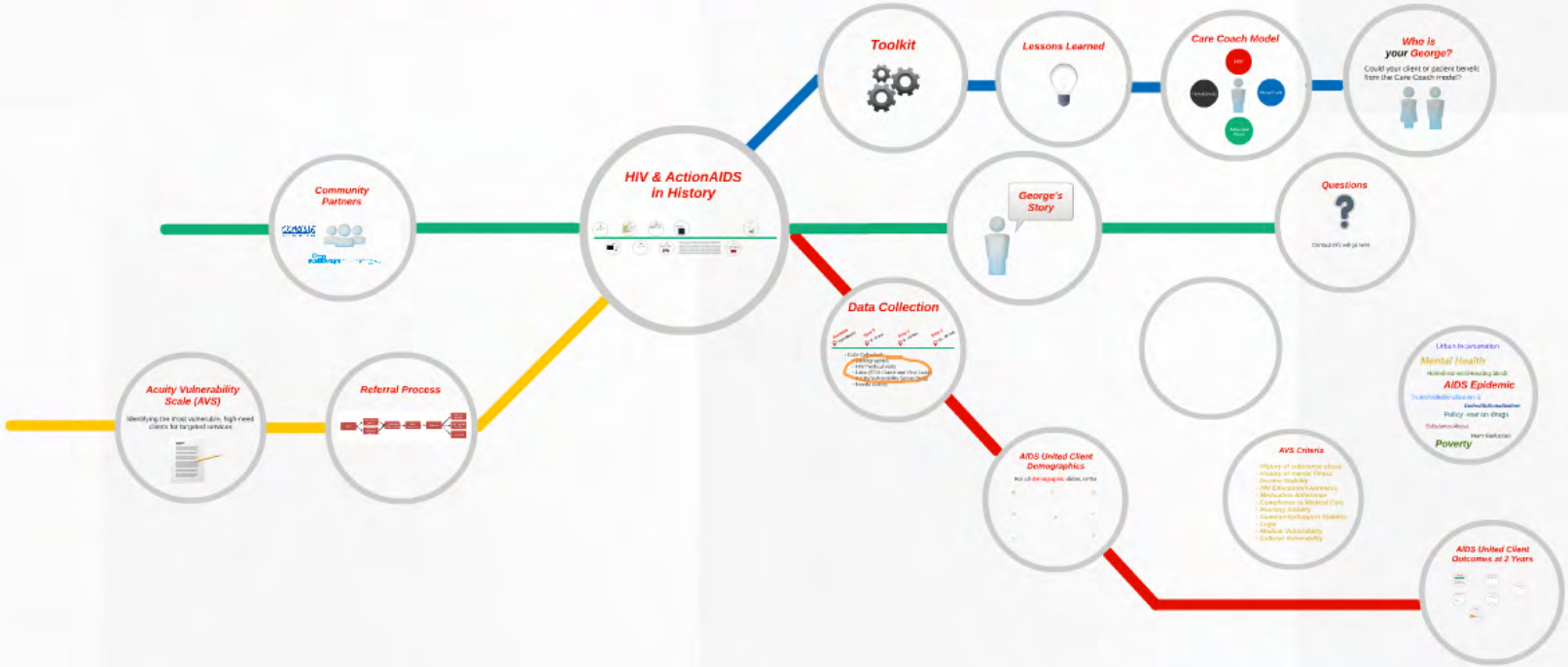
Bridging the Gap of Medical Linkage with HIV Positive Inmates:

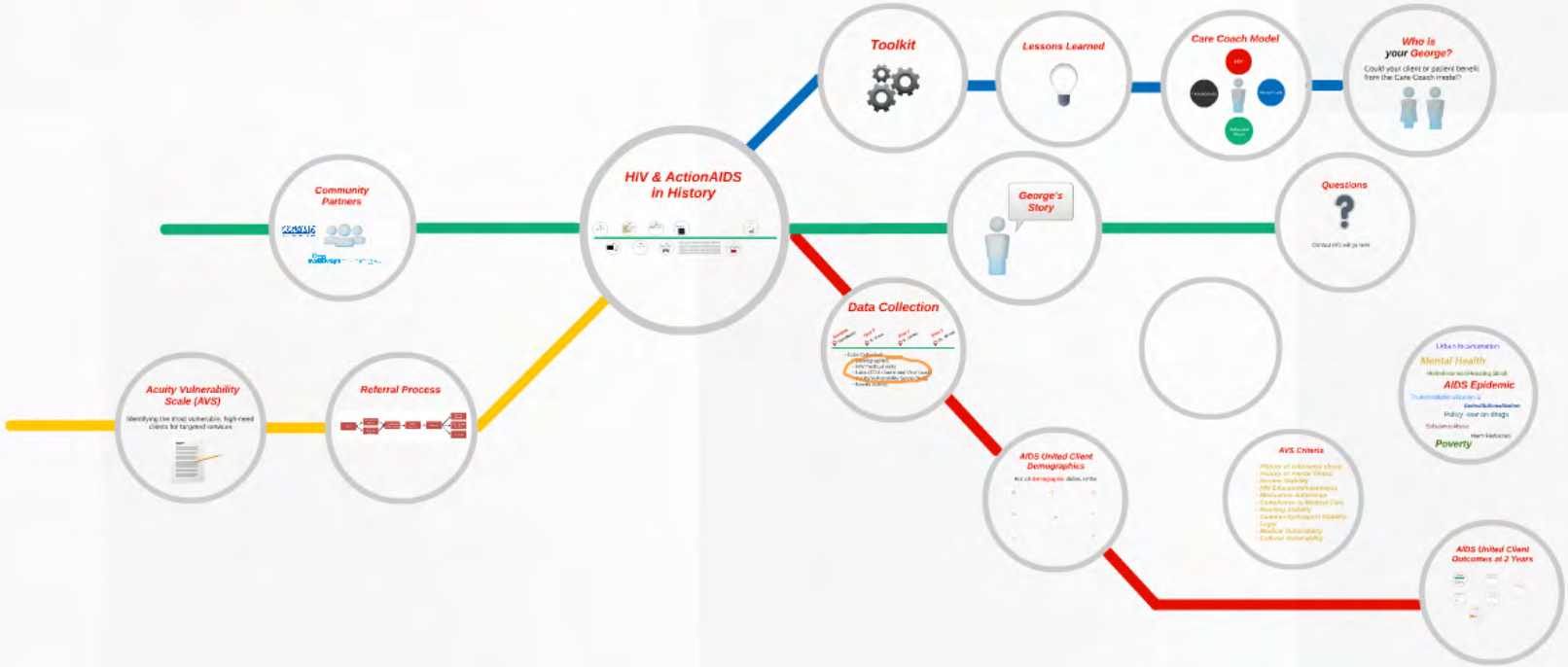
The Care Coach Collaborative Model



Prezi

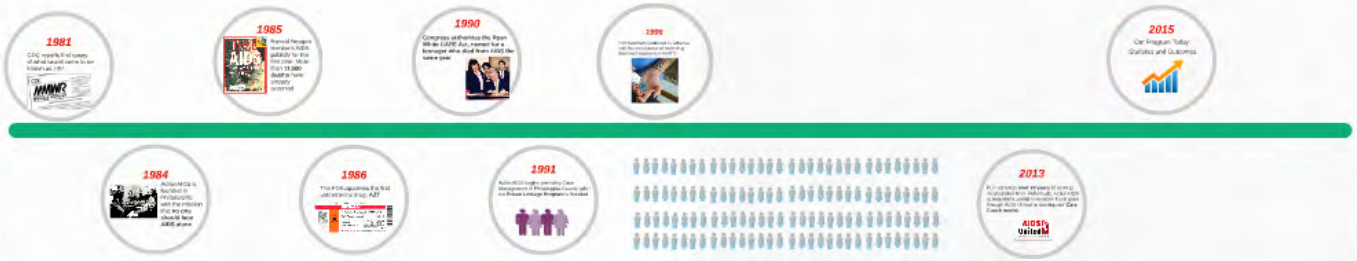
Bridging the Gap of Medical Linkage with HIV Positive Inmates:

