AETC AIDS Education & Training Center Program Mountain West

King County Jail-Madison Clinic HIV Telehealth Program: An Innovative Collaboration

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Disclaimer

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Disclosures

None

Data Considerations

Data in this presentation offer a limited perspective of how systemic, social, and economic factors impact health. We recognize that racism, not race, creates and perpetuates health disparities.

To Learn More:
https://www.cdc.gov/minorityhealth/racism-disparities

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Learning Objectives

- Describe barriers to care for people with HIV affected by incarceration and the need for innovative models of care
- Define the components of a successful telemedicine program for incarcerated populations with HIV
- Identify the importance of multidisciplinary collaboration between community and correctional health partners to improve HIV care
- Discuss how telehealth can facilitate HIV diagnosis, initiation of treatment, and linkage to care for people with HIV in jails

Corrections 101: Jails vs. Prisons

JAILS

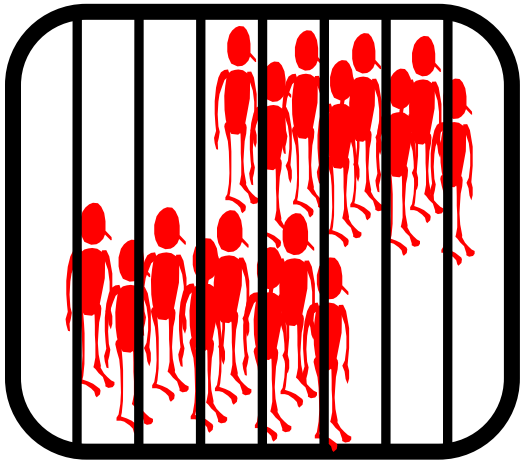
- County, town, or regional
- Sheriff's Department or Tribal
- Pre- & Post-sentencing
- Term of incarceration generally < 1 year
- House people under investigation and with misdemeanors & felonies

PRISONS

- State or federal
- State DOC, BOP, or ICE
- Post-sentencing
- Term of incarceration generally > 1 year
- House people with felonies only

