Linkage Facilitation Across the Justice Community Opioid Innovation Network (JCOIN)

Sept. 19, 2024
Coordination/ Translation Center
Webinar

Lyn Stein, PhD, Moderator
University of Rhode Island
Brown University hub, Providence, RI

Dennis Watson, PhD, Discussant
Chestnut Health Systems
Bloomington, IL

LIST OF HUBS AND PRESENTERS

BROWN U. HUB

Anthony Coetzer-Liversage, PhD
University of Rhode Island

Machiste Rankin
Brown University

CHESTNUT HUB

Christine Grella, PhD
John Palmer, BA
Lighthouse Institute
Chestnut Health Systems

U. OF CHICAGO HUB

Maggie Kaufmann, MPH/MA
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U. OF KENTUCKY HUB

Martha Tillson, PhD
University of Kentucky

YALE HUB

Dorel Clayton
Transitions Clinic Network

YALE – HIV HUB

Sandra Springer, MD
Stazja Stuccio, BA
Yale University

WHAT TO EXPECT

Introductions (5 min)

Sites summarize their approach to LF, challenges, what works well, including experiences of LFs. Possible next steps for the field are addressed (8 min each).

A review of a taxonomy to LF and brief overview of preliminary results of a checklist of LF activities across sites (8 min).

Discussant (10 min)…

- Summarize commonalities/ challenges across sites.
- What we've learned about LF so far
- Next steps for research and practice.

Audience questions/ answers/ comments (10 min)

Coordination & Translation Center will keep time.

Please keep questions/ comments for end.

Improving Retention Across the OUD Service Cascade upon Re-entry from Jail using Recovery Management Checkups

Christine E. Grella, Ph.D. & John Palmer, B.A.

Lighthouse Institute

Chestnut Health Systems, Chicago, IL

JCOIN Webinar: Linkage Facilitation across the Justice Community Opioid Innovation Network

September 19, 2024

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Opinions are those of the authors and not official positions of the government.

RMC
Recovery Management Checkups

CHESTNUT HEALTH SYSTEMS
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Recovery Management Checkup Model:

Earlier detection and re-intervention improves long-term outcomes

- Chronic disease management approach
- Consistent, personalized, long-term (12 - 48 months) monitoring
- Early intervention and re-intervention
- Goals:
  - Detect need for treatment and relapse
  - Shorten time to treatment entry and re-entry
  - Improve long-term outcomes

Findings across Studies

- Compared with individuals who did not get RMC, participants in RMC were significantly more likely to:
  - Enter SUD treatment
  - Spend more time in treatment
  - Return to treatment sooner
- Yet some individuals have persistent substance use and/or need for treatment
- Chestnut JCOIN Hub is testing an "adapted" version of RMC that provides a higher-intensity intervention
  - Participants are recruited following discharge from jail
  - Focus on linkage to treatment with medications for OUD
  - Reduce risk of opioid-related overdose

LIFT-UP

- **L**inkage Managers
- **I**nspirational and Motivational Techniques
- **F**ollow-up through Regular Checkups
- **T**reatment Connections
- **U**nwavering and Ongoing Support
- **P**roactive Re-Linkage

LIFT-UP: A Case Example

- **L**inkage Managers
  - Conduit to treatment; establish goals
- **I**nspirational and Motivational Techniques
  - Trained in MI; ongoing monitoring; MI Spirit
- **F**ollow-up through Regular Checkups
  - Establish & sustain connection; share journey; safety net
- **T**reatment Connections
  - Rapid access to treatment; help with transportation, paperwork, other barriers
- **U**nwavering and Ongoing Support
  - Always there for client; partnership through ups & downs
- **P**roactive Re-Linkage
  - Able to relink to treatment or change provider as needed

Chestnut JCOIN Hub Linkage Manager Team: Keo, Diana, Halina, Anthony, John (2024)

NIH HEAL INITIATIVE
JUSTICE COMMUNITY OPIOID INNOVATION NETWORK (JCOIN)

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Thank you!

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NIH HEAL INITIATIVE
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Kentucky-JCOIN: A Peer Navigation Intervention for Incarcerated Women

Martha Tillson, Mandi Bowen, Amber Clemons, Kevin Crabtree, Jimmy Chadwell, Amanda Fallin-Bennett, Erin Winston, & Michele Staton

University of Kentucky JCOIN hub (PI: Staton)

Linkage Facilitation across the JCOIN Network (Webinar) – September 19, 2024

Acknowledgement

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- The contents of this presentation are solely the responsibility of the authors and do not necessarily represent the official views of NIDA, the NIH HEAL Initiative, or the participating sites.
- Amanda Fallin-Bennett is a co-founder of Voices of Hope. No other presentation authors have conflicts of interest to report.

Agenda

- Overview of KY JCOIN peer navigation intervention

Peer perspectives:

- Challenges of the KY JCOIN approach
- What works well with the KY JCOIN approach
- Next steps for research and practice

KY-JCOIN Peer Navigation Intervention

- KY is the only JCOIN hub to focus exclusively on **women**
  - Two intervention arms – one of which includes peer navigation
  - Overall goal of linkage to OUD treatment, particularly medications for OUD (MOUD)
- Our research team partners with a local KY recovery community organization (*Voices of Hope*)
- JCOIN grant funding supports two certified peer support specialists, both women with relevant lived experiences

NIH HEAL INITIATIVE

Voices of Hope (Lexington KY)

KY-JCOIN Peer Navigation Intervention

PRE- Jail Release

- Introductory telehealth session (via videoconference) while participant is incarcerated
- 7-60 days before anticipated release
- Session includes assessment of…
  - Recovery capital
  - Post-release challenges & supports
  - Goals after jail

POST- Jail Release

- Peers notified of participants' release by research team
- Track & locate in the community to provide 12 weeks of navigation to treatment and recovery support
  - Aiming for at least weekly contact
- After the 12-week intervention period, participants can choose to sign up for free ongoing recovery support services

KY JCOIN Peer Perspectives

Challenges of the KY JCOIN Approach

- Sometimes hard to connect – jails are busy environments
- Can't always plan – jail releases are difficult to predict (timing and location)
- Difficult to reach participants post-release due to remote service approach
- Hard to remotely support participants who face significant resource insecurities

What Works Well with the KY JCOIN Approach

- Shared lived experience supports connection; peers are consistent and persistent
- Resource-gathering trips to KY JCOIN counties: get to know recovery resources
- Use of social media to maintain contact with participants
- Embedding peers in larger research team
- Benefits for peers – seeing they've had an impact, made a difference

Next Steps for Peer Research and Practice

- Employ more peers in more places
  - Can reach more people who may benefit from services
  - E.g., resource centers helping with basic needs
- Peers in more places = more opportunities for exposure to peer supports
  - = more chances to start engaging in services, work on recovery
  - = more examples of what recovery can look like
  - = more hope for jobs, careers that celebrate lived experience

Next Steps for Peer Research and Practice

- Criminal-legal contexts
  - Integrate w/ court systems, advocate for participants, be more involved with pre-release planning
  - Face-to-face contacts
  - Help navigate challenging relationships (e.g., with POs), reduce stigma
- More work to determine how to best measure "success" of peer support
  - Might not be reduced substance use
  - Social support? Stigma?

Thank You!

martha.tillson@uky.edu

Check out our article in *Journal of Clinical and Translational Science!*

Reducing Opioid Mortality in Illinois (ROMI)/ University of Chicago Hub

Presenter: Maggie Kaufmann, ROMI Intervention Project Director

Study PIs: Dr. Harold Pollack and Dr. Mai Pho
The University of Chicago

Intervention PIs: Dr. Basmattee Boodram and Dr. Antonio Jimenez
The University of Illinois Chicago

Overview: Reducing Opioid Mortality in IL (ROMI)

Research question: Can a paired case manager / peer recovery coach (CM/PRC) intervention engage individuals re-entering the community from jail or prison into substance use disorder treatment?

