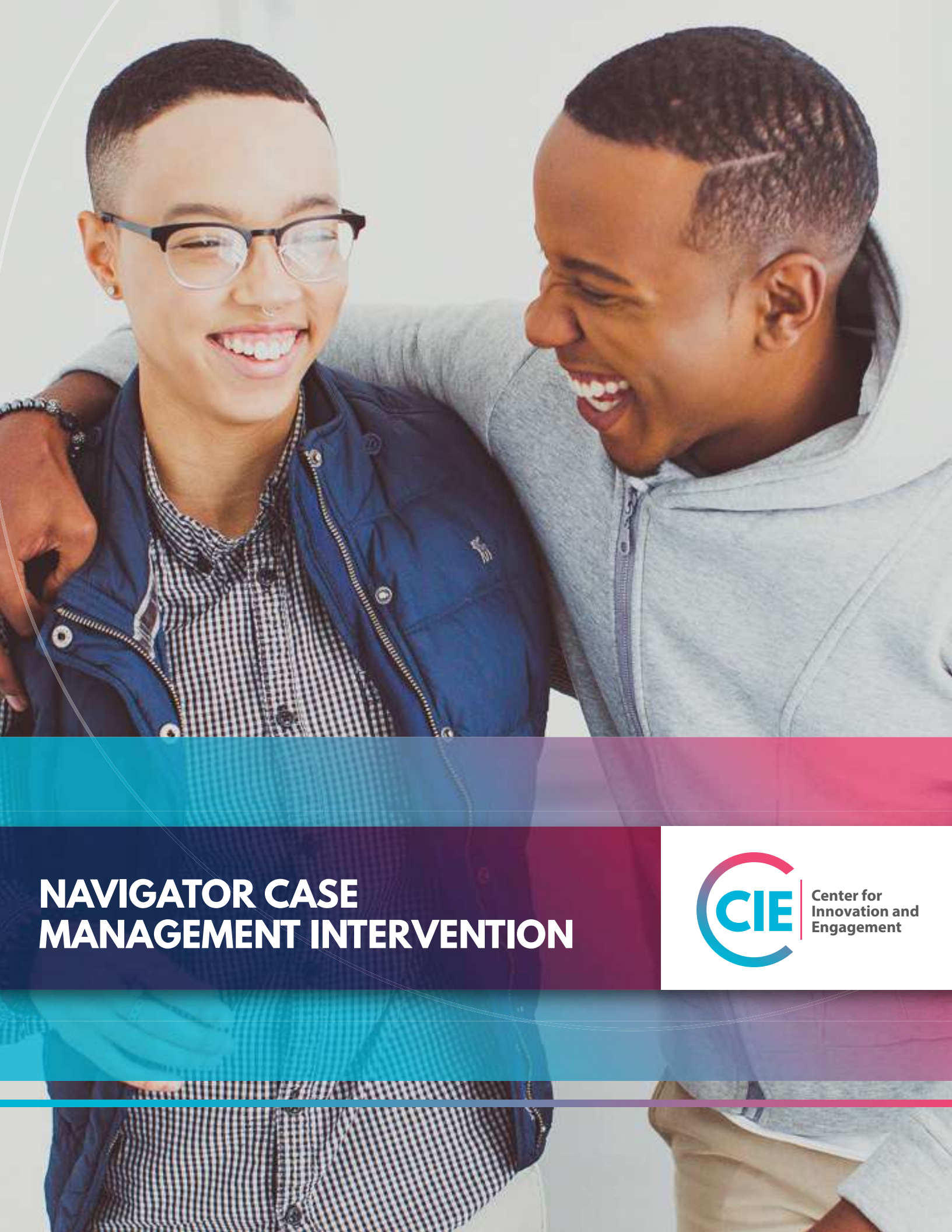

# NAVIGATOR CASE MANAGEMENT INTERVENTION

Center for Innovation and Engagement

## Background

The Health Resources and Services Administration's (HRSA's) Ryan White HIV/AIDS Program (RWHAP) provides a comprehensive system of HIV primary medical care, essential support services, and medications for low-income people living with HIV who are uninsured and underserved. RWHAP funds states, cities, counties, and local community-based organizations to provide care and treatment services to people with HIV to improve health outcomes and reduce HIV transmission among hard-to-reach populations.

NASTAD's Center for Innovation and Engagement (CIE) is funded by HRSA's HIV/AIDS Bureau (HAB), RWHAP Part F, Special Projects of National Significance (SPNS), under a three-year cooperative agreement entitled Evidence-Informed Approaches to Improving Health Outcomes for People with HIV. The purpose of this initiative is to identify, catalog, disseminate, and support the replication of evidence-informed approaches and interventions to engage people with HIV who are not receiving HIV health care or who are at risk of not continuing to receive HIV health care.


## Acknowledgements

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Stock photos. Posed by models.

## Intervention Snapshot

| | | |
|---|---|---|
|  | Priority Population | People with HIV who are currently incarcerated and are leaving jail |
|  | Setting | Jail |
|  | Pilot and Trial Sites | San Francisco County Jail |
|  | Model | The NCM intervention addresses the challenges faced by incarcerated individuals who are returning to the community by using a patient navigation-enhanced case management approach to support engagement in HIV care. The model leverages the expertise of patient navigators who assist case managers with monitoring clients' adherence to care and who mentor and counsel clients before and after their release from jail. |
|  | RWHAP Ending the Epidemic (EHE) Opportunity | An estimated one in seven people with HIV leave prison or jails each year in the United States, and many struggle to access care and treatment upon release, with as many as 95 percent experiencing a gap in HIV treatment. Intervention outcomes indicate that clients were twice as likely to be linked to care within 30 days of being released from jail and were almost twice as likely to be retained in care during the intervention period. Additionally, individuals who received treatment for substance use disorders were four times as likely to be linked to care upon release. |
|  | Intervention Funding | The intervention was funded and evaluated by a National Institute on Drug Abuse grant. |
|  | Staffing | Staff positions in the original intervention included a Deputy Director, Case Manager, Outreach Coordinator, and Patient Navigator. |
|  | Infrastructure Needed | Systems to facilitate care coordination, including linkage and referral to health and social services and relationships with local jails |

# Intervention Overview & Replication Tips

## Why This Intervention?

Navigator Case Management (NCM) is a 12-month linkage intervention for people with HIV who are incarcerated, leveraging harm reduction, prevention case management, and Motivational Interviewing techniques to promote healthy behaviors. NCM was originally implemented in the San Francisco County adult jail system[1] and used Project START's principles to facilitate post-release care services for clients with HIV who had a history of drug or alcohol use and who were incarcerated.[2] Project START is based on the research of an individual-level multi-session intervention for young men being released from prison and returning to the community. Project START is a client-centered HIV, sexually transmitted infection, and hepatitis risk-reduction and engagement-in-care intervention for people being released from prison or jail. Patient navigators used START's principles to support people with HIV who were receiving care while incarcerated through the Ryan White HIV/AIDS Program. They facilitated reentry into care in the community, provided referrals, and also counseled clients about how to avoid reincarceration.[3]

