm transition” and answers any questions that the client may have about linkage or re-entry  
CC addresses client-identified immediate needs | • Intake Assessment  
• CC reflects on their interactions with clients |
| CC creates a transitional care plan alongside the client (ideally during the initial jail contact) | CC collaboratively creates a plan that addresses client-identified immediate needs and client-identified barriers to accessing care after incarceration (prioritizing patient goals)  
CC uses open-ended questions, affirmations, reflections, summaries, active listening, non-judgmental responses  
CC assesses client confidence to take the steps needed to meet the goals outlined in the TCP plan post-incarceration  
CC will use Motivational Interviewing techniques and principles of trauma-informed care when creating the TCP with the client. | • Transitional Care Plan  
• Supervisor monitoring report |
<table>
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<tr>
<th>Client experiences a warm transition from incarceration to release in the community, and client links to HIV primary care</th>
<th>CC sets up a linkage to care appointment for the client, and accompanies client to the provider. CC assists in troubleshooting any potential barriers to attendance at first appointment (such as transportation). CC prepares a client for release by jail / court authorities to the community.</th>
</tr>
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<tr>
<td>CC offers appropriate follow up during the 90 days after the client has been released.</td>
<td>CC demonstrates understanding of community resources and various providers CC is willing to meet the client in a location that works for the client CC is flexible and responsive to client needs CC encourages client to stay engaged in their HIV primary care CC encourages client to adhere to ART and other treatment regimens CC uses open-ended questions, affirmations, reflections, summaries, active listening, non-judgmental responses CC supports client decision making CC supports client in adhering to any conditions of parole/probation including (with client permission) communication with parole/probation officer</td>
</tr>
<tr>
<td>Client is transitioned to the standard of care after 90 days post-incarceration</td>
<td>CC, case manager, and client are all present at the transition meeting and together review the TCP. TCP is then passed to case manager to help support their efforts. CC facilitates a caring and compassionate transition to case manager at a community-based agency Role of CC and role of case manager discussed with client Client’s ongoing barriers to care and struggles raised with case manager</td>
</tr>
</tbody>
</table>

- Project Manager observation
- Transitional Care Plan
- Linkage to care

- Encounter form
- Interventionist reflection on interaction with clients

- Audio recording
- Project Manager observation
- Updated TCP
- Encounter form
Intervention Implementation Activities: Initiating TCC while the client is incarcerated

The following intervention activities take place while the client is incarcerated:

☑ The project manager identifies eligible potential clients using the protocol developed in the pre-implementation phase. In the first three months of the intervention, the existing client roster will be reviewed to determine who may have been admitted to the jail prior to the start of intervention activities. The project manager will identify eligible clients from this existing list of incarcerated individuals. The project manager will review active incarceration rosters throughout the intervention to make sure all eligible potential clients have been asked if they would like to receive the intervention at least twice.

☑ The project manager assigns eligible potential clients to a care coordinator.

☑ The care coordinator contacts the potential client and meets one on one with the individual in jail in locations such as housing area day rooms or jail health clinic (typically, within 24 hours and at least within 48 hours of medical intake).

☑ Once the care coordinator has connected with the individual, the care coordinator will explain the intervention including their role as the care coordinator, the goal of linking the client to HIV primary care after incarceration, the transition between the care coordinator and the case manager post-incarceration, and the timeline of the intervention. At this point, the individual is referred to as a client.

☑ The care coordinator will complete an intake and assessment with all clients who are interested in participating in the intervention within 48 hours of the client’s incarceration (see Appendix D for the intake form). Any information from secondary sources (i.e. EMR or other health record) will be discussed and confirmed with the client and modified as needed. In the intake and assessment process, the care coordinator will:
  - Obtain HIPAA consent to coordinate care with other service providers, the defense attorney, and family members (as appropriate).
  - Determine the client’s presenting problem, substance use history, medical history, educational experience, vocational experience, and legal history.
  - Assess recent living arrangements, past utilization of services, mental health service needs, and any other service needs.
  - Determine health insurance status and prepare and submit health insurance or ADAP application if necessary.
  - Determine eligibility for other entitlement programs and complete applications as available and practicable (i.e. Supplemental Nutrition Assistance Program).
  - Determine any needs related to child care (custody support or issues related to freezing child support payments during incarceration).
  - Determine client interest in, and eligibility for, court advocacy and/or compassionate release:
    ▪ Determine if client meets criteria for an Alternative to Incarceration (ATI) program, placement in substance use treatment program, assistance in
restoration of parole terms and conditions as an Alternative to Sentencing (ATS) or skilled nursing care with or without hospice care.

- Notify Project Manager: The Project Manager will contact defense attorney before engaging in discussions with court advocates and/or ATI/ATS programs. Reminder: Ensure client HIPAA consent is obtained for all entities prior to contact (i.e., defense attorney, justices, prosecutors, and substance use, ATI/S programs).

Note: For clients that have been rearrested, and are still in the window for 90 day follow up after incarceration, the care coordinator will update the original needs assessment and care plan based on the client’s progress and continued goals, and update HIPAA consent forms consistent with regulations. If the case was closed, a new Intake & Assessment and consent forms are to be completed.

- The care coordinator will develop a Transitional Care Plan (TCP) within 48 hours of incarceration and immediately after completing the intake and assessment, ideally during the same session wherever practicable (a sample Appendix E). The TCP is based on the client assessment.
  - The care coordinator will create a two-pronged plan: one for the projected release date and a contingency plan in case the client is unexpectedly released to the community before the next session.
  - The care coordinator will identify community resources and schedule appointments or arrange walk-in visits with community health and social services providers as appropriate.
  - The care coordinator will contact community partners to alert them to any pressing client needs upon release.
  - The care coordinator will provide client with a copy of the TCP and his/her contact information. At each subsequent encounter with the client in the jail the care coordinator will review the TCP and revise as necessary. Every time the TCP is updated, the care coordinator will provide an updated version to the client.
  - The care coordinator will conduct follow-up sessions in jail to update TCP:
    - When changes are made to planned release date
    - prior to next court date
    - after return from court
    - 30 days prior to release (if possible)
    - after lab results with latest CD4/vL are received from jail-based clinic
    - as needed (i.e. expiration of HIPAA consent, client request).

- The care coordinator will explain the multi-site evaluation to the client and ask the client if s/he wants to participate in the multi-site evaluation.
  - If the client wants to participate in the multi-site evaluation, the care coordinator will make an appointment for the client to meet with the data manager who will enroll them into the multi-site evaluation. The meeting with the data manager should ideally occur on that day. If this is not possible, the meeting between the data manager and the client must occur within seven days from the initial meeting between the care coordinator and the client.
    - If the client wants to participate in the multi-site evaluation, the data manager will obtain consent from the client into the evaluation and administer the
baseline survey (the data manager should refer to the evaluation protocol for specific instructions on administering the baseline survey).

- The data manager will explain the process for withdrawing from the intervention and/or the evaluation:
  - If the client chooses to withdraw from multi-site evaluation: The client has to tell a staff member. That staff member will inform the data manager and the care coordinator. The client can still be enrolled in the intervention after discontinuing engagement in the multi-site evaluation.
  - If the client chooses to withdraw from the intervention: The client can tell a staff member and the staff member must then inform the care coordinator. The client can still be enrolled in the multi-site evaluation even after discontinuing engagement in the intervention, unless they withdraw from both.
- If the client decides that s/he does not want to participate in the multi-site evaluation, the care coordinator will explain his/her options for care. The care coordinator will complete the form documenting the client’s stated reason(s) for declining participation and document what care the client ultimately chooses receive.
  - Raw, individual client level data from clients who decline to be a part of the multi-site evaluation will not be submitted to the DEC (only aggregate data will be reviewed).

Based on the client’s planned release date, the care coordinator will make an HIV primary care appointment within 48 hours of the client’s planned release. At this session or other subsequent sessions, as appropriate to meet client’s needs, the care coordinator will contact the case manager at the clinic or community-based agency that will provide case management and arrange for that case manager to come to the primary care appointment or other location to facilitate relationship building and answer any questions about the planned transition to case management over the next 90 days.

The care coordinator will conduct ongoing activities (depending on the client’s length of incarceration) while the client is incarcerated including:
- Communicate with the client weekly during the first 30 days of incarceration, at least monthly thereafter, at least once during the 24-48 hours before and 24-48 hours after each court appearance, the week before any projected release date, on client request (i.e. through sick call), any time changes are needed to the TCP (including legal circumstances or health status), and as warranted by medical / treatment issues including changes in blood work.
- Provide 3 health education sessions using the curriculum outlined in Appendix I. Depending on the client’s release date, the care coordinator may conduct some of these health education sessions in jail, and then the remainder after incarceration in the community.
- Provide ART support and counseling: All HIV clients previously receiving antiretroviral therapy (ART) in the community will continue treatment in the jail. Newly diagnosed clients initiated on treatment are provided treatment adherence counseling during the jail stay.
  - For those who have not initiated ART, the care coordinator will ask clients if they have discussed ART with their Primary Care Provider (PCP). If a client has not had
that discussion, the coordinator will encourage clients to speak with jail health provider and/or community PCP about starting treatment and inquire about barriers and challenges to initiating ART (e.g. substance use or unstable housing). If additional barriers are identified, appropriate interventions and/or referrals for assistance should be implemented.

- At each subsequent encounter, the coordinator will follow-up with the client about whether or not they started ART and the outcome of any conversation with their health care provider. The provider should also follow up on any referrals addressing barriers to initiating treatment (such as a referral to a harm reduction or a housing program), at the next client encounter, if appropriate. These discussions, referrals and subsequent linkages are documented in the client record.

- Provide accompaniment from jail or court.

**Intervention Implementation Activities: Preparing a client for release**

In order to make the transition as seamless as possible, the care coordinator will:

- Arrange transportation or accompaniment from jail to the community. The care coordinator will coordinate jail release with corrections to facilitate transportation assistance and avoid releases during hours when public transit and transportation services are not available. If this is not possible, the care coordinator will provide viable transportation alternatives to the client prior to release.

- Assess and address client’s basic needs for food security, clothing appropriate for the weather at the time of release, and housing stability after incarceration.
  - Housing is an essential component of stability and safety post release. If a client does not have stable housing to return to post-incarceration, offer housing assistance and make arrangements for safe residence, food and clothing.
  - Consider HOPWA funded programs, supportive housing programs, residential treatment programs, and day treatment programs with housing components.
  - Contact family members to negotiate temporary shelter if viable.
  - If no viable alternatives are available, the last resource is to arrange for placement and/or accompaniment to community shelters or recovery houses.

- Provide client with a list of community resources and a number (preferably toll-free) to call if they encounter challenges.

- Determine if the client will be released with medication in hand and facilitate continuity of medication.
  - The care coordinator arranges for “walking” medications and/or prescriptions (including ARV and medications used to manage physical and mental health conditions) with correctional health service at the point of release from incarceration to the community, including those released from jails and courts.
  - The care coordinator facilitates access to medical summary and other information needed by community providers, programs, and court advocates to facilitate placement in an ATI, ATS or other community program or nursing home or hospice care for those eligible.
☑ Provide TCP Summary and other needed medical documentation to courts, treatment programs, and primary care providers to facilitate continuity of care.

☑ Identify resources that the client may need to access immediately upon release and arrange for appointments for other services such as housing assistance, substance use treatment, mental health treatment, health insurance access case management, and/or other services as needed.
Intervention Implementation Activities: Post-incarceration linkage and follow up

- The care coordinator will accompany the client to his/her linkage to care appointment within 48 hours of release.
  - Acceptable RW documentation for linkage to care includes:
    - CD4 order, and/or result, from the agency to which the client was referred
    - Viral load order, and/or result, from the agency to which the client was referred
    - The word ‘HIV’ or ‘AIDS’ in the medical note in the context of the client’s diagnosed condition, from the agency to which the client was referred.
    - Orders and/or prescription for any ARV, from the agency to which the client was referred.
    - Letter, note or email from staff at the treating agency to which the client was referred, stating that the medical visit was HIV and/or AIDS-related
  - If the home is not a suitable location because of safety, disclosure concerns, or other obstacles, the accompaniment may originate at an alternative, mutually-agreed upon location in the community (e.g. somewhere the client hangs out, the client’s favorite park, or other set location near his or her home or work). Accompaniment is intended for PLWH who struggle with conventional treatment regimens and the intent is that staff provides social support and help the client connect to medical care in order to improve client health outcomes. Accompaniment may include:
    - Transportation assistance
    - Walking with the client to the appointment, waiting with the client until seen, and going with them on the return trip home
    - Emotional support during their medical visit

- The care coordinator will ask the client if the care coordinator can work with the client’s probation officer during the 90 day post-incarceration time period.

