HIV and Incarceration: Models for the Linkage, Retention, and Continuity of Care (inside and at release)

Barry Zack (The Bridging Group), Cody Poerio (Action Wellness), Alison Jordan (Correctional Health Services)

March 28 2017
Learning Objectives

By the end of this presentation, participants will:

- Understand the context of HIV care in corrections and the importance of post-incarceration planning
- Understand obstacles and opportunities for continuity of care for people with HIV while incarcerated and after discharge
- Be aware of models used to link people with HIV to care after incarceration
- Learn best practices that can be applied in your organization or community
Agenda

- Welcome, technical details, overview of program, introduction of presenters (5 minutes): Paola Barahona, AIDS United
- Project START: (13-15 mins) Barry Zach, The Bridging Group
- Philadelphia Linkage Program (13-15 mins): Cody Poerio, Action Wellness
- Rikers Island Transitional Care Services (13-15 mins): Alison Jordan, Correctional Health Services
- Q&A (10 mins): Paola
Project START Plus (PS+)

Barry Zack
Caveat:

- Project **START+** materials are currently going through a comprehensive clearance process with federal agencies and UCSF.

- Issues being updated:
  - Language (transitional and reentry)
  - Logic Model (prioritizing linkage)
  - Additional Assessment

- By May, we hope to have the materials available.

- **PS+** is “in the field” with a RCT adaptation for transgender women.
Cycle of Incarceration

Community → Jail → Court → Prison/Jail

National Center for Innovation in HIV Care
The Linkages Challenge

What can we be doing?
- Screening
- Diagnosis
  - Infectious diseases
    - HIV, STI, TB, HCV, HBV
  - Mental Illness
  - Substance Use Disorder
- Treatment
- Pre-release planning

Making reentry work!
- Linkage to care and services
- Treatment
  - ID (TB, HIV, HCV, STIs, HBV, etc.)
  - Chronic (hypertension, diabetes)
  - Substance Use Disorder & Mental Illness
- Adequate community resources
- Addressing life’s competing priorities

How to break the cycle?
- Societal challenge (poverty, discrimination, etc.)
- Policy (Sentencing, Drugs, Housing, Immigration, etc.)
Criminogenic factors are measures of risk associated with reincarceration, including:

- Housing
- Pro-Social Leisure/Recreation factors
- Antisocial behavior
- Antisocial personality pattern
- Antisocial cognition
- School/Work/Income factors
- Family/Marital/Relationship factors
- Substance Use Disorder
- Mental Illness
- Antisocial associates
Original Research & Adaptation Process
Primary Research Finding

Participants in the multi-session intervention group (Project START) were less likely to have unprotected vaginal or anal intercourse at six months after they were released from prison compared to those in the single session group.

Informal Adaptation of Project START for People Living With HIV (PLWH)

- Pilot with MA Department of Public Health
  - 70% of participants attended first medical appt after release (N=33)
  

- SET RCT (Ecosystem/SET vs. Individual/PS)
  - PS participants more likely to take HIV meds or adhere to meds than SET participants
  - PS participants less likely to be reincarcerated
  - Both groups reduced sexual risk behaviors at 12 months

PS+ Adaptation Pilot

- **Goal:** To pilot adapted PS+ tools and materials
- 2 Pilot Sites (prison and jail)
- Conducted adaptation site visit and training on materials and pilot protocol
- Provided post training TA support for 5 months
- Collected process and outcome evaluation data
Adaptation Pilot Results (N=28)

- 100% received their supply of medications upon release
- 75% received prescription for their medication
- 93% filled their prescription post release
- 96% linked to HIV care

At one site:
- 100% reenrolled (or reinstated) into ADAP
- 57% enrolled in Medicaid
- 53% enrolled in insurance

Project START Plus (PS+)

An HIV/STI/hepatitis linkage to care and risk reduction program for people living with HIV returning to the community after incarceration.
Goal of PS+

To reduce the risk of transmission of HIV/sexually transmitted infections/hepatitis for people living with HIV by prioritizing a successful linkage to care while addressing the many other issues that a person faces during reentry to the community after incarceration.
Recruitment

- How to recruit people living with HIV in a correctional facility without compromising privacy?
  - Work with medical staff, social workers, etc. that work with PLWH
  - Recruit from other programs for PLWH within the correctional facility.
  - Be conscious of privacy and confidentiality with recruitment materials.
  - Other ideas?
PS+: A Bridge to Success

- A short-term, multi-session program that works one-on-one with individuals.