The NCM intervention utilized a peer navigation model by leveraging the expertise of patient navigators. They assisted case managers with monitoring clients' adherence to care and mentored and counseled clients before and after their release from jail. Patient navigators were people with HIV who provided peer support, and they had similar backgrounds and experiences to clients. They were thus an integral part of the care management team as they were able to relate to the client populations they were serving. Patient navigation can be an effective model of HIV care coordination that can facilitate greater continuity in care and treatment, particularly for people who have been recently released from the criminal justice system.[4] NCM also provided post-release planning support, education, legal

support, transportation assistance for medical and social service appointments, and referrals (e.g., mental health and substance use services, housing, food, employment, social benefits, health insurance) to clients. By facilitating access to these multilayered services, the NCM intervention aimed to reduce recidivism rates, substance use, and HIV transmission and help clients obtain and maintain housing, establish and sustain connections with providers, and achieve HIV medication adherence.[1]

## Study Findings

The NCM intervention's effectiveness and impact in linking and engaging people with HIV were demonstrated in a randomized controlled trial (RCT) implemented from 2010 to 2013 in the San Francisco County Jail. People with HIV who were incarcerated and who were likely to be released during the RCT recruitment phase were the focus of the study. Clients were randomly assigned to the control group that received standard case management or the intervention group that received navigation-enhanced case management. Standard case management consisted of discharge planning and up to 90 days of as-needed case management based on specifications developed and adopted in San Francisco. Clients enrolled in the study were surveyed while in jail to develop a baseline. Clients were surveyed again at two, six, and 12 months after release. The NCM intervention resulted in greater linkage to care within 30 days of a client's release from jail (odds ratio [OR]=2.15; 95 percent confidence interval [CI]=1.23, 3.75) and consistent retention over 12 months (OR=1.95; 95 percent CI=1.11, 3.46). A client's receipt of substance use treatment while in jail also resulted in early linkage (OR=4.06; 95 percent CI=1.93, 8.53) and retention (OR=2.52; 95 percent CI=1.21, 5.23). For this study, linkage to care was defined as having at least one documented non-urgent visit to a community medical provider within 30 days of being released from jail. Retention was defined as having had a non-urgent medical care visit between each of the follow-up visits (two, six, and 12 months).

A separate qualitative analysis of interactions between clients and patient navigators found that the clients' and patient navigators' shared life experiences fostered easy-to-build relationships and trust.[4] Patient navigators were sensitive to what life was like for their clients because they had previous experiences with incarceration and drug use and had HIV. The patient navigators' lived experiences made them indispensable to the intervention and highlighted the need for organizations to invest in similar public health interventions for priority populations. The NCM intervention helped to address gaps in transitional care for people leaving jail and demonstrated how patient navigation could support linkage and retention-in-care efforts and mitigate health and other structural inequities experienced by people with HIV who have been incarcerated.

**"[The intervention] was really providing intensive support to help people navigate to services that they may or may not be connected to. There are a lot of other case managers in the setting. But it was an opportunity for navigators to support people."**

– PRINCIPAL INVESTIGATOR

## Intervention at a Glance

This section describes the NCM intervention conducted in the San Francisco County Jail to help readers assess the steps required for replication. This intervention is intended for use in care settings, including clinics, community-based organizations, and jails.

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|  Step 1 | **Engage Stakeholders**<br>Meaningfully gather input from potential clients, providers, case managers, jail staff, and community-based organizations to gauge interest and identify shared outcomes. |
|  Step 2 | **Assess Gaps and Resources and Hire Staff**<br>Decide the priority populations that will be served by discussing existing service delivery gaps and health inequities both in and out of the jail setting. Identify and hire patient navigators and assign case managers who can work collaboratively on client cases. |
|  Step 3 | **Conduct Pre-Release Care Planning Activities**<br>Conduct a psychosocial needs and risk assessment and design an individualized, client-centered care plan that includes short and long-term goals for each client. Provide HIV education and counseling to clients. Connect clients to Ryan White HIV/AIDS Program AIDS Drug Assistance Program (ADAP) resources. |
|  Step 4 | **Monitor Legal Status of Clients**<br>Use the client's conditions of release from jail to inform post-release care plan activities. |
|  Step 5 | **Conduct Post-Release Care Plan Activities**<br>Assist clients within 24 hours after they are discharged from jail. Accompany clients to the central intervention site for an orientation and their identified housing. Coordinate clients' assessments to confirm information gathered during intake and identify needed support. Develop a care plan for each client. |
|  Step 6 | **Implement the Care Plan**<br>Provide ongoing support, coaching, and mentoring to clients. Secure transportation for clients to medical and social service appointments. Help clients obtain food and housing services. Provide insurance navigation and assist clients with creating their first medical appointments. |

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|  Step 7 | **Follow-up and Monitor Client Progress**<br>Communicate with the intervention team regarding client progress. Reassess clients' needs and respond to emerging needs. Coordinate reoccurring individual and group meetings for clients. |
|  Step 8 | **Graduate Clients**<br>Discuss the completion of the intervention and transition plan goals with clients and the broader intervention team. Highlight the client's achievements. |

## Cost Analysis

The NCM intervention was funded and evaluated by a National Institute of Health (NIH) National Institute on Drug Abuse (NIDA) grant. HRSA's RWHAP can also be used to fund core medical and support services to people with HIV who are incarcerated or were formerly incarcerated. (See Additional Resources Box). HRSA HAB's RWHAP Technical Expert Panel Executive Summary on Addressing the HIV Care Needs of People with HIV in State Prisons and Local Jails can provide more context. (See Additional Resources Box). Additionally, RWHAP's Policy Clarification Notice 18-02 outlines details on allowable costs. This resource provides guidance to HRSA RWHAP recipients and subrecipients on the use of program funds to provide HRSA RWHAP core medical services and support services: 1) on a transitional basis to people with HIV (PWH) who are incarcerated in Federal and State prison systems; and 2) on a short-term and/or transitional basis to PWH who are incarcerated in other correctional systems (e.g., local prisons and jails) or under community supervision (e.g., parole or home detention).

The NCM intervention cost analysis was not available when this guide was developed. However, you can use the CIE Cost Calculator to create an estimate of the cost of implementing the intervention at your organization. (See Additional Resources Box).