Jails vs. Prison Population
Single Point in Time

Prison



1.6 Million

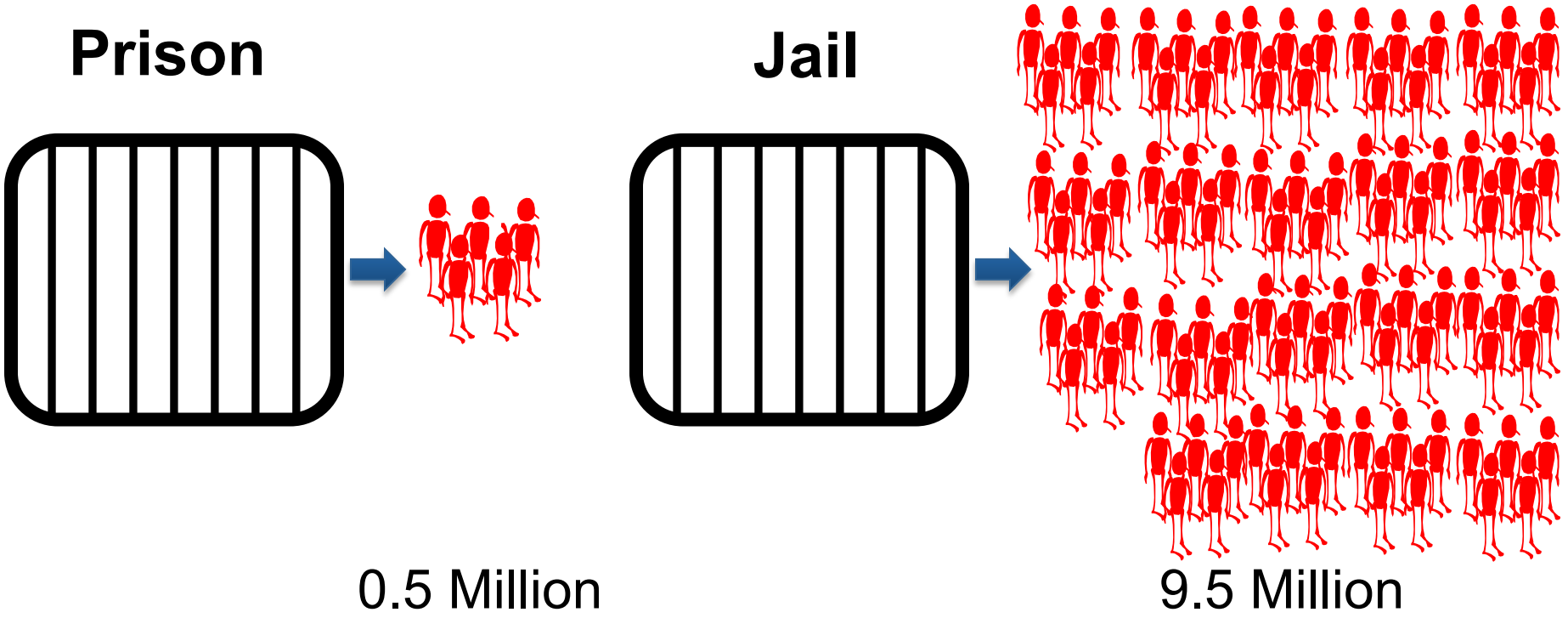
Jail

0.8 Million

On any given day, approximately twice as many individuals are in prison than jail.

Source: Bureau of Justice Statistics (2007-2008)