- Serves as a “bridge” for participants who are reentering the community after incarceration.

- Begins before release and continues in the community after release:
  - 2 months pre-release
  - 3 months post-release

- Does not replace longer term systems of care.
Basic Structure of PS+

- Enrollment plus six one-on-one sessions:
  - Two sessions completed before release
  - Four sessions completed after release
- Other sessions as needed.
- Required tasks per session.
- Supplemental exercises as needed.
Overview of PS+ Program Components
Sessions 1-2 Overview (Pre-Release)

- **Complete assessment process**
  - HIV Linkage to Care Assessment
  - HIV, STI, Hepatitis Behavioral Risk Assessment
  - Reentry Needs Assessment

- Develop personalized goal sheets (linkages, risk, reentry needs)

- Facilitate immediate release planning

- Facilitate post-release service referrals for housing, employment, substance use disorder treatment, etc.
Sessions 3-6 Overview (Post Release)

- Hold session 3 ideally within 48 hours of release and at the community medical provider location
- Assist & confirm linkage to community medical care
- Assure medications obtained in community
- Provide facilitated referrals to treatment and other social service needs
- Review and update goal sheets
- Provide risk reduction materials
- Link to longer-term system of care
HIV Linkage to Care Assessment

- HIV Diagnosis
  - Location and date of 1st positive test
- Past and Current Medical Care
- Past and Current Medication Adherence
- ADAP and Medicare/Insurance Enrollment
  - Terminated vs. Suspended
HIV Linkage to Care Assessment (cont.)

- Medical Care Post Release
  - Reengage with previous medical provider
  - Link to new medical provider

- Medication Adherence Post Release

- Items from Prison/Jail
  - LOD, ADAP/Medicaid app, medical file, meds, RX, HIPAA form

- Appointments in the Community
  - Medical provider, peer navigator, case manager, benefits counselor
Goal Sheet

- Helps clients to:
  - Set a goal
  - Determine resources and people that can help
  - Develop a to-do list of action steps
- It is a required form. Serves as linkages, risk reduction and transitional work plans.
- Updated throughout the program based on changing needs and goals of clients.
- Goal type and personal pledge statement
Reentry Needs Assessment

- Housing Assistance
- Food, Clothing or Other Basic Needs
- Medical Care: HIV
- Medical Care: non-HIV
- Behavioral Intervention for HIV/STD Prevention
- Dental Care
- Income / Employment
- Substance Use Treatment
- Mental Health Treatment
- HIV Partner Testing
Reentry Needs Assessment (cont.)

- HIV Harm / Risk Reduction
- Identification (IDs)
- Insurance Enrollment (medical only)
- Medical Care – Non HIV
- Mental Health Services
- Pre and Post Exposure Prophylaxis (PrEP)
- Screening, Treatment and Vaccinations (non HIV)
- Support Groups/Programs
- Transportation
- Transgender Transition and Support Services
- Parole / Probation / other legal
HIV Behavioral Risk Assessment

- HIV/STI/Hepatitis Transmission Knowledge
- HIV/STI/Hepatitis Testing, Treatment & Vaccine Knowledge
- Sexual Risk Behavior
- Disclosure
- PrEP and PEP Knowledge
- Non-injecting Drug Use Behavior
- Injection Drug Use Behavior
HIV Behavioral Risk Assessment (cont.)

- Overdose Education and Prevention
- Barriers and Facilitators to Risk Reduction
- Previous Risk Reduction Efforts
- Summary of Assessment
- Additional Activities
- Condom demonstration, role plays, cleaning syringes demonstration
Immediate Release Checklist

- HIV Care
- **Transportation** from the correctional facility
- **Housing** for first night out
- **Money** from personal account at facility
- Identification
- Basic needs (e.g., medications, clothing, toiletries, food)
- Required appointments (e.g., parole, medical)
- Connecting with family/partners/kids
- HIV/STI/hepatitis risk reduction supplies (e.g., condoms, clean drug using paraphernalia)
Post Release Sessions

- Session 3 ideally within 48 hours of release at the community medical provider location
- Assure medications obtained in community
- Ongoing facilitated referrals to treatment and other social service needs
- Review and update goal sheets
- Provide risk reduction materials
- Transition to longer-term system of care
Post-Release Sessions Overview (cont.)