## Resources Assessment Checklist

Before implementing the NCM intervention, your organization should walk through the following Resources Assessment (or Readiness) Checklist to assess your ability to do this work. If your organization does not have these components in place, you are encouraged to further develop your capacity to conduct this intervention successfully. Questions to consider include:

- ❑ Have you identified the needs of the clients you plan to assist?
- ❑ Does your organization have a relationship with the jail (e.g., staff, medical teams, leadership)?
- ❑ Has your organization previously supported people who have been incarcerated?
- ❑ Can your organization serve as the central location for clients after they are released from jail?
- ❑ Can your organization offer flexible hours (e.g., drop-in)?
- ❑ Does your organization serve as a nexus between the courts, prosecution, and defense? If not, are you connected to an organization that can advocate for clients and liaise with judges and jail staff?
- ❑ Does your organization integrate a harm reduction lens into its work with people who have been incarcerated and who use substances (e.g., offer naloxone, make referrals to local syringe access services)? Harm reduction assumes that eliminating a potentially harmful behavior (e.g., substance misuse, sexual behaviors that put one's health at risk) may not be possible and seeks to decrease the negative consequences that may occur as a result of continuing the behavior.[5]
- ❑ Does your organization have connections to local organizations, agencies, and health centers to which you can refer clients after they are discharged from jail?
- ❑ Are transitional care programs available for clients?
- ❑ Does your organization have case managers who can assist with pre-and post-release planning and activities?
- ❑ Can your organization hire patient navigators who are representative of the client population?
- ❑ Does your organization have mechanisms in place to support people with lived experience working as patient navigators (e.g., investing in the development and retention of people with HIV, incarceration history, in recovery, etc.)?
- ❑ Have you designated a case manager to supervise and support the patient navigators?
- ❑ Has your staff received the proper training to deliver services and support to clients who are navigating the correctional system?
- ❑ Are financial resources available to sustain the intervention (e.g., state and city funding)?

## Setting the Stage

According to the U.S. Centers for Disease Control and Prevention (CDC), there are an estimated 1.2 million people with HIV in the United States.[6] During 2018, approximately 75.7 percent of people with HIV received HIV medical care, 57.9 percent were retained in care, and 64.7 percent were virally suppressed.[7] People with HIV who receive ongoing, regularly scheduled care are more likely to have significantly lower viral loads, higher CD4 cell counts, reduced morbidity and mortality, and improved overall health than those who missed even one medical visit over a two-year period.[8] Receipt of medical care is defined as one or more tests (CD4 or viral load) in the measurement year. While significant strides have been made in ensuring people with HIV effectively progress through the HIV care continuum, these figures demonstrate that retention continues to be a critical issue. In 2014, approximately 38 percent of people with HIV were not in care, and, therefore, more likely to not be virally suppressed.[8] Furthermore, there are interconnected factors that contribute to poor engagement in care, including race, age, gender, socioeconomic status, comorbidities, unmet psychosocial needs, and client distrust in physicians and health care institutions.[9] Improving client engagement and reengagement in care is a national priority with targeted retention measures established by the HIV National Strategic Plan (see Additional Resources Box), HRSA, and the Ending the HIV Epidemic (EHE) initiative.

Access to HIV treatment and linkage services before and after release from jail is a health equity issue. Of the more than two million people incarcerated in the United States, more than 20,000 have HIV.[1] Although Black, African American, and White people use drugs at similar rates, the imprisonment rate of of Blacks and African Americans for drug-related charges is almost six times that of Whites.

HIV prevalence rates among Blacks and African Americans are also disproportionately high. They constitute approximately 12 percent of the U.S. population, but they comprise 44 percent of people with newly diagnosed HIV.[10] In some prison systems, Blacks and African Americans constitute the highest proportion of people with HIV.[9] Although public health interventions centered on HIV care and treatment within correctional settings have increased over time, more programs are necessary to address the interconnected needs of people with HIV who have been incarcerated, both during their incarceration and after their release. Additionally, more programs are necessary to reform the systems that imprison disproportionate rates of people with intersecting identities.[9]

An estimated one in seven people with HIV leave prisons and jails each year in the United States. Many struggle to access care and treatment upon release, with as many as 95 percent experiencing a gap in HIV treatment.[1] It is important to apply a holistic approach to support people with HIV who use substances and are being released from jail through intentional, care-related, post-release planning, and intensive case management programs.

## Description of the Intervention Model

The NCM intervention was developed during a five-year research study that was collaboratively implemented by the Center for AIDS Prevention Studies at the University of California, San Francisco (CAPS), the San Francisco Pretrial Diversion Project, Inc. (SFPDP), and the Forensic AIDS Project (FAP), a division of the San Francisco Department of Public Health. The intervention is an enhanced case management program that utilizes patient navigators to assist people with HIV, leaving the San Francisco County Jail to access medical and support services in the community. The patient navigation model initially developed for cancer care has been increasingly used with people with HIV in which the navigator, usually a nonclinical paraprofessional or peer, acts as a "coach" to the client.[1] Patient navigators use a strengths-based philosophy to support clients in leveraging their resources, talents, and strengths to best access available services.[1] Patient navigators do not replace traditional case managers and their role is similar to peer navigators.

The NCM intervention uses a strengths-based philosophy to support clients in leveraging their assets, skills, and resilience to best access available services (e.g., mental and substance use services, HIV treatment, housing, and employment). The intervention is based on harm reduction, motivational interviewing, and general social work principles to facilitate adherence to a comprehensive care plan designed to address each client's intersecting needs. The model's key components include an integrated team approach, intensive case management services, ease of accessibility to services for clients by utilizing drop-in hours, and meeting with clients in the community environments where they are most comfortable.

The demographics of clients served in the NCM intervention highlight the need for linkage and retention programs tailored to specific populations and address underlying health inequities. In the original intervention study, participants were mostly male (81.5 percent), averaged 43 years of age, had at least a high school education (55.6 percent) and were mostly Black/African American (43.7 percent), followed by White (28.9 percent),

and Latinx (15.2 percent). Approximately half of the participants identified as heterosexual (49.3 percent). The most-reported modes of HIV transmission were sex with a man with HIV (41.3 percent), followed by sharing needles (29.7 percent), and sex with a woman with HIV (21.2 percent). Ninety-four percent of participants reported substance use in the 30 days before being jailed. Crystal methamphetamine was the primary drug used (63.1 percent). The mean number of detentions in the year before the index detention was 1.76, and the mean length of the index incarceration was 98.3 days, making the intervention mostly applicable for jail facilities with long-term detention.

While each jail is different and approaches to better serve these client populations vary (see Additional Resources Box), the NCM intervention allows interventionists to address people's unique needs who are disproportionately impacted by the HIV epidemic and the criminal justice system. Discharge planning and intensive case management programs can help ease a client's transition from jail back to the community.[1] By supporting clients after release and connecting them with medical and social services, the NCM intervention can increase the level of engagement in HIV care and improve overall health outcomes for people with HIV.[11] The intervention is divided into eight overarching phases:

### 1. Engage Stakeholders

Successful implementation of the intervention will differ depending on whether the organization has pre-established relationships with the local jail(s). The organization implementing NCM should facilitate conversations with social service agencies, care sites, and jail medical providers to discuss the feasibility of implementing the intervention. Case managers can obtain feedback from potential clients to gauge interest and determine a patient-navigation intervention's value. Use data collected through interviews, focus groups, surveys, and other methods to help assess clients and tailor the patient navigation intervention to meet those needs.