Study arms:

- CM/PRC and harm reduction (HR) services, including naloxone: n=300
- Naloxone and information about local HR and treatment services: n=300

Study sites: 4 county jails; multiple state prisons; rural and urban settings

Eligibility: ≥ 18 years old, reside in study counties, meets criteria for likely SUD (opioids or stimulants), and any interface/interaction with the criminal legal system in the past 30 days (e.g. arrest, re-entry, etc.).

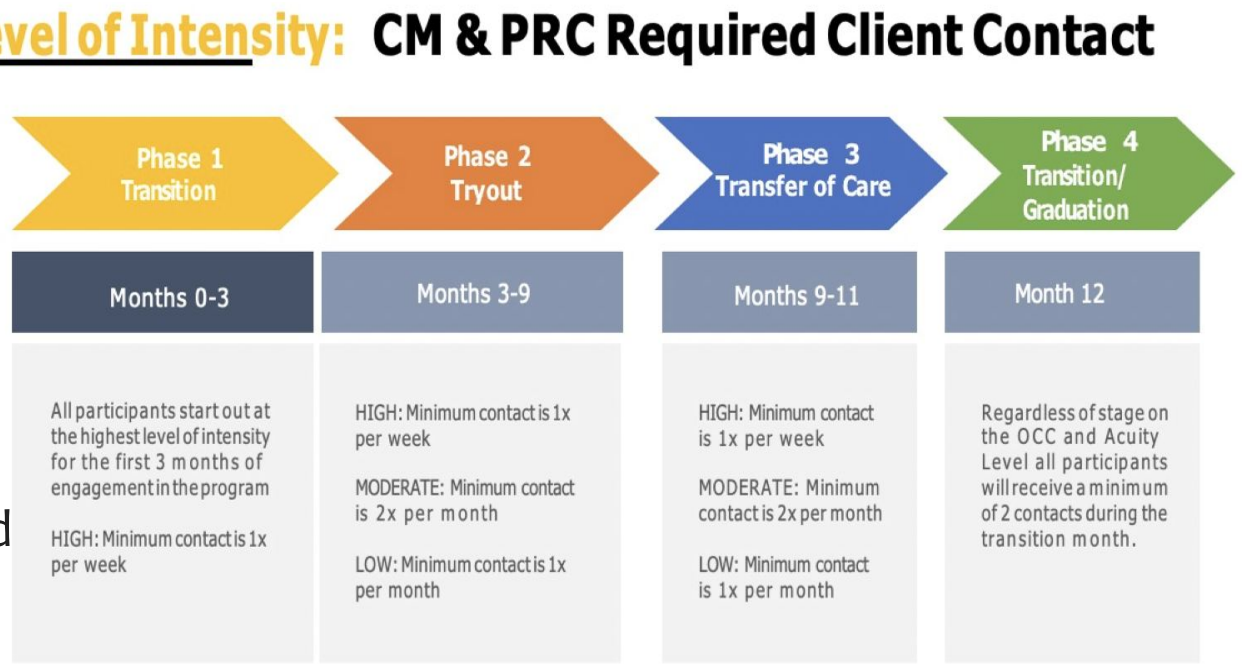
Subject participant duration: 12 months

Outcomes:

- **Primary:** MOUD treatment engagement / retention (3 visits within 2 months)
- **Secondary:** Re-arrest, insurance enrollment, mental health service engagement, among others

ROMI CM/PRC Overview: Remote Hub and Spoke Model

- Research Assistant to CM-PRC: **warm hand-off to support engagement and retention from start**
- CM and PRC: synergistic, **holistic, locally tailored, support to increase recovery capital over time:**
  - Motivational Interviewing, trauma-informed care, harm reduction, ethics and systems navigation
- CM and participant determine goals and barriers, and **CM provides linkage support:** referrals, assistance with forms, etc.
- PRC's provide **psychosocial recovery support** grounded in local lived experience



Support Strategies for Linkage Facilitators:

Acknowledges the **difficulty in providing** this type of support for staff (**especially those with lived experience**)

- Ongoing individual and group supervision
- Ongoing administrative technical assistance

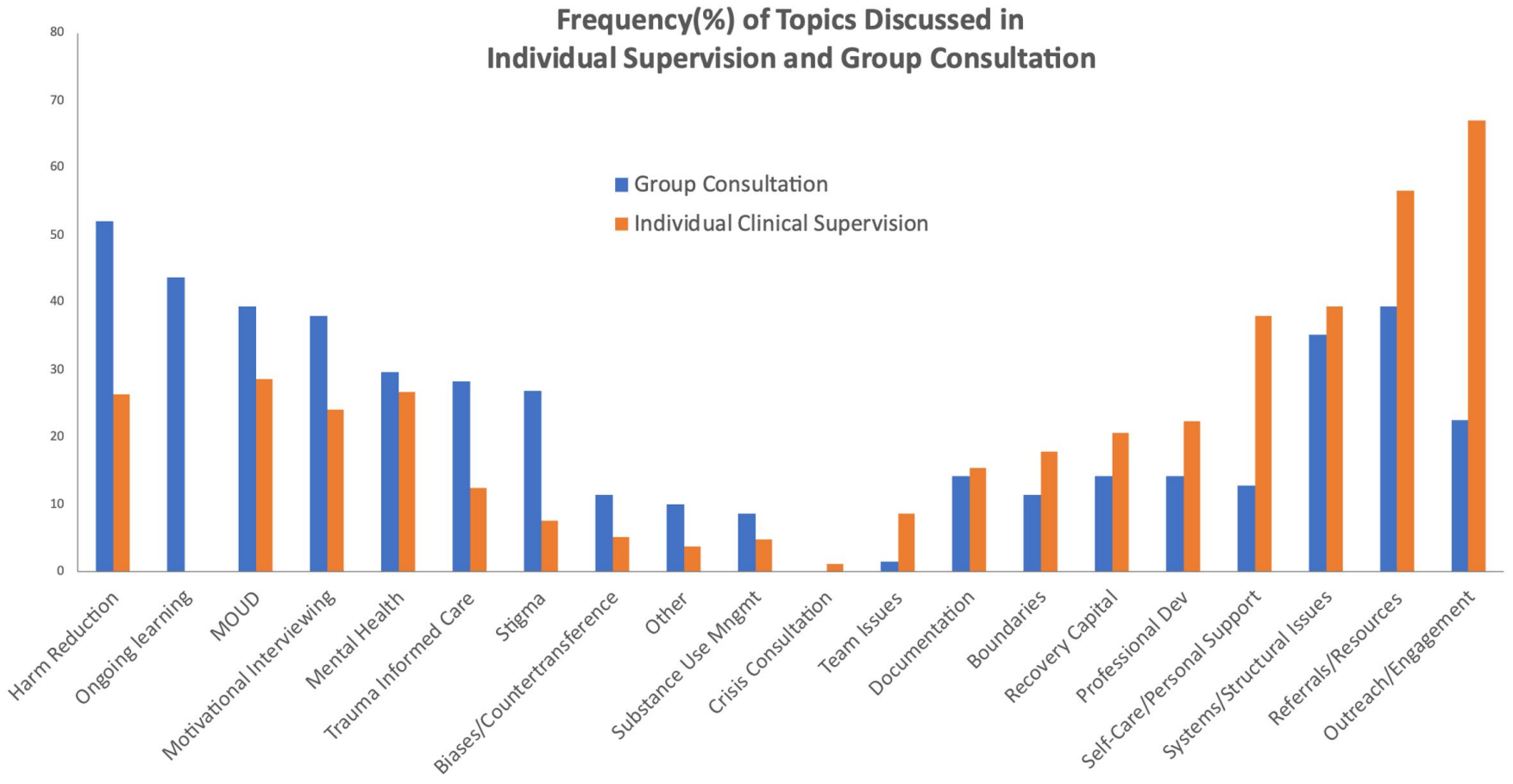
Weekly Individual Clinical Supervision

- **CM/PRC** space to talk with Supervisor about their **work and wellbeing**
- Provides a supportive space for staff to **discuss challenges of the work** including self-care, boundary maintenance, challenges to recovery, etc.
- Clinical supervision provides opportunity to **assess ongoing fidelity to core intervention** components.