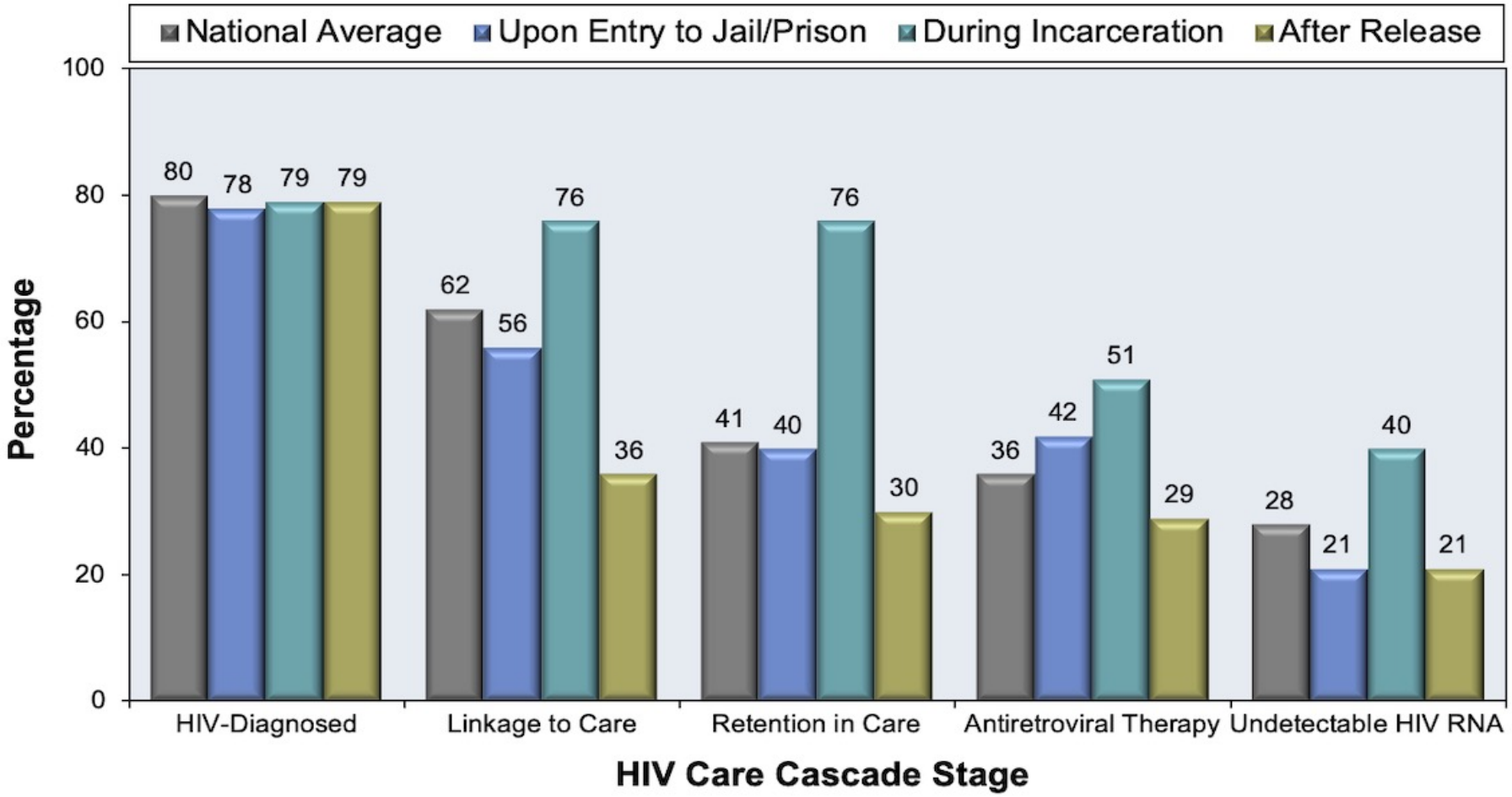
Jails vs. Prison Population Across Time



Each year, approximately 95% of the 10 million individuals released from the criminal justice system are from jails

Source: Spaulding A, et al. PLoS One, 2009.

Incarceration and the HIV Care Cascade



Iroh PA, et al. The HIV care cascade before during and incarceration: a systemic review and data synthesis, *Am J Public Health* 2015; 105:e5-e16

Recognizing a Need

- ~1 in 7 PWH cycle through the correctional system annually in the US
- Highly marginalized and vulnerable population, often out of—or intermittently in—care