- The care coordinator will provide 90 days of follow up support services after the client has been released from jail based on the TCP, including:
  - Help filling out forms
  - Making referrals and appointments
  - Reminder calls/messages
  - Arranging for transportation, child care, interpreting services, and advocacy
  - Assistance with social services (included, but not limited to accessing food, clothing, and securing consistent housing)
  - Assistance with entitlements and benefits
  - Address any ongoing mental health and substance use disorder treatment needs
  - Assistance arranging consistent access to health insurance
  - Assistance arranging consistent access to medication

- The care coordinator will provide any of the remaining health education sessions that were not covered while the client was incarcerated.
The care coordinator will conduct outreach for ongoing client re-engagement. Regardless of activities conducted with or on behalf of a client, if the client misses an appointment or fails to adhere to any part of the TCP, the care coordinator is to conduct one or more of the following outreach activities with prior client consent and record up to one daily client re-engagement including:

For any individual who is not linked to care within 7 days after incarceration, the care coordinator will conduct outreach to reengage the client in HIV primary care in the community. Attempts are made for up to 90 days after client is released from incarceration and the case may be closed within 30 days after incarceration when there is no further information available to conduct outreach, confirmation of primary care, or up to 90 days after release to the community when viable avenues to locate the client are present. The following steps are taken to facilitate linkage to care:

- Telephone calls made to the client starting the day of the missed appointment.
- Checking in with social service providers where the client may receive services.
- Checking in with the client’s probation officer (with client consent).
- Community locations where the client may “hang out.”
- Letter to the client (not disclosing the client’s protected health information) after two sequential weeks of failed outreach by phone and home visit.
- Internet-based searching for persons whose address may have changed is warranted at any point where phone and field outreach do not result in contact with the client.
- A second, certified letter, specifying the client’s case may be closed after 90 days post-incarceration, is sent after two sequential months of failed outreach by phone and home visit.
- Home visits:
  - If individual is home: Staff attempt to engage client in care coordination to link or re-link person to care.
  - If no one is home, the care coordinator leaves a letter on agency letterhead with contact information at addresses visited.
  - If a collateral resource, such as family member is home and individual’s whereabouts are known the care coordinator provides a letter in a sealed envelope addressed to the client and/or obtains information to arrange next home visit. No information that might reveal a client’s HIV status should be left with anyone absent client consent.
    - For those where contact is made with the client or a collateral resource, such as family member or designated contact person, the care coordinator will continue to attempt to engage the client in care for 90 days post-incarceration.
  - For those where client is determined to be deceased, the case is closed.
  - For those where the contact is made with the client and the client refuses services, the case is closed.

If a client is released to a location outside of the care coordinator’s service area, or the conditions of the client’s probation restrict the client’s geographic mobility, the care coordinator will make the appropriate referrals or appointments to support the client’s linkage to HIV primary care. These referrals/appointments may require the care coordinator to contact agencies outside of their service area or find appropriate home visit teams.
Intervention Implementation Activities: Transitioning a client to the standard of care

- The case manager from the local community-based agency, client, and care coordinator will meet to transfer case management support ideally over a period of at least 4 weeks prior to the end of the 90 day post-incarceration period.

- At the end of the 90 days post-release, the case manager, client, and care coordinator will meet to officially transfer the client to the standard of care.

- The following are situations where the client would not be transferred to the standard of care:
  - Client requests or requires more intensive patient navigation or case management services. In the weeks leading up to the planned transition or during the transition meeting, the case manager, client, and care coordinator may determine that the standard of care is not the appropriate next step for the client. If this is the case, the case manager and the care coordinator will work to find the appropriate patient navigation or case management services to meet the client’s needs.
  - Client moved/relocated outside of service area.
  - Client sentenced and transferred to facility outside of jurisdiction.
  - Client requested transfer to another provider prior to the end of the 90 day post-incarceration follow-up period.
  - Client is in long-term care: Long term care may be considered linkage to care or institutional placement, depending on the setting. In any case, after 90 days in LTC, the case is closed.
  - Client who has not linked to care is re-incarcerated or institutionalized for a period greater than 90 days: Close each case when client not verified as linked to care is re-incarcerated for 90 days or more. A re-referral may then be made and a new case (re-assessment) may be started based on assigned jail and client consent.
  - If a client who has not linked to care is re-incarcerated or institutionalized for a period less than 90 days, continue to follow up in the community, attempting to link to care. If linkage to care is verified, 90 day post linkage to care milestone is needed.
  - Client lost to follow up/unsuccessful reengagement efforts.
  - Client withdraws from the intervention.
  - Client died.
Maintenance and Integration Activities
The following activities will be conducted by clinic administration and intervention staff:

☑ Maintain relationships with community partners and referral resources.
  • Update MOUs every two years.

☑ Re-assess points of integration with the local continuum of care and with the jail-based health services.
  • Identify amended / new jail, transitional and community programs and policies that could dovetail with / impact implementation.
  • Integrate changes to National HIV Strategy, local health agency policies and practices, corrections’ security protocols / access, national and local substance use policies, and additions of newly funded programs.

☑ Provide trainings to agency staff on the intervention, working with incarcerated individuals, and talking points for the intervention to spread awareness of the intervention throughout the community.

☑ Continue to recruit, hire, and train TCC interventionists to expand the program as appropriate.
Appendices:

Appendix A: Logic Model

<table>
<thead>
<tr>
<th>Resources</th>
<th>Activities</th>
<th>Outputs</th>
<th>Short Term Outcomes</th>
<th>Intermediate Outcomes</th>
<th>Long Term Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>• TCC Staff</td>
<td>• Pre-Implementation Activities</td>
<td>• # individuals identified as HIV+ in jail</td>
<td>• Increase in client:</td>
<td>• 75% of those who receive TCC services, are enrolled in the TCC MSE, and are released with a Transitional Care Plan, attend a HIV primary care appointment within one week of being released.</td>
<td>• Increase in client linkage to and long-term retention in care post release</td>
</tr>
<tr>
<td>• Project Manager</td>
<td>• Training: TCC Staff, jail staff, community partners</td>
<td>• # eligible individuals offered TCC services</td>
<td>• HIV knowledge</td>
<td>• Improvement in the following client outcomes:</td>
<td>• Improvement in the following client outcomes:</td>
</tr>
<tr>
<td>• 2 Care Coordinator</td>
<td>• Protocol and MOU development</td>
<td>• # individuals who accept TCC services</td>
<td>• Awareness of community resources and ways to access resources</td>
<td>• HIV viral load</td>
<td>• Housing stability and food security</td>
</tr>
<tr>
<td>• Data Manager</td>
<td>• Medical Intake conducted by the Jail</td>
<td>• # intakes</td>
<td>• Adherence to existing ARV prescription, for those prescribed ARV prior to incarceration</td>
<td>• Engagement in behavioral health treatment (Substance use disorder; Mental health)</td>
<td>• Increase in client satisfaction with care</td>
</tr>
<tr>
<td>• Community Health Centers</td>
<td>• Transitional Care Coordination: HIV testing</td>
<td>• # clients who have a TCP</td>
<td>• Adherence to new ARV prescription, for those not prescribed ARV prior to incarceration</td>
<td>• Linkage to care coordination for those identified as in need of social supports</td>
<td>• Linkage to care coordination for those identified as in need of social supports</td>
</tr>
<tr>
<td>• Community Partners (including substance abuse and mental health resources)</td>
<td>• Intake assessment</td>
<td>• # weekly encounters with clients</td>
<td>• # unsuccessful outreach attempts with clients</td>
<td>• Integration of the Transitional Care Coordination intervention into the clinic and jail setting</td>
<td></td>
</tr>
<tr>
<td>• Jail administration</td>
<td>• Development of Transitional Care Plan</td>
<td>• # clients released</td>
<td>• # verified linkages to primary HIV Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Assigned/dedicated officers</td>
<td>• Connecting clients with: Health insurance/ADAP, Discharge medications/prescription scripts, social services in the community (housing, food stamps, etc.)</td>
<td>• # Verified linkages to primary HIV Care</td>
<td>• # Placements in programs in lieu of incarceration through Health Liaison</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Dedicated space</td>
<td>• Health liaison activities</td>
<td>• # clients prescribed ART</td>
<td>• # clients prescribed ART</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Electronic health record/RW service data collection and reporting system</td>
<td>• 3 HIV education sessions</td>
<td>• # referrals made to community partners</td>
<td>• # referrals made to community partners</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Evaluation Support from the Dissemination and Evaluation (DEC) Team</td>
<td>• Post-incarceration linkage to care</td>
<td>• Linkage agreements in place with community providers</td>
<td>• Linkage agreements in place with community providers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Implementation Support from the Implementation Technical Assistance Team (ITAG).</td>
<td>• Post-incarceration follow-up and support in achieving goals outlined in the transitional care plan (90 days)</td>
<td>• # clients transitioned to the standard of care</td>
<td>• # clients transitioned to the standard of care</td>
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</tbody>
</table>
Appendix B: Staffing Plan and Job Descriptions

| Project Manager | The project manager coordinates all aspects of the intervention with jail and community-based staff and community partners. The project manager is responsible for:
|                 | • being the point of contact for the intervention and providing oversight of the project;  
|                 | • providing administrative supervision to the care coordinators and the data manager;  
|                 | • serving as the health liaison to the courts; and  
|                 | • serving as the liaison with local jail administration, the Dissemination and Evaluation Center (DEC), and the Implementation Technical Assistance Center (ITAC). |

| Care Coordinator | The care coordinator has five primary responsibilities: patient engagement, patient education, discharge planning, care coordination, and facilitating a warm transition to the community and linking a client to care.  
|                  | **Patient engagement during incarceration.** The care coordinator is responsible for:  
|                  | • client engagement and assessment during the client’s jail stay; and  
|                  | • conducting care coordination with jail- and community-based organizations.  
|                  | **Patient education.** The care coordinator is responsible for:  
|                  | • providing patient education on HIV, including treatment adherence, risk reduction as well as a range of other health-related topics (e.g. STI, hepatitis, and TB overviews; prevention strategies and safe sex negotiation; relapse prevention; symptoms evaluation, etc.).  
|                  | **Discharge planning.** The care coordinator is responsible for:  
|                  | • assessing client needs;  
|                  | • developing a plan with client to address basic needs;  
|                  | • identifying resources to facilitate access to community health care; and  
|                  | • scheduling initial linkage appointment.  
|                  | **Care coordination for care upon release.** The care coordinator is responsible for:  
|                  | • completing patient assessment and discharge plan to initiate the process of coordinating care upon release, meeting the person in jail and initiating follow-up to verify linkage to care after incarceration;  
|                  | • arranging discharge medications and prescriptions; and  
|                  | • obtaining consent to collaborate with external entities and individuals (e.g. community health providers, social service programs, courts).  
|                  | **Facilitating a warm transition to the community and linking a client to care.** The care coordinator is responsible for:  
|                  | • accompanying individuals who are newly released to appointments to ensure connection to care;  
|                  | • coordinating community-based HIV care linkage services;  
|                  | • providing home visits, appointment accompaniment, or transportation;  
|                  | • conducting, arranging, or coordinating outreach activities to find individuals who fall out of care and facilitate re-engagement in community care;  
|                  | • assessing and addressing basic needs like housing, food, clothing, etc.; and |
- transitioning the client to the standard of care after 90 days post-incarceration.