Bimonthly Group Case Consultation

- Enables CMs and PRCs to **reflect on their work** in a supportive group setting (Facilitation strategy)
- **Case-based** discussions, **resource sharing**, and **team building**
- Additional **training to respond to dynamic implementation contexts**, e.g., xylazine

Topics Discussed in Individual Supervision and Group Consultation



What Works Well With This Approach:

- **Training:** strong foundation needed to fulfill role
  - Significant on-the-job-learning: novel "real world" scenarios

- **Individual Supervision:** successfully navigate the work and maintain their mental health, boundaries, and recovery
  - **Relational aspect** of supervision
  - **Focus on role**, without trying to "do it all" as often happens in settings where staffing is limited

- Group Supervision: **Fosters team cohesiveness,** community and skill in a remote hub-and-spoke model

- **Benefits of a dyadic approach** to service provision

"Weekly clinical supervisor trainings were very helpful and the bi-weekly CM/PRC meetings were very helpful. The weekly meetings with the clinical supervisor let us work out how to best to specifically assist clients, and it also gives us a place to vent any issues or problems we are having. There was different levels of expertise amongst the staff so we could rely on those seasoned staff to assist us with their experience and knowledge. Also, it builds solidarity with other staff when you don't feel isolated and feel that others are going through the same problems/barriers in assisting clients."

-ROMI Case Manager

Challenges of linkage facilitation

- Stigma: cross-cutting barrier in criminal legal system (CLS) and community
- Site-level differences in CLS
  - Variability in site / CLS staff support and buy-in
  - Recruitment and meeting with participants
  - Long-term incarceration
  - Policy: IL bond reform (Sept. 18, 2023): **First state to eliminate cash bail** via the Pretrial Fairness Act
- Lack of local resources: transportation in rural areas
- Research structure vs. real-world settings
  - Lengthy rapport building process
  - Bond with one team member or favor contact with one person if can't handoff to full team
  - Delayed engagement until close to study exit (12mos)

"Sometimes people ask for what they think you want to hear, rather than what they actually want. This can look like they are not "motivated", when in reality they are having a hard time with trust & self-worth. There are many barriers in getting into the treatment center system, location, insurance, bed availability, wait lists, dual diagnoses. Working with the jail staff in the beginning created some issues, but building healthy relationships through education has improved that space. STIGMA across all, in community, mental healthcare system, medical system, justice system, family dynamics, old friends, education, housing, employment"

-ROMI Peer Recovery Coach

Future Directions for Linkage Facilitation Field

- More LFs in **correctional/court settings**
  - **Better access** in correctional settings to provide support before release.
  - **Better relationships/collaboration** with other community stakeholders (city officials, law enforcement, etc.), especially in rural areas

- **CM/PRCs in more settings**: "standard" in many more supportive settings given value to people who use drugs

- **Further professionalization** of the field to bring more validity to roles utilizing "lived experience": **increase pay and professional pathways**

"I would love to see a linkage facilitator in every jail and every court room."
-ROMI Peer Recovery Coach

"Professionalizing the work more. Giving people the opportunities needed to know more than just what they have been through. I believe the linkage facilitation can be a position all of its own. I think that will increase the meaningfulness of the connections. I think that can bring more validation"

-ROMI Peer Recovery Coach

Remembrances:

The ROMI study would like to dedicate this presentation to the memories of Dr. MoDena Stinnette and Mr. Floyd McGee. They both left large shoes to fill and helped people with compassion, understanding and unconditional love.

"If you have come here to help me, you are wasting your time. But if you have come because your liberation is bound up with mine, then let us work together."

--Lilla Watson

PIERS:
PROVIDING INTERVENTIONS FOR ENHANCING RECOVERY IN COMMUNITY SUPERVISION

Sept. 19, 2024
Coordination/ Translation Center Webinar

BROWN U. HUB, PI-Martin, U01DA050442

Anthony Coetzer-Liversage, PhD
University of Rhode Island

Machiste Rankin
Brown University

Brown University Hub: Peer Support Specialists

- Target population: people on probation with opioid use disorders
- Randomized experiment
  - Consented eligible participants assigned to receive a Peer Support Specialist (PSS) or TAU
  - Three sites: RI, Brunswick County NC, Philadelphia PA
  - Total target N=450
- Focus on linkage to MOUD and other treatment
- Baseline, 3- and 6-month assessments
- Key outcomes
  - Engagement with MOUD
  - Opioid and other drug use
  - Rearrest and probation violation

PEER SUPPORT SPECIALISTS

- Two PSS per site
- *FACILITATOR IDENTITY:* Certified Peer
- *FACILITATOR LIVED EXPERIENCE:* Direct (CLS and prior opioid use involvement)
- *LINKAGE CLIENT:* Person in need
- *FACILITATOR-CLIENT RELATIONSHIP:* Collaborative-flexible
- *LINKAGE ACTIVITY:* Targeted navigation – ad hoc support
- *LINKAGE METHOD:* In person – digital synchronous
- *LINKAGE CONNECTIVITY:* Assertive and passive linkage
- *LINKAGE TARGET:* MOUD plus other services and supports as needed

PSS ROLE AND ACTIVITIES

- SAMHSA Peer Core Competencies as framework
- Initial in-person meeting(s) to establish rapport and develop recovery plan using Wellness Recovery Plan tool
- Help clients reflect on challenges and successes on probation
- Use Motivational Interviewing skills
- Review court and/or community supervision stipulations and expectations, if needed
- Set recovery goals with clients
- Assist with connection to MOUD
- Discuss and/or connect with other providers or community resources

MAINTAINING AND DOCUMENTING FIDELITY TO PSS ROLE

- PSS protocol detailed manual
- PSS activity log
- Oversight by research supervisor
- Cross-site peer supervisor
  - Regular meetings with all site peers
  - Trouble shooting and addressing challenges
  - Sharing strategies and successes
  - Supporting peers in their own long-term recovery

CHALLENGES

- Cumbersome and lengthy hiring process by University
- Making initial contacts with clients
- Navigating the services landscape
- Maintaining fidelity to the study protocols while allowing flexibility
  - Potential record keeping burden as caseloads increase

Linkage Facilitator Perspective

- LF Personal Experiences.
  - What works well.
    - Patience/ persistence.
    - Empowerment.
    - Hard truths/ balance.
    - Marathon v sprint.
  - Challenges.
    - Consistent client engagement.

