Protocol

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Brief Title: Improving Linkage to Health and Other Services for Veterans Leaving Incarceration (PIE)

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Veterans Justice Reentry, Post-Incarceration Engagement Project, Massachusetts

1. SPECIFIC AIMS

Veterans leaving incarceration (henceforth, "reentry Veterans") are among the most underserved by the VA and thus are an increasingly high priority population. The Bureau of Justice Statistics estimates that 140,000 Veterans are incarcerated in the U.S. at a given time, approximately 80% of whom are eligible for VA benefits (Noonan 2007). Among Veterans incarcerated in state prisons nationally, 75% reported using drugs prior to incarceration, and roughly 25% of those reported injection drug use history (Noonan 2007). Also, about 50% of incarcerated Veterans report having recently experienced symptoms of mental health disorders (Noonan 2007). Veterans are more likely to report a recent history of mental health (MH) service use (30%) than non-Veterans (24%) (Noonan 2007). The VA's national Health Care for Reentry Veterans (HCRV) program identifies 10,000-15,000 incarcerated Veterans annually preparing to transition back to the community (2014). Despite many health needs, it is difficult to link reentry Veterans to Veterans Health Administration (VHA) primary care (the gateway to all VHA health care services). Lack of linkage to health care can lead to a downward spiral in health and mental health from worsening substance use disorders (SUDs) or MH, or from complications from hypertension and diabetes. This worsening health can lead to inefficient use of emergency and hospital services, and can derail progress in vocational training, education, work, and housing, which may lead to re-offending and re-incarceration (Visher 2003; Travis 2005; Mallik-Kane 2008; Baillargeon, Giordano et al. 2009; Meyer, Chen et al. 2011; Swan 2015).

The HCRV program was started to combat these issues. A designated outreach specialist works with incarcerated VHA-eligible Veterans to establish a post-release plan for linkage to VHA services (2014). This program, with 1-2 outreach specialists per state, has improved the connection between reentry Veterans and the VHA. However, our analyses of homeless program data linked to CDW indicate that 43% of eligible HCRV Veterans ***do not*** have a VHA outpatient contact in the first 4 months post incarceration. Reducing this number is critical given the elevated rates of chronic health conditions, as well as MH or SUDs in this population (Noonan 2007; Taxman 2010; Maruschak 2012). To address this gap, we will work with the national HCRV office to implement an evidence-based peer support intervention to extend the reach and effectiveness of the HCRV program in linking Veterans to VHA. Peers with incarceration experience are likely to better understand and connect with Veterans on a personal level than the outreach specialist, and thus are more likely to maintain contact and link to VHA during the first months post-release (Blodgett 2013; Chinman, George et al. 2014; Bagnall, South et al. 2015). Peers are gaining popularity in forensic settings (called "forensic peer specialists") with civilian populations and would likely be beneficial for a Veteran population (Miller and Massaro 2008) . The aims of this project are,

1. Conduct contextual analysis to identify VA and community reentry resources, and to describe how reentry Veterans use them.
2. Implement peer-support to link reentry veterans to VHA primary, mental health, and SUD services. We will use external and internal facilitation as the implementation strategy.
3. At the end of this project, we will develop a proposal for a multi-VISN expansion study, which will use a hybrid type III, stepped-wedge design, to demonstrate effectiveness in multiple geographic and contextual settings.

2. RATIONALE

Reentry from incarceration is a precarious time. Individuals (including Veterans) leaving incarceration often have complicated biopsychosocial needs (Mallik-Kane 2008). They face many barriers to accessing needed services for co-occurring substance use and MH disorders, infectious diseases, other chronic medical conditions. Homelessness, unemployment, and financial instability are prevalent (Visher 2003; Travis 2005; Baillargeon, Giordano et al. 2009; Meyer, Chen et al. 2011; Swan 2015). Literally overnight they experience sudden responsibilities, and competing needs, and yet they have rusty social and self-management skills, and may mistrust service providers and health care systems (Visher 2003; Meyer, Chen et al. 2011; Anaya 2012).

A 2012 study examined Veterans leaving Los Angeles jails and found that, commonly, Veterans held negative views of the VA and were resistant to link to VHA services upon their release (Anaya 2012). Peers may help bridge this mistrust.