### 2. Assess Gaps and Resources and Hire Staff

a. *Define Population:* Define the population that you will serve. The priority population should be reflective of the local context. Replicators can develop eligibility criteria including people with HIV not held in high-security jails; people arrested in a local jurisdiction (e.g., not transfers); people reporting previous or current drug or alcohol use; or people detained for a minimum of 48 hours.

b. *Hire Patient Navigators*: Employing patient navigators with whom clients can relate and who can assist clients both before and after they are released from jail is the key to successfully replicating the NCM intervention.

The intervention team should select and hire patient navigators who share characteristics with the clients you intend to serve (e.g., people with HIV, similar cultural backgrounds, past histories of incarceration, and substance use recovery). It is imperative that patient navigators also have resources available (e.g., supervising case managers) to support them individually and in their role. Patient navigators are meant to enhance case management for people with HIV—before and after their release from prison—by working in tandem with case managers.

### 3. Conduct Pre-Release Care Planning Activities

a. *Deliver Comprehensive Assessment:* Before a client is released from jail, the case manager provides discharge planning and education for clients. The case manager delivers a psychosocial needs and risk assessment to inform the client's individualized care plan. The initial assessment is used to collect client demographics and information about their physical health, mental health, substance use, health-seeking behaviors, and medication use. The case manager can obtain medical data that may be of interest to the intervention team (e.g., viral load, CD4 counts) from electronic records. During the client's intake and pre-release HIV prevention counseling session, case managers and patient navigators should aim to:

- Build rapport with the client.
- Describe the services provided by the NCM intervention.
- Conduct a comprehensive psychosocial needs assessment.
- Assess the client's needs for immediate post-release services and benefits (e.g., enrollment in ADAP) and conditions of release (e.g., court return, probation, parole). The assessment should also include intersecting service needs (e.g., housing for clients with disabilities, coordination of transgender affirming healthcare).
- Review the pre-release discharge plan, if available.
- Identify different forms of communication (e.g., email, phone) and determine the best method for contacting the client.

- Obtain the client's signature on release of information forms. Ascertain whether each contact is aware of the participant's HIV status.
- Assess the client's risk for viral hepatitis and other sexually transmitted diseases and develop a plan to prevent HIV transmission (e.g., viral load suppression, safer sex practices).
- Provide health education and identify relevant community resources regarding HIV, viral hepatitis, sexually transmitted diseases, and other conditions (e.g., diabetes, hypertension, mental health).
- Incorporate relevant risk reduction elements into the pre-release care plan.
- Develop a release plan that describes how the client will connect with the intervention team after their release from jail.
- Discuss the program completion process and requirements.

b. *Access Medical Records:* With the client's consent, gather documentation to help the intervention team link the client to appropriate services. This documentation may include a diagnosis letter, tuberculosis clearance, medication list, follow-up appointments, or an existing release plan.

c. *Coordinate Ongoing Pre-Release Sessions:* Following the client's initial session with the case manager, staff should attempt to consistently engage clients while they are incarcerated. Check-in intervals will vary depending on the client's needs and the length of time they are expected to be incarcerated.

### 4. Monitor Legal Status of Clients

The client's case may change, impacting their discharge and care plan in the long run. Staff should consider the following during pre-release planning:

a. *Pending (Unsentenced) Cases:* Staff can closely track all court return dates and communicate with court personnel to remain advised of the client's release date.

b. *Sentenced Cases*: Staff can confirm the client's release date and check the client's court record to see if the court specified that the jail sentence can be served in residential treatment or if the court-mandated that the client be excluded from early release programs.

c. *Residential Treatment:* If the sentence permits the client to participate in a treatment alternative to custody, intervention staff should identify an appropriate program and facilitate the linkage. If the client is accepted in the program, intervention staff should communicate with the sheriff's department or the appropriate law enforcement agency to (1) ensure the department or agency has the necessary paperwork and (2) monitor when the department or agency transports the client to the treatment program.

d. *Early Release Programs*: Staff should consult with the person overseeing these programs to remain advised of the client's early release date.

### 5. Conduct Post-Release Care Plan Activities

a. *Assist Clients Within 24 Hours Post-Release*: An important goal of the intervention is to meet clients as they are released from jail. Achieving this goal supports the client as they transition back to the community, reduces potential transportation barriers, increases the likelihood of follow-through with the post-release care plan, and fosters a continued working relationship with the intervention team. The case manager and navigator should meet clients after release (e.g., meeting them at the probation department or post-release facility) and take them to the NCM office for orientation.

Depending on your local jurisdiction and jails, clients released in court on their recognizance or who are sentenced to credit-for-time-served may not be released until late at night. Whenever possible, staff should work with the sheriff's department or the appropriate law enforcement agency in your jurisdiction to expedite the client's release and stay after business hours to meet the client when they are released so they can accompany the client to their identified housing.

If the client's release is expected to be too late for staff to stay on duty, the NCM case manager can meet with the client in custody

to review the housing and transportation plan and schedule an orientation for the next business day. When appropriate, the NCM case manager can arrange a one-night hotel stay for the client, give the client the hotel name, and ensure the client's parole officer accepts this plan. The case manager should leave transportation vouchers and prescription medications or written prescriptions in the client's in-jail property, which they can access upon their release from jail.

When staff cannot meet a client at the gate upon the client's release, and a client does not come to the NCM office within 24-hours post-release, staff should attempt to contact the client using the outreach information gathered during the initial pre-release needs assessment. This effort may entail contacting friends and family, conducting outreach in certain neighborhoods and establishments, collaborating with medical or other social service providers, and monitoring jails if the client is incarcerated again.

b. *Meet with Clients:* The case manager and patient navigator should meet with recently released clients to review goals and their seven-day post-release plan. Ideally, clients are matched with one patient navigator. However, restrictions (e.g., the maximum number of hours a patient navigator can work without the risk of losing their benefits eligibility) may cause the intervention team to alternate the person performing this role. Staff should give the client a printed schedule of appointments—including an individual counseling session with the case manager within 30 days of their release from jail and weekly check-in groups for all clients who choose to participate. The case managers should also review a release checklist, which includes:
   - Insurance or ADAP;
   - Medications;
   - Prescriptions;
   - TB records;
   - Letter of diagnosis;
   - Custody letter verifying incarceration dates for those whose benefits have been suspended;
   - Medical appointments; and
   - Housing plan.

c. *Conduct a Client Assessment:* Clients commonly experience major changes after they are released from jail. The case manager should confirm information gathered during the pre-release intake and conduct a full client assessment again, post-release. During the client assessment, the case manager should:
   - Determine whether the client's contact information has changed.
   - Work with the client to assess immediate service linkages, legal issues, and needs for benefits and discuss the client's existing support system.
   - Work with the client to identify short-term and long-term goals related to their health, employment, housing, and education, among others. This goal-setting should include determining if anything will limit the client's ability to work with patient navigators.

d. *Develop a Post-Release Care Plan:* The post-release care plan is an extension of the pre-release care plan. Information such as the risk reduction strategies identified in the pre-release care plan should be included. The case manager should work with the client to develop the care plan, which serves as the map for short-term and long-term service planning. The care plan is a realistic reflection of the client, case manager, and patient navigators strive to accomplish together. The care plan contains broad goals (e.g., increased linkages to medical care) and specific tasks (e.g., accompanying patient navigators to all medical appointments).