Linkage Facilitator Perspective

- Next steps for the field.
  - Add qualified peers to permanent staff positions in research
  - Provide educational opportunities for peer staff members that can yield a college degree.
  - Mandate cultural competency training to all researchers and RAs.
  - Include the voices of the community/stakeholders in planning and execution of studies
  - Recognize the power of the "lab coat"

ENGAGING INDIVIDUALS IN CARE POST-RELEASE: IMPLEMENTING THE TCN PROGRAM TO IMPROVE MOUD CONTINUITY

YALE HUB: TCN PATHS
JCOIN RESEARCH MEETING
JUNE 11, 2024

Dorel Clayton

CHW Trainer, TCN

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TCN PATHS

Yale SCHOOL OF MEDICINE

TRANSITIONS CLINIC

OVERVIEW: TCN PATHS

- **Hypothesis**: TCN program participation improves measures within the opioid treatment cascade among those just released from jails on medications for OUD
  - Treatment arm: Transitions Clinic Network Model (TCN)
  - Control arm: Standard Primary Care (SPC)
- **Study Sites**: 5 – CT, MN, NY, NC, and PR
- Baseline, 3M, 6M, 9M, and 12M assesments
- Enrollment conducted in community

- **Target Enrollment** - 400
- **Aim 1 outcomes**:
  - Primary care engagement
  - MOUD engagement and retention
- **Aim 2 Outcomes**:
  - TCN cost effectiveness vs SPC
- **Aim 3 Outcomes**:
  - Acceptability and appropriateness of TCN

TCN PATHS LINKAGE FACILITATOR APPROACH

- TCN PATHS employs community health workers (CHWs) with lived experience of incarceration
- CHWs are integrated into primary care teams to support the health and well-being of individuals returning from incarceration
- Patients with OUD were randomized into two arms, TCN vs Standard Primary Care, at 5 sites for continuity of care

Yale SCHOOL OF MEDICINE

TRANSITIONS CLINIC

WHAT WORKS WELL

- TCN CHWs act as cultural interpreters, navigators, and mentors who facilitate trust and engagement in health systems which patients may (understandably) fear or mistrust.
- By being integrated into primary care teams, TCN CHWs are able to help patients with OUD address their physical, mental health and reentry needs
- TCN trains the individual CHW in core competencies of working as part of a primary care team and serving individuals impacted by incarceration.
- TCN also trains and supports transformation among the health systems to support these CHWs and patients.

TCN CHWS UNIQUE APPROACH

- Role Modeling -TCN CHWs serve as powerful role models, demonstrating that recovery and reintegration to society is possible.
- Motivation and Hope- CHWs are credible messengers and inspire hope and motivation by sharing their own stories of overcoming similar challenges.
- Shared Understanding of Incarceration- CHWs understand the culture and shared experiences of those who have been incarcerated , allowing for more effective communication and tailored interventions.
- Comprehensive Care- CHWs adopt a holistic approach, addressing not just OUD, but other aspects of health and well being.
- Documentation- CHWs use outreach to keep participants engaged while tracking and documenting consistently.

CHW TRAININGS & EDUCATION

Additional Sessions to Support CHWs

- Dealing with patient ambivalence
- Helping people with time management
- Dealing with Probation +/- Parole
- Creating boundaries
- Partnering with jail staff
- Dealing with self stigma with patients

CHALLENGES

- Lack of sustainable funding for CHW role and changing of supervisors
- Legal barriers to hiring, as well as accessing the jails with CHWs being justice involved
- Stigma and discrimination related to SUD and carceral system involvement
- Lack of access to medical records
- Co-occurring mental health disorders
- Stigma from Health Systems
- Cultural and language barriers
- When the CHW doesn't initiate contact it Changes the report building process for CHW's

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TRANSITIONS CLINIC

WHAT'S NEXT IN THE FIELD

- 1115 Medicaid reentry waiver (potential to expand this workforce/care and SUD treatment for this population)
- CHW certification
- HRSA funding for reentry projects

"They [Transitions clinic staff] don't judge you – they treat you like a human being, like you're still a person. That's something that prison takes away from you, and when you get out, society takes that away from you… I think that's what makes Transitions clinic so successful."

TCN Patient

Yale SCHOOL OF MEDICINE

TRANSITIONS CLINIC

ACTION study

Linkage Facilitation:

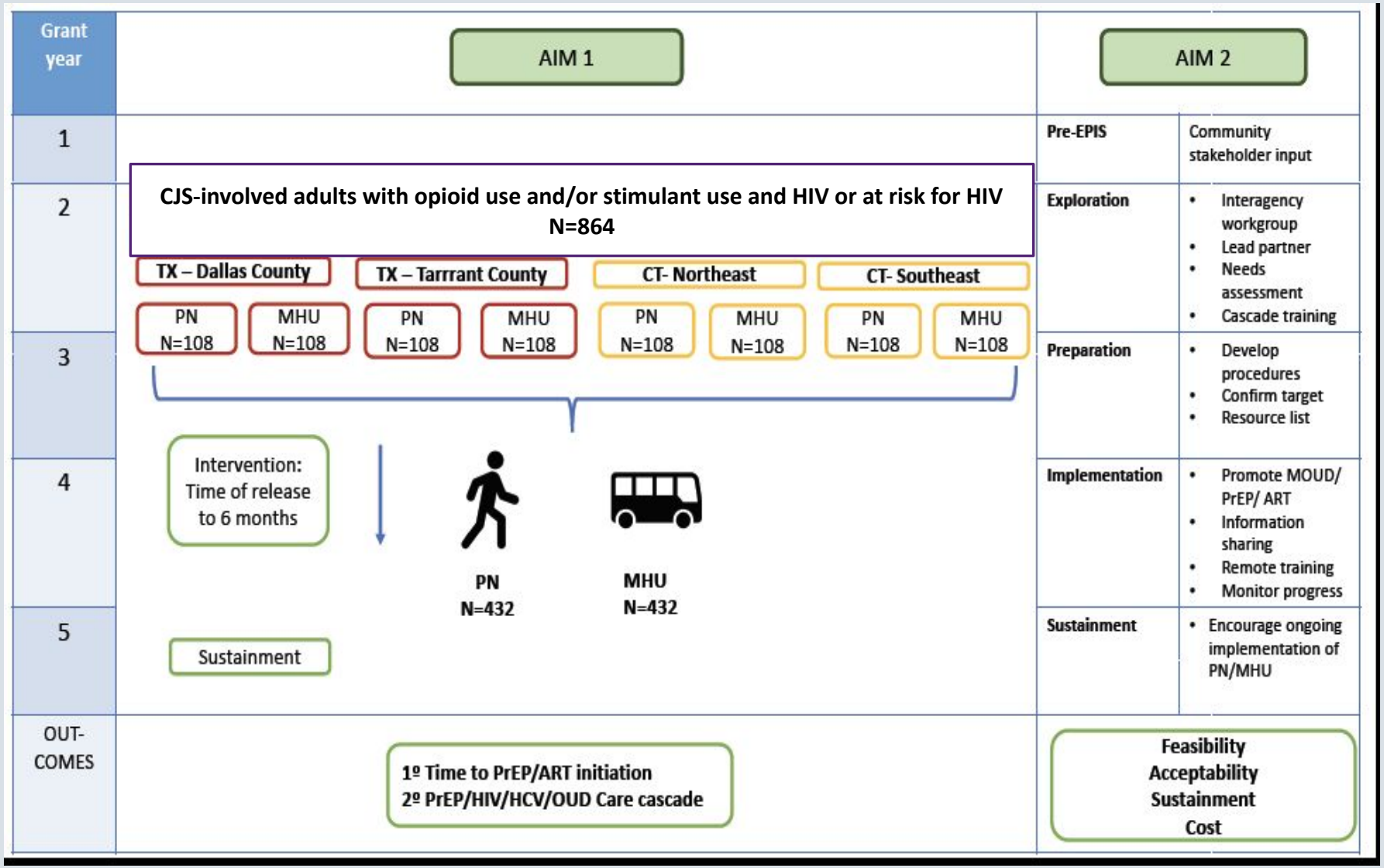
Patient Navigators and Community Health Workers

Sandra A. Springer, MD
Professor of Medicine
Section of Infectious Disease
Yale School of Medicine