<table>
<thead>
<tr>
<th>Clinical Supervisor</th>
<th>The Clinical Supervisor is responsible for:</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>• Participating in case conferencing (as needed);</td>
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<tr>
<td></td>
<td>• Providing monthly (or as requested) individual clinical supervision to care coordinators; and</td>
</tr>
<tr>
<td></td>
<td>• Providing monthly group clinical supervision to intervention team (as needed)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Data Manager</th>
<th>The Data Manager is responsible for:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Consenting patients into the study;</td>
</tr>
<tr>
<td></td>
<td>• Collecting and submitting data required for multi-site evaluation;</td>
</tr>
<tr>
<td></td>
<td>• Coordinating the collection of patient surveys, encounter forms, basic chart data abstraction, and implementation measures, and reporting them to the Dissemination and Evaluation Center (DEC); and</td>
</tr>
<tr>
<td></td>
<td>• Providing quality assurance reports and updates to intervention team about study referrals, enrollment retention, etc.</td>
</tr>
</tbody>
</table>
**Project Manager**

**Job Description**

**Description of the Transitional Care Coordination**

The Transitional Care Coordination (TCC) model is responsible for supporting the continuity of healthcare for HIV positive incarcerated individuals using a nationally recognized public health model. The central aim of this model is to facilitate the linkage of a client living with HIV to community-based care and treatment services after incarceration. The Transitional Care Coordination intervention activities include identifying and engaging people living with HIV during the jail stay, identifying “right fit” community resources, developing a client plan for their time during and post-incarceration, and coordinating activities needed to facilitate linkage to care after incarceration. Service provision includes health education, discharge planning, and community collaborations to facilitate linkages to health care for those leaving jails. TCC works closely with the jail based health providers to facilitate continuity of care from intake jails to community health care.

**Purpose of Position**

The TCC Project Manager will report to either the Senior Director or Director and be responsible for oversight and provision of administrative services, program operations, quality assurance, facilitating best practices, supervision, reporting and monitoring of direct and contracted program services.

The Project Manager is responsible for:

- being the point of contact for the intervention and providing oversight of the project;
- providing administrative supervision to the care coordinators and the data manager;
- serving as the health liaison to the courts; and
- serving as the liaison with local jail administration, the Dissemination and Evaluation Center (DEC), and the Implementation Technical Assistance Center (ITAC).

**Key Responsibilities**

1. Works in a dynamic management team environment to build commitment to program goals and initiatives by working closely with all levels of staff.
2. Provides administrative supervision of the care coordinators and the data manager.
3. Interprets human resource policies and procedures and relays these to staff. Performs human resources related duties (e.g.: labor relations disciplinary actions, hiring packages, interviews).
4. Monitors office budget by tracking planned and actual encumbrances and ensuring adherence to grant funding regulations and deadlines.
5. Serves as a liaison between TCC and community partner organizations and maintains positive relationships and MOUs with community partners.
6. Supervises the generation of reports including summary of referrals made to community partner organizations and rate of linkages to care.
7. Conducts in-service training to the TCC team and other community-based providers.
8. Ensures TCC practices are consistent with the grant award, training manual, implementation manual, and evaluation protocols.
9. Participates in administrative staff meetings and attends other HR related meetings.
Qualifications/Requirements

- A Master’s Degree from an accredited college or university in Healthcare, Hospital, Public, or Business Administration, Industrial/Organizational Psychology, Organizational Behavior, or a related field.
- Three years of full-time experience planning, developing and monitoring programs, systems, and/or procedures in support of administrative management initiatives, two years of which must have been in a responsible managerial or supervisory capacity; or
- A Baccalaureate Degree from an accredited college or university in Healthcare, Hospital, Public, or Business Administration, Psychology or a related discipline.
- A satisfactory combination of education, training, and experience.

Preferred skills

- Comfortable working in a correctional setting.
- One or more years successfully supervising staff that operate in more than one settings (such as staff working within a jail facility and in a community office).
- Experience building relationships with stakeholders that represent varied interests (grant funders, community-based partners, etc.).
- Knowledge of community-based programs and providers in the local service area
- Bilingual as needed to serve client population.
- Knowledge of HIV, substance use disorders, mental health, the criminal justice system, and chronic care management.
Description of the Transitional Care Coordination model
The Transitional Care Coordination (TCC) model is responsible for supporting the continuity of healthcare for HIV positive incarcerated individuals using a nationally recognized public health model. The central aim of this model is to facilitate the linkage of a client living with HIV to community-based care and treatment services after incarceration. The Transitional Care Coordination intervention activities include identifying and engaging people living with HIV during the jail stay, identifying “right fit” community resources, developing a client plan for their time during and post-incarceration, and coordinating activities needed to facilitate linkage to care after incarceration. Service provision includes health education, discharge planning, and community collaborations to facilitate linkages to health care for those leaving jails. TCC works closely with the jail based health providers to facilitate continuity of care from intake jails to community health care.

Purpose of Position
The care coordinator provides health-related discharge planning and education to individuals and groups of those incarcerated in jails, facilitating linkages to health care and supportive services, and improving community health outcomes.

The care coordinator has five primary responsibilities: patient engagement, patient education, discharge planning, care coordination, and facilitating a warm transition to the community and linking a client to care.

Patient engagement during incarceration. The care coordinator is responsible for:
- client engagement and assessment during the client’s jail stay; and
- conducting care coordination with jail- and community-based organizations.

Patient education. The care coordinator is responsible for:
- providing patient education on HIV, including treatment adherence, risk reduction as well as a range of other health-related topics (e.g. STI, hepatitis, and TB overviews; prevention strategies and safe sex negotiation; relapse prevention; symptoms evaluation, etc.).

Discharge planning. The care coordinator is responsible for:
- assessing client needs;
- developing a plan with client to address basic needs;
- identifying resources to facilitate access to community health care; and
- scheduling initial linkage appointment.

Care coordination for care upon release. The care coordinator is responsible for:
- completing patient assessment and discharge plan to initiate the process of coordinating care upon release, meeting the person in jail and initiating follow-up to verify linkage to care after incarceration;
- arranging discharge medications and prescriptions; and
• obtaining consent to collaborate with external entities and individuals (e.g. community health providers, social service programs, courts).

Facilitating a warm transition to the community and linking a client to care. The care coordinator is responsible for:
• accompanying individuals who are newly released to appointments to ensure connection to care;
• coordinating community-based HIV care linkage services;
• providing home visits, appointment accompaniment, or transportation;
• conducting, arranging, or coordinating outreach activities to find individuals who fall out of care and facilitate re-engagement in community care;
• assessing and addressing basic needs like housing, food, clothing, etc.; and
• transitioning the client to the standard of care after 90 days post-incarceration.

Key Responsibilities
1. Meets with and interviews clients (HIV+ and other chronically ill inmates) and conducts a needs assessment and health education/counseling sessions, as needed).
2. Evaluates and makes recommendations regarding the counseling and discharge planning process with clients.
3. Provides direct counseling to clients with HIV/AIDS, substance abuse and other chronically related health conditions.
4. Identifies appropriate community-based service providers based on client’s needs.
5. Makes appointments and/or provides referral information for community-based providers.
6. Serves as a liaison between clients and community-based service providers.
7. Maintains client records and updates as needed.
8. Updates HIPAA consent forms and other documents in accordance with regulations.
9. Prepares pre-release documentation for clients with a known release date.
10. Maintains documentation of services provided and referrals made.
11. Monitors enrollment for Medicaid and other public health insurances, and medical discharge planning for people leaving jail requiring continued care, treatment and social services.
12. Conducts in-service training to the TCC team and other community-based providers.
13. Arranging transportation at the time of release from jail custody to an appointment in order to engage in HIV primary care or supportive services appointments.
14. Accompany clients to initial HIV primary care and subsequent supportive service appointments (if needed by the client).
15. Facilitate access to a variety of services including primary medical care, social services, housing, entitlements, and benefits. This may include assisting with any necessary paperwork, compiling eligibility documentation required by other service providers, and other tasks required to connect the client to needed services.
16. Provide care coordination services for clients through face-to-face interactions, and phone calls with the client’s medical provider and other service providers who are in the position to assist the client. Coordination of Care also includes case conferences with other internal or external care providers.
17. Conduct re-engagement efforts when clients miss medical appointments without prior notice to the medical provider or program staff. Re-engagement activities may be conducted via phone or in person visit to the client’s place of residence.
18. Provides administrative coverage in the absence of the project manager.
Qualifications/Requirements

- Ability to obtain correctional facility clearance and work within the constraints of facility guidelines which can include lock downs, screening of personal items including food and clothing restrictions, which can be changed at the discretion of the jail.
- High school diploma or GED/HSE required, some college preferred.
- Experience counseling HIV+ clients on connecting to available services. Experience working with the local criminal justice system and Department of Health and Mental Health.
- Experience supervising a team of staff.
- Well versed on community resources.
- Strong computer skills, and experience working with Microsoft Office and database entry.
- Strong oral and written communication skills.
- Bi-lingual as needed to serve the client population.

Preferred skills

- The TCC program encourages individuals to apply who have successfully made the transition from incarceration and/or substance abuse into a stable, productive lifestyle in the community. Please note that while we support “drop the box” employment practices, previous charges of arson, sexual assault, murder or possessing contraband, currently being on probation or parole, or having had contact with the criminal justice system in the last 2 years may disqualify individuals from receiving correctional facility clearance.

Physical demands

- To perform this job successfully, an individual must be able to perform each essential duty satisfactorily. The responsibilities and requirements listed are representative of the knowledge, skills, minimum education, training, licensing, experience and/or ability required. Reasonable accommodations may be made to enable intervals with disabilities to perform the essential functions of the job.
Clinical Supervisor
Job Description

Description of the Transitional Care Coordination
The Transitional Care Coordination (TCC) model is responsible for supporting the continuity of healthcare for HIV positive incarcerated individuals using a nationally recognized public health model. The central aim of this model is to facilitate the linkage of a client living with HIV to community-based care and treatment services after incarceration. The Transitional Care Coordination intervention activities include identifying and engaging people living with HIV during the jail stay, identifying “right fit” community resources, developing a client plan for their time during and post-incarceration, and coordinating activities needed to facilitate linkage to care after incarceration. Service provision includes health education, discharge planning, and community collaborations to facilitate linkages to health care for those leaving jails. TCC works closely with the jail based health providers to facilitate continuity of care from intake jails to community health care.

Purpose of the Position
The purpose of the Clinical Supervisor is to coordinate and provide clinical support to the intervention staff.

Key Responsibilities
1. Participate in case conferencing (as needed).
2. Conduct 1 hour, monthly, or as needed, individual clinical supervision with each care coordinator.
3. Conduct 1 hour, monthly group clinical supervision with the intervention team (as needed).

Qualifications/Requirements
- Licensed mental health clinician (e.g., licensed clinical social worker, psychologist, or psychiatrist).
- 2-4 years counseling or case management experience in assessing and managing the psychosocial needs of persons with HIV/AIDS.
- Experience in working with patients with complex and/or comorbid conditions, sexual and gender minorities, and communities of color.
- Knowledge of harm reduction philosophy, patient centered counseling, and motivational interviewing techniques.
- Excellent oral and written communication skills.
- Excellent interpersonal skills. Able to build relationships with individuals, groups, and organizations.
Data Manager

Job Description

Description of the Transitional Care Coordination
The Transitional Care Coordination (TCC) model is responsible for supporting the continuity of healthcare for HIV positive incarcerated individuals using a nationally recognized public health model. The central aim of this model is to facilitate the linkage of a client living with HIV to community-based care and treatment services after incarceration. The Transitional Care Coordination intervention activities include identifying and engaging people living with HIV during the jail stay, identifying “right fit” community resources, developing a client plan for their time during and post-incarceration, and coordinating activities needed to facilitate linkage to care after incarceration. Service provision includes health education, discharge planning, and community collaborations to facilitate linkages to health care for those leaving jails. TCC works closely with the jail based health providers to facilitate continuity of care from intake jails to community health care.

Purpose of the Position
The Data Manager is responsible for the overall coordination of the data collection and management for the Transitional Care Coordination intervention at the site level. The Data Manager will work with the Dissemination and Evaluation Center (DEC) at the Boston University School of Public Health to insure that data collection and management is consistent with the multi-site evaluation protocol.