Reentry represents a major break in continuity of care (Palepu 2004; Springer and Altice 2005; Harzke 2006; Baillargeon, Giordano et al. 2009; Massoglia 2009; Meyer, Chen et al. 2011). Compared to the other pressing needs, health needs are often de-prioritized by the reentering individual due to drug use relapse and/or untreated mental health disorders (Seaman 1198; Visher 2003; Inciardi 2007; Pettus-Davis 2009; Rebholz 2009; Merrall 2010; Meyer, Chen et al. 2011; Swan 2015). Without addressing a Veteran's behavioral and physical health issues, the other components of reentry and reintegration (housing, employment, family, etc.) can be undermined, which may lead to unstable housing or homelessness, or repeat incarceration. The VA established the HCRV program to: 1) identify Veterans incarcerated in state and Federal prisons, 2) conduct a clinical assessment of these Veterans' needs, and 3) link them to the services that they need when they transition back to the community after they complete their sentence (2014; 2015; 2015).

Preliminary research (Anaya 2012) and discussions with operational partners indicate that the HCRV program excels at identifying incarcerated Veterans and conducting reentry planning – a process that occurs inside prisons and jails. However, the HCRV outreach specialists have quite limited time, given the very small size of the program and the demand that they cover such large geographic areas, to ensure that Veterans link to and engage with VHA in the first months post-release. Such attention to reentry success requires frequent contact with these Veterans and a thorough understanding of their abilities, potential pitfalls, needs and priorities during this vulnerable and thus critical period. Better meeting reentry Veterans' needs would be facilitated if HCRV could leverage other VA and community resources such as peers who understand the attitudes and experiences of reentry Veterans and who can build rapport (Chinman, Shoai et al. 2010). Studies have shown that in various settings, including VA, peer-mentoring facilitates health related behavior change (Chinman, Lucksted et al. 2008; Blodgett 2013; Chinman, George et al. 2014; Bagnall, South et al. 2015). Peer-support provided in prison environments, and to individuals under community corrections supervision (such as parole) is effective at reducing risk behaviors and improving health among justice-involved populations (Bagnall, South et al. 2015; Nyamathi, Salem et al. 2015), and a recent structured evidence review has shown that peers provide critically important emotional, informational, and instrumental support for this justice-involved Veterans (Blodgett 2013). Moreover, in the context of Veterans treatment courts, peer support has been shown to facilitate linkage to VHA services and Veterans' progress through their treatment programs and goals (Blodgett 2013). It is reasonable to expect a similar facilitating effect of peer support with reentry Veterans in linking and engaging them in needed treatment services.

3. PROCEDURES:

<u>Peer-Support Interventions</u>: Peers provide support that differs from professionals (Solomon, Jonikas et al. 1998). First, peers tend to offer practical help; second, relationships between the peer and the recipient may involve self-disclosure and friendship; and third, peers can offer hope as a result of having experienced similar issues. In the current project a peer will be a Veteran who has been incarcerated, but has not committed a felony (which would prevent many reentry Veterans with associating with the peer), and who has received VHA services. The peer support program will be adapted from two models: one developed by O'Toole, shown highly effective in an RCT with homeless Veterans, involves basic health-related instrumental support (e.g. accompanying to 1st clinic visit) to help link and engage vulnerable Veterans in VHA health (O'Toole, Johnson et al. 2015), while the other is Ellison's VetSEd model which is a recovery oriented approach supported by RCTs (Ellison, Mueller et al. 2012; Smelson, Kalman et al. 2012; Smelson, Kline et al. 2013), to assist returning OIF/OEF/OND Veterans reintegrate into civilian life (Ellison, Mueller et al. 2012). The proposed HCRV peer support program will focus on a limited number of specific health-related linkage and engagement goals – recognizing that for several years the Veterans will have used few health navigation and management skills. Our guidebook, to be developed during the project by building on O'Toole and Ellison materials, will likely consist of modules such as these: a) understanding the goals, elements, and processes of the HCRV program; b) insights and experiences that peers bring; c) review of VHA services (and community services) that emphasize primary care, MH, and SUD; d) navigating reentry Veterans to their first and subsequent health-related appointments; and, e) facilitating, motivating, and advising skills. 2 peers will be hired for each state. Peers will be expected to have at least twice monthly contact with each Veteran (Smelson 2010). One

of the first Veteran-peer encounters will involve accompanying the Veteran to his first VHA health care appointment and orienting him to check-in, appointment making, laboratory, and pharmacy. Other encounters may include reviewing health-related priorities and goal setting, assistance with health tasks (e.g. refilling prescriptions), and brief motivational interviewing related to health goals. Training of peers will be conducted by Drs. Smelson, Ellison, Swan and Visher, over a 4-day period, at Bedford VAMC. Following training, the HCRV team (VISN coordinator(s), outreach specialists, and peers) will participate on twice monthly conference calls, led by the trainers and the external facilitators (McInnes and Swan), to discuss issues that arise in the use of peer support.