Stazja Stuccio, BA
Community Health Worker
Yale School of Medicine
Yale-HIV JCOIN Hub

NIDA U01DA053039, MPIs: Springer, Knight, Nijhawan

Addressing risk Through Community Treatment for Infectious disease and Opioid use disorder Now among Justice-Involved Populations (**ACTION**) Study design



Linkage facilitators:

- Patient navigators (PNs)
- Community Health Workers (CHWs)

NIDA U01DA053039
JCOIN Study
MPIs: Springer, Knight, Nijhawan

PNs and CHWs

UTSW:

Gerald Strickland, CHW

Shirley Cooper, PN

Eston Dixon, PN

TCU:

Sabrina Roberson, CHW

Ahrein Bennet, CHW

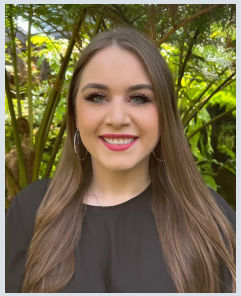
Christy Wooten, CHW

Chelsea Wood, PN

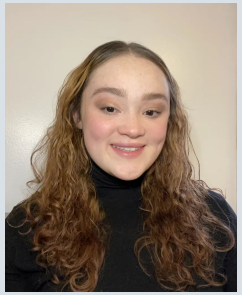
Ashley Gainey, PN

Olivia Persinger, PN

Yale:



E.Stazja Stuccio, CHW



Linda Lopez, CHW

Elda Martinez, PN

Melissa Borker, PN

Documentation: Needs Assessment and SMART goals

Rank #	Area of Focus	Specific Goal: (what, when, where)	Measurable: (milestones, how much?)	Achievable: (Have skills to accomplish this? List strengths)	Relevant: (Does it fit with overall objectives?)	Time-Bound: (immediate and final timeline)	Action items	Status Progess scale
	Substance /Alcohol use							-2 -1 0 1 2
	Housing							-2 -1 0 1 2
	Food							-2 -1 0 1 2
	Transportation							-2 -1 0 1 2
	Relationship/Family							-2 -1 0 1 2
	Childcare							-2 -1 0 1 2
	Mental health care							-2 -1 0 1 2
	HIV/PrEP care							-2 -1 0 1 2
	Hepatitis C care							-2 -1 0 1 2
	General medical care							-2 -1 0 1 2
	COVID-19							-2 -1 0 1 2
	Legal issues							-2 -1 0 1 2
	Employment							-2 -1 0 1 2
	Financial benefits							-2 -1 0 1 2
	Health insurance							-2 -1 0 1 2
	Personal safety							-2 -1 0 1 2
	Other:							-2 -1 0 1 2

PN VISIT structure

1. Orientation to study/intervention: provide ***Patient Navigation Information sheet*** *(Initial visit)*
2. Exchange/update contact information: Confirm ***Locator Information Form***, enter PN number into patient phone and vice versa
3. Identify participant strengths
4. Set and prioritize goals, using ***Needs Assessment and Smart Goals Form***
5. Create action plan
6. Make arrangements for next visit

Visit	Month 0					Month 1				Month 2				Month 3				Month 4				Month 5				Month 6
	Week 0	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8	Week 9	Week 10	Week 11	Week 12	Week 13	Week 14	Week 15	Week 16	Week 17	Week 18	Week 19	Week 20	Week 21	Week 22	Week 23	Week 24	Week 25
Baseline																										
PN visit																										
Study visit																										

Timing:

CHWs are on Mobile Health Units

TCU's Mobile Health Unit in Fort Worth, TX

Yale's Mobile Health Unit in Northeast, CT

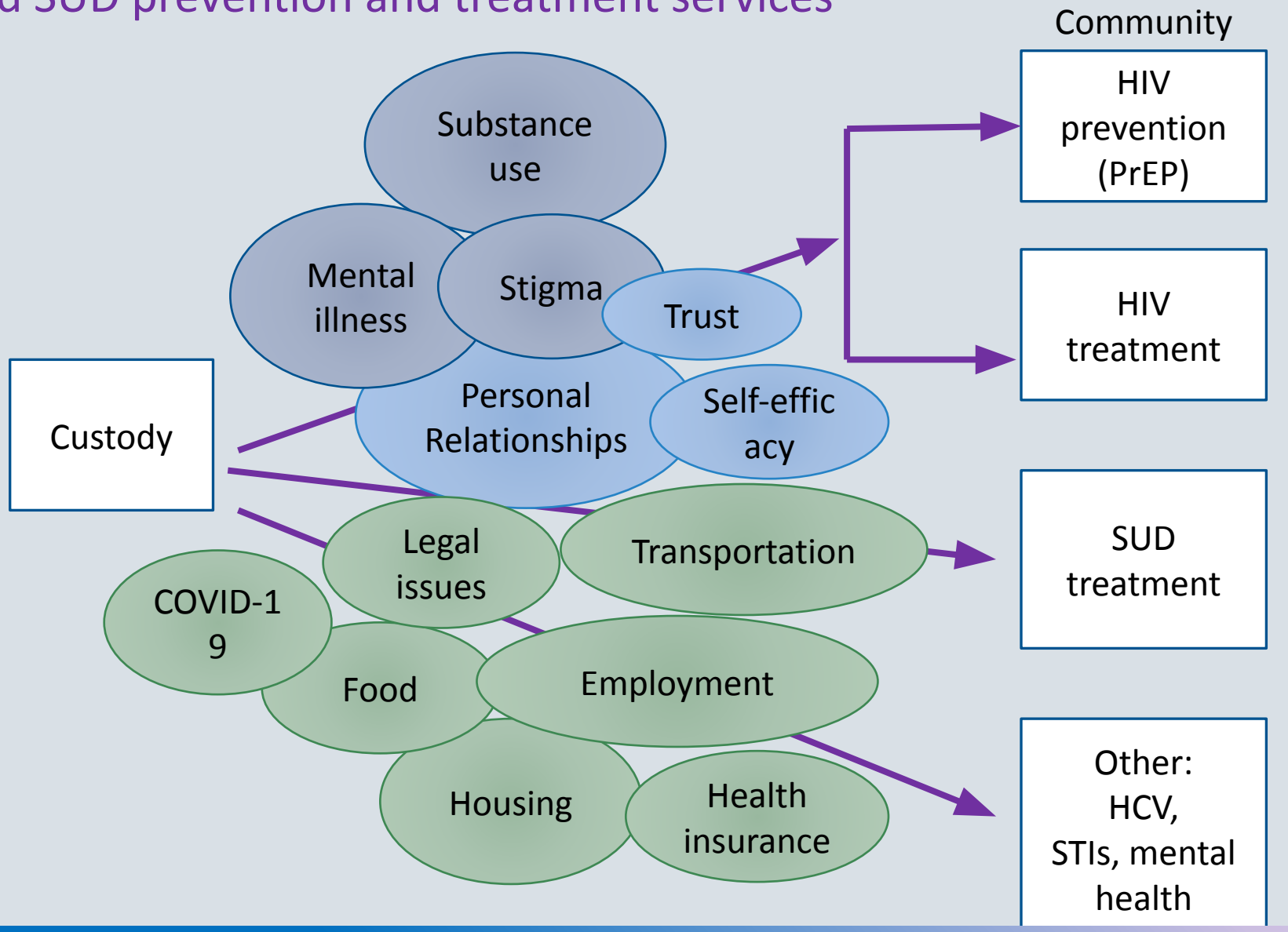
The HOMES Mobile Health Unit UTSW will be using in Dallas, TX

The Homeless Outreach Medical Services (HOMES) program at Parkland Health and Hospital System in Dallas consists of five medical mobile units and has provided medical, dental and behavioral health services to children and adults who are homeless for 30 years.