Key Responsibilities
1. Consent patients into the study and track and manage follow up interviews.
2. Implement data collection procedures developed by the DEC.
3. Coordinate the collection of:
   a. Patient surveys
   b. Encounter forms
   c. Basic chart data abstraction
   d. Implementation measures
   e. Monthly eligible patient list
4. Review and monitor quality of the incoming data collection forms to ensure data are complete and consistent.
5. Ensure that all data collection and management activities are performed with the utmost attention to participant confidentiality, as well as HIPAA and IRB requirements.
6. Serve as a liaison between the DEC and clinic for all data collection and reporting.
7. Communicate problems with data collection and management to the DEC.
8. Participate in technical assistance and training sessions conducted by the DEC.

Qualifications/Requirements
- Knowledge of fundamental concepts of collecting and processing research data.
- Ability to communicate clearly and concisely, both verbally and in writing.
- Understanding of HIPAA and IRB requirements for health care research.
• Ability to manage competing priorities; willing and able to work flexible hours.
• Ability to work in a team as well as independently and to establish and maintain cooperative, supportive relationships with project staff.
• Experience with MS Office software (e.g. Access, Excel) is strongly preferred.
• Familiarity with basic computer programming and statistical software packages (SAS, Stata, SPSS) is preferred.
• Bachelor’s degree required.
## Appendix C: 3 Year Work Plan

<table>
<thead>
<tr>
<th>Goal</th>
<th>Action Steps</th>
<th>Project Staff Responsible</th>
<th>Post-notice of award</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Stage: Pre-implementation</strong></td>
<td></td>
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<tr>
<td>Conduct functional assessment and build external relationships</td>
<td>Strengthen relationships with jail leadership to ensure ongoing cooperation and support throughout implementation.</td>
<td>Clinic administration intervention team</td>
<td>X</td>
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<tr>
<td></td>
<td>Formalize logistical commitments and develop mutual memorandum of understanding (MOU) linkage agreement with the jail.</td>
<td>Clinic administration intervention team</td>
<td>X</td>
<td></td>
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<tr>
<td></td>
<td>Assess existing jail-based health services.</td>
<td>Clinic administration intervention team</td>
<td>X</td>
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<tr>
<td></td>
<td>Conduct jail workflow analysis</td>
<td>Clinic administration intervention team</td>
<td>X</td>
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<tr>
<td></td>
<td>Identify existing jail, transitional and community programs and policies that could dovetail with / impact implementation National HIV Strategy, local health agency policies and practices, corrections' security protocols / access, National and local substance use policies (ongoing thereafter (i.e. with introduction of new programs)).</td>
<td>Clinic administration intervention team</td>
<td>X</td>
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<tr>
<td></td>
<td>Strengthen relationships with community partners and referral resources.</td>
<td>Clinic administration intervention team</td>
<td>X</td>
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<tr>
<td>Hire or identify intervention team members</td>
<td>Hire or identify intervention team members (project manager, care coordinators, data manager)</td>
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<tr>
<td></td>
<td>Obtain clearance for hired jail-based staff to work in the jail setting (program manager, care coordinators, data manager)</td>
<td>Clinic administration intervention team</td>
<td>X</td>
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<tr>
<td></td>
<td>Participate in trainings provided by ITAC</td>
<td>Intervention team</td>
<td>X</td>
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<tr>
<td></td>
<td>Participate in trainings provided by DEC</td>
<td>Intervention team</td>
<td>X</td>
<td></td>
<td></td>
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<tr>
<td>Ready operations</td>
<td>Determine mechanism to identify eligible clients</td>
<td>Intervention team</td>
<td>X</td>
<td></td>
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<tr>
<td></td>
<td>Document protocols for creating a client list</td>
<td>Intervention team</td>
<td>X</td>
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<tr>
<td></td>
<td>Develop protocol for referral to local medical and social service providers</td>
<td>Intervention team</td>
<td>X</td>
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<td></td>
</tr>
<tr>
<td>Goal</td>
<td>Action Steps</td>
<td>Project Staff Responsible</td>
<td>Post-notice of award</td>
<td>Year 1</td>
<td>Year 2</td>
<td>Year 3</td>
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<tr>
<td>Provide intervention team with access to health records and any</td>
<td>Provide intervention team with access to health records and any Electronic</td>
<td>Clinic administrators</td>
<td>X</td>
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</tr>
<tr>
<td>Electronic Health Record (EHR) systems (including Ryan White Service</td>
<td>Health Record (EHR) systems (including Ryan White Service Report (RSR) data).</td>
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<tr>
<td>Develop grievance procedure and health liaison to the court procedure</td>
<td></td>
<td>Intervention team</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prepare health education materials</td>
<td></td>
<td>Intervention team</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Schedule regular meetings with the ITAC</td>
<td></td>
<td>Intervention team, ITAC</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Schedule regular meetings with the DEC</td>
<td></td>
<td>Intervention team, DEC</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participate in human subjects training</td>
<td></td>
<td>Intervention team</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obtain IRB approval</td>
<td></td>
<td>Project manager</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Schedule weekly case-conferencing meetings with the intervention team</td>
<td></td>
<td>Intervention team</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Schedule supervision sessions (weekly individual sessions)</td>
<td></td>
<td>Care coordinators</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Stage: Implementation and Maintenance</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intervention Implementation Activities: Initiating TCC while the client</td>
<td>Identify and recruit eligible clients using the protocol developed in pre-</td>
<td>Care Coordinator, Project Manager</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>is incarcerated</td>
<td>implementation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assign clients to a care coordinator</td>
<td></td>
<td>Project Manager</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Meet with the client</td>
<td></td>
<td>Care Coordinator</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Conduct client assessment</td>
<td></td>
<td>Care Coordinator</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Develop Transitional Care Plan within 48 hours of incarceration</td>
<td></td>
<td>Care Coordinator</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Consent client into multi-site evaluation</td>
<td></td>
<td>Data Manager</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Provide 3 health education sessions</td>
<td></td>
<td>Care Coordinator</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Provide ART support and counseling</td>
<td></td>
<td>Care Coordinator</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Identify client needs related to housing assistance, substance use</td>
<td></td>
<td>Care Coordinator</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>and mental health treatment health insurance access case management,</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Transitional Care Coordination Intervention – Implementation Manual - pg. 32
<table>
<thead>
<tr>
<th>Goal</th>
<th>Action Steps</th>
<th>Project Staff Responsible</th>
<th>Post-notice of award</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>and/or other services as needed.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Schedule post-incarceration HIV primary care appointment for client.</td>
<td>Care Coordinator</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Provide health liaison to the court services</td>
<td>Project Manager</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Provide accompaniment from jail or court.</td>
<td>Care Coordinator</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Conduct follow-up sessions in jail.</td>
<td>Care Coordinator</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Intervention Implementation Activities: Preparing a client for release</td>
<td>Provide / arrange for transportation/ accompaniment from jail to community. Coordinate jail release with corrections to facilitate transportation assistance and avoid releases during hours when public transit and program services are not available.</td>
<td>Care Coordinator</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Assess and address client’s basic needs for food security, clothing appropriate for the weather at the time of release, and housing stability after incarceration.</td>
<td>Care Coordinator</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Provide client with a copy of the TCP and contact information for care coordinator.</td>
<td>Care Coordinator</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Provide client with a list of community resources and a number (preferably toll-free) to call if they encounter challenges.</td>
<td>Care Coordinator</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Facilitate continuity of medication post-release</td>
<td>Care Coordinator</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Provide TCP Summary and other need medical documentation to courts, treatment programs, and primary care providers to facilitate continuity of care.</td>
<td>Care Coordinator</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Identify resources and arrange for appointments for primary care as well as housing assistance, substance use and mental health treatment health insurance access case management, and/or other services as needed.</td>
<td>Care Coordinator</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Post-incarceration activities</td>
<td>Contact the client post-incarceration</td>
<td>Care Coordinator</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Accompany client to first primary care visit post-incarceration</td>
<td>Care Coordinator</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Provide ongoing support services to help clients achieve goals outlined in their TCP</td>
<td>Care Coordinator</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Provide accompaniment to medical and social service appointments</td>
<td>Care Coordinator</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Goal</td>
<td>Action Steps</td>
<td>Project Staff Responsible</td>
<td>Post-notice of award</td>
<td>Year 1</td>
<td>Year 2</td>
<td>Year 3</td>
</tr>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Care Coordinator</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Care Coordinator</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Care Coordinator</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Care Coordinator</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Care Coordinator</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Care Coordinator</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Stage: Implementation, Maintenance, Integration**

<table>
<thead>
<tr>
<th>Integrate intervention into the clinic setting</th>
<th>Action Steps</th>
<th>Project Staff Responsible</th>
<th>Post-notice of award</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Update MOU with community collaborators and consortium partners</td>
<td>Intervention Team</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>Identify amended/additional policies in the jail that impact the intervention activities</td>
<td>Intervention Team</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>Identify amended/additional programs in the jail that impact intervention activities</td>
<td>Intervention Team</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>Conduct quarterly trainings/meetings with jail and intervention staff to facilitate knowledge sharing between groups</td>
<td>Intervention Team</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>Continue to recruit, train, and hire interventionists</td>
<td>Intervention Team</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>Provide new interventionists with DOC trainings and security clearance</td>
<td>Intervention Team</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

**Stage: Implementation, Maintenance, Integration**

<table>
<thead>
<tr>
<th>Track program outcomes and conduct quality assurance review</th>
<th>Action Steps</th>
<th>Project Staff Responsible</th>
<th>Post-notice of award</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Track incoming referrals and community outreach</td>
<td>Data manager</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>Follow DEC protocols for fidelity monitoring</td>
<td>Intervention team, DEC</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>Review and audit intervention encounter forms for quality</td>
<td>Data manager, DEC</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>Conduct monthly data cleaning</td>
<td>Data manager, DEC</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>Map each piece of chart collection to a location in the EMR</td>
<td>Data manager, DEC</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>
### Appendix D: Intake and Assessment Form

Transitional Care Coordination Intake Assessment

Today’s Date: 

#### Section I:

<table>
<thead>
<tr>
<th>Client name:</th>
<th>Care coordinator name:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. Gender
   - [ ] Male
   - [ ] Female
   - [ ] Transgender
   - [ ] Declined to answer

5. Date of incarceration:
   - [ ] Yes
   - [ ] No
   - [ ] Unknown

2. Age

6. Is this the first time the client has been incarcerated?
   - [ ] Yes
   - [ ] No
   - [ ] Unknown

3. Primary language spoken
   - [ ] English
   - [ ] Spanish
   - [ ] Other: ____________________________
   - [ ] Declined to answer

6a. If yes, how many times has the client been incarcerated prior to this period of incarceration?

4. Has the client seen a medical provider in the jail?
   - [ ] Yes
   - [ ] No
   - [ ] Unknown

#### Section II:

7. HIV Status: (Check only one)
   - [ ] HIV+, Not AIDS
   - [ ] HIV+, AIDS status unknown
   - [ ] CDC-Defined AIDS

8. HIV diagnosis date:

9. If the client has AIDS, AIDS diagnosis date:

10. Did you know that you were HIV+ or that you had AIDS before being incarcerated?
   - [ ] Yes
   - [ ] No
   - [ ] Client declined to answer

11. HIV Risk Factor: (Check all that apply)
   - [ ] MSM
   - [ ] IDU
   - [ ] Heterosexual
   - [ ] Blood transfusion/components
   - [ ] Hemophilia/coagulation disorder
   - [ ] Perinatal
   - [ ] Risk factor not reported or not identified

12. Do you currently have a primary care physician (PCP) or HIV primary care provider?
   - [ ] Yes
   - [ ] No

12a. If yes, who is your provider (doctor’s name)?