### 6. Implement the Care Plan

a. *Coaching, Mentoring, and Support:* Implementing the care plan requires the client to actively participate with the patient navigators and case managers to receive coaching, mentoring, and support. Depending on the goals and tasks the client and the case manager identified, the care plan may include:

- Implementing cognitive-based interventions to reduce the likelihood of recidivism;
- Providing guidance on symptom monitoring (e.g., reducing harm related to drug use), leisure activities, social skills, harm reduction planning, and identifying situations that are not aligned with their goals;
- Scheduling client appointments and accompanying clients to appointments, including those outside of the usual follow-up time;
- Providing referrals to appropriate community resources including safe housing, employment agencies, mental health counseling, harm reduction services, and substance use treatment;
- Collaborating with other service providers and coordinating services, including regularly scheduled case conferences with other case managers on mutual clients;
- Placing clients into residential or outpatient treatment programs;
- Advocating for client housing;
- Developing transportation plans, including providing travel assistance;
- Creating travel plans that accommodate parole requirement;
- Facilitating linkages to benefits, advocates, and representative payee services;
- Facilitating access to HIV-related medications after release and before appointments with community HIV primary care providers; and
- Following up with legal services (e.g., criminal and civil) as needed.

If a client is reincarcerated, the NCM case manager should visit the client in jail as soon as possible to begin discharge planning and offer support. Staff should also cancel outstanding appointments, and address housing issues (e.g., moving and storing the client's belongings). With the client's consent, inform family, friends, and other providers about their incarceration status.

### 7. Follow-up and Monitor Client Progress

a. *Conduct Periodic Assessments:* The case manager should conduct ongoing monitoring of the care plan during the client's follow-up visits. Additionally, the patient navigators, who accompany clients to appointments with external providers, should inform the case manager about changes in the client's situation that may impact the client's care plan's relevancy or validity. The NCM team should decide the frequency for conducting assessments. For example, a comprehensive evaluation of the client's medical, psychosocial, and financial situation might be conducted quarterly or more often if needed.

b. *Securely Store Information:* Case managers and patient navigators should safely record and keep client information in a central location that can be accessed during the client's follow up visits. Patient navigators and case managers should appropriately document the following information for each client in a central database and review it on an ongoing basis for completeness and accuracy:

- Client demographics and identification;
- Client contact information;
- Contact information for the client' other providers;
- The date and length of time of each NCM staff's client contact;
- Tasks completed with or on behalf of a client during each client contact;
- Changes in the client's psychosocial status or disposition;
- Pre-release plan, seven-day release plan, and post-discharge care plans; and
- Notations of hospitalizations, stays in substance use treatment facilities, or reincarcerations.

c. *Coordinate Individual Meetings with Clients:* NCM staff should decide the frequency of client check-ins (e.g., three contacts per week for the first-month post-release). Subsequent contact frequency can be determined based on the complexity or severity of the client's needs (e.g., after the first month, clients who need less support can meet every other week). Meetings can occur in the office or community settings based on client preference (e.g., coffee shops). To facilitate client meetings:

- Ensure the NCM model is organized such that staff availability can be adjusted as clients' circumstances change.
- Encourage clients to drop in the office throughout the week or during predetermined hours.
- Provide incentives (e.g., grocery store gift cards) to clients for attending scheduled appointments with the NCM team and community providers.

d. *Coordinate Group Meetings with Clients:* Invite current and "graduated" NCM clients to participate in a weekly support and education group. Patient navigators can co-facilitate the group, and case managers can attend. In addition to providing support, the group can help build a sense of community among the clients and the NCM team. Specifically, the group can provide an open forum and safe space for clients to voice their experiences navigating service systems and dealing with other social issues.

### 8. Graduate Clients

a. *Develop a Process to Graduate Clients:* The standard length of participation in NCM case management is twelve months post-release from jail. The key steps in discharging a client from the NCM intervention are:

1. Include "graduation" on the care plan as a default item.
2. Clearly communicate the discharge timeline. For example, staff should discuss termination with the client six months before termination. And, staff should review the transition plan goals with the client one month before termination.
3. Consult with other providers about the client's impending termination date and plan for the client's transition. When possible, introduce clients to the providers to whom they are being referred. Scheduling a joint session with both the NCM team and the new case manager, if applicable, can assist the client transition process.
4. Acknowledge the client's accomplishments during their participation in the NCM intervention and review the client's progress toward achieving the goals identified in their care plan.
5. Recognize the relationships developed between the client, support group members, and the NCM team.
6. Identify resources the client plans to use after their relationship with the NCM team ends.
7. Complete paperwork required to transfer clients to another case management provider and other relevant services.
8. Document the transition plan in the client's chart and give the client a copy.
9. Present resources available through NCM (e.g., a drop-in group).

b. *Highlight Accomplishments:* Because clients may "graduate" from the program within any number of circumstances, this milestone

may be acknowledged or postponed in the following ways:

- For clients who reside in the community:
  - During the last scheduled NCM session, present a graduation certificate that states the client's name, congratulate them for their hard work and accomplishments, and thank them for participating in the program.
- For clients who are incarcerated in jail:
  - If a client has been reincarcerated and is expected to be discharged within 30 to 60 days, NCM staff can postpone the graduation date until their release to assist the client in post-release care planning and to coordinate a successful transition plan.
  - If a client is expected to stay in jail for more than 60 days, the NCM case manager can review the client's accomplishments during the past year while visiting them in jail. This graduation visit is intended to motivate the client to continue working towards goals identified during the past year and remind them that they are more than their incarceration status. During this visit, the NCM case manager will review the client's transition plan. If possible, a representative from the case management agency to which the client will be referred accompanies the NCM case manager. The NCM case manager will give the client a graduation certificate and put the transition plan in the client's jail property. For clients incarcerated in state or federal prison, NCM staff should send a letter acknowledging the client's accomplishments during the past year. The client can use this letter to document their changed behavior and personal growth as a tool to advocate for increased access to programs and other "privileges." The letter can also be used to remind the client of the goals they have been working towards. Include a copy of the client's transition plan and contact information for provider referrals with the letter.

c. *Client Termination or Withdrawal from Participation:* Clients can also choose to withdraw from the program informally, becoming "inactive" clients. Clients can also be temporarily or permanently terminated from the NCM intervention for unsafe behavior. In the case of a deceased client, the NCM team should be available to provide support to the client's family, friends, and other caregivers and make bereavement resources available.