The Care Coach Collaborative Model



Prezi

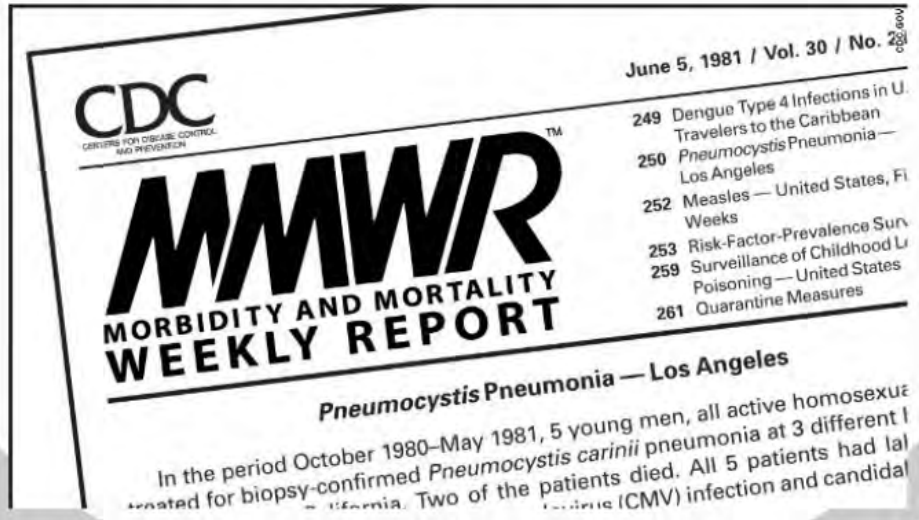
HIV & ActionAIDS in History



Prezi

1981

CDC reports first cases of what would come to be known as HIV



CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

MMWR™
MORBIDITY AND MORTALITY WEEKLY REPORT

June 5, 1981 / Vol. 30 / No. 2

249 Dengue Type 4 Infections in U. Travelers to the Caribbean
250 *Pneumocystis* Pneumonia — Los Angeles
252 Measles — United States, Fi Weeks
253 Risk-Factor-Prevalence Sur
259 Surveillance of Childhood L Poisoning — United States
261 Quarantine Measures

***Pneumocystis* Pneumonia — Los Angeles**

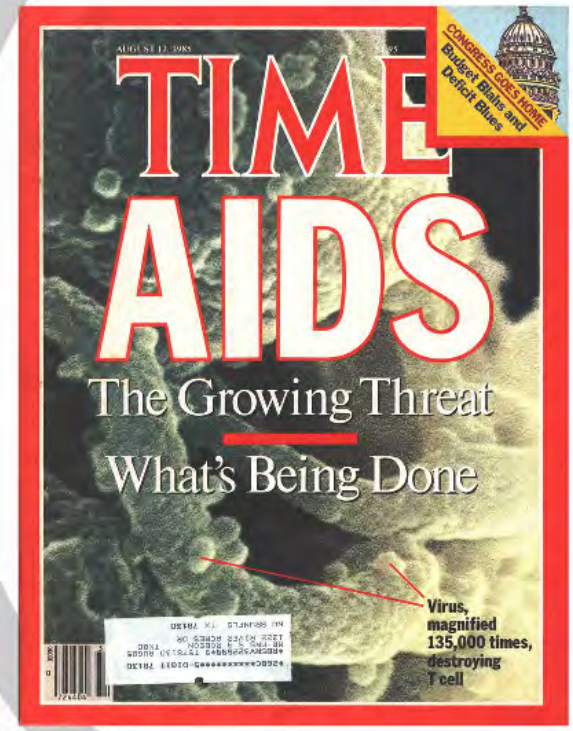
In the period October 1980–May 1981, 5 young men, all active homosexua treated for biopsy-confirmed *Pneumocystis carinii* pneumonia at 3 different l ...lifornia. Two of the patients died. All 5 patients had lal ...virus (CMV) infection and candidal

1984

ActionAIDS is founded in Philadelphia with the mission that **no one should face AIDS alone**

Prezi

1985



Ronald Reagan mentions AIDS publicly for the first time. More than **11,000 deaths** have already occurred

Prezi

1986

The FDA approves the first antiretroviral drug, **AZT**

Prezi

1990

Congress authorizes the Ryan White CARE Act, named for a teenager who died from AIDS the same year

Prezi

1991

ActionAIDS begins providing Case Management in Philadelphia County jails - the **Prison Linkage Program** is founded

Prezi

1996

HIV treatment continues to advance with the introduction of multi-drug treatment regimens (HAART)

Prezi

2013

PLP achieves **over 20 years** of serving incarcerated HIV+ individuals. ActionAIDS is awarded a Social Innovation Fund grant through AIDS United to develop our **Care Coach model.**

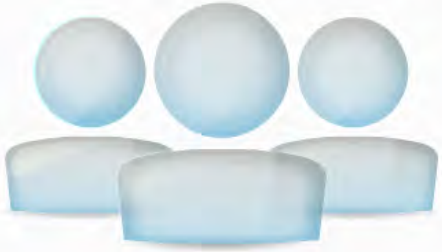
AIDS United

EVERY PERSON EVERY COMMUNITY

Prezi

Community Partners

COMHAR INC.
Quality Care by Caring Professionals



GAUDENZIA

Pathways to Housing PA

Prezi

Acuity Vulnerability Scale (AVS)

Identifying the most vulnerable, high-need clients for targeted services

Prezi

AVS Criteria

- History of substance abuse
- History of mental illness
- Income Stability
- HIV Education/Awareness
- Medication Adherence
- Compliance to Medical Care
- Housing Stability
- Community/Support Stability
- Legal
- Medical Vulnerability
- Cultural Vulnerability

Prezi

Referral Process

Prezi

Urban Incarceration

Mental Health

Homelessness/Housing Stock

AIDS Epidemic

Transinstitutionalization &

Deinstitutionalization

Policy -war on drugs

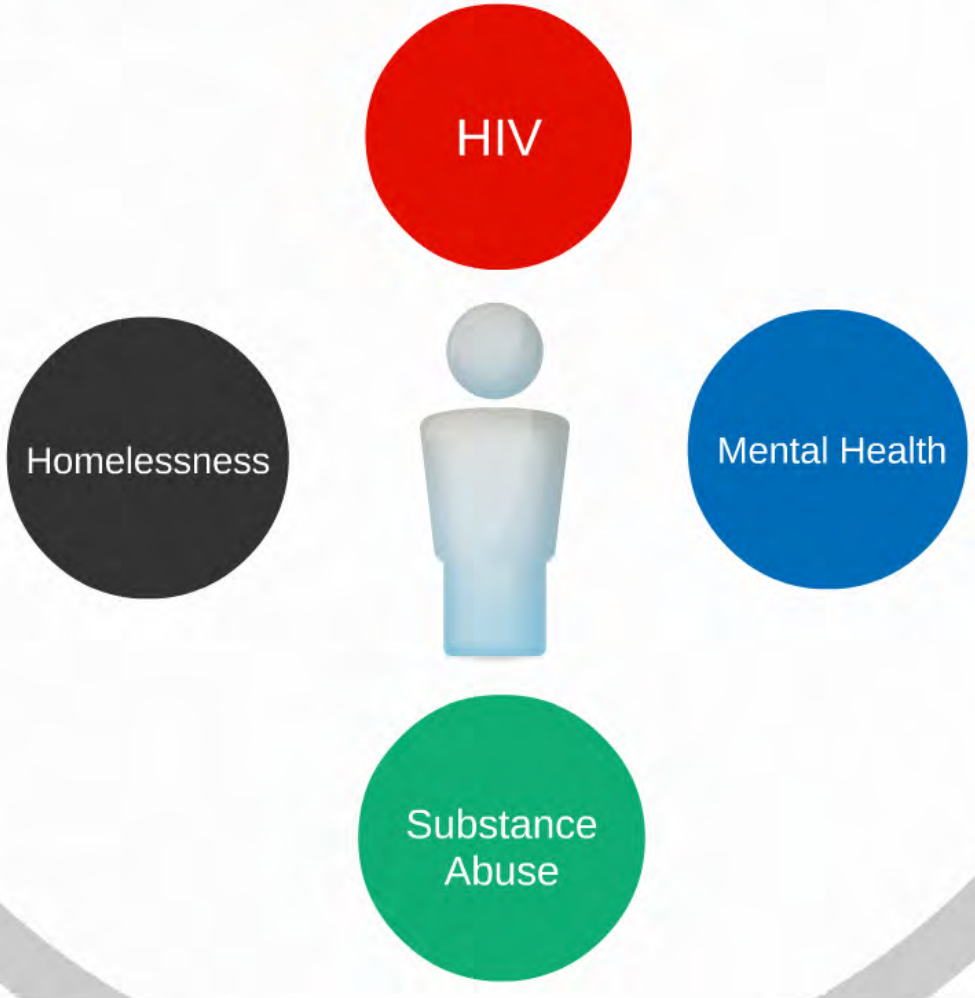
Substance Abuse

Harm Reduction

Poverty

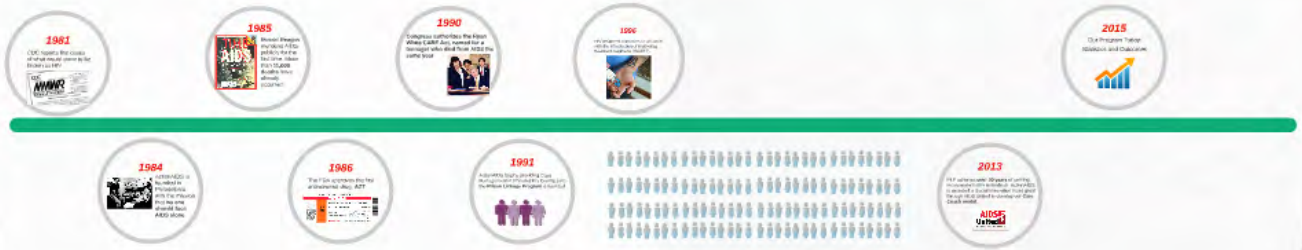
Prezi

Care Coach Model



Prezi

HIV & ActionAIDS in History



Prezi

2015

Our Program Today:

Statistics and Outcomes

Prezi

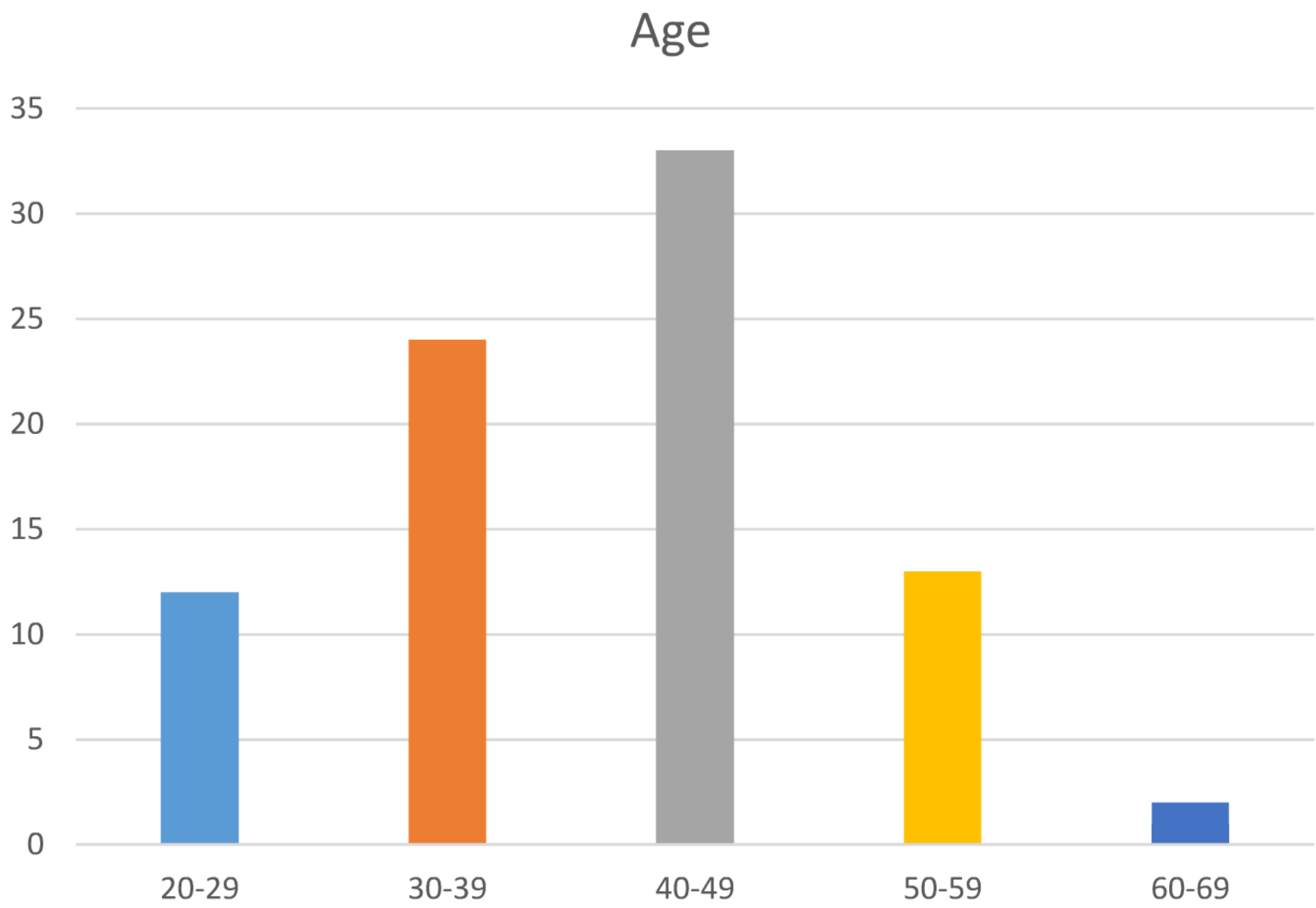
Data Collection

- Data Collected:
  - Demographics
  - HIV medical visits
  - Labs (CD4 Count and Viral Load)
  - Acuity Vulnerability Score (AVS)
  - Needs Survey

Prezi

AIDS United Client Demographics

For all demographic slides, n=84



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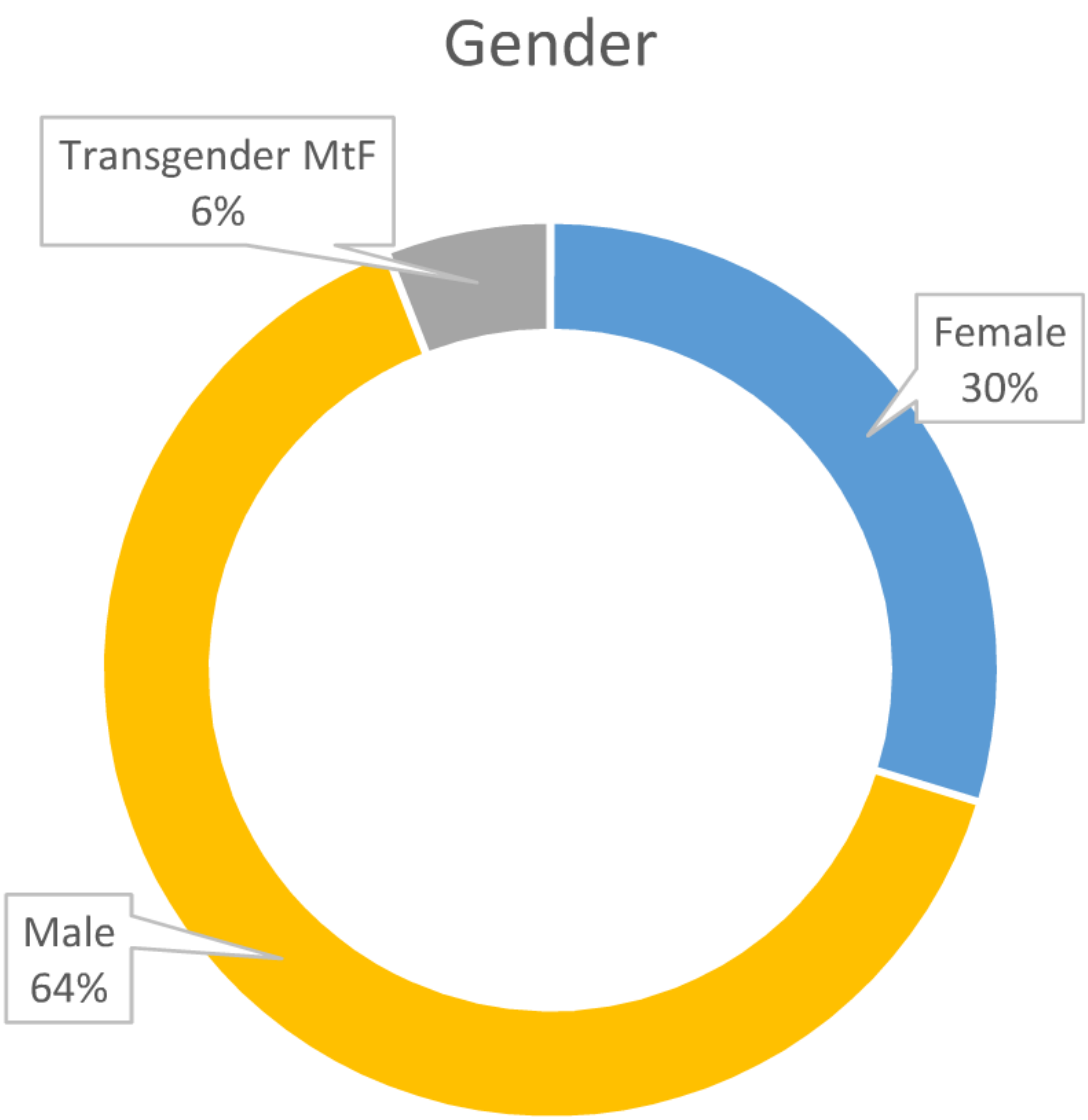