12b. Where is the provider located (clinic)?
<table>
<thead>
<tr>
<th>name?</th>
<th>12c. When was your last visit with this provider?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 13. CD4 Records

<table>
<thead>
<tr>
<th>CD4 count</th>
<th>CD4 % <em>(optional)</em></th>
<th>Date (mm/dd/yyyy)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

☐ No CD4 count on record

### 14. Viral Load Records

<table>
<thead>
<tr>
<th>Viral Load Count</th>
<th>Viral Load Undetectable</th>
<th>Date (mm/dd/yyyy)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐ Yes ☐ No ☐ Unknown</td>
<td></td>
</tr>
<tr>
<td></td>
<td>☐ Yes ☐ No ☐ Unknown</td>
<td></td>
</tr>
<tr>
<td></td>
<td>☐ Yes ☐ No ☐ Unknown</td>
<td></td>
</tr>
<tr>
<td></td>
<td>☐ Yes ☐ No ☐ Unknown</td>
<td></td>
</tr>
</tbody>
</table>

☐ No viral load count on record

### Section III:

15. Does you have any other medical conditions requiring treatment?

☐ Yes  ☐ No  ☐ Unknown

15a. If yes, what conditions? (Check all that apply)

☐ Cancer  ☐ Diabetes  ☐ Heart disease/hypertension  ☐ Liver disease  ☐ Kidney disease  ☐ Hepatitis C  ☐ Tuberculosis (TB)  ☐ Asthma  ☐ Other (specify):

16. Have you ever received a mental health diagnosis?

☐ Yes  ☐ No  ☐ Unknown
16a. If yes, what diagnosis or diagnoses? (Check all that apply)

- Depression
- Anxiety disorder (Panic, GAD, etc.)
- PTSD
- Bipolar disorder
- Psychosis (Schizophrenia, etc.)
- HIV-associated dementia
- Other (specify):

Section IV:

17. Are you currently pregnant?

- Yes
- No
- N/A (male)
- Unknown (if no, n/a, or unknown, skip to section V)

18. Are you enrolled in prenatal care?

- Yes
- No
- Unknown

19. Estimated due date:

Enter MM/DD/YY:
Or
- Unknown

20. Have you been prescribed ART to prevent maternal-to-child (vertical) transmission of HIV?

- Yes
- No
- Unknown

Section V:

21. Are you currently prescribed ART?

- Yes (complete table below)
- No (skip this table)
- Unknown (skip this table)

<table>
<thead>
<tr>
<th>HIV Medication Names</th>
<th># per dose</th>
<th>Dose unit (pills, ccs, mls)</th>
<th># doses</th>
<th>Frequency</th>
<th>Date started (mm/yyyy)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Daily</td>
<td>Monthly</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Daily</td>
<td>Monthly</td>
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<tr>
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<td></td>
<td></td>
<td></td>
<td>Daily</td>
<td>Monthly</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Daily</td>
<td>Monthly</td>
</tr>
</tbody>
</table>

22. If the client is not on ART: Why haven’t you been prescribed ART? (Check only one)

- Not medically indicated
- Not ready – by PCP determination
- Intolerance/side effects/toxicity
- Payment/insurance/cost issue
- Client refused
- Unknown
- Other (specify):
### Section VI:

23. Where were you living before you were incarcerated?

<table>
<thead>
<tr>
<th>Option</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Homeless / living on the street, in an abandoned building, outside, etc.</td>
<td>Name of shelter:</td>
</tr>
<tr>
<td>b. Emergency shelter (non-SRO)</td>
<td>Name of shelter:</td>
</tr>
<tr>
<td>c. Single Room Occupancy (SRO) hotel</td>
<td>Name of SRO:</td>
</tr>
<tr>
<td>d. Other hotel or motel (paid for without emergency shelter voucher or rental subsidy)</td>
<td>Name of hotel or motel:</td>
</tr>
<tr>
<td>e. Supportive housing program</td>
<td>Name of supportive housing program:</td>
</tr>
<tr>
<td>f. Room, apartment, or house that you rent (not affiliated with a supportive housing program)</td>
<td>Total number of people in your household (including you): Annual household income:</td>
</tr>
<tr>
<td>g. Apartment or house that you own</td>
<td>Total number of people in your household (including you): Annual household income:</td>
</tr>
<tr>
<td>h. Staying or living in someone else’s (family or friend’s) room, apartment or house</td>
<td>Name of hospital, long term care facility, or treatment/detox center:</td>
</tr>
<tr>
<td>i. Hospital, institution, long term care facility, or substance abuse treatment/detox center</td>
<td>Name of foster care/group home:</td>
</tr>
<tr>
<td>j. Foster care home or foster group home</td>
<td>Name of foster care/group home:</td>
</tr>
</tbody>
</table>

24. When did you start living in that location?

- (mm/yyyy)
- Unknown
- Client declined to answer

25. Do you anticipate going back to this location upon release?

- Yes
- No
- Unknown
- Client declined to answer

26. Have you ever been homeless?

- Yes
- No
- Unknown
- Client declined to answer

26a. If yes, when were you last homeless?

- (mm/yyyy)
- Unknown
- Client declined to answer

27. Only ask if client reports that they were not homeless when they were incarcerated: Did you have any housing issues prior to being incarcerated?

- Yes
- No
- Client declined to answer

27a. If yes, what were your housing issues?

- Cost
- Doubled-up in the unit
<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>28. What is your current employment status?</td>
<td>□ Full-time&lt;br&gt;□ Part-time&lt;br&gt;□ Unemployed&lt;br&gt;□ Unpaid volunteer/peer worker&lt;br&gt;□ Out of the workforce&lt;br&gt;□ Other (specify): Client declined to answer</td>
</tr>
<tr>
<td>29. What is the highest level of education that you’ve achieved?</td>
<td>□ No schooling&lt;br&gt;□ 8th grade or less&lt;br&gt;□ Some high school&lt;br&gt;□ High school or GED equivalent&lt;br&gt;□ Come college&lt;br&gt;□ Bachelors/technical degree&lt;br&gt;□ Postgraduate&lt;br&gt;□ Client declined to answer</td>
</tr>
<tr>
<td>30. Where were you born?</td>
<td>□ United States&lt;br&gt;□ US Territory/dependency (specify): ________________&lt;br&gt;□ Other country&lt;br&gt;□ Client declined to answer</td>
</tr>
<tr>
<td>30a. If the client was not born in the US or in a US territory: When did you come to the US?</td>
<td>(MM/YYYY)</td>
</tr>
</tbody>
</table>

**Section VII:**

| 31. What is your insurance status? | □ Uninsured<br>□ Insured (If insured, complete the details in the table below)<br>□ Unknown<br>□ Other (specify): Client declined to answer |

<table>
<thead>
<tr>
<th>Insurance type</th>
<th>Insurance details</th>
<th>Effective Date</th>
<th>End/expiration date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private</td>
<td>(Check only one)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ADAP / ADAP+</td>
<td>(Check all that apply)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicaid or CHIP</td>
<td>(Check only one plan type)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Section VIII: Use of Prescriptions, injectables, and other substances

We will be asking you questions in the next two sections about substance use and sexual behaviors. Some of these questions may seem personal in nature, but we ask them of everyone in this program.

- Please answer honestly. You may refuse to answer a question; refusing will not affect your care.
- Please feel free to ask if you need any of the questions explained to you.
- If you do not want to answer a question now, please tell me and we will return to it another time.

32. In the past 3 months, have you used:

<table>
<thead>
<tr>
<th>Substances</th>
<th>Use</th>
<th>How Used</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Tobacco</td>
<td></td>
<td>cigarettes smoked weekly (for other forms of tobacco, # times used weekly)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Orally</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Smoked</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Injected</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Client declined to answer</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Client declined to answer</td>
</tr>
</tbody>
</table>

| b. Alcohol        |     | drinks weekly     |
|                   |     | Orally            |
|                   |     | Smoked            |
|                   |     | Injected          |
|                   |     | Client declined to answer |

| c. Marijuana      |     | times weekly      |
|                   |     | Orally            |
|                   |     | Smoked            |
|                   |     | Injected          |
|                   |     | Client declined to answer |

| d. PCP/Hallucinogens |     | times weekly       |
|                       |     | Orally             |
|                       |     | Smoked             |
|                       |     | Injected           |
|                       |     | Client declined to answer |

| e. Crystal Meth    |     | times weekly       |
|                   |     | Orally             |

<table>
<thead>
<tr>
<th>Insurance Type</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Military/VA/Tricare</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IHS (Indian Health Service)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other public insurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>f. Cocaine/Crack</td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. Heroin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>h. Rx Pills to get high</td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. Hormones/steroids</td>
<td></td>
<td></td>
</tr>
<tr>
<td>j. Other (specify):</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
I have not used any substances in the past 3 months.

If client has, at this interview, reported injecting any substance in the table above, ask the client directly about sharing injection equipment. If the client did not report injecting any substance, skip to section IX.

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>33. Have you ever injected any drug or substance?</td>
<td>☐ Yes</td>
</tr>
<tr>
<td></td>
<td>☐ No (If no, skip to next section)</td>
</tr>
<tr>
<td></td>
<td>☐ Client declined to answer</td>
</tr>
<tr>
<td>34. If yes, when was the last time you injected any substance?</td>
<td>☐ In the past 3 months</td>
</tr>
<tr>
<td></td>
<td>☐ Between 3 and 12 months ago</td>
</tr>
<tr>
<td></td>
<td>☐ More than 12 months ago</td>
</tr>
<tr>
<td></td>
<td>☐ Client declined to answer</td>
</tr>
<tr>
<td>34a. If the client reported any injection behavior in the past 3 months: Do you receive clean syringes from a syringe exchange program or pharmacy?</td>
<td>☐ Yes</td>
</tr>
<tr>
<td></td>
<td>☐ No</td>
</tr>
<tr>
<td></td>
<td>☐ Client declined to answer</td>
</tr>
<tr>
<td>35. Have you ever shared needles or injection equipment with others?</td>
<td>☐ Yes</td>
</tr>
<tr>
<td></td>
<td>☐ No</td>
</tr>
<tr>
<td></td>
<td>☐ Client declined to answer</td>
</tr>
<tr>
<td>36. If yes, when was the last time you shared needles or injection equipment?</td>
<td>☐ In the past 3 months</td>
</tr>
<tr>
<td></td>
<td>☐ Between 3 and 12 months ago</td>
</tr>
<tr>
<td></td>
<td>☐ More than 12 months ago</td>
</tr>
<tr>
<td></td>
<td>☐ Client declined to answer</td>
</tr>
</tbody>
</table>

Section IX:

37. In the past 12 months, have you:

a. Had sex with anyone (oral, anal, or vaginal) 
   ☐ Yes 
   If yes, how many sexual partners have you had in the past 12 months? ______
   ☐ No (skip to the next section)
   ☐ Client declined to answer

b. Had vaginal sex with a male? *(optional if client is biologically male)*
   ☐ Yes
   ☐ No
   ☐ Client declined to answer

c. Had vaginal sex with a female? *(optional if client is biologically female)*
   ☐ Yes
   ☐ No
   ☐ Client declined to answer

d. Had vaginal sex with a transgender person?
   ☐ Yes
   ☐ No
   ☐ Client declined to answer

e. Had vaginal sex without a condom?
   ☐ Yes
   ☐ No
   ☐ Client declined to answer

f. Had anal sex with a male?
   ☐ Yes
   ☐ No
<table>
<thead>
<tr>
<th>Question</th>
<th>Client declined to answer</th>
<th>Yes</th>
<th>No</th>
<th>Client declined to answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>g. Had anal sex with a female?</td>
<td>Client declined to answer</td>
<td>Yes</td>
<td>No</td>
<td>Client declined to answer</td>
</tr>
<tr>
<td>h. Had anal sex with a transgender person?</td>
<td>Client declined to answer</td>
<td>Yes</td>
<td>No</td>
<td>Client declined to answer</td>
</tr>
<tr>
<td>i. Had anal sex without a condom?</td>
<td>Client declined to answer</td>
<td>Yes</td>
<td>No</td>
<td>Client declined to answer</td>
</tr>
<tr>
<td>j. Had oral sex with a male?</td>
<td>Client declined to answer</td>
<td>Yes</td>
<td>No</td>
<td>Client declined to answer</td>
</tr>
<tr>
<td>k. Had oral sex with a female?</td>
<td>Client declined to answer</td>
<td>Yes</td>
<td>No</td>
<td>Client declined to answer</td>
</tr>
<tr>
<td>l. Had oral sex with a transgender person?</td>
<td>Client declined to answer</td>
<td>Yes</td>
<td>No</td>
<td>Client declined to answer</td>
</tr>
<tr>
<td>m. Had oral sex without a condom, dental dam, or other barrier?</td>
<td>Client declined to answer</td>
<td>Yes</td>
<td>No</td>
<td>Client declined to answer</td>
</tr>
<tr>
<td>n. Had sex without your consent?</td>
<td>Client declined to answer</td>
<td>Yes</td>
<td>No</td>
<td>Client declined to answer</td>
</tr>
</tbody>
</table>