# Logic Model

Logic models are effective tools to assist in planning, implementing, and managing an intervention. Below is a logic model highlighting the resources, activities, outputs, outcomes, and impact of the NCM intervention referenced throughout this guide.

| Resources | Activities | Outputs | Outcomes | Impact |
|---|---|---|---|---|
| • Funding source that supports linkage interventions for clients who are incarcerated before and after their discharge from jail<br>• Staff members (patient navigator, case managers) with knowledge and expertise in harm reduction, HIV education, the criminal legal system, and the intersecting identities of the clients being served<br>• Relationships and collaborations with jail staff, medical providers, clients, and community organizations<br>• Systems to facilitate care coordination, including linkage and referral to health and social services | • Engage stakeholders and obtain community input<br>• Conduct client assessments before and after their discharge from jail<br>• Monitor client's legal status<br>• Assist clients within 24 hours of their discharge from jail<br>• Connect clients to resources within the community (e.g., education, legal support, housing, employment, food assistance, mental health, and substance use services)<br>• Coach and mentor clients<br>• Deliver comprehensive evaluations<br>• Provide ongoing support to clients through individual and group counseling<br>• Graduate clients and acknowledge achievement | • Comprehensive understanding of clients' health and social needs among the case management team<br>• Providers, community organizations, and jails are informed about the intervention's benefits<br>• Implementation of a robust care plan for clients after discharge<br>• Clients are linked to responsive health and social services<br>• Clients have relationships with patient navigators | Among people with HIV:<br>• Improved self-efficacy to start and stay in HIV care<br>• Decreased time to HIV care re-engagement<br>• Increased retention in care<br>• Improvement in HIV and overall health outcomes<br>• Return to a supportive community post-release<br>• Reduced reincarceration rates<br>• Reduced unwanted substance use<br>• Reduced HIV transmission among client networks<br>Within the implementation agency:<br>• Enhanced infrastructure to provide pre-and post-release services to people with HIV who experience incarceration<br>• Demonstrated investment in HIV relinkage efforts and clients impacted by mass incarceration and the criminalization of drug use<br>• Sustained connections with providers | • Reduce HIV morbidity and mortality<br>• Reduce HIV transmission<br>• Advance health equity for people with HIV and those who use substances<br>• Address barriers to HIV care addressed for people who have been incarcerated |

Your Planned Work

Your Intended Results

# Staffing Requirements and Considerations

## Staff Capacity

Organizations can implement the NCM intervention by leveraging existing case management teams within jails and organizations and centering the lived experiences of clients who serve as patient navigators. Successful replication of NCM involves careful attention to each staff member's roles, carefully planning the training, supervision, and compensation for patient navigators, emphasizing "client first" principles, and employing multiple means of intervention promotion. All staff should be familiar with strengths-based social work and harm-reduction principles. The following staff implemented the NCM intervention in San Francisco, CA:

- *Deputy Director:* The deputy director's responsibilities include:
  - Developing policies and procedures for the program and overseeing adherence to program protocols;
  - Assisting case managers, patient navigators, and the outreach coordinator in the implementation of client care plans;
  - Providing supervision and training to all staff, including patient navigators;
  - Producing cumulative reports on the program's ability to achieve outcomes and objectives outlined in the study protocol; and
  - Monitoring the length of incarceration for participants in jail by checking court appearance schedules and communicating with clients' attorneys.
- *Case Manager:* The case manager is primarily responsible for conducting HIV prevention sessions with clients two weeks before their jail release in addition to:
  - Screening, assessing, and completing client care plans;
  - Assisting in recruiting, hiring, and training patient navigators and facilitating regular staff skill-building meetings;
  - Conducting at least one individual care planning and service linkage session with each client as soon as possible after their release from jail;
  - Providing ongoing management of active client caseloads;
  - Assisting the deputy director and the clinical case manager with developing an information management system and all project forms and protocols;
  - Developing relationships with HIV and other community-based service providers;
  - Working with the NCM team to ensure all active clients are regularly seen and are progressing with their care plans;
  - Overseeing the maintenance of case files and records;
  - Working with the NCM team to provide crisis intervention, as needed;
  - Maintaining contact with jail staff;
  - Providing ongoing supervision to patient navigators; and
  - Maintaining security clearance.
- *Outreach Coordinator:* This individual's responsibilities include:
  - Serving as the point person for patient navigators and providing ongoing support;
  - Negotiating the schedules and client loads for patient navigators;
  - Ensuring maintenance of daily case notes;
  - Handling most of the communication with housing providers and hotel managers to ensure timely payments and to provide crisis intervention for clients; and
  - Providing training and supervision for patient navigators on effective outreach methods.

- *Patient Navigator:* This person is, ideally, an individual with HIV who is in substance use recovery and has experience with the criminal justice system. Responsibilities of the person in this role include:
  - Serving as a member of the case management team and providing clients with mentorship and emotional and practical support;
  - Assisting each client in adhering to the care plans developed before their release;
  - Teaching clients how to address barriers to care;
  - Assisting the NCM team with client advocacy and case management;
  - Accompanying clients to appointments;
  - Developing relationships with HIV and other community-based service providers;
  - Writing client case notes;
  - Working with the NCM team to provide crisis intervention, as needed;
  - Following up with clients who have fallen out of contact; and
  - Participating in staff development activities, including education and training opportunities.

Since the NCM intervention utilizes an integrated team approach to case management, there are inherent overlaps in the various team members' roles and responsibilities. However, the patient navigator's role is distinct from that of other staff. They are closely supervised and do not have the same organizational, administrative, and clinical responsibilities. Their day-to-day tasks are focused on developing relationships with clients, helping clients get to their appointments, and taking care of the client's other practical and emotional needs. All patient navigator contact with clients will occur in the community. Patient navigators often serve as a model of someone who has been able to successfully "navigate the system." The relationships clients have with the patient navigators are qualitatively different from those they have with the other NCM staff, contributing to a more comprehensive understanding of clients' experience by the NCM team.

The most overlap in responsibility occurs with the case manager and patient navigator roles. Case managers provide ongoing support to patient navigators. Consistent and open communication between these two staff members is key to completing client-centered tasks. Table 1 shows the overlap in the case manager to patient navigator roles.

### Staff Characteristics

Core competencies of all staff should include:

- An affirming demeanor and flexibility in identifying individual client needs;
- Experience with case management or working with clients and navigating health systems;
- Commitment to cultural sensitivity, cultural responsiveness, and harm reduction;
- Familiarity with the criminal justice system and its dynamics;
- Fluency in Spanish and English (or other languages based on local needs);
- Demonstrated ability to work with diverse client populations affected by HIV, including persons with mental and behavioral health conditions; and
- A client-centered orientation.