Implementation Frameworks and Strategy: Guided by our QUERI's selection of Consolidated Framework for Implementation Research (CFIR), we will ensure that our intervention is appropriate for the contexts in different states. Context, in CFIR, is delineated by the domains of Outer Setting (e.g. external policies, patient needs and resources) and Inner Setting (e.g. structure of the organization, culture). As with the other BridgeQUERI projects, we have selected facilitation as our implementation strategy. In addition our peer-support intervention is enhanced by the Behavioral Model for Vulnerable Populations (BMVP), (see description of BridgeQUERI Implementation Core), namely ***Predisposing*** characteristics (demographics, social structure, health beliefs), ***Enabling*** characteristics (personal/family, community, insurance, competing needs, ability to negotiate bureaucracy), and health-related ***Need*** based factors(perceived and evaluated health conditions). We propose both **external** and **internal** facilitation, because we are working in a complex setting with a highly complex population (Stetler, Legro et al. 2006; Jones, Auton et al. 2008; Kirchner, Kearney et al. 2014). To our knowledge there has been no evaluation of facilitation as an implementation strategy for state-level implementation of a VA program. Thus we have an excellent opportunity to contribute to the VA knowledge base on using facilitation as an implementation strategy. Additionally, we will vary the organizational level of internal facilitation. The internal facilitator will be one of the Outreach Specialists (Thomas Baker, LCSW). Facilitation will include use of a manualized peer-support training (using a peer-support guidebook from Aim 1), and ongoing problem solving and technical assistance provided to VISN HCRV leadership, outreach specialists, and peers over the course of the project. Our implementation strategy was developed with our operational partners at HCRV program. They have great interest in HCRV program differences from state to state, realizing that states vary considerably in the resources available for reentry programs, and the supportiveness of the culture in relation to ex-offenders.

Project Plan Overview: We propose to implement the Post Incarceration Engagement intervention in Massachusetts using a facilitation implementation strategy. We conduct formative and summative analyses, including assessment of fidelity, and a matched comparison group to evaluate the intervention's Veteran outcomes of linkage and engagement in VHA health care (using health care utilization measures). The project proceeds in 3 phases (see Figure 1). First, in preparation for implementation of peer-support intervention in the first state, we will conduct a contextual analysis in MA of the resources available in VHA and in community organizations to meet the needs of Veterans released from incarceration (Aim 1), development of peer-support guidebook (based on findings of the contextual analysis) and hiring of 2 peers. Next the intervention will be implemented in MA (Aim 2). It will last 6 months with a total of 30 Veterans receiving the peer support. We will identify a matched sample of comparison reentry Veterans. Qualitative formative and summative interviews will be conducted with a sample of stakeholders and Veterans to assess fidelity of the intervention. A review of peer worksheets documenting contacts with Veterans will also help evaluate fidelity evaluation. Utilization of VHA primary care, mental health care, and SUD care will be evaluated through chart reviews, and self-report (self-report for intervention Veterans only). Finally we will develop a proposal for the spread of this intervention through the use of a cluster-randomized multi-VISN hybrid implementation-effectiveness study (Aim 3).

Design and Methods: Key Outcomes: Our Veteran level outcomes include # of primary care visits, MH visits, and SUD visits (where diagnosis indicates appropriateness); and missed opportunity rates (no-shows and cancellations) for primary care, MH, and SUD visits. Secondary outcomes include # of emergency room (ER) visits, hospitalizations, and hospital days – these are also being assessed in the BridgeQUERI MISSION project, providing cross-project comparisons. Our main implementation outcome will be fidelity of the intervention as implemented, in comparison to core elements as contained in the peer-support guidebook. We use a practical approach based on the NIH's Behavioral Change Consortium fidelity framework for psychosocial Treatments (Bellg, Borrelli et al. 2004). Our two primary fidelity measures are number of peer

contacts attempted and made with each Veteran, number of months in the 6 month-intervention period in which a Veteran had at least 1 peer contact, proportion of contacts in person and by phone. This will be assessed through a Peer Encounter Workload form adapted from Ellison, which is completed by the peer and includes his weekly delivery of service, the types of contacts (in person, phone) and the content discussed (e.g, navigating VHA, logistics of appointments, or increasing motivation for seeking health care).(Ellison, Mueller et al. 2012)