**Section X:**

<table>
<thead>
<tr>
<th>Question</th>
<th>Client declined to answer</th>
<th>Yes</th>
<th>No</th>
<th>Not asked</th>
<th>Client declined to answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>38. Are you deaf or do you have difficulty hearing?</td>
<td>Client declined to answer</td>
<td>Yes</td>
<td>No</td>
<td>Not asked</td>
<td>Client declined to answer</td>
</tr>
<tr>
<td>39. Are you blind or do you have serious difficulty seeing, even when wearing glasses or contact lenses?</td>
<td>Client declined to answer</td>
<td>Yes</td>
<td>No</td>
<td>Not asked</td>
<td>Client declined to answer</td>
</tr>
<tr>
<td>40. Do you have difficulty concentrating, remembering, or making decisions because of a physical, mental, or emotional condition?</td>
<td>Client declined to answer</td>
<td>Yes</td>
<td>No</td>
<td>Not asked</td>
<td>Client declined to answer</td>
</tr>
<tr>
<td>41. Do you have serious difficulty walking or climbing the stairs?</td>
<td>Client declined to answer</td>
<td>Yes</td>
<td>No</td>
<td>Not asked</td>
<td>Client declined to answer</td>
</tr>
<tr>
<td>42. Do you have difficulty dressing or bathing?</td>
<td>Client declined to answer</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Question</td>
<td>Options</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>----------------------------------------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 43. Do you have serious difficulty doing errands alone such as visiting a doctor’s office or shopping? | Not asked  
|                                                                          | Client declined to answer  
|                                                                          | Yes  
|                                                                          | No  
|                                                                          | Not asked  
|                                                                          | Client declined to answer                     |

**Additional Client Notes:**

---

**Client signature**

**Care coordinator signature**
## Appendix E: Transitional Care Plan (TCP)

<table>
<thead>
<tr>
<th>Client name</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Coordinator Name</td>
<td></td>
</tr>
<tr>
<td>Original TCP created on (date):</td>
<td></td>
</tr>
<tr>
<td>Today’s date</td>
<td></td>
</tr>
</tbody>
</table>

| Planned release date: |  |

<table>
<thead>
<tr>
<th>How can we reach you in the community?</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone:</td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>Email:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Who is your emergency contact?</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td></td>
</tr>
<tr>
<td>Relationship:</td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>Phone:</td>
<td></td>
</tr>
<tr>
<td>Email:</td>
<td></td>
</tr>
</tbody>
</table>

### Scheduling Primary Care

<table>
<thead>
<tr>
<th>Provider Name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Location:</td>
<td></td>
</tr>
<tr>
<td>Contact Information:</td>
<td></td>
</tr>
<tr>
<td>Appointment Date:</td>
<td></td>
</tr>
<tr>
<td>Appointment Time:</td>
<td></td>
</tr>
<tr>
<td>Clinic Hours:</td>
<td></td>
</tr>
</tbody>
</table>
## Additional Needs During Incarceration

Does the client need any of the following:  

<table>
<thead>
<tr>
<th>Needs</th>
<th>Yes □</th>
<th>No □</th>
<th>Plan for addressing this need:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Primary Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Health Home</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Housing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Help filling out forms</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Eligibility assessment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Referral/appointment making</td>
<td></td>
<td></td>
<td>Details of referral:</td>
</tr>
<tr>
<td>d. Reminder call/message about housing related appointment</td>
<td></td>
<td></td>
<td>Date of appointment:</td>
</tr>
<tr>
<td>e. Arrange childcare for housing related appointment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Appointment preparation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. Arrange for interpretation services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Substance Use Treatment</td>
<td></td>
<td></td>
<td>Name of provider:</td>
</tr>
<tr>
<td>5. Entitlements or Benefits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Help filling out forms</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Eligibility assessment</td>
<td></td>
<td></td>
<td>Client is eligible for:</td>
</tr>
<tr>
<td>c. Referral/appointment making</td>
<td></td>
<td></td>
<td>Details of referral:</td>
</tr>
<tr>
<td>d. Reminder call/message about appointment</td>
<td></td>
<td></td>
<td>Date of appointment:</td>
</tr>
<tr>
<td>e. Arrange childcare for appointment</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Client is eligible for:

☐ HASA  ☐ Medicaid  ☐ Medicare  ☐ ADAP  ☐ SSI/DI  ☐ SSA  ☐ VA  ☐ TANF  ☐ Safety Net  ☐ Food Stamps  ☐ Birth Certificate Request  ☐ Single Stop Coordination  ☐ Other  

______________
<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>f. Appointment preparation</td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>g. Arrange for interpretation services</td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>6. Court Advocacy</td>
<td>Yes</td>
<td>No</td>
<td>If yes, determine eligibility before offering services. Court date:</td>
</tr>
<tr>
<td>7. Transportation</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>8. Safety Plan</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>9. Mental Health Services</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

Client needs 72 hours or less before release

**Transportation**

1. Will someone be picking you up?  
   Yes | No | If yes, who?
2. Will you need transportation from the jail?  
   Yes | No | Where will you be dropped off? Is this your final destination? If no, how will you get to your final destination?
3. Will you be taking public transportation?  
   Yes | No
   a. Do you know the schedule?  
      Yes | No
   b. Do you know how you will cover the cost?  
      Yes | No

**Housing**

1. Where are you staying on your first night out?  
   a. Do they know you are coming?  
      Yes | No
   b. Do they know what time you’ll be arriving?  
      Yes | No
   c. Do you have a backup plan in case this place isn’t safe, available, etc?  
      Yes | No
   d. Do you need a referral for housing?  
      Yes | No
   e. Do you need support in obtaining housing (appointment reminders, help filling out...  
      Yes | No
<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>f. Do you have money to pay for housing?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Money</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Will you have any money when you get out?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. If yes, where will the money come from?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. How will you get the money?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. If the money is in the form of the check, do you know where to cash the check and do you have an ID to cash the check?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identification</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Do you have an ID?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. If no, do you know how to get one?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Do you have a driver’s license?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. If yes, are there any holds on your ID that you need to take care of?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basic needs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Will you need food when you first get out?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Will you need clothing or shoes when you are released?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. If yes, is anyone bringing you clothes?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Will you need any toiletry items (soap, toothbrush, toothpaste, comb, etc.) when you are released?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Will you need a supply of medications when you are released?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. If no, what is your plan of obtaining medications</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Assessing needs post-incarceration

<table>
<thead>
<tr>
<th>Does the client need any of the following:</th>
<th>Plan for addressing this need:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Primary Care</td>
<td>Yes ☐ □ No ☐ □</td>
</tr>
<tr>
<td>2. Health Home</td>
<td>Yes ☐ □ No ☐ □</td>
</tr>
<tr>
<td>3. Housing</td>
<td>Yes ☐ □ No ☐ □</td>
</tr>
<tr>
<td>h. Help filling out forms</td>
<td>Yes ☐ □ No ☐ □</td>
</tr>
<tr>
<td>i. Eligibility assessment</td>
<td>Yes ☐ □ No ☐ □</td>
</tr>
<tr>
<td>j. Referral/appointment making</td>
<td>Yes ☐ □ No ☐ □</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>k. Reminder call/message about housing related appointment</td>
<td>Yes ☐ □ No ☐ □</td>
</tr>
<tr>
<td>l. Arrange childcare for housing related appointment</td>
<td>Yes ☐ □ No ☐ □</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>m. Appointment preparation</td>
<td>Yes □</td>
</tr>
<tr>
<td>n. Arrange for interpretation services</td>
<td>Yes □</td>
</tr>
<tr>
<td>4. Substance Use Treatment</td>
<td>Yes □</td>
</tr>
<tr>
<td>5. Entitlements or Benefits</td>
<td>Yes □</td>
</tr>
<tr>
<td>h. Help filling out forms</td>
<td>Yes □</td>
</tr>
</tbody>
</table>
| i. Eligibility assessment | Yes □ | No □ | Client is eligible for:  
 □ HASA □ Medicaid □ Medicare □ ADAP □ SSI/DI □ SSA □ VA □ TANF □ Safety Net □  
 Food Stamps □ Birth Certificate Request □  
 Single Stop Coordination □ Other □  |
| j. Referral/appointment making | Yes □ | No □ | Details of referral:  
 Date of appointment: |
| k. Reminder call/message about appointment | Yes □ | No □ | Date of appointment: |
| l. Arrange childcare for appointment | Yes □ | No □ |   |
| m. Appointment preparation | Yes □ | No □ |   |
| n. Arrange for interpretation services | Yes □ | No □ |   |
| 6. Court Advocacy | Yes □ | No □ | If yes, determine eligibility before offering services.  
 Court date: |
| 7. Transportation | Yes □ | No □ |   |
| 8. Safety Plan | Yes □ | No □ | Details of referral:  
 Date of appointment: |
| 9. Mental Health Services | Yes □ | No □ | Details of referral:  
 Date of appointment: |
Appendix F: Health Liaison to the Courts: Sample Policy and Procedure

Policy: The Health Liaison to the courts and court advocates provides legal assistance to incarcerated persons with substance use and/or chronic or severe health issues in order to arrange their transition from jail to an Alternative to Incarceration (ATI) program or other transitional care or residential substance abuse treatment program, skilled nursing facility, hospice care program or hospital based program. The goal of the Health Liaison to the Courts is to facilitate program and care management through community programs that will then monitor care and treatment until court mandates or treatment needs are fulfilled. The care coordinator screens and communicates with the individual and the project manager (Health Liaison) communicates with the courts, court advocates, and/or community-based program. Case conferences or pre-screening may need to be facilitated by care coordinator so that the court program case manager may teleconference with the individual.

Procedure:

1) Screen individuals to determine program eligibility. Based on court requirements and individual needs, eligibility criteria may include:
   a) Willing to enter hospice, skilled nursing facility, or residential substance use treatment program or outpatient treatment program tied to supportive housing.
   b) No violent offense on record (murder, manslaughter, rape, sex offense, pedophilia, and arson).
   c) Detainee or a parole violator for ATI
   d) People who are sentenced that may be eligible for compassionate release or time served
   e) No immigration hold
   f) Living with HIV, chronic health condition, and/or substance use disorder.

2) If individuals meet eligibility criteria for court advocacy services, the project manager (Health Liaison) or care coordinator obtains client consent to coordinate with courts or court advocates to arrange the Transitional Care Plan and:
   a) Identify an appropriate program (medically equipped to meet individual needs).
   b) Establish that there is a vacancy and confirm that the person will be accepted.
   c) Communicate client’s personal information to the court advocate, including a short summary (e.g. age, sex, ethnicity, criminal history, medical status, contact information).
   d) Document the process, discharge plan, and connection to care. The Health Liaison and other assigned staff may work on diversion and compassionate release as well.

3) Considerations to include in any decision making regarding the provision of services:
   a) Legal History:
      • Parole status
      • Current case/charges
      • History of felony convictions
      • History of misdemeanors
      • Incarceration history
      • Attorney agreement
   b) Medical Information:
      • Medical conditions
      • Laboratory results
      • Medications
      • CD4 count and viral load
   c) Program Information:
      • Program acceptance
      • Program location
4) Based on the jurisdiction, the process for court advocacy may vary. Typically, each individual eligible for court advocacy will meet with a community-based court advocate for an interview before s/he arrives in court. The court advocate will review the intake/assessment to ensure that it contains all necessary information (e.g. CD4 count, Viral Load, PPD, Chest X-Ray, nursing home assessment, medications, social determinants and letter from Health Liaison). The following are typical steps in the court advocacy process (your site will need to tailor this workflow to the process within your jurisdiction):

   a) The court advocate arrives in court before the hearing allowing sufficient time to meet with the individual and the court representatives (defender, District Attorney, justices’ clerk)
   b) With defenders’ consent, the court advocate introduces his/herself to the District Attorney and presents the proposed Transitional Care Plan (and all necessary information including consent form(s)).
   c) The court advocate meets with the individual’s lawyer to review the proposed plan and issues raised by the DA.
   d) If there is a preceding court date for the individual, the District Attorney will let the court advocate know if he/she will need to attend the hearing.
   e) If the proposed plan is accepted and individual receives “time served,” s/he will be released from the court. The court advocate shall escort the individual to the designated community program/provider.
   f) If the proposed plan is not accepted, TCC intervention staff will continue to work with each client to provide discharge planning services until a final determination (release/sentencing) is made.

