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HIV Continuum of Care: From Intake Jail to Community Provider

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NYC DOHMH
Health Care Access & Improvement
HRSA / Ryan White Care Program
All-Grantee Meeting
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TAKE CARE NETWORK

NYC Department of Correction (DOC) operates Rikers Island (9 jails) and 2 borough facilities

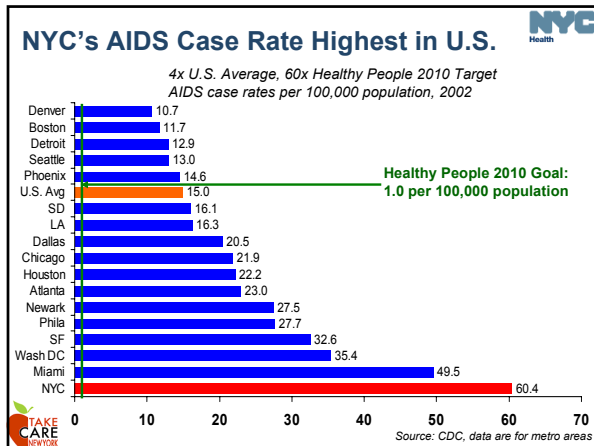
NYC DOHMH provides health and mental health care for all in DOC custody.

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Inmates in the U.S.

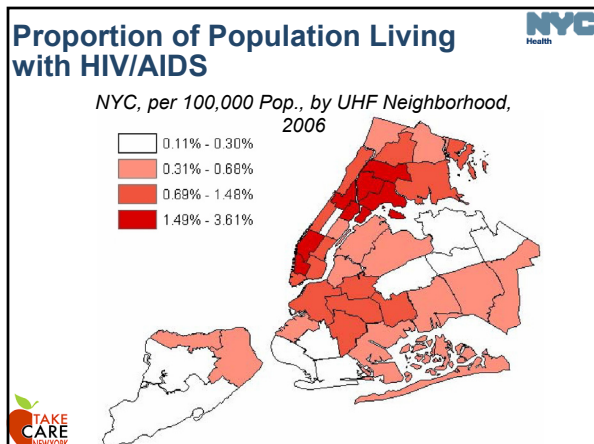
- 6x more likely to have AIDS than general public
- Higher rates of HIV-related risk behaviors
- 5-15x more likely to have tuberculosis
- 10x more likely to have Hepatitis C

TAKE CARE NETWORK



Mayor Bloomberg's HIV/AIDS Policy


- City must be accountable for confronting and reversing the epidemic
 - Better monitoring of epidemic
 - Best possible prevention, treatment, care, control
- More testing so everyone can know their status
- Confront and reduce stigma
- Make NYC a national and global model



NYC Jail System

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- **NYC Department of Correction (DOC) operates 11 jails:**
 - Rikers Island (9 facilities)
 - 2 borough facilities (Manhattan & the Bronx)
- **Population:**
 - Over 100,000 admissions / yr (11% female)
 - Avg daily census: 13,000 - 14,000
 - Avg length of stay: 37 days (sentenced ≤1 yr)
46 days (detained)

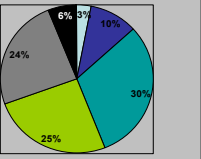


NYC Jail Population

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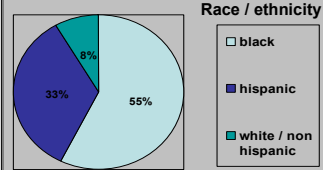
Age Range