**Table 1** — Case Manager and Patient Navigator Roles

| Task | Case Manager | Patient Navigator |
|---|---|---|
| Conduct in-jail intake and prevention education sessions | X | |
| Monitor status of client's legal case | X | |
| Visit clients in jail | X | |
| Meet clients at the jail gate when they are released | X | X |
| Develop post-release care plans | X | |
| Conduct ongoing monitoring of the care plans | X | X |
| Conduct formal client reassessments | X | |
| Accompany clients to appointments in the community | X | X |
| Accompany clients to court appearances | X | X |
| Meet with clients post-release | X | X |
| Confer with other providers working with clients or speak to clients' family or support system, with clients' consent | X | X |
| Formally link clients to other providers, with clients' consent | X | |
| Follow-up with clients who have fallen out of contact | | X |
| Visit clients in treatment facilities or hospitals | X | X |
| Document all client contact in the program database | X | X |

### Supervision for Patient Navigators

The NCM outreach coordinator provides supervision for patient navigators and helps them identify situations where they should call other team members for additional assistance. The patient navigators should also maintain ongoing contact via phone and in-person check-ins with the case managers throughout their shifts. Ongoing communications enable the case manager to provide guidance and problem-solving assistance to patient navigators in real-time. Additionally, patient navigators should meet with the case manager for individual supervision in addition to a monthly group supervision session with all patient navigators. Since patient navigators may be in the same social circles as the clients or may also be in different stages with their substance use, reinforcement of boundaries is essential to this model's success. Patient navigators must have consistent support as they learn their roles.

### Patient Navigator Compensation

Depending on their financial situations, many patient navigators may be receiving various Social Security benefits, which restrict the amount of compensation they can receive without putting the benefit (e.g., housing) in jeopardy. Therefore, it is important to provide benefits counseling to patient navigators as part of their hiring and training process. In previous models, patient navigators were scheduled for no more than two five-hour shifts a week, enabling them to work for the program and maintain their full Social Security benefits. Prioritize the employee's self-determination in deciding which option works best for their needs. Additionally, patient navigators must be equitably compensated for their time and efforts (e.g., be paid a living wage, be provided with gift cards to purchase food and other items).

## Replication Tips for Intervention Procedures and Client Engagement

Successful replication of the NCM intervention involves careful attention to each staff member's roles, carefully planning the training, supervision, and compensation for patient navigators, emphasizing "client first" principles, and employing multiple means of intervention promotion.

- *Appropriately Divide Responsibilities & Identify Overlap and Collaboration Between Staff*. The NCM intervention consists of many one-time and ongoing tasks divided among the roles of the intervention team. Recognizing how these roles differ and where they overlap can make replication less difficult.
- *Carefully Plan Training, Supervision, and Compensation for Patient Navigators.* Below are patient navigator training topics to be led by the deputy director and case manager. When appropriate, tailor these topics to the laws and regulations of your state/city/organization. Training can also include other topics that are relevant to your organizational structure:
  - Criminal justice
  - HIV education and prevention
  - Harm reduction
  - Navigating the local service system
  - Patient navigator roles
  - Confidentiality
  - Boundaries
  - Conflict de-escalation and resolution
  - Addressing medical emergencies
  - Needs and risk assessments
  - Stages of Change
  - Motivational Interviewing
  - Anti-sexual harassment (all-agency training)
  - Effective communication and professional responsibilities
  - Self-care
  - Time management
  - Creating and maintaining a healthy workload
  - Workplace ethics

- *Incorporate and Emphasize "Client First" Principles*. The Navigator Program emphasizes Harm Reduction and Social Work principles and utilizes approaches such as *Motivational Interviewing* and *Assertive Community Treatment*. These are described below:
  - *Harm Reduction*—An approach to behavior change that "meets people where they're at." Harm reduction assumes that elimination of potentially destructive behavior (e.g., substance abuse, sexual behaviors that put one's health at risk) may not be possible and seeks to decrease the negative consequences that may occur as a result of continuing the behavior.

- *General Social Work Principles*—According to the National Association of Social Work Code of Ethics, the primary mission of social work is to enhance well-being and help meet the basic needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty.
- *Motivational Interviewing*—A focused, client-centered approach to counseling that helps clients identify, explore, and deal with ambivalence.
- *Assertive Community Treatment*—A mental health treatment approach developed to enable frequently and chronically hospitalized psychiatric patients to live more successfully in the community. The NCM intervention uses key aspects of assertive community treatment that include:
  - An integrated team-based approach to client care;
  - Intensive case management; and
  - The flexibility of drop-in hours and the ability to meet clients in their own environments (rather than in the office).

- *Employ Multiple Means of Intervention Promotion*. Using a variety of promotional mediums can lead to higher intervention enrollment. Depending on the type of organization, some methods may work better than others. Providers within jails, such as medical staff or case managers, can refer clients to the intervention. While the use of marketing materials may depend on the policies that jails have in place, consider including marketing materials in the medical offices. Examples include flyers and referrals. Organizations that function as or work closely with medical facilities that serve people with HIV who are incarcerated may find success with:
  - Posting flyers in the waiting room;
  - Receiving client referrals from medical providers; and
  - Presenting to medical providers during meetings.

## Securing Buy-In

This intervention is well-suited for organizations that provide services with a public health-focused mission. Organizations can secure successful buy-in from stakeholders and clients through careful consideration of previous and present staff experience. More specifically, organizations can:

- **Leverage peers:** Utilize a team of professionals that has previously worked with the priority population, shows a genuine interest in learning from communities, and shares lived experiences with the priority population. The peer navigators' commitment to social justice is key.
- **Assess organizational readiness:** Prepare the organization to adapt the intervention based on changes in client or staff needs. If feasible, open a drop-in center to allow both clients and navigators time together outside intervention activities to build trust and relationships. Drop-in hours can also provide clients with additional opportunities to receive support from someone with similar lived experiences. This provides them with the opportunity to discuss common challenges such as stigmatization within healthcare settings and to celebrate successes.
- **Engage clients:** Client buy-in is anchored by patient navigator recruitment and bolstered by clients' interaction with patient navigators, who play an important role in helping clients experience positive outcomes. Flexible working conditions for patient navigators can prevent a decrease in client benefits. For example, the current or changing needs of a client may mandate longer hours for a patient navigator and can thus decrease the effectiveness of the intervention due to the patient navigator's burnout. Having clients work with more than one patient navigator can alleviate work-related stress.
- **Emphasize commitment to social justice:** Ultimately, successful replication of the intervention is facilitated by each collaborating organization's commitment to the issues and their client's self-determination. Because peers have pertinent first-hand knowledge, employing them as patient navigators is an appropriate gateway to working with a criminal justice-involved population—even if the organization has worked with this population before.