CHW VISIT structure on MHU

1. CHW meets with the participant first on MHU
2. CHW provides an orientation to study/intervention and summarizes the role of the CHW and the time frame of the intervention *(Initial visit)*
3. Exchange/update contact information: Confirm ***Locator Information Form***, enter CHW number into patient phone and vice versa
4. CHW conducts new/updates ***Needs Assessment***
5. Participant meets with the clinician and creates a clinical plan.
6. During this time the CHW makes referrals that were identified in the ***Needs Assessment***
7. After meeting with the clinician, the participant meets with the CHW and Clinician as a team.
8. The CHW and participant create action plan.
9. Make arrangements for next visit

Various barriers that linkage facilitators need to help participants navigate for HIV and SUD prevention and treatment services



Participants Reported Needs at Baseline by State

Medical Needs	TX	CT
COVID-19	6.2%	16.8%
General medical care	66.7%	65.5%
Vision care	30.9%	34.5%
Dental care	45.1%	56.3%
Health insurance	52.5%	25.2%
Hepatitis C care	17.3%	16.0%
HIV care/ ART	4.3%	7.6%
Mental health care	45.1%	58.8%
Naloxone access	25.9%	38.7%
Opioid use disorder Tx/ MOUD	14.8%	28.6%
PrEP	30.2%	28.6%
Stimulant Use Disorder	26.5%	31.1%
Substance/alcohol use disorder	12.3%	14.3%
Syringe Services	7.4%	5.9%
STIs	12.3%	37.0%

Socio-Economic Needs	TX	CT
Childcare	4.9%	6.7%
ID / Documentation	58.6%	43.7%
Communication issues	51.2%	56.3%
Employment	63.6%	69.7%
Financial benefits	59.9%	84.9%
Food	68.5%	72.3%
Housing	71.6%	82.4%
Legal issues	30.2%	21.0%
Peer/ Family Support	24.1%	43.7%
Personal safety	8.6%	28.6%
Transportation	68.5%	82.4%

N=361

PN1- UTSW-Dallas, TX

Helping participants set priorities:

"I have experienced there being somewhat of **a challenge in prioritizing goals**. You know, somebody may say 'I need a job' because of course, they're thinking I need money, when you don't have a place to stay. …So I may say, 'Okay, and that's very important. So, I definitely understand that and we can and will assist you with employment. However, how about your housing? You know talk to me a little bit about that…and then they may think for a second and say 'I need housing'"

Impact of support and accountability:

"[Participant] said I would have never went through this process without your help. And, and he was a young man that, you know, he was somewhat reserved, and he wouldn't have followed through with certain appointments. **He wouldn't have talked to the doctor and, you know, I would make sure-** 'I'm gonna meet you there, so, are you on your way? I'm here,' you know, and things like that and he's like, 'I'm on my way now, Miss [PN],' Things like that and the outcome was grand because he received and completed the eight weeks of Mavyret."

PN 2- UTSW- Dallas, TX

Benefit of lived experience:

"For me what works well is I am able to go and meet with the participant wherever they are…**I am able to use my experience to help the participant navigate resources they need.** My counterparts support me in all that I do. My [fellow PN] is the most supportive teammate I've ever had."

Challenge of ongoing participant substance use:

"The **main challenge that I see is participants who are still active in their addiction** …They sometimes don't take advantage of the resources that are offered to them… Most are not concerned with taking PrEP to help further them from getting HIV. So in their addictive state some are trying to get to their next fix. They don't keep their appointments, answer their phones, or complete goals that they have set."

CHW- UTSW- Dallas, TX

Engaging with participants:

"Some participants who made their appointments, called me back and told me they enjoyed the visit. They thanked me and it went well, I had a couple of cases where they actually went through the treatments for Hepatitis C, Suboxone, and really appreciate what I did for them. And you know, for me, that was a beautiful feeling for me because …I know it's gonna work with some people and ain't work with other people. But those who are actually, really want the help that be really persist about getting help. I feel thankful they did get the help, that makes me feel good."

Patient Navigator Quotes –TCU- Tarrant County, TX

Connecting to services

It's been a little difficult. There's the **insurance** plans that we can sign them up with. We were doing them through paper copies at first but [HOSPITAL 1] recently put the application online, so that makes it a little easier. And so it's **difficult walking them through the process when we don't quite know the process**. And **so we just have to listen to our participants and hear what they have gone through to be able to relay that information to other participants**.

[PN 1]: There's, I think it's called FindHelp.org. That one stays pretty up to date. And then just Google. The whole idea behind that spreadsheet is to see, you can filter it out by like city and zip code so you know what's closer to the participant. I like that aspect of it, but actually seeing it on Google Maps and all of that is a little helpful, especially for like our [HALFWAY HOUSE 1] participants who have to rely on bus transportation and walking and bicycling.

Barriers

I think **just having those available resources for our participants**. Yeah, that's the hardest part, I think is once you find an organization, that would be perfect for them. You tend to refer to that organization for everyone else on your caseload. And we try not to do that, because we know we'll overburden that organization, or they'll run out of money and all kinds of stuff like that.

CHW Quotes- TCU- Tarrant County, TX

Finding resources in the community

[CHW 1]: Mostly **organizations, we have some good ones but we never know. Like right now, several of them are out of funding**. We have referrals to some other agencies for like dental and vision. One, my understanding for vision was free, but it's actually $30. And for some people fresh out of jail or prison don't have $30.

Barriers

[CHW 1]: One barrier for seeing people is that **Mobile Health Unit has certain hours on certain days, and [PARTICIPANTS] may not be off on those days** if they're working.

PN Quotes- 6 counties in CT

- It has been great like I connect with them [the participants], **I tell them you are the driver of this car and I'm just helping you navigate your way through.**
- **Education and empowerment are important**, because some people may be ready to address the issue, and some may not. So just continuously educating them, not pressing them.
- A participant called at 4:30 pm on a Friday. They [the provider] sent the **Suboxone** to a pharmacy that was closed, so **I immediately called the provider** about where was this script sent to. We contacted another pharmacy, and **we were able to get him the medication**.
- And I always tell them listen, we just met I'm not trying to lose you, so let's try to stay in touch and let's try to meet so that we can address some of the needs that you have, and **we can tackle this together**. This has played a role in successfully **keeping them [the participant] engaged**
- **I think that 6 months is not enough**, honestly, to work with participants, because sometimes let's say, you know, things happen, they may miss a couple of sessions and now you're trying to catch up with some of the goals that they have and sometimes, you know, linking them, once my intervention is over, sometimes they're not receptive to being linked with the case manager because they've already built this report with me

Stazja Stuccio, BA

Community Health Worker

Yale School of Medicine

Yale-HIV Hub

CHW experience 6 counties, Connecticut

1) Logistical considerations (scheduling, staffing, parking, managing the visit)
2) Collaboration between clinician and CHW
3) Research and non-research days
4) Work on and off the unit
5) Experiences working with participants

What works well

- PNs and CHWs are good at building trust with participants
- Mobility/flexibility allows them to literally meet people where they are at
- PNs/CHWs have gained and shared a lot of knowledge about local health and social services
- PNs and CHWs support one another (trouble shooting, service recommendations, cross cover)
- Have been very successful at connecting people to certain services that were high priorities (housing, dental, hepatitis C treatment)

Challenges

Hard to contact some participants despite providing phones

PrEP typically not a top priority for participants

Recidivism

Time-limited intervention (some ppts just getting on track at 6 months)

ACTION

Thank you!