- 16-17
- 18-20
- 21-30
- 31-40
- 41-50
- 51-60



Race / ethnicity

- black
- hispanic
- white / non hispanic




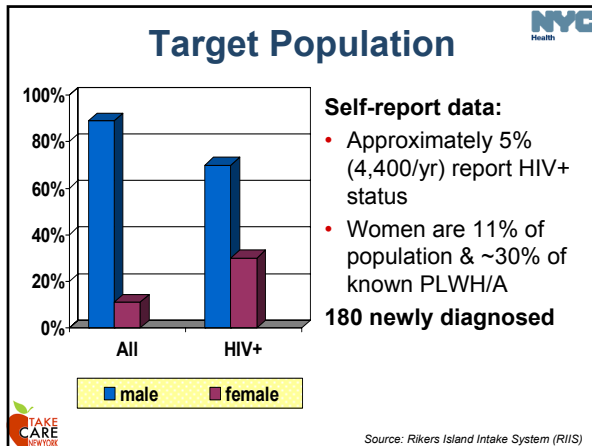


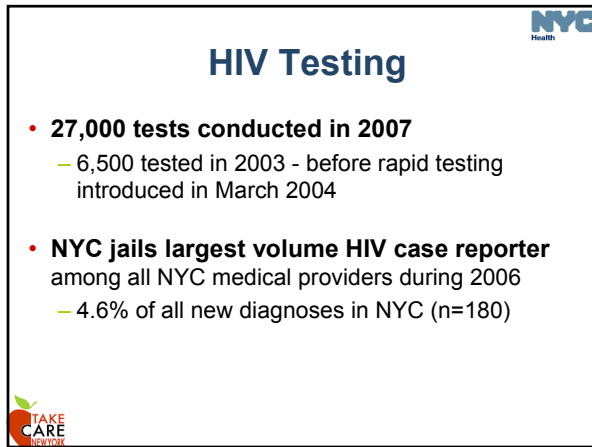
NYC Correctional Health

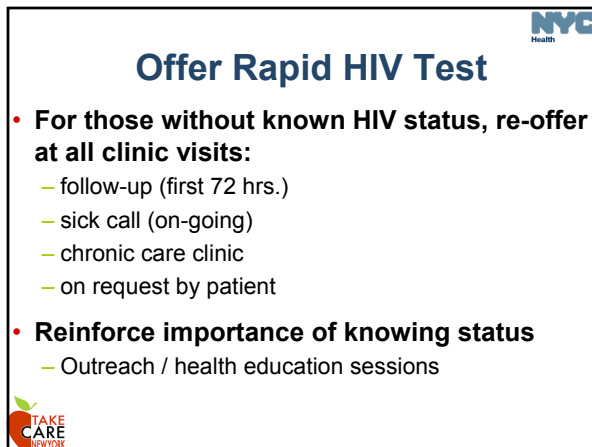
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- **Health Care Access & Improvement:**
 - Health Insurance Programs / Medicaid Managed Care
 - Take Care New York
 - Transitional Health Care Coordination
 - Primary Care Information Project
- **Correctional Health Services (CHS)**
 - Coordinates medical, mental health, and dental services for all persons in custody of DOC
 - Includes comprehensive intake history and physical exam, voluntary health screening for all newly admitted to City jails









Newly identified PLWH/A

- Care starts immediately after identification
- Case management throughout stay
- HIV education
- Treatment information and adherence
- Case conference with medical and mental health providers
- Discharge planning



Treatment Adherence

- Performed by Public Health Educators
- Individual counseling regarding medication compliance
- Carry medication for 7 days at a time
- Can place patients on DOT therapy
- Provide medications / Rx on release



Patient Care

- Follow NYS AIDS Institute Guidelines
- All receive CD4, HIV Viral Load, STD screenings, CBC, chemistries and viral hepatitis panel
- Offer vaccines
 - Hep A & B, Pneumococcus and Influenza
- Continuity of community HAART regimens
- Monitor CD4 and Viral Loads
 - check every 3-4 months
 - Follow-up medical visits



Care Coordination



All known positive patients, by 2nd day, receive individual education and counseling

- Universal interview tool
- Initial resource identification, appointments
- Court advocacy need determined
- Refer to RI Transitional Consortium partner
 - Palladia, Inc, Exponents, Women's Prison Assoc.
 - The Fortune Society, Dept. of Correction
- Coordinate with RITC; track progress / release
- Ongoing contact / Case conferencing



HIV Discharge Planning



- Use universal interview tool / data system
- Screen for benefits (HASA, ADAP, Medicaid)
- Arrange discharge medications
- Coordinate post-release plan
- Identify / confirm community providers
 - Aftercare letters / transfer medical information
 - Make appointments / walk-in arrangements
 - Arrange transportation / escort



Linkages to Community Providers




- Care Coordination with community providers
 - Discharge Planning fairs pre-release
 - Partner meetings / agreements
- Correction to Community Linkages
 - Health education outstations Parole / Probation offices, RI Central Visitor Center
 - Health Screenings and referrals to community providers
- SPNS Enhancing Linkages
 - State-funded Alternatives to Incarceration (ATI)
 - Local court advocacy for detainees and parole violators



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RITC Paradigm Shift


<u>Before</u>	<u>After</u>
<ul style="list-style-type: none"> • Individual recruitment for discharge planning • 5 RW funded organizations act independently • Multiple interview tools • Individual contractor accountable for client assigned while in jail 	<ul style="list-style-type: none"> • Universal offer of discharge plan to all who self identify • Single point of contact (DOHMH) to RW partners • Universal initial assessment • Single point of accountability for entire population of PLWH/A in City jails



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Outcomes


<u>Before</u>	<u>After</u>
<ul style="list-style-type: none"> • Plan Target: 30% of those confirmed HIV+ • Goal: Discharge plan • Outcome: ~90% of target receive a plan 	<ul style="list-style-type: none"> • Plan Target: 80% of those who self identify as HIV+ • Goal: Discharge Plan & Connection to care in the community • Outcome: Of those released with a plan, ~90% connected to care



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SPNS Program


- One of ten sites funded by HRSA SPNS to Enhance Linkages to Primary Care for PLWH/A in Jails
- Enhances HCCM created in 2006 to improve diagnosis, treatment and discharge planning
 - Improve acceptance rate for rapid HIV testing
 - Court advocacy leading to ATS/ATI to increase number released / linked to care in first 30 days
 - Follow-up at three, six and twelve mo. post-release



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Challenges / Solutions


<ul style="list-style-type: none"> • Short-term stays are norm <ul style="list-style-type: none"> ~25% leave in 2-3 days ~5% leave within 7 days 	<ul style="list-style-type: none"> • Intake and Rapid Testing <ul style="list-style-type: none"> – universal voluntary < 24 hrs – ongoing offer thereafter
<ul style="list-style-type: none"> • Limited time to diagnose 	<ul style="list-style-type: none"> • Work from self-reports
<ul style="list-style-type: none"> • Limited time to start treatment, ensure continuity of care 	<ul style="list-style-type: none"> • Discharge plan <2 days <ul style="list-style-type: none"> – engage in housing areas – escort / transport if possible
<ul style="list-style-type: none"> • Paper records 	<ul style="list-style-type: none"> • Electronic Health Records
<ul style="list-style-type: none"> • Post-release tracking 	<ul style="list-style-type: none"> • FQHC with EHR / HIE



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Next Steps

- Enhance the Ask – Improve acceptance rate, # tested and leaving jail with known status
- SPNS Program Evaluation
 - Initiate surveys: collect data for 27 months
 - Court Advocacy: Work closely with courts, attorneys, parole & DA
- Further collaborations to improve services
 - Sponsor / support health awareness events
 - Collaborative events focused on court release, alternatives to incarceration and communication with NYS prison system



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