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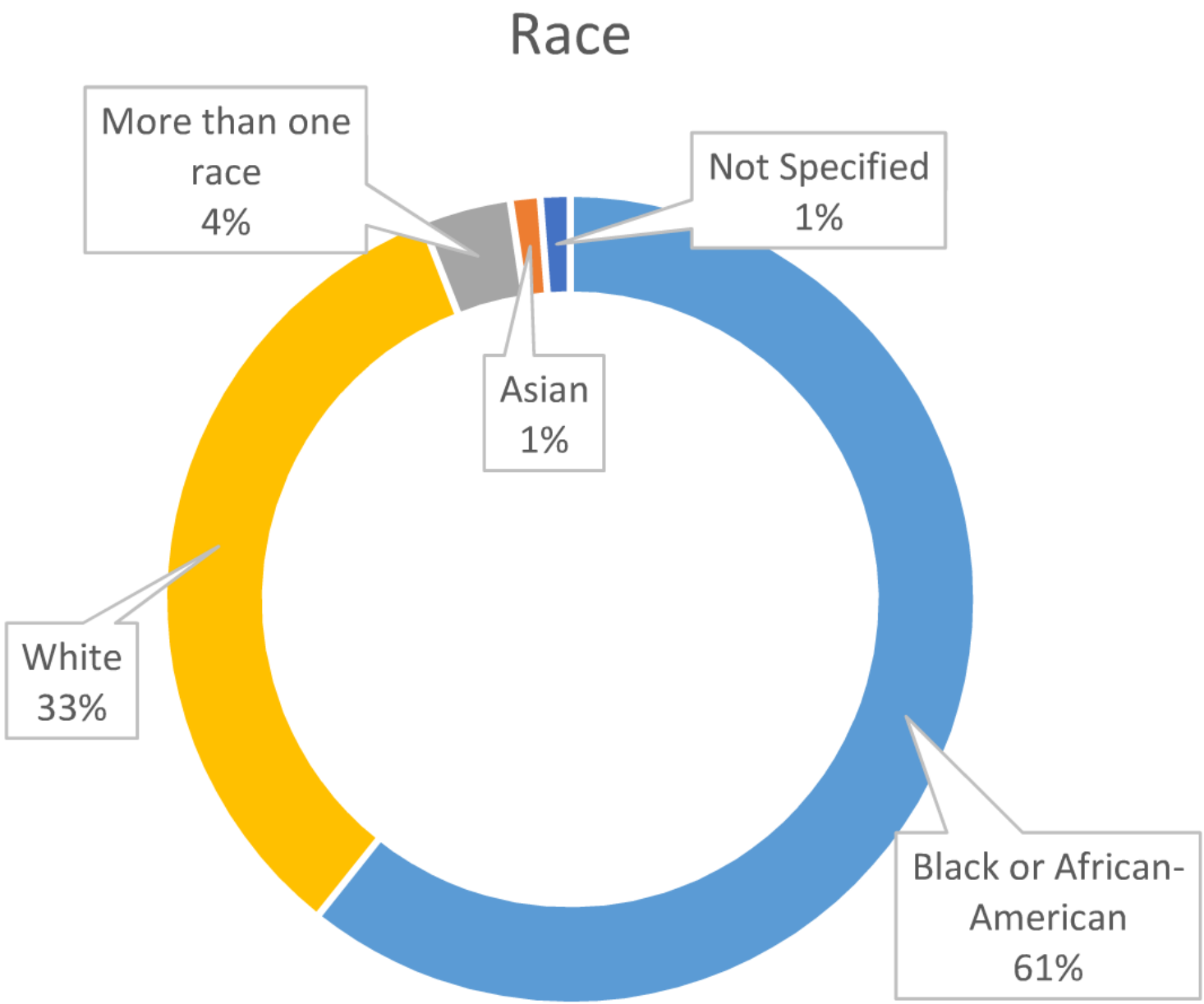
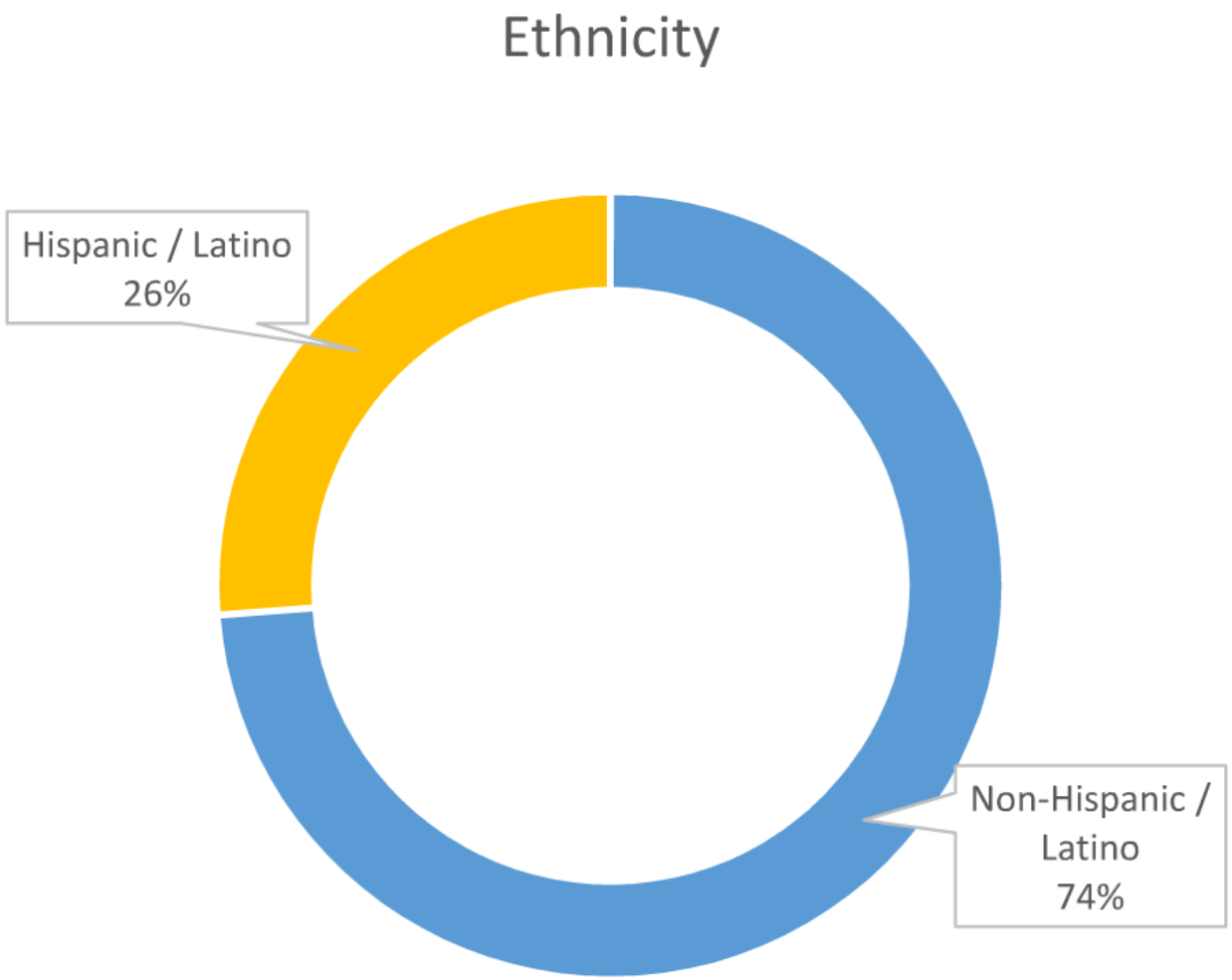

Race
More than one race 4%
Not Specified 1%
Asian 1%
White 33%
Black or African-American 61%