Phase 1: **Contextual Analysis and Preparation for Implementation in Massachusetts**. We will conduct contextual analysis (Chambers, Mustard et al. 2013; Chambers, Glasgow et al. 2013; Lyon, Pullmann et al. 2015) through interviews and network mapping (Aim 1). At the end of this phase the findings will be incorporated into the peer-support guidebook. This phase will involve interviewing Veterans (thrice over 6 months) and stakeholders (once). Network mapping is a technique used in business and engineering, and is increasingly being applied in health care. It involves documenting potential paths that individuals and groups follow in the process of accomplishing a task (here, linkage to primary care and other health services)(Lyalin and Williams 2005; Williams, Lyalin et al. 2005; Rico, Yalcin et al. 2014). We use interview questions that seek temporal, spatial, and participatory information. The timing, sequence, and duration of Veterans' contacts with individuals and organizations are mapped in an activity diagram (Lyalin and Williams 2005), which are then combined to comprehensively map the network of reentry-related contacts that Veterans make. These maps may reveal unhelpful contacts, waiting between contacts, and useful but infrequently tapped resources. Population: There are about 200 Veterans, released from Massachusetts prisons each year. Recruitment of Veterans: We will use a method currently in use VHA by a contractor, Policy Research Associates (Delmar, NY), to contact reentry Veterans. During prison visits, the outreach specialists will collect contact information from incarcerated Veterans who indicate willingness to participate in the project after their release. The outreach specialist will provide our team with the contact sheets of those Veterans and their release dates. We will contact these Veterans after their release, enrolling 10 Veterans. Inclusion/Exclusion: Released from an MA state prison, eligible for VHA services, and no history of dementia.

Data Sources, Collection, and Analysis: The 10 Veterans will each be interviewed 3 times (at 1-week, 1-month, and 6-months post-release), while up to 20 stakeholders will be interviewed once. Interview questions will be guided by CFIR and BMVP frameworks, address ***patient needs and resources*** (CFIR) and ***enabling characteristics*** and health-related ***need*** based factors(BMVP) (see Section 3, above). As indicated above, the interviews will also involve questions to create activity diagrams and network maps. (See draft interview guide in Appendix) Stakeholder Interviews: participants will include leaders, managers, and providers in VA (e.g. primary care, MH, SUD, homeless programs) and in non-VA organizations. Community interviews will include stakeholders from community organizations such as health care for homeless programs, programs for persons with justice involvement, hospital ERs, and Vet Centers. Discussions with community organizations indicates high interest in participation on this project (see letter of support from Boston Health Care for the Homeless Program; and from the National Health Care for the Homeless Council). Veterans will receive a $25 store gift card for completion of each interview. Analysis will involve verbatim transcription of interview audio recordings, and use of NVIVO, a qualitative data analysis software (this will be the procedure for all interviews in all phases). Drs. Swan, Kim, and Drainoni will separately code transcripts using *a-priori* coding (based on CFIR and BMVP constructs) for example coding for *Enabling* characteristics and health *Need*. They will also use tenets of grounded theory to identify new themes that may help understand issues related to linkage and engagement in health care. Dr. Kim will conduct the network analysis and then the research team will combine interview and network map findings to create two descriptions of reentry resources: one from the perspectives of Veterans and reentry stakeholders, respectively. This information will guide the content of the peer-support intervention, and will be incorporated into the peer-support guidebook.

Phase 2 - **MA Implementation of Peer Support**. This phase involves implementation and evaluation of the peer-support intervention in MA. For Population, Recruitment of Veterans, Inclusion/Exclusion, see Phase 1, above. Our target is 30 Veterans receiving peer support. We will enroll Veterans on a rolling basis as released from MA correctional facilities. We will use HOMES database to create a matched comparison group of Veterans released in the same time period in MA, matching on demographics, SUD/MH diagnoses, criminal offense, length of incarceration, and # of arrests. Intervention will last for 6 months for any single Veteran, with peers having caseloads of 15 Veterans (Dihoff 2009). A VISN 1 outreach specialist, Thom Baker, will serve as

internal facilitator, while McInnes and Swan will be external facilitators. Peer Training: see above in "Peer-Support Intervention".

Data Sources, Collection and Analysis: Peers will administer a health care utilization questionnaire with intervention Veterans at baseline (week 1) and at 6 months to capture information about VA and non-VA health service use (the former for comparison with VA medical record data).