  - Many not on ART→ personal and public health issues
  - 37% people at KCJ report unstable housing/homeless, 19% street living
- Many coexisting conditions, including substance use and mental health
- Most jails do not have providers with specialty HIV care training
- Short stays in jails make in-person visits challenging

Spaulding AC, et al. HIV/AIDS among inmates of and releasees from US correctional facilities, 2006: declining share of epidemic but persistent public health opportunity. PLoS One. 2009. Nov 11;4(11):e7558.

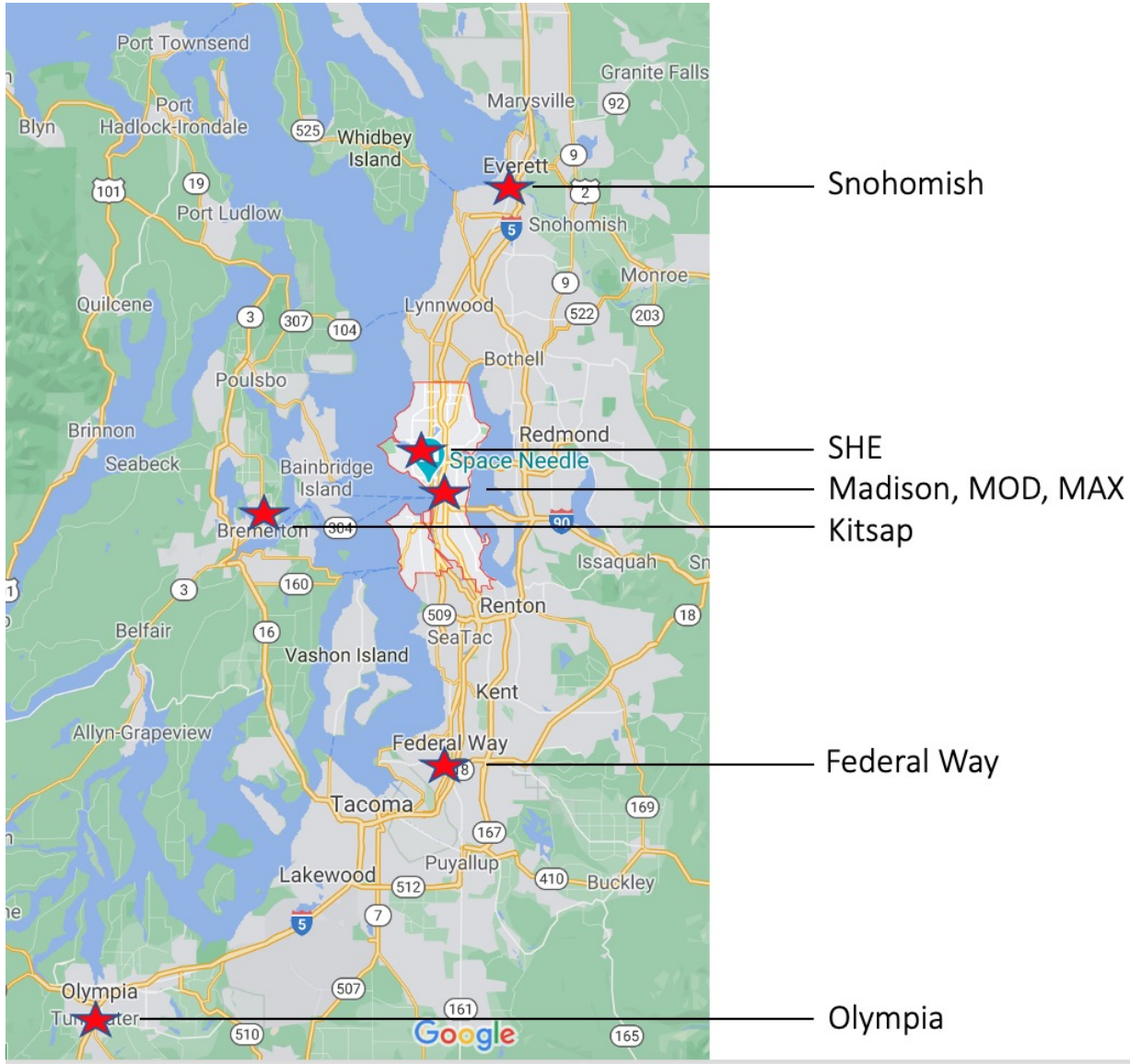
Why In-Person HIV Visits Don’t Always Work in Jails