Prezi



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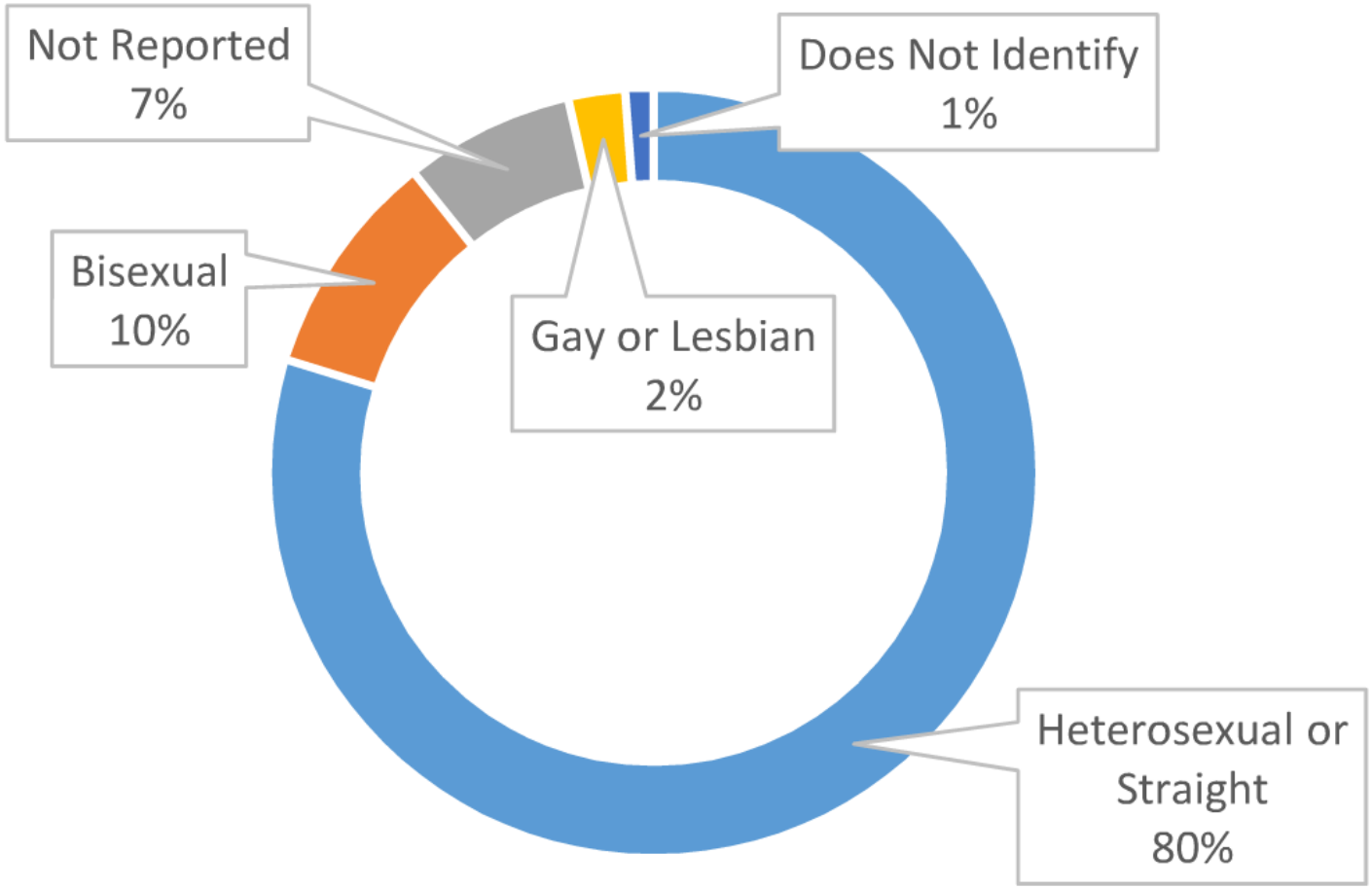
Sexual Orientation



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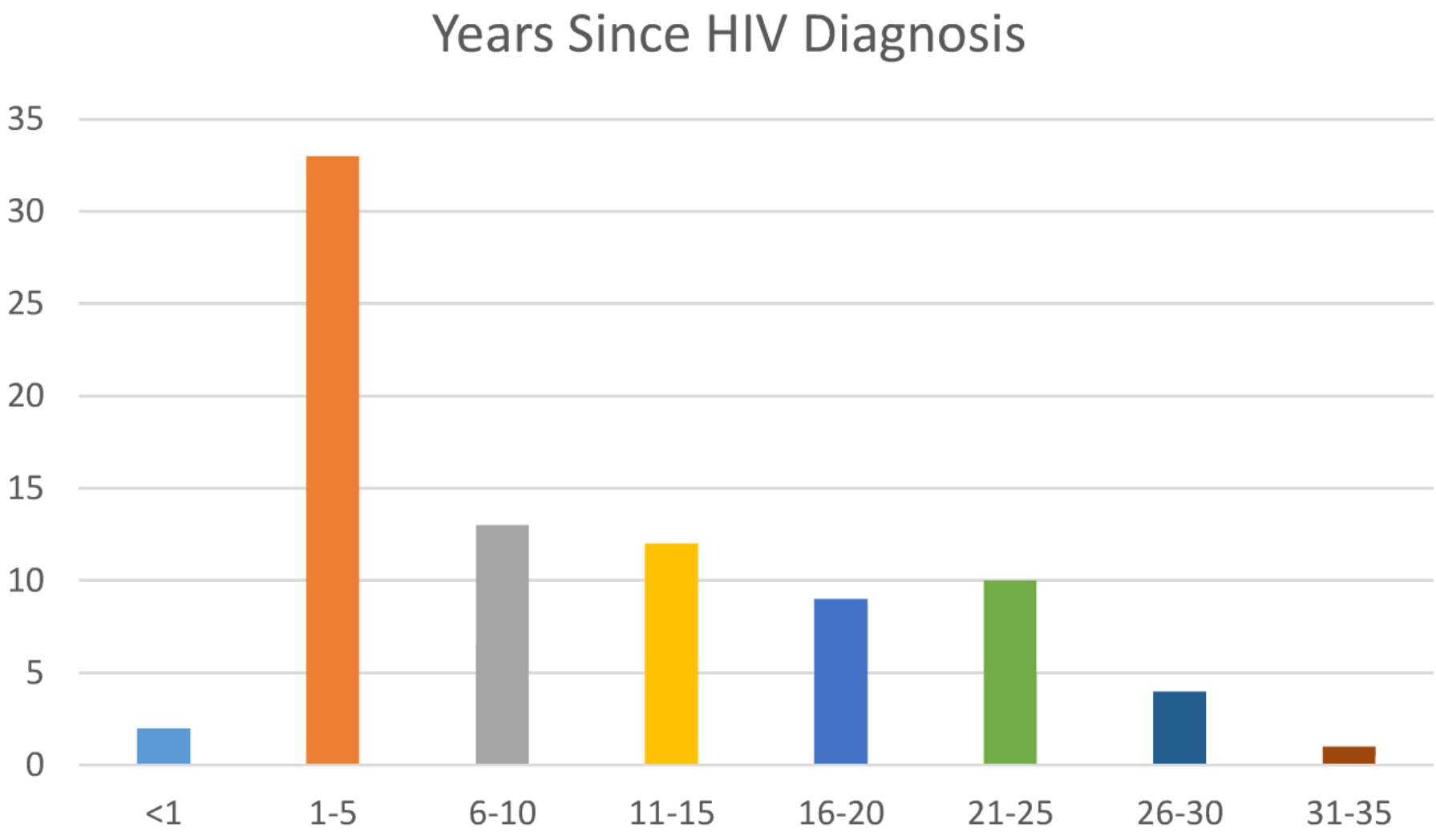
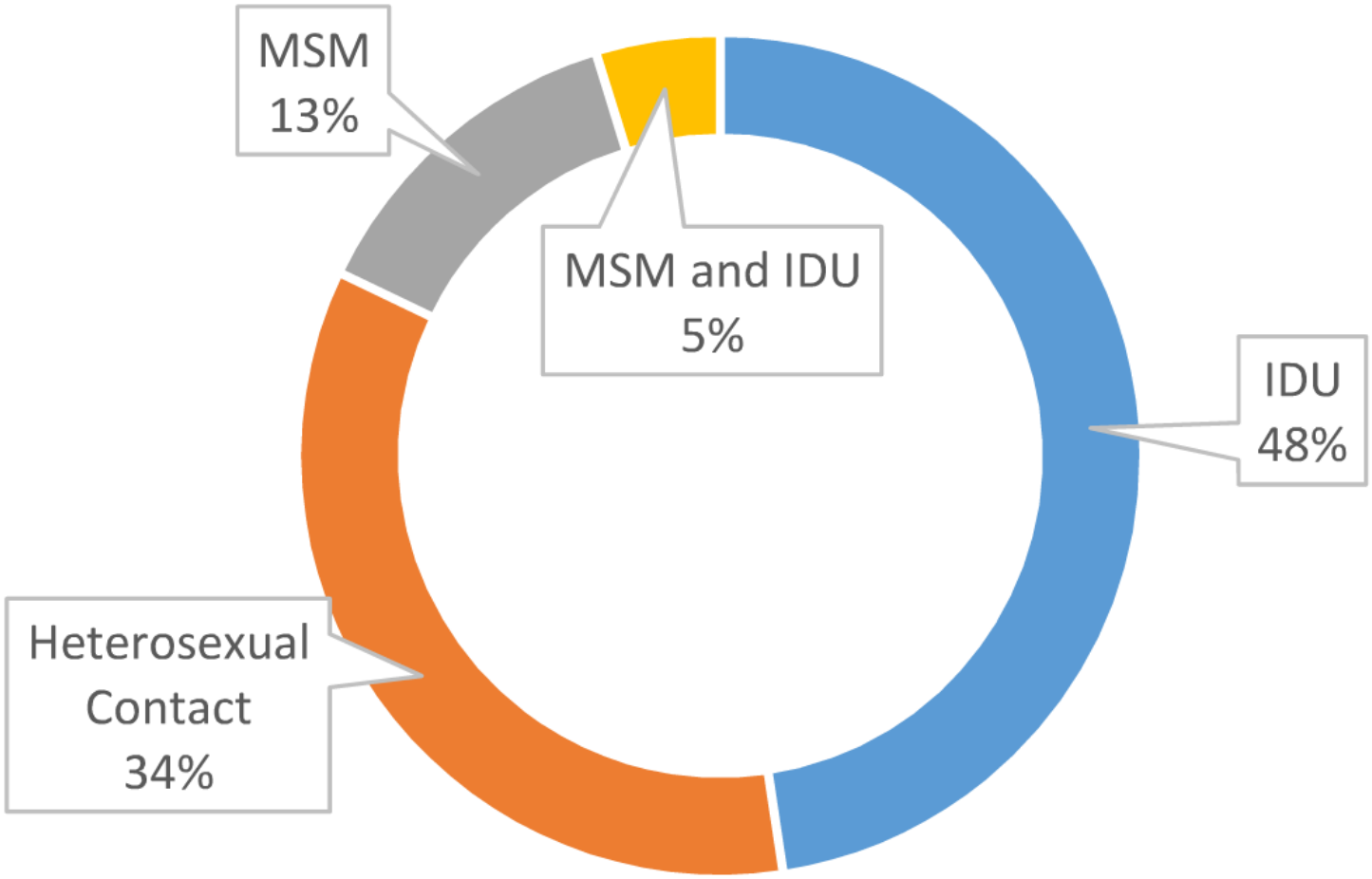