**"I was a junior investigator … and every time I walked into the room I would be so starstruck working with all these amazing people that have been doing this work for so long."**

– PRINCIPAL INVESTIGATOR

## Overcoming Implementation Challenges

There are always challenges when implementing any program or intervention. Anticipated challenges, as well as possible solutions, include:

- **Implementing a Peer-based Model:** Challenges related to continuous staffing, service provision methods, and choosing appropriate training models may occur when using a peer-based model. You can address this type of challenge by involving people who have previously worked with peer-based interventions to troubleshoot potential issues. Consider engaging people who work within your organization, at other organizations, or as consultants. Researching examples of peer-based interventions may also be useful.
- **Funding:** Organizations that have robustly funded HIV services may be at an advantage. However, a lack of funding or change in funding can threaten success with sustaining the intervention. Securing smaller, diverse funding sources can assist with facilitating best practices for client retention, such as providing incentives, transportation reimbursement, or food. Work with a local university or foundation to assess available resources to support program services or evaluation.
- **Geographically Distant Navigators and Clients:** This intervention may be more difficult to implement in a large city if there is a vast geographical distance between navigators and clients. Suppose your organization does not have multiple locations that your clients can access. In that case, this challenge may be remedied by offering flexible hours to allow for more convenient scheduling and travel time. Providing transportation assistance may also prove effective.
- **Commitment to Social Justice Among All Involved:** A commitment to criminal justice-related work is an important factor in this intervention. However, the systems in place within the jails and in the broader community (e.g., social service agencies) can be triggering and retraumatizing for both staff and clients. Many social justice issues have yet to be systemically addressed by the state and federal government and other institutions (e.g., mass incarceration of Black/African American and Latinx populations; criminalization of people who use drugs). All involved parties (e.g., stakeholders, staff, health service providers, jail staff) should meet before the intervention is implemented to discuss its planning and execution. This will ensure that the intervention team agrees, and that potential social justice issues and solutions are explored early in the process. Additional meetings during and after intervention implementation can also help evaluate the success of their efforts.

## Promoting Sustainability

Successful replication and sustainability of the NCM intervention will require that some organizations explore various funding sources. Identifying alternative funding sources is ideal for maintaining intervention elements dependent on short-term or one-time financial support. It may also be necessary to develop a plan to modify the intervention based on available funding.

Organizations must also prepare to address staffing due to high turnover rates common in social and human services work. Develop a plan for temporarily covering staff workload and promptly hiring new staff as needed. Planning for staff turnover will reduce the disruption of services and help to maintain intervention operations over time.

It is also important to recognize the intervention's overall fit in light of changing organizational or client needs. Ongoing evaluation is important to program success. Sustaining parts of the intervention that proved successful and eliminating components that were not successful can improve outcomes in the future.

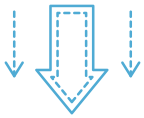
# SWOT Analysis

SWOT is an acronym for Strengths, Weaknesses, Opportunities, and Threats. A SWOT analysis is a structured planning method that can assess the viability of a project or intervention. By conducting a SWOT analysis before an intervention, organizations can proactively identify challenges before they occur and think through how to best leverage their organizational strengths and opportunities to improve future performance. A SWOT analysis of the NCM intervention in the San Francisco County adult jail system identified the following:

## STRENGTHS

The intervention increases relinkage and retention outcomes for clients who are out of care by:

- Establishing a network between clients, organizational staff, leadership, and providers in jails,
- Enhancing existing case management linkage efforts,
- Employing staff who are representative of the client population,
- Identifying the priority population(s), that will be served based on local context,
- Responding to client needs both before and after their release from jail,
- Collaborating with community organizations, jails, and other external stakeholders who have resources to support clients' engagement and retention in HIV care,
- Designating case managers who can lead client pre-release care planning and implementation,
- Presenting professional development opportunities for patient navigators, and
- Operationalizing an organization's commitment to addressing criminal and social justice issues.



## WEAKNESSES

Agencies will find it challenging to implement the NCM intervention without:

- Case managers and intervention leads with experience in peer navigation models,
- Patient navigators who can both promote the intervention and support clients,
- Organizations that can support the delivery of a peer model-based intervention,
- Coordinated efforts at the city or state level to provide HIV care services to people who have been incarcerated,
- Input from potential clients and providers and leadership at jails,
- Comprehensive client assessments before and after their release from jail,
- Support for patient navigators,
- Connections to broader health and social services in the community, and
- Staff who understand harm reduction principles, strengths-based case management, and how social determinants of health impact clients.

## OPPORTUNITIES

The NCM intervention offers opportunities to:

- Facilitate a client's ability to confidently and fluently navigate the healthcare system,
- Reduce client reincarceration rates and negative health outcomes,
- Employ peer navigators with lived experience,
- Invest in people with HIV who have been incarcerated and disenfranchised by many social systems,
- Integrate public health efforts within jails to improve HIV health outcomes,
- Expand the reach of support services,
- Enhance relationships among the provider and peer community through client-centered care, and
- Provide ongoing and intentional support for 12 months, thereby increasing HIV engagement and retention.

## THREATS

Threats to the success of the NCM intervention include:

- Policies or protocols that hinder intervention implementation within jails,
- Changes and availability of funding that does not cover peer navigation or client support,
- Changes in organizational priorities,
- Parole requirements that hinder client success, and
- Lack of commitment to criminal justice work.

## Conclusion

The NCM intervention involves individualized and comprehensive risk-reduction care planning along with peer navigation upon the client's release from jail. The intervention allows organizations and jails to leverage harm reduction, prevention case management, and Motivational Interviewing techniques to promote healthy behaviors among people with HIV who have been incarcerated. This holistic model utilizes the expertise of patient navigators and case managers to facilitate linkage to care in the community while meeting clients' interconnected health and social needs. In the original research study, clients in NCM were twice as likely to be linked to care within 30 days of their release from jail compared with those in the control group (OR = 2.01; 95 percent CI = 1.21, 3.35). Clients receiving the NCM intervention were also almost twice as likely to be retained in care during the intervention year (OR = 1.71; 95 percent CI = 1.02, 2.87). Individuals who received treatment for substance use disorders were four times as likely to be linked to care upon release (OR = 4.06; 95 percent CI = 1.93, 8.53). The NCM intervention has proven to be effective in linking people with HIV, who have been incarcerated, into care and serves as a model to assist people who have been impacted by both the criminal injustice system and the HIV epidemic.

## Additional Resources

**Ryan White HIV/AIDS Program Fact Sheet**
https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/resources/program-factsheet-program-overview.pdf

**Ryan White HIV/AIDS Program Technical Expert Panel Executive Summary on Addressing the HIV Care Needs of People with HIV in State Prisons and Local Jails**
https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/resources/hrsa-justice-tep.pdf

**Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds Policy Clarification Notice 16-02**
hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-0

**CIE Cost Analysis Calculator**
CIEhealth.org/innovations

**Creating a Jail Linkage Program: Training Manual**
https://targethiv.org/ihip/creating-jail-linkage-program-training-manual

# Endnotes

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