- Short stays
- Transportation limitations and cost
- Staffing issues
- Stigma, confidentiality
- Patient refusals
  - Mistrust, stigma, mental health or SUD
  - Concern about effect on jobs/housing
- Court/legal conflicts or visits
- COVID!

Our Institutions: Madison Clinic

- Ryan White funded clinic, established in 1985, ~4500 patients served annually
- At Harborview Medical Center, mission-driven county hospital, managed by UW Medicine
  - Contracts with King County Jail for specialty care
- Largest provider of HIV primary care services in the region
- Multidisciplinary services including PrEP/PEP program, drop-in clinics, triage services, and satellite clinics
- On-site case management, mental health services, and 7 other specialty services for PWH
  - Dermatology, Psychiatry, Psychology, Heme-Onc, Pharmacy, Anoscopy, Neurology, Metabolic, Cardiology, Nutrition

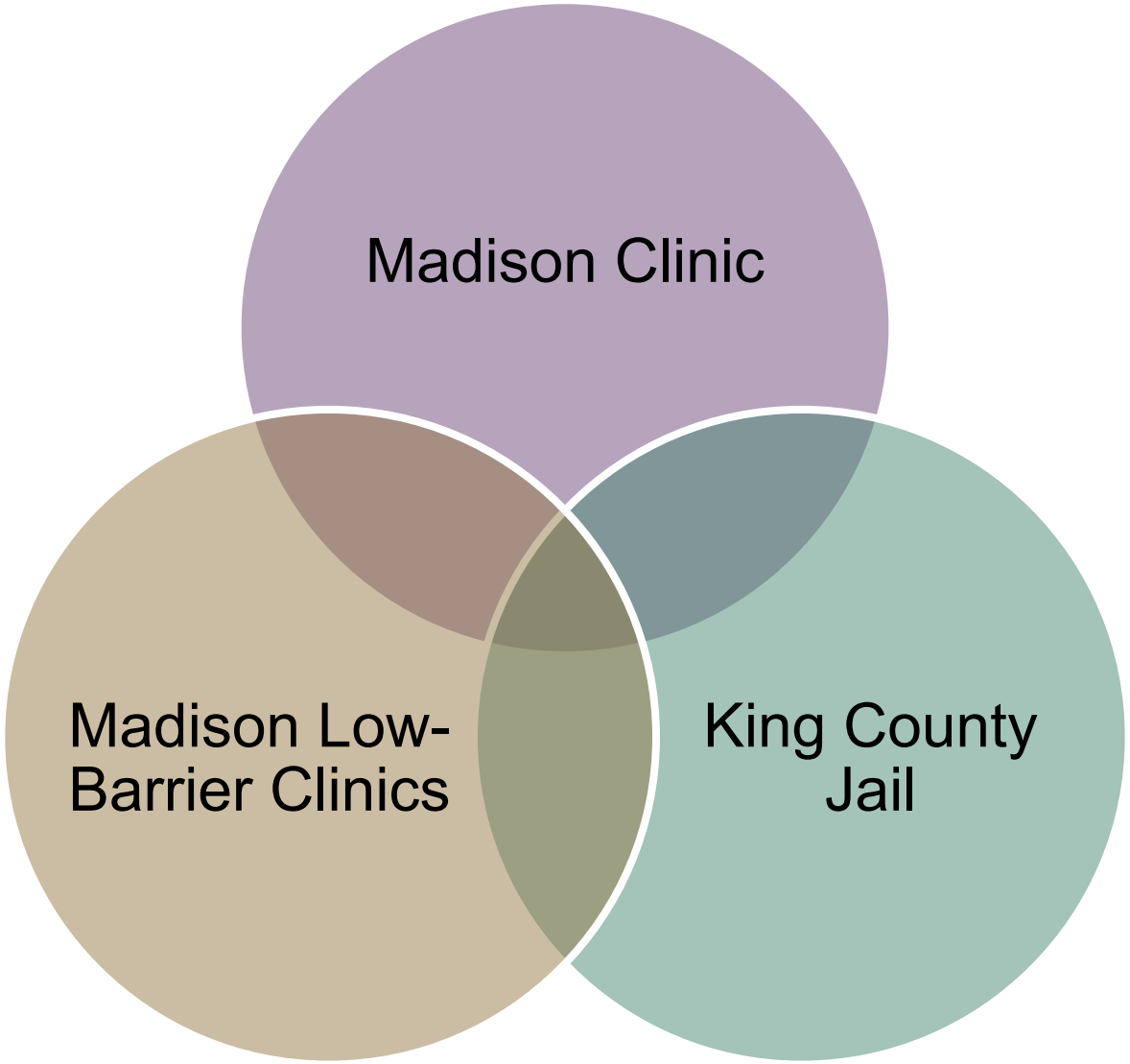
Madison Satellite Clinics



Our Institutions: King County Jails

- 2 adult facilities
- Avg daily pop 1600, 80% men, 20% women, majority (65%) 25-44 years old
- Median length of stay=3 days, mean=30.5 days
- Public Health-Seattle King County employees
- Medical, psychiatric, SUD, release planning services, in-house pharmacy
- Voluntary HIV screening offered

Significant Overlap of Patient Populations



Recognizing a Need: Madison-KCJ Specifics

- In 2017, KCJ JHS submitted 184 referrals to Madison Clinic
  - Only 62 visits completed (some may have been ID)
  - Average 6 week wait to be seen
- Out of 31 specialties at HMC, Madison Clinic had the highest volumes of patient transports from KCJ for non-procedure-based care
- In 2020, KCJ median LOS=3 days, mean=30.5 days

- As such, we embarked on a collaborative telehealth program
- **Before telehealth was cool!** (first patient seen January 2019)

Mission and Goals of the Program

- Partnerships between correctional facilities and community HIV specialty clinics can reduce health disparities for PWH and others at risk for acquiring HIV
- Utilizing telehealth in this setting will allow more incarcerated PWH to be seen, diagnosed, treated, and linked to care after incarceration

- Initial goals:
  - Weekly telehealth session to collaboratively see incarcerated PWH
  - Focus on patients already engaged in care at Madison or associated clinics
  - Only at King County Correctional Facility (KCCF), not at 2nd facility
  - Proved direct patient care, as well as chart review/consultation