The Health Liaison obtains all documents of the proceedings, confirms the individual’s arrival at the program with the court advocate, and records the linkage to the program in the electronic health record for tabulation in the monthly report. At the point in which Health Liaison services are no longer appropriate for the client, intervention staff case conference with the court advocate and Health Liaison, and others as needed to determine next steps.

Appendix G: Compassionate Release: Sample Policy and Procedure

Policy: The goal of the compassionate release policy is to create a method for promote the release of persons terminally ill, with a significant, permanent disability, or with chronic conditions that cannot be optimally managed within the correctional realm. Referrals from all sources (e.g. health educators, physicians, care coordinators, etc.) are accepted.

Procedure:

1) TCC staff receives consent from each individual eligible for compassionate release to share his/her medical information between and among medical staff, care coordinators, and attorneys for the purpose of the compassionate release plan.

2) TCC staff submit a referral with the following information to jail-based medical staff (e.g. Medical Director or Deputy Medical Director) or designee:
   a. Name of individual
   b. Book and case number
   c. Current facility location
   d. Current case/charges
   e. Parole status
   f. Immigration status
   g. Assessment completed by person referring the individual
   h. Familial and/or community support (to determine if discharge plan/community placement necessary)
i. Attorney contact information

3) If compassionate release is pursued, assigned TCC staff arranges a Transitional Care Plan and may arrange court advocacy.

4) Communication between and among all staff, attorneys, Department of Correction, community corrections (parole or probation), and ICE is maintained in order to execute successful compassionate release while maintaining client confidentiality consistent with HIPAA regulations.

Appendix H: Confidentiality: Sample Policy and Procedure

All records pertaining to a client’s medical history, treatment, discharge planning and transitional care are private and confidential and may not be disclosed unless the disclosure is authorized by law. Only TCC staff with a legitimate job-related reason may have access to confidential information. It is the responsibility of all TCC staff to maintain the confidentiality of all records containing confidential information. All discussions regarding confidential client information will be held as private and confidential as possible within a correctional health environment.

Personal information is to be appropriately acquired, used, maintained, and stored. Client consent is required prior to disclosing confidential information regarding the client’s health status to third party community partners for the purposes of transitional care, placement, and/or reporting. In circumstances in which disclosure of information to third parties occurs, it is imperative to disclose information in a controlled manner.

“Confidential Information” includes:

1. The contents of the client’s medical record, including a record in electronic format;
2. The contents of records used in the discharge planning;
3. Documents which should be included in the client’s medical record;
4. Other documents, including sign-in sheets, rosters, logs, which convey information concerning the health status of the client or otherwise identify the client;
5. Other private information regarding the client, including social security number, Medicaid ID number, home address, phone number;
6. Secondary documents (paper or electronic) which contain information that can be used to identify the client and concerns the health status of a client.

Procedure:

1. Do not discuss confidential information in open spaces or when a third party is present. Only discuss confidential information to other TCC staff or the client outside of the presence of a third party. Maintain a private space and speak in a voice that is audible only to the person who is authorized to hear the confidential information.

2. Request written consent from individuals receiving a transitional care plan. The consent should authorize TCC to release their confidential information to any third party.

3. The HIPAA consent form should be used to obtain written consent. The HIPAA consent form must be filled out with the names of all parties or agencies to whom TCC staff plans to disclose information. Each individual receiving a transitional care plan should sign the HIPAA consent form. The HIPAA consent form is signed by each individual receiving a transitional care plan.

4. A specific consent is required prior to disclosing HIV and substance use disorder information.

5. Confidential information must be stored in locked cabinets. Keys to these cabinets are to be held by TCC staff authorized to access the records.

6. Confidential information must not be left unattended in work spaces, fax machines, conference rooms, or any space where they may disclosed to third parties, including
individuals who work in the correctional setting but are not authorized to see the confidential information.

7. Do not place confidential information in the trash can. Confidential information may only be discarded in a shredder.

8. When transporting confidential information by hand, package the information in two envelopes marked “Confidential”.

Only TCC staff may photocopy, fax, or in any way handle confidential information that is not in a sealed envelope. Never include any information that can be used to identify a client in the body of an email. Where authorized, client information may only be electronically transmitted in an attachment that is password protected.

Appendix I: Curriculum
The education sessions will address the following learning objectives:

**Session 1: HIV, the Viral Life Cycle & Understanding HAART**
- By the end of session 1, the patient will be able to define:
  - the stages of HIV infection
  - routes of HIV transmission
  - HIV viral life cycle
  - How medications work in body
  - How HIV medications help the body’s immune system get stronger (CD4 increase)
  - How medications can reduce the amount of HIV in the body (reduce viral load)

**Session 2: Communicating with Health Care Provider about adherence & managing side effects**
- By the end of session 2, the patient will understand:
  - The relationship between missing doses of HIV pills and the amount of HIV virus in the body
  - The relationship between the time of day when medications are taken and HIV drug resistance
- By the end of session 2, the patient will be confident in her ability to talk to her doctor about:
  - How and when meds are taken and when meds are not taken
  - Potential side effects of treatment (nausea, diarrhea, dizziness)
  - Ways to cope with side effects

**Session 3: Review understanding of basic lab tests: CD4 & Viral Load**
- By the end of session 3, the patient will be able to identify the relationship between CD4 count and her immune system.
- By the end of session 3, the patient will be able to define viral load and the relationship between viral load and disease progression.

**Session 1: HIV Life cycle and medications at work**
Conversation starter: transmission:
- Today I’d like to discuss how HIV is transmitted and the different stages it goes through once it enters your blood. This includes the body fluids that transmit HIV and the ones that don’t, the pathways that allow HIV to enter the body, HIV symptoms and AIDS symptoms.
- We’ll also discuss the immune system, the stages of HIV infection, and how HIV invades CD4 cells to multiply and then destroy those cells. This is called the viral life cycle.
- Knowing how the virus works gives you the power to control it.
- In a couple of weeks, we will learn where/how medications work in reducing replication of HIV that allows the viral load to be low and your immune system strong.
• Let’s plan to meet again on ____________________

Handouts for patients:
• Stages of HIV Infection
• Routes of Transmission Risk
• HIV Life Cycle—the Big Picture (attached pdf)
• Videos to show: https://www.youtube.com/watch?v=HL02lVDExIw

HIV Transmission
Modes of Transmission:
1. Oral, vaginal, anal ________________________
2. Sharing _________________________________
3. _______________________

Fluids:
1. _______________________________________
2. _______________________________________
3. _______________________________________
4. _______________________________________

What is HIV?
H –
I –
V –

Page Break
Session 2: Coaching/Mentoring patients

Conversation starter:
• Let’s review the importance of communicating effectively with your providers and how that impacts your health, as well as the importance of advocating for yourself.
• Having a partnership with your health provider is important because you want to have equal ownership about health decisions. Usually, as a patient we follow whatever the doctor/nurse tells us to do; however research has shown that patients who ask questions increase their knowledge of their health/disease and have better health outcomes when fully involved in making health decisions.
• Suggestions to communicate more effectively include:
  ▪ To come prepared with a list of questions for your medical appointments and/or I can help you prepare the list before your appointment.
  ▪ Writing down any symptoms you experience between medical appointments is helpful – it’s called a “symptom log.”
- Letting your provider know if you have missed appointments,
- Honestly telling your doctor that you are uncomfortable with changes they may be recommending, and
- Being truthful with your providers
- These suggestions are all ways to increase communication with your health provider while advocating for yourself.
- Sometimes it may take a while to gain a trusting relationship, but know that I can attend your appointments with you, or if there is a supportive person in your life, you can ask them to attend the appointments with you.
- Let’s plan to meet again on ____________________

**Handouts**
- How to Prepare for a Visit with your Doctor
- Symptoms Log

---

### PREPARING FOR A VISIT WITH YOUR DOCTOR

<table>
<thead>
<tr>
<th>Check</th>
<th>Task</th>
<th>Questions/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Keep a journal or calendar of your symptoms.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Be prepared to describe side effect including symptom.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bring a list of your medications and dosages, or bring your medications in a bag.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Be prepared to let your provider know how many doses you missed in the past week and month.</td>
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</tr>
<tr>
<td></td>
<td>Bring a list of questions.</td>
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</tr>
<tr>
<td></td>
<td>Bring snacks/water and something to help you stay busy while waiting.</td>
<td></td>
</tr>
</tbody>
</table>
Bring a friend, family member or care coordinator to help you during your visit.

Questions to ask your provider:
1. Why have I been prescribed this medication?
2. How should I take it?
3. Are there any special storage requirements?
4. Should I take it with or without food?
5. How many and how often should I take the medication?
6. Will it make me feel worse? What are the side effects?
7. What do I do if I forget a dose?
8. How long will I have to take it?
9. __________________________________________________________________________
   __________________________________________________________________________
10. __________________________________________________________________________
   __________________________________________________________________________
11. __________________________________________________________________________
   __________________________________________________________________________
12. __________________________________________________________________________
   __________________________________________________________________________

Symptoms Log
NAME ______________________________________________________DATE

1. Is it hard for you to take your HIV medicines the way your healthcare provider told you to?
   □ Yes □ No

2. How hard are your HIV medicines to take? Mark an X on the line below.
   ________________________________
   Very Hard    Not Hard At All

3. If you miss a dose, is it in the morning, evening, or middle of the day?
   □ Morning □ Evening □ Middle of the day □ I don’t forget or skip doses

4. Do you ever skip a dose because the medicines make you feel bad? □ Yes □ No

5. Do you ever go a day without taking your HIV medicines?
   □ Yes; why? ____________________________________________________________ □ No

6. Do you ever have any of these possible side effects?
<table>
<thead>
<tr>
<th>Side Effect</th>
<th>How many times a month?</th>
<th>How long have you had this side effect?</th>
<th>How much does it affect your daily activities?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feeling sick to my stomach</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vomiting</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diarrhea</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Headache</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feeling tired</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rash</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shortness of breath</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trouble sleeping</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change in skin color</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rash</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shortness of breath</td>
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<td>Trouble sleeping</td>
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<tr>
<td>Change in skin color</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rash</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nervousness</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

7. Has your energy changed since you started taking your current HIV medicines? Mark an X on the line below.

<table>
<thead>
<tr>
<th>Lower Energy</th>
<th>About the same</th>
<th>Higher Energy</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

8. Are you concerned that the HIV medicines you are taking now might cause either of these side effects?
   a. Weight loss in the arms, legs, buttocks, or face □ Yes □ No
   b. Weight gain in the upper back and neck, breast, or trunk □ Yes □ No

9. Would you be interested in talking to your healthcare provider about whether a change to your HIV regimen is right for you? □ Yes □ No

10. If you could change one thing about your HIV treatment, what would it be?
    _______________________________________________________________________
    _______________________________________________________________________
    _______________________________________________________________________

Use your answers to talk to your healthcare provider.