Analysis: During implementation we will collect formative evaluation data about the intervention through interviews (5 stakeholders and 5 Veterans). We will assess elements of the implementation by learning what meanings the participants (stakeholder, peers, Veterans) assign to the intervention and the processes that the intervention is designed to affect (Orlikowski and Baroudi 1991). We will also conduct summative evaluation, including qualitative interviews (5 Veterans and 5 stakeholders) to evaluate, for example, whether peers were *Enabling* linkage to and engagement in health care, and whether this helped address Veteran's health care *Need*. With stakeholders we will explore the effectiveness of external and internal facilitation, and identify facilitators and barriers to implementation. Quantitatively, we will use HOMES and CDW to compare intervention and comparison Veterans. Also for intervention Veterans we will have self-report diagnoses and utilization from baseline and 6-month follow up (including utilization of non-VA health care sources). We will compare rates of visits for primary care, MH, and SUD between intervention and comparison groups using t-tests and chi-square tests. For our secondary measures we will compare intervention to comparison Veterans on ER and hospital use (episodes and # of days) during the 6 month reentry period.

Key Covariates. We will use CDW and HOMES data to evaluate whether there are substantial differences between the intervention and comparison Veterans at baseline. This approach accounts for the possibility that observed differences in our outcomes, such as linkage rates, may be partially explained by factors such as duration of sentence, severity of crime, number of incarcerations, ever used VHA services, length of time since last used VHA services, and socio-demographics such as age and race.

Additional Design Considerations: The focus of the *Post-Incarceration* project is to develop implementation methods, materials and training, identify appropriate level of internal facilitation, and assess dissemination processes across different states. It is not designed to demonstrate a statistically significant effect of the intervention. With the anticipated sample size of 30 in the peer-support intervention groups and the 30 in the comparison group, the linkage rate, now at 57%, would need to increase by at least 20% to detect the intervention effect with 80% power at the 0.05 significance level. However, our measurement of these outcomes in the current project will allow us to estimate effect sizes and sample sizes for the next phase of this implementation, i.e. a cluster-randomized multi-VISN hybrid implementation-effectiveness study (this next phase will occur after the current project, supported by a separate funding source).

4. IMPACT

The implementation work described here is highly aligned with our operational partners in the national HCRV program (see letter of support) who recognize many HCRV Veterans are not linking to VHA, and likely are receiving inadequate care from a patchwork of sources. It helps address the known challenge for HCRV of overcoming reentry Veterans' mistrust of and past negative experiences with large systems – a process that data indicate is best done by a peer. Our project will help answer the question of whether peer-support for Veterans after their incarceration increases VHA linkage rates. Also the project will provide a roadmap (with guidebook, training materials and implementation strategies) so that other states and VISNs can efficiently adapt and implement this peer-support approach in their HCRV programs. The ultimate impact will be an increased rate of linkage to VHA services, substantially beyond the current 57% rate. This linkage will help contribute to improved health and mental health of the thousands of Veterans released from incarceration annually. It has the potential to prevent the cascade of events for many former offenders, when health and mental health deterioration rapidly lead to negative behaviors, re-offending and more incarceration.

5. PARTNERSHIPS AND PROJECT MANAGEMENT

We have developed this project over more than 12 months with the **national HCRV program**. In addition, the **National Center on Homelessness Among Veterans** (NCHAV) enthusiastically supports this project and contributed to its design (see letters and NCHAV's MOU). **McInnes (PI)** will lead all aspects. He has led

multiple quantitative and qualitative VA research studies of vulnerable Veterans. **Blue-Howells**, an operational partner, is the VA's leader of HCRV. She will actively engage as a Co-Investigator and will ensure the project activities are relevant to her program's needs. **Drainoni, Swan, and Visher** have experience with prison reentry programs -- **Visher** is one of the nation's foremost reentry experts. Drainoni and Swan are qualitative experts and will lead that work with assistance from **Bolton**, experienced in qualitative methods. **Smelson** is a national expert on co-occurring mental illness and SUD among homeless and incarcerated persons. He contributes to intervention development and peer training. **Kim** is a systems engineer who will lead the context analysis and network mapping. **Ellison** leads a VA study of the use of peer-support for individuals with serious mental illness, and will contribute to intervention development and training. **Byrne**, highly knowledgeable of HOMES and related database, will do analyses. **Fincke**, an MD-researcher and former Director of General Internal Medicine at Boston VA, will guide interview content and navigation aspects of the peer-support. **Petrakis** is a highly experienced research coordinator who will assist all aspects of project management and communication, and facilitate weekly team meetings.

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