Pre-Program Launch Work

- In late summer 2018, multiple meetings (5-6 hours) involving both institutions (Madison and KCJ)
  - Clinic medical directors and managers, administrators, finance, us
  - IT support
  - Bilateral education about sites and capabilities/limitations
- Established start-up needs
  - 1-2 cameras and speakers/mics per site
  - HIPAA-compliant Zoom license (or equivalent)
  - Protocols/flow-charts
  - Staffing needs
- **In January 2019, we saw our first patient via telehealth!**

Anatomy of a Jail Telehealth Visit

- Jail staff emails list of incarcerated PWH to Madison provider
- Madison provider reviews, updates pt lists, decides on next session's pts
- 2 hours weekly to see patients and review list
- Provider from both sites get on HIPAA-protected Zoom and set session agenda
- Custody officer brings pt to KCJ JHS clinic
- RN takes vitals
- Provider at KCJ JHS brings pt to clinic room, introduces pt to Madison provider
- Collaborative visit, often involving SW/CM/release planners @Madison, MAX, KCJ
- Madison provider documents and bills in EHR, KCJ provider also writes brief note
- KCJ JHS provider executes care plan and follow-up

Release Planning Needs

- Setting up insurance as this is discontinued when incarcerated
- Bridge supply of ART
- Linkage to care
  - Transportation assistance
- Housing
- Substance use and mental health care
- Understanding ongoing legal issues
  - Electronic Home Detention, Temporary Release, Prison, Community Custody/Parole
- Solution: weekly multidisciplinary videoconference (medical, public health, community low-barrier clinic, social work/release planners, community-based organization, DOC, housing representatives) to assist with transitions to community or prison, adherence, outreach, and linkage/engagement/retention in care

Success Stories

- In 4 yrs, we have seen or discussed over 300 unduplicated incarcerated PWH
  - Many incarcerated multiple times
  - Average weekly census 15-20 incarcerated PWH, currently ~30
- Multiple new diagnoses of HIV with rapid start ART within days/weeks of diagnosis
- Reengagement and relinkage to care
- Identification of HIV in a pregnant person with linkage to care
- Improved communication with prison systems when patients transfer
- Triage of level of care needed after release
  - Linkage to Madison, MOD, MAX or other clinic depending on need
  - Care of patients with HIV regardless of where they previously received care
- Expansion of the program to additional KCJ site
- Mentorship relationship with jail MD getting AAHIVM-specialist certified!

Ongoing Challenges

- Short stays
- Patient refusals still occur
- Identifying incarcerated patients with HIV
- Language barriers
- Staffing challenges
- Recidivism
- Disclosure issues in correctional setting

What is Needed to Set up a Similar Program in Your Setting?

- Relationship building with jail
  - Important to have a clinician champion at both sites
  - Willingness for bidirectional learning
- Administration support on both sides
- System in place to identify incarcerated PWH
- Pharmacy/lab access
- Basic telehealth technology, HIPAA Zoom or Teams or similar platform
- Protected FTE for providers on both ends
- Plan in place if in-person care is required

Future Directions

- Involve more providers at both current sites
- Expand to other jails
  - Locally and elsewhere
  - Provide guidance/mentorship to others interested
- Quantitative and qualitative evaluation of the program outcomes

Strategies to Improve HIV Treatment and Care in Correctional Settings

HRSA's Ryan White HIV/AIDS Program
Addressing the HIV Care Needs of People With HIV in State Prisons and Local Jails
Technical Expert Panel Executive Summary

- Ensure uninterrupted access to medication, on entry, KOP strategies
- Advocate to treat co-morbidities
- Provide multidisciplinary team
- Use HIV telehealth to access specialist, others
- Identify champion to advocate for needs of pt with HIV in custody and out
- Ensure that provision of HIV in custody aligns with HIV treatment guidelines
- Encourage representation of DOC and individual facilities on RWHAP planning councils.

We Could Not Do This Without…

- Shireesha Dhanireddy, medical director Madison Clinic
- Ben Sanders, medical director Jail Health Services
- John Scott, head of UW telehealth
- Danotra McBride, Jail Health Services division director
- Lara Strick, head of ID for WA DOC
- Release planners at KCJ
- MAX Clinic staff
- Community partners including Bailey Boushay House
- PH-SKC Partners

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