**HIV PATIENT BILL OF RIGHTS**

- The person with HIV has the right to considerate and respectful care regardless of race, ethnicity, national origin, religion, age, sexual orientation, gender, or payment source.
- The person with HIV has the right to, and is encouraged to obtain current and understandable information concerning diagnosis, treatment and prognosis.
- The person with HIV has the right to know the identity of the physician, nurses and others involved in her care, including those who are students, residents or other trainees.
- The person with HIV has the right to work with the physician or nurse in establishing their plan of care, including the refusal of a recommended treatment, without the fear of reprisal or discrimination.
• The person living with HIV has the right to privacy.
• The person living with HIV has the right to expect that all records and communication are treated as confidential except in the case of abuse.
• The person living with HIV has the right to review his/her own medical records and request copies of them.
• The person living with HIV has the right to expect that an advance directive (such as a living will, health care power of attorney) will be honored by the medical staff.
• The person living with HIV has the right to receive timely notice and explanation of changes in fees or billing practices.
• The person living with HIV has the right to expect an appropriate amount of time during their medical visit to discuss their concerns and questions.
• The person living with HIV has the right to expect that his/her medical caregivers will follow universal precautions.
• The person living with HIV has the right to voice his/her concerns, complaints and questions about care and expect a timely response.
• The person living with HIV has the right to expect that the medical caregivers will give the necessary health services to the best of their ability. If a transfer of care is recommended, she should be informed of the benefits and alternatives.
• The person living with HIV has the right to know the relationships his/her medical caregivers have with outside parties (such as health care providers or insurers) that may influence treatment and care.
• The person living with HIV has the right to be told of realistic care alternatives when the current treatment is no longer working.
• The person living with HIV has the right to expect reasonable assistance to overcome language (including limited English proficiency), cultural, physical or communication barriers.
• The person living with HIV has the right to avoid lengthy delays in seeing medical providers; when delays occur, he/she should expect an explanation of why they occurred and, if appropriate, an apology.

**HIV PATIENT BILL OF RESPONSIBILITIES**

• Provide your medical caregivers with accurate and complete information, and convey your understanding about what is expected of you in regard to your treatment. If you believe you cannot follow through with your treatment, let them know.
• Meet your financial obligations as promptly as possible.
• Be considerate of the rights of other patients and medical personnel in the control of noise and respect of property at your appointments or in the hospital.
• Recognize the reality of risks and limits of the science of medical care and the human fallibility of the health care professional.
• Be aware of the health care provider’s obligation to be reasonably efficient and equitable in providing care to other patients and the community.
• Become knowledgeable about your health care plan.
• Report wrong doing and fraud to the appropriate personnel or legal authorities.
• Keep appointments and notify the clinic if unable to do so.
• Inform the clinic of the existence of, and any changes to, advance directives.
• Notify the clinic of changes in your condition or care situation.

**Session 3: Understanding lab values and medication adherence**

Understanding Lab Values Conversation starter:
Your doctor will order blood tests on a regular basis to check HIV progression, see if your medications are working (if you’re taking medications), and determine the effects of HIV and medications on your organ function. This is why it’s so important to come in to get your blood drawn every 3-4 months; if you don’t, it will be very hard to take control of HIV and understand how the medications impact the virus.

We’re not going to cover every single blood test in this session, just the most common ones including: CD4 count, CD4 percent, viral load count, complete blood-cell count, liver function, kidney function, lipid profile, blood pressure, glucose levels, cholesterol, etc. These tests tell a story about your health and what needs to be done to keep you healthy.

We’ll also discuss healthy heart health and the effects of HIV disease.

Another reason to get your labs done regularly and understand what the numbers mean is that you and your doctor can do certain things to change the lab values if they’re not normal. For example, if your cholesterol is too high, you and your doctor can intervene to lower it. If your CD4 is too low, you and your doctor can intervene to increase it.

It’s kind of like checking the oil in acar engine or taking a car in for a tune-up. If you don’t do these things, what will happen to your car eventually? [Responses: A car will need costly repairs or a person may need a new car.]

Routine screenings for preventive care are very important such as: eye exams, mammograms, PAPS, prostate, STD screenings. In addition, preventive care vaccines like flu, pneumonia and hepatitis are essential to maintaining good health.

Have you had labs done, and what were the results?

Let’s review them to ensure that you understand the different labs that are monitored. [Pull up patient’s record/Share printed copy of labs] We can also track your results on a spreadsheet or a grid. That way you can monitor independently and increase understanding of labs and your health. Always ask for a copy of your labs and keep them in one place so that if you move or change physicians, your new physician has a history of your care and treatment. If you are interested in making a spreadsheet, let’s make one together that you can update as you visit your doctor.

Let’s plan to meet again on ____________________

HIV medications conversation starter:

- HIV medications are beneficial for you. Because of HIV meds, many people are living longer, fuller lives. I don’t think many of us would be alive today if it weren’t for HIV meds. Many people are living longer – 10, 20, 30 years and beyond – because of HIV meds. You can too!
- Taking meds is one of the most important things you can do to take control of HIV.
- Each individual responds differently to meds: some people get intense side effects, while others get mild or no side effects; some people have side effects in the first 30 days and then they disappear. Because of this, it is important not to judge how your body will respond to medications by other people’s experiences but from your own experience.
- Remember: the benefits of taking meds outweigh any difficulty taking them. Remember, too, that if they don’t work for you, your doctor can put you on different meds until you find the ones that are just right for you.
- We’re fortunate that today there are many meds to choose from, and newer meds have fewer side effects than the older ones.
- Taking meds can feel complicated at first, but once you develop a daily routine, it gets easier.
- I can give you ideas about how to remember to take meds on time, how to take them correctly, and I will be here for you whenever you need to talk about them.
• It’s a big commitment, but one that eventually becomes second nature for most, and one that could bring you good, stable health and long life.
• Together we – you, me, the doctor, case manager and anyone else involved in your care – can minimize any negative experiences that may (or may not) develop.
• Now, let’s take a look at the goals of HIV meds and how they work to stop HIV from multiplying in order to give your immune system a fighting chance.
• Let’s look at the different combination of medications that are available and where they work in the viral life cycle to reduce the virus.
• Let’s plan to meet again on ____________________

Drug resistance & adherence conversation starter:
  • Today’s session builds on the last session we had on HIV medications: adherence, resistance and managing side effects.
  • Adherence means “sticking to your medication schedule” at least 95% of the time. It means taking your meds correctly and on time every day. It also means managing side effects so that you’re not discouraged from continuing to take your meds.
  • Most people who stop taking meds do so because of side effects. Perhaps they didn’t have information about how to manage side effects, or no one helped them learn how to manage them. But you have a team of people supporting you in sticking to your meds and identifying possible barriers to adherence, including me. In addition, there are many methods and tools (e.g. pillboxes, calendars, alarm watches, etc.) available to help.
  • We’ll also talk about medication resistance; there are different types, and some are the direct result of non-adherence.
  • Resistance means that the meds no longer work in blocking HIV from multiplying. HIV usually becomes resistant when it is not totally controlled by medications. Now, let’s get started.
    o (USE Handout Viral load and non-adherence).
    o When you take medications correctly your viral load goes down—because the treatment stops the virus from growing in the body.
    o If you miss one or two doses—the virus becomes “resistant” to treatment and can start growing in the body.
    o Eventually if you keep missing doses or stop taking meds as directed by your doctor, the treatment will not work to stop the virus. The virus will become resistant until your doctor can find a new treatment.

Managing side effects conversation starter:
  • Many side effects are related to your digestive system, e.g., nausea, diarrhea, bloating, gas, etc. Many people manage these with other medications or certain foods:
    o BRAT diet: Bananas, Rice, Applesauce, and Toast
      ▪ Apples and apple products like apple juice and apple sauce
      ▪ Black or green decaf tea
      ▪ Boiled white rice
      ▪ White toast
    o Ginger and ginger products like ginger tea, candied ginger, ginger ale, ginger snaps, etc.
    o Yogurt
    o Soda crackers or saltines
    o Fiber-rich foods or supplements
    o Medication: Imodium AD (loperamide)
- It’s always important to contact your provider immediately to let them know if you’re experiencing side effects.
- Never stop taking your medications without getting guidance from your providers.

**Handouts**
- Monitoring Tests for People with HIV (attached PDF)
- How medications work
  - Youtube videos:
    - How HIV treatment works: [https://www.youtube.com/watch?v=06mQyXQlR08](https://www.youtube.com/watch?v=06mQyXQlR08)
    - Understanding HIV treatments: [https://www.youtube.com/watch?v=8OO3tTj2XFe](https://www.youtube.com/watch?v=8OO3tTj2XFe)
- Assessing Adherence (below)
- Resistance and Viral load (below)

**Addressing Adherence: 10 questions care coordinators should ask their patients**
1. Which medications are you currently taking?
2. How frequently do you have to take each one of your meds?
3. What are the food restrictions for each of your meds (i.e. with or without food)?
4. Why do you think some meds need to be taken with food and some on an empty stomach?
5. Why do you think that some medications are taken once a day and others twice a day?
6. What helps you remember to take your meds?
7. What do you do when you miss a dose?
8. What problems have you encountered from taking meds?
9. How soon before you run out of medications do you order refills?
10. Do you believe the meds are helping you and if so, how?

**Boundaries to Adherence: To be filled out by the care coordinator and the patient**

Date:

Patient name:

Care coordinator:

<table>
<thead>
<tr>
<th>Past/current barriers to adherence</th>
<th>Strategies to overcome barriers</th>
</tr>
</thead>
<tbody>
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Appendix J. SAMPLE MOU with HRSA Language

*The following is a SAMPLE MOU from a prior SPNS initiative. This sample MOU has been provided to help guide the process of creating a site-specific MOU.

SAMPLE MEMORANDUM OF UNDERSTANDING BETWEEN CORRECTIONAL HEALTH SERVICES

This Memorandum of Understanding ("MOU") describes the intended working relationship between Correctional Health Services ("CHS"), located at 200 Construction Way, East Elmhurst, New York, 11370, Tel: (347) 774-7170 and ______________ ("Service Provider") with an office at _______________ Tel: ______________ (each a "Party" and, collectively, the "Parties").

This MOU is a good faith agreement that demonstrates a plan for collaboration which will facilitate the referral for, and provision of, effectively coordinated and integrated services for people incarcerated in NYC jails, their families, visitors and/or people returning to the community after incarceration ("patients") in need of health-related services or service referrals and is not intended to be binding on the Parties.

The Parties agree that they will endeavor to conduct the following:

1) CHS will make efforts to refer patients to the Service Provider for the purpose of linking patients to health providers in the community. The Parties will endeavor to accept referrals from each other in accordance with eligibility criteria.

2) The Service Provider will endeavor to participate in a collaborative program to outreach to inmates, their partners/families at the central visit center and at other special events at Riker’s Island in order to explain the services that the Service Provider offers within its community area.

3) CHS staff may request joint participation with Service Provider in a patient case referral ("Joint Participation"). Joint Participation may include, but not be limited to case conferences and staff risk assessment prior to making and/or accepting referrals. Further, CHS may conduct referral follow-up to insure adequate participation.

4) The Service Provider is willing and able to collect and report clinical data from participants seen at community medical providers after release from NYC Jails including Rikers Island to CHS consistent with federal grant award. The Service Provider 1) is willing and able to collected and report such clinical data to the Evaluation and Technical Assistance Center (ETAC) and HRSA /HAB Special Projects of National Significance (SPNS) Program staff will obtain Institutional Review Board (IRB) approval and annual renewals to collect and report this data; and 3) is willing to submit these IRB approvals and renewals to the ETAC and SPNS Program staff. The Service Provider is also willing to obtain appropriate approvals to agree to conform to DOHMH IRB approvals.

5) CHS maintains specific protocols for patient assessment, interviews, referrals, linkages, and confirmation of referrals with providers. These protocols are supplemented with detailed memoranda of understanding with other community-based partners to ensure that discharged inmates have access to HIV secondary prevention and other services (i.e. primary care, medical and mental health services, social services, respite or support services). CHS protocols are
guidelines for the Service Provider to follow and will be provided by CHS, if requested by the Service Provider, for the Service Provider’s benefit.

6) All referrals made should be confirmed by the Service Provider, contacting offices to set up the appointment and to confirm the appointment was kept. The service provider will seek any needed consent from enrolled participants to provide follow-up information regarding continuity of care (ie appointments made and kept) to CHS.

7) CHS and Service Provider should endeavor to meet on occasion to discuss issues related to program implementation, referrals or other programmatic issues.

8) In matters concerning confidential patient information, including confidential HIV related information, all interactions between and within the Parties should conform with all relevant laws, rules and regulations including, but not limited to Article 27-F of the New York State Public Health Law.

9) This MOU is merely a statement of the intended responsibilities among the Parties. No element of this MOU will be construed to imply any form of financial obligation or liability on to the other nor does it impose responsibility for actions of one Party upon the other.