Years Since HIV Diagnosis
35
30
25
20
15
10
5
0
<1
1-5
6-10
11-15
16-20
21-25
26-30
31-35

Prezi

HIV Risk Factor



Prezi

45% of AIDS United clients are coinfected with Hepatitis C, compared to **21%** of all ActionAIDS Case Management clients.

48% of AIDS United clients report IDU as their primary HIV risk factor, compared to **14%** of all ActionAIDS Case Management clients.

Prezi

AIDS United Client Outcomes at 2 Years

Prezi

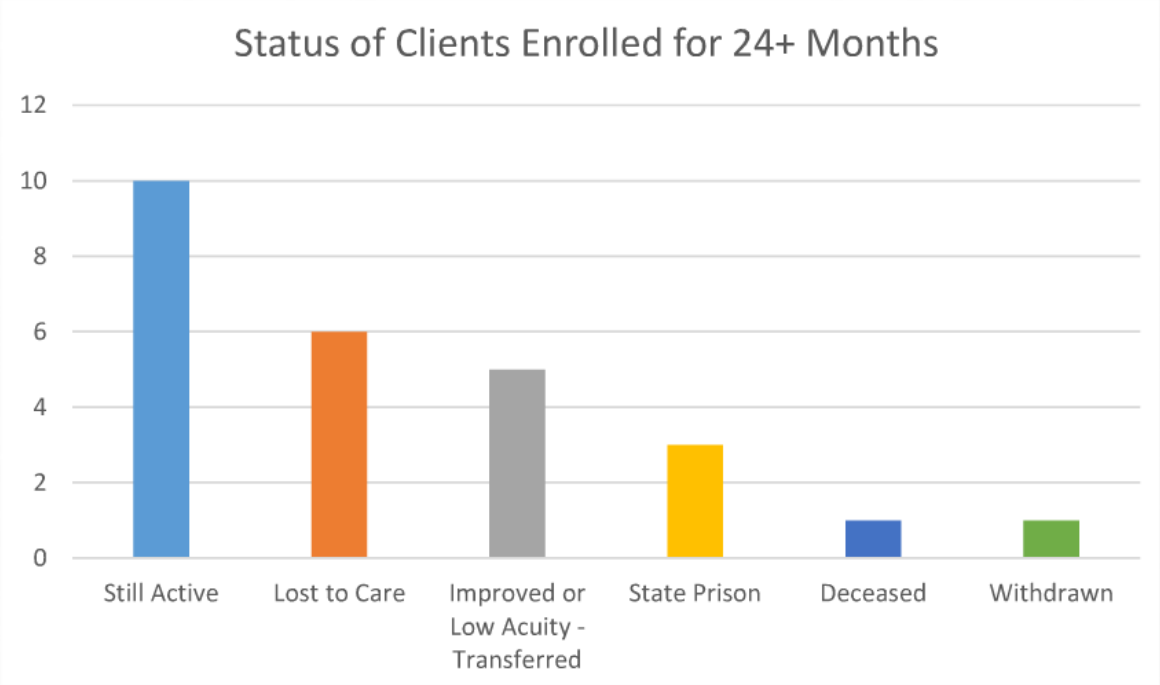
Overview

- 84 clients enrolled since the program began in May 2013 and have some follow-up data. These clients are currently in all four time frames, depending on when they enrolled.
- 26 clients have entered Time 3 as of 7/31/15; not all of them have complete data at each time frame.
- Missing data is an unavoidable problem in working with this population due to homelessness/transience, recidivism and parole/probation issues, drug use, active mental health issues, and other barriers.
- **For the purposes of this presentation, we will focus on clients who have data at all 4 time frames.** The number of clients considered for each measure will be noted on the slide.

Prezi

Where Are They Now?

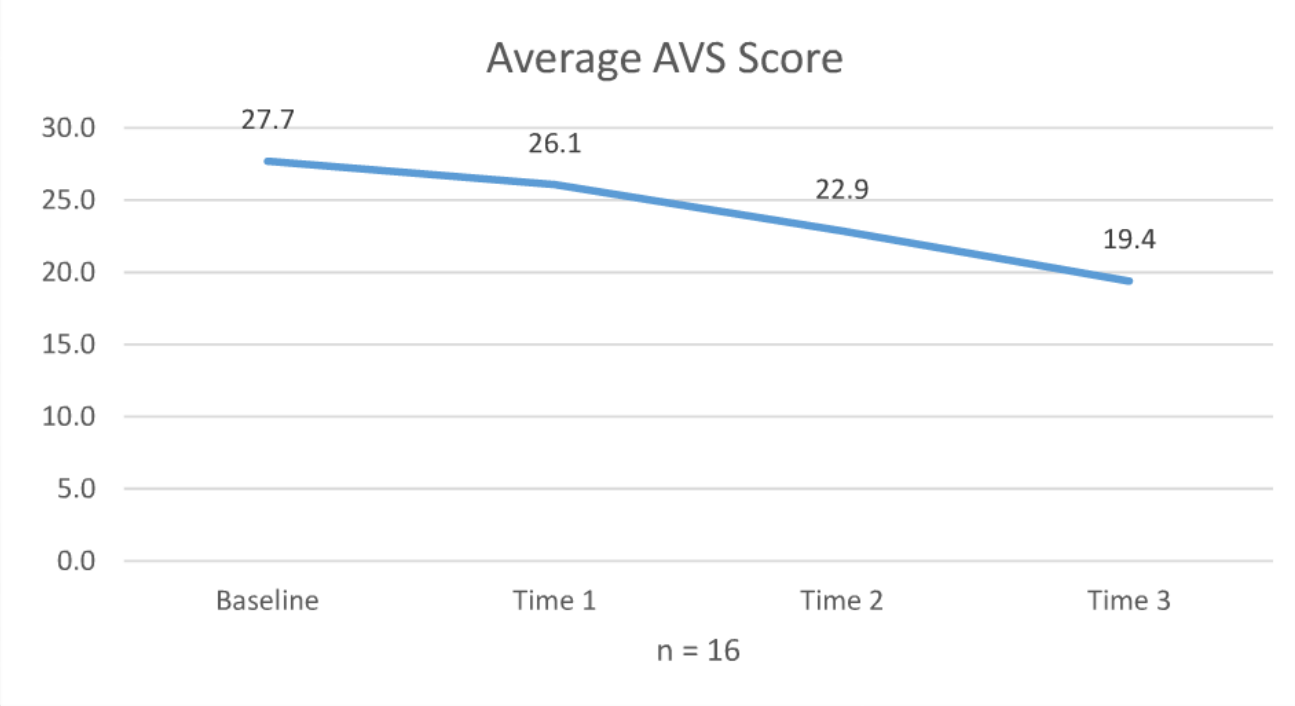
26 clients have entered Time 3 as of 7/31/15...