DISCUSSION

NIH HEAL INITIATIVE | Justice Community Opioid Innovation Network (JCOIN)

Evaluating Linkage Facilitation: Use of a Taxonomy and a Checklist

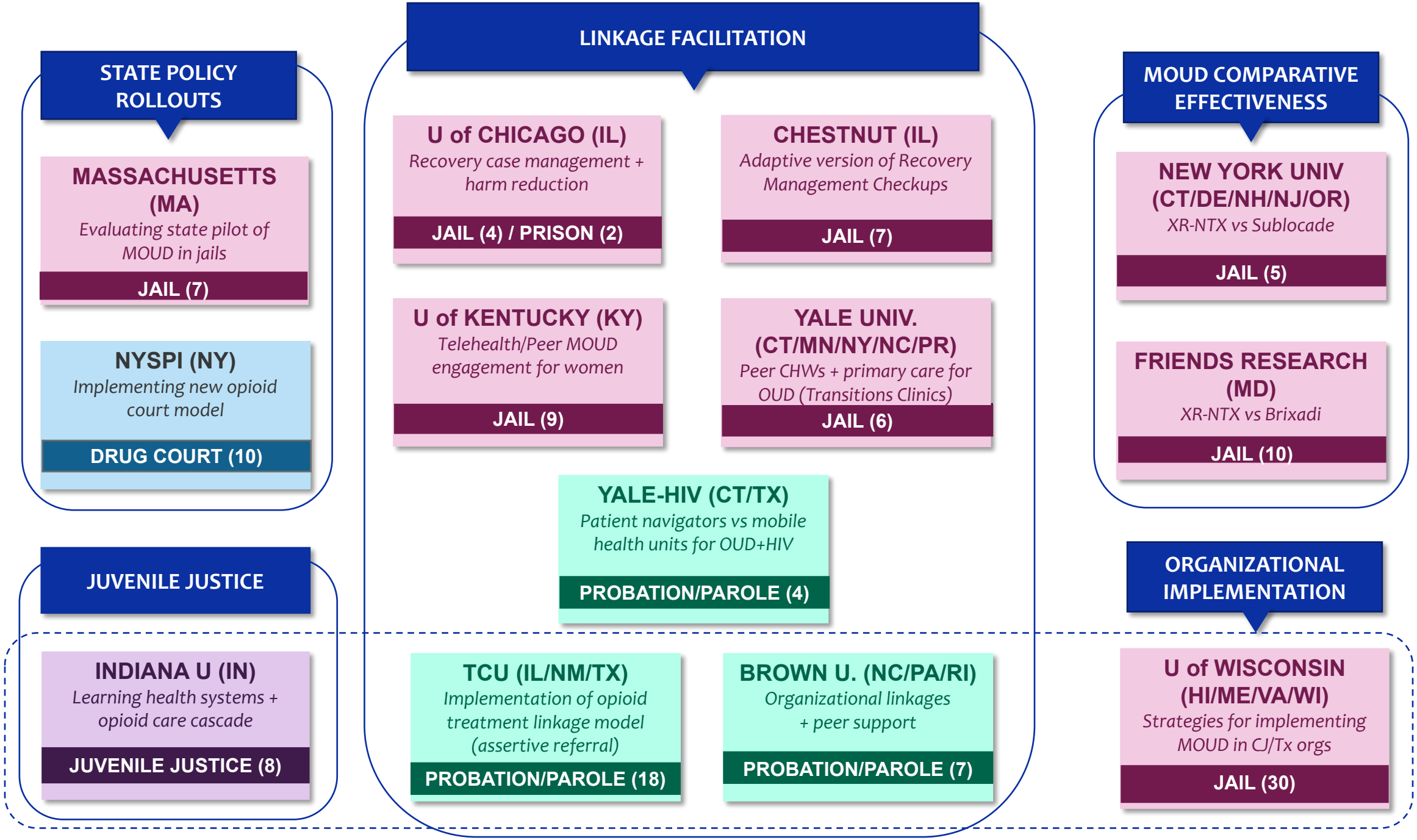
Sept. 19, 2024
Coordination/ Translation Center Webinar

BROWN U. HUB, PI-Martin, U01DA050442

Anthony Coetzer-Liversage, PhD
University of Rhode Island

Linkage Facilitation Checklist

Development of Linkage Facilitation Checklist


STATE POLICY ROLLOUTS
MASSACHUSETTS (MA)
Evaluating state pilot of MOUD in jails
JAIL (7)
NYSPI (NY)
Implementing new opioid court model
DRUG COURT (10)
JUVENILE JUSTICE
INDIANA U (IN)
Learning health systems + opioid care cascade
JUVENILE JUSTICE (8)
LINKAGE FACILITATION
U of CHICAGO (IL)
Recovery case management + harm reduction
JAIL (4) / PRISON (2)
CHESTNUT (IL)
Adaptive version of Recovery Management Checkups
JAIL (7)
U of KENTUCKY (KY)
Telehealth/Peer MOUD engagement for women
JAIL (9)
YALE UNIV. (CT/MN/NY/NC/PR)
Peer CHWs + primary care for OUD (Transitions Clinics)
JAIL (6)
YALE-HIV (CT/TX)
Patient navigators vs mobile health units for OUD+HIV
PROBATION/PAROLE (4)
TCU (IL/NM/TX)
Implementation of opioid treatment linkage model (assertive referral)
PROBATION/PAROLE (18)
BROWN U. (NC/PA/RI)
Organizational linkages + peer support
PROBATION/PAROLE (7)
MOUD COMPARATIVE EFFECTIVENESS
NEW YORK UNIV (CT/DE/NH/NJ/OR)
XR-NTX vs Sublocade
JAIL (5)
FRIENDS RESEARCH (MD)
XR-NTX vs Brixadi
JAIL (10)
ORGANIZATIONAL IMPLEMENTATION
U of WISCONSIN (HI/ME/VA/WI)
Strategies for implementing MOUD in CJ/Tx orgs
JAIL (30)

Linkage Facilitation Checklist Scales

Scale	No. of Items	Likert Response	Sample Item
Usefulness of Personal Experience for your Job	9	Usefulness (4-item Likert; "somewhat")	For your job, how useful is your… **Lived experience with substance use?**
Training Usefulness	8	Usefulness (4-item Likert)	For your job, how useful is your… **Peer specialist or peer recovery coach training?**
Work Activities	19	Frequency of occurrence (5-item Likert; "sometimes")	How often do you engage in these activities with clients… **Facilitate client enrollment into services?**
Client Connection to Local Resources	9	Frequency of occurrence (5-item Likert)	Connect client to local resources… **Housing**
Client Connection Methods	4	Frequency of occurrence (5-item Likert)	Methods used to connect clients to resources… **Provide / arrange transportation**
Activity Supporting Work	4	Frequency of occurrence (6-item Likert; "6+ days/wk")	To support your work how often to you engage these activities… **Community outreach for potential clients?**
Stakeholder Communication	5	Frequency of occurrence (5-item Likert)	How often do you communicate with… **Providers who administer Medication Assisted Treatment regarding your clients?**
Client Communication Type	8	Frequency of occurrence (5-item Likert)	How often do you communicate with clients using… **Text?**
Usefulness of Guidance	4	Usefulness (4-item Likert)	How useful was the guidance you received in… **Appropriate client boundaries (e.g., where you can meet with clients, etc.)?**