Prezi

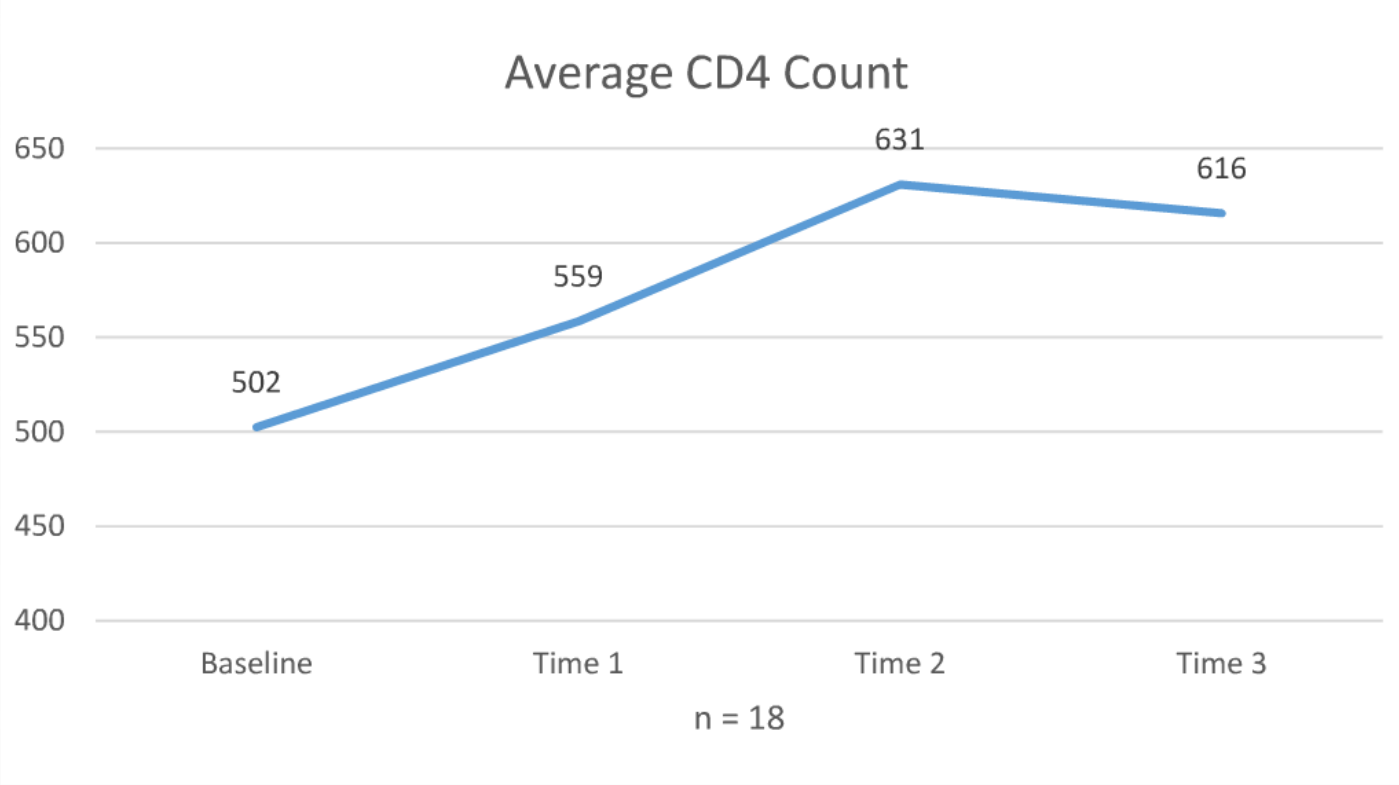
Acuity Vulnerability Scale

- Scale was revised multiple times over two years
- Scores were weighted out of a maximum of 30 points