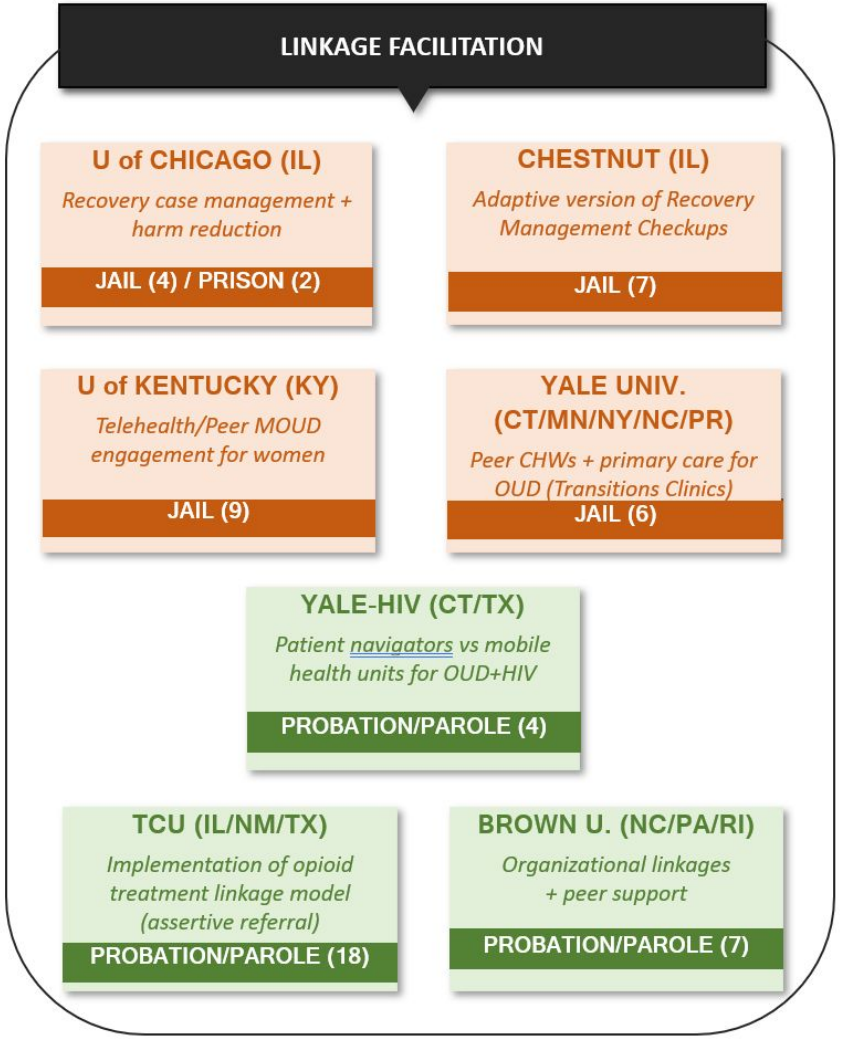
Application of the Linkage Facilitation Checklist

- **Description**
  - N's: BL = 30, 3M = 22, 6M = 15 and 9M = 15 (Wave 6)
  - Response rates: BL = 77%; FU = 73%.
  - 2 most common job titles: Peer = 36%, Community Health Worker = 27%
  - Employed full-time = 83%
  - Supervised approximately weekly.
- **Basic findings**
  - Communicate with clients about once per week.
  - At furthest FU, 44.4% of saw clients for at least 6 months.
  - Client engagement/ support remained important over time.
  - Links to health services increased over time.
  - Communication with family decreased over time.

Linkage Facilitation Taxonomy

Development of a Linkage Facilitation Taxonomy

Linkage Facilitation Across Hubs



Need For Taxonomy

- LF is growing in OUD settings with a diverse workforce, including peer support specialists.
- Current research lacks a comprehensive framework for LF services in SUD.

Taxonomy Paper Goals

- Develop a practical lexicon for LF services in OUD.
- Describe the MOUD services continuum and LF as a common practice for OUD.
- Propose a conceptual framework (taxonomy) of LF for OUD with eight domains.
  - Define each domain's categories, key research themes, and recent innovations in MOUD.

MOUD Services Continuum

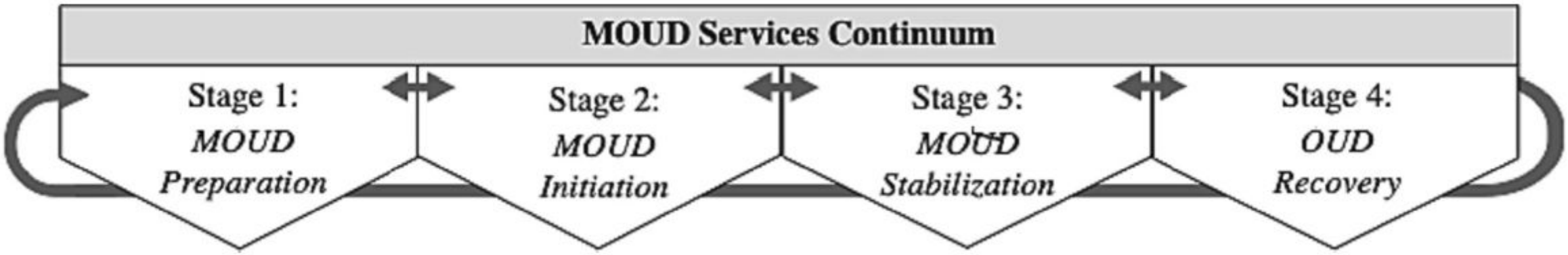


Fig. 1. MOUD services continuum.

Linkage Facilitation Taxonomy

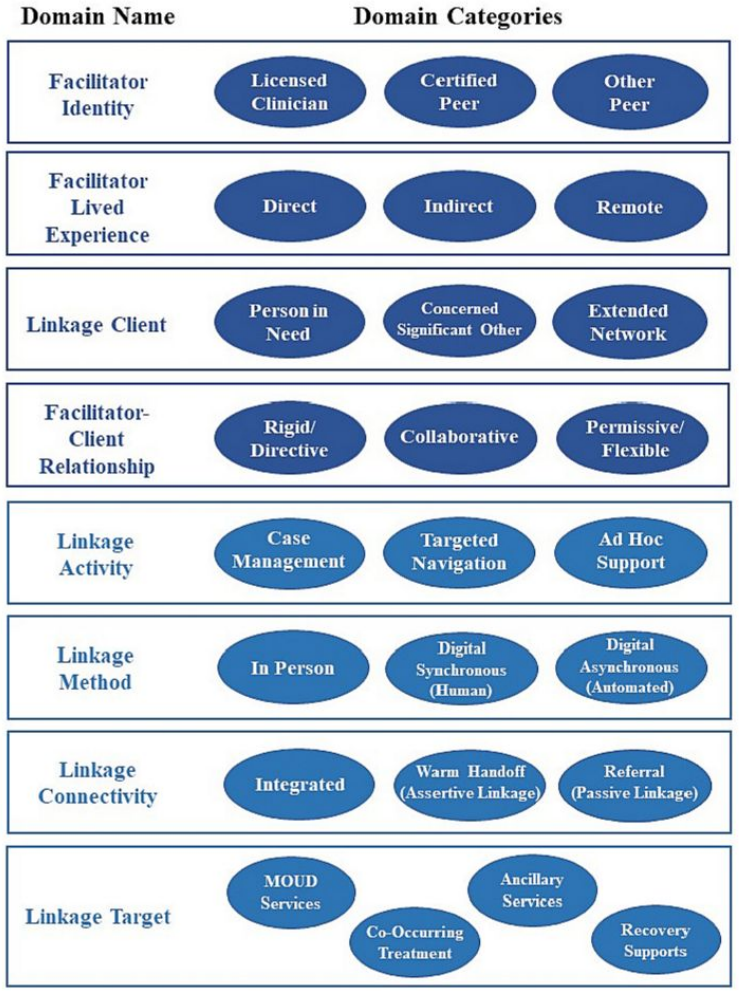


Fig. 2. Taxonomy of linkage facilitation for OUD services.

Discussion