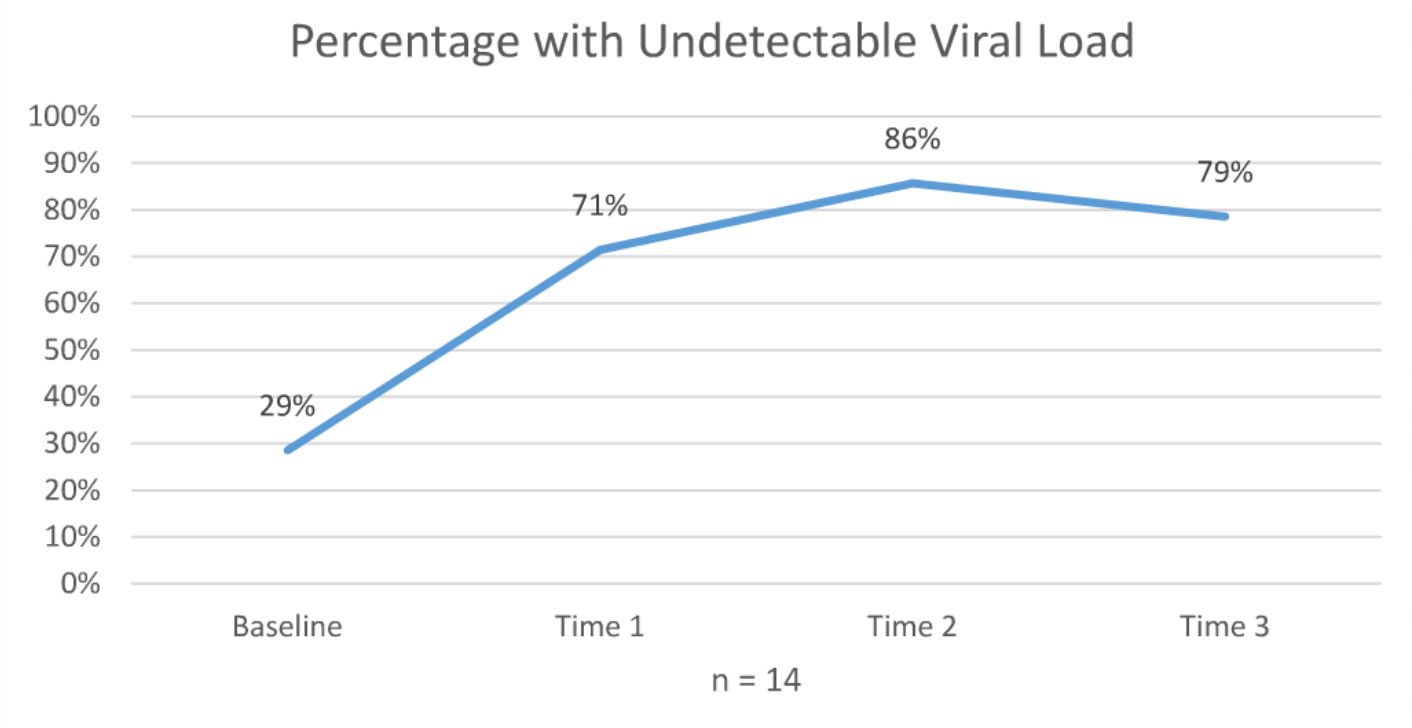
Prezi

CD4 Count



Prezi

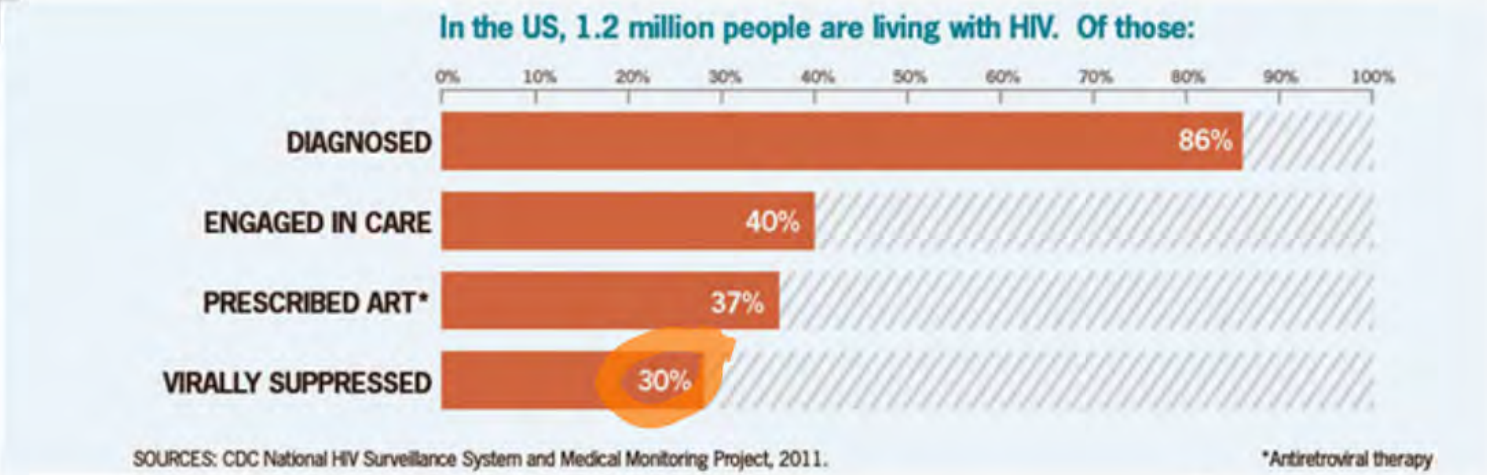
Viral Load



Assay <= 20

Prezi

National HIV Care Continuum



Source: AIDS.gov

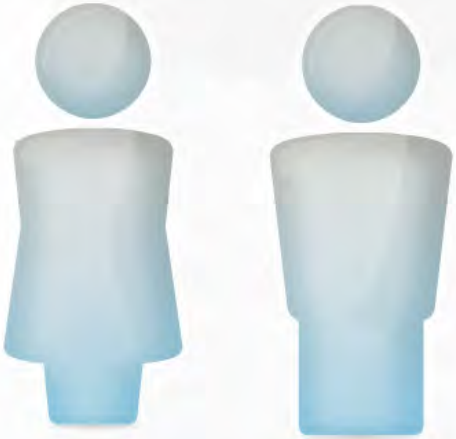
85% of Care Coach clients who remained engaged for 24 months achieved viral load suppression (<200 copies/mL)

George's Story

Prezi

Who is your George?

Could your client or patient benefit from the Care Coach model?



Prezi

Lessons Learned

Prezi

Toolkit

Prezi

Questions

Contact info will go here

Prezi

Care Coach Collaborative Model

Bridging Gap of Medical Linkage for HIV Positive Inmates — "Go home, kiss your Mother, and come into our offices." (Patsy Fitzgerald)

93% OF PARTICIPANTS IN THE CARE COACH PROGRAM WERE LINKED TO CARE

Background

ActionAIDS
FRIENDS FOR LIFE

The stages of HIV care, also known as the HIV care continuum, demonstrate significant gaps in HIV services, and efforts are underway at the federal, state, and local levels to develop and implement strategies to improve health outcomes for people living with HIV (PLWH). The HIV care continuum can be described by the following sequential steps: (1) diagnosis of HIV infection, (2) linkage to care, (3) retention in care, (4) receipt of antiretroviral therapy (ART), and (5) achievement of viral suppression (a very low level of HIV in the body). In the United States, there are 1.2 million people living with HIV, and according to the Centers for Disease Control and Prevention (CDC), 66% have been linked to HIV-specific medical care.[1] Engagement in care is a critical step in ensuring access to highly effective HIV treatment, which can ultimately lead to viral suppression. Viral suppression results in significantly improved health outcomes as well as dramatically decreased likelihood of HIV transmission (96% reduced risk of transmission).[2] According to the CDC, 30% of people living with HIV had achieved viral suppression, which means that only 3 out of 10 people living with HIV had the virus under control. Barriers to engagement in care include lack of stable housing, poverty, mental health and substance use issues, lack of access to culturally competent care, transportation, and other competing needs; interventions to engage people in HIV care must address these needs at the point of engagement in care as well as in subsequent support for retention in care. Improvements along the HIV continuum of care hold great promise for both treatment as well as prevention.

What Are We Doing?

Thanks to private-public partnerships, the Philadelphia Linkage Program has expanded its prison programming with the development and implementation of the Care Coach Collaborative Model. This model targets people living with HIV who are incarcerated and are identified as being most at-risk for becoming lost to HIV care and disengaged from vital care services. Our model provides case management and discharge planning services to incarcerated individuals living with HIV through their transition back into independent living, minimizing the likelihood that they will become lost to medical care, all while providing continuity of care. Interrelated factors that increase this likelihood have been associated with untreated mental health diagnosis, drug and alcohol dependency, and sub-standard housing and homelessness. Our intervention integrates collaboration with a provider organization designated in each of these specialized areas.

UNIQUE FEATURES OF THE CARE COACH PROGRAM

- The Care Coach Program has increased the time period post-release in which we are able to work with each enrolled individual. This allows us to **better retain** them in HIV medical care, decreasing the number of individuals falling out of medical services between HIV diagnosis, linkage and medical retention.
- Our Care Outreach Specialist works in tandem with Care Coaches to ensure each enrolled individual receives a level of support and access to HIV medical care and social services, which leads to **improved health outcomes**.
- At enrollment, individuals reported their greatest **need** as **housing/shelter (88%)**, and their largest **barrier** to care as **drug use (35%)**. The relationship we have established with our collaborative partners, allows for the **expedited access** to mental health, recovery services and housing services. The integration of these partner services has allowed for us to reduce, and in some cases, eliminate these external stressors, allowing for greater engagement in medical care services as well as increased access and adherence to ART.

[1] "HIV/AIDS Care Continuum." AIDS.gov. U.S. Department of Health & Human Services, 6 Mar. 2015. Web. 11 May 2015.
[2] "Prevention Benefits of HIV Treatment." Centers for Disease Control & Prevention, 2013. Web. 11 May 2015.

CLIENT STORY

"Melissa," a 49 year old African American heterosexual female with a 30+ year history of addiction, is chronically homeless, and was diagnosed with a mental health disorder that has gone untreated. Diagnosed with HIV in 1990, she declined antiretroviral therapy (ART) for 24 years until enrolled in the Care Coach Program while incarcerated in May 2014. Melissa had been out of general medical care for over 12 months at the time of incarceration and enrollment into ActionAIDS's program. Upon enrollment into the intervention, her lab work showed a relatively high viral load and a low CD4 count, indicating that her health was in decline and that she was in need of being reconnected to medical care and started on antiretroviral therapy. Since her enrollment, Melissa has been released from prison and remains engaged in services under her Care Coach and Care Outreach Specialist. She has been retained in medical care, having attended all but one of her five scheduled medical appointments and has been adherent to ART. Melissa's current viral load has been greatly reduced and is now undetectable, and her CD4 count has increased to 507, both indicating noteworthy health improvement and consistent engagement in medical care services. She was accepted to and remains a resident at a personal care home for PLWH and continues to work hard to maintain her recovery and outpatient mental health treatment.*

**Melissa is a pseudonym for a client at ActionAIDS.*

Initial Trends of the Care Coach Program

Within the first two years of program implementation, 84% of enrolled clients have been retained in HIV care services. We have seen an increase in viral load suppression between enrollment and 6- and 12-month follow-up appointments with clients.

Agency Overview

ActionAIDS is a Philadelphia-based organization, which works in partnership with people living with or affected by HIV/AIDS, to sustain and enhance their quality of life. We provide a range of services and take an active and professional approach to leadership in service, education, and advocacy. Our mission statement is simple: "**ActionAIDS believes that no one should face AIDS alone.**" Since 1986, ActionAIDS has grown to become Pennsylvania's largest AIDS Service organization and our services are relationship-focused, client-centered, and individualized to best provide each client with meaningful care services.

ActionAIDS
FRIENDS FOR LIFE

PROGRAM CONTACT

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6th Floor
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actionaids.org

This project was supported by a grant from AIDS United and the Social Innovation Fund (SIF), a program of the Corporation for National and Community Service (CNCS)

AIDS United

AIDSUNITED.~~ORG~~