- Focused activities include:
  - Confirm linkage to community medical care
  - Assure medications obtained in community
  - Provide ongoing facilitated referrals to treatment and other social service needs
  - Review and update goal sheets
  - Provide harm reduction materials
  - Link to longer-term system of care
  - Provide closure with participant
Thank you

Barry Zack

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Objectives

- Overview of the Philadelphia Linkage Program
- Review client demographics
- Review “Securing the Link” Implementation Manual
- Care Coach Model
- RE-Link
Facts & Figures

- An estimated 1 in 7 people living with HIV will pass through a correctional facility in their lifetime. Most of them acquired HIV in the community, not while they were incarcerated.

http://aids.gov/federal-resources/policies/incarceration/
Background

- The Philadelphia Linkage Program (PLP) is the *city prison program of Action Wellness (formerly ActionAIDS).  
- The Philadelphia Linkage Program has been providing medical discharge planning services in the *Philadelphia Department of Prisons (Philadelphia County jail) for 26 years  
- To ensure linkage to medical and social services for people with HIV as they transition from the county jail back into the community  
- To develop a connection with clients while they are in jail and retention of clients in healthcare at the crucial, yet challenging, transition from the correctional facility back into their community.

* Philadelphia’s County Jail is named the Philadelphia Department of Prisons
Referral process

- Clients can also self-refer by sending a letter to Action Wellness.
- Intake & Assessment Specialist is stationed off-site at jails.
- Intakes are conducted within the first week of receipt to ensure linkage.
Demographics of Clients Served

For all slides, n=357

*All data shown is internal to Action Wellness
HIV Risk Factor

- Heterosexual: 47%
- IDU: 29%
- MSM: 18%
- MSM and IDU: 4%
- Other: 2%

Sexual Orientation

- Heterosexual or Straight: 69%
- Gay or Lesbian: 12%
- Bisexual: 12%
- Not Reported: 6%
- Does Not Identify: 1%
### Age

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Female</th>
<th>Male</th>
<th>Transgender</th>
</tr>
</thead>
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<tr>
<td>20-29</td>
<td>17%</td>
<td>14%</td>
<td>44%</td>
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<tr>
<td>30-39</td>
<td>24%</td>
<td>22%</td>
<td>44%</td>
</tr>
<tr>
<td>40-49</td>
<td>42%</td>
<td>33%</td>
<td>13%</td>
</tr>
<tr>
<td>50-59</td>
<td>15%</td>
<td>26%</td>
<td>0%</td>
</tr>
<tr>
<td>60-69</td>
<td>1%</td>
<td>5%</td>
<td>0%</td>
</tr>
</tbody>
</table>
Co-infected with Hepatitis C

- Yes, 31%
- No, 69%
SECURING THE LINK
A Guide to Support Individuals Transitioning Back Into the Community from Jail

AIDS United & ActionAIDS
The Bridging Group

Thanks to funding from AIDS United, the Philadelphia Linkage Program expanded its prison programming with the development and implementation of the Care Coach Collaborative Model. This model targets people living with HIV who are incarcerated and are identified as being most at-risk for becoming lost to HIV care and disengaged from vital care services. Our model provides case management and discharge planning services to incarcerated individuals living with HIV through their transition back into independent living, minimizing the likelihood that they will become lost to medical care, all while providing continuity of care. Interrelated factors that increase this likelihood have been associated with untreated mental health diagnosis, drug and alcohol dependency, and substandard housing and homelessness. Our intervention integrates collaboration with a provider organization designated in each of these specialized areas.

Care Coach Partners

[Logos of Gaudenzia, COMHAR, and Pathways to Housing PA]
The Care Coach Program increased the time period post-release in which we are able to work with each enrolled individual. This allows us to **better retain** them in HIV medical care, decreasing the number of individuals falling out of medical services between HIV diagnosis, linkage and medical retention.

Our Care Outreach Specialist works in tandem with Care Coaches to ensure each enrolled individual receives a level of support and access to HIV medical care and social services, which correlates with **improved health outcomes**.

At enrollment, individuals reported their greatest need as housing/shelter (88%), and their largest barrier to care as drug use (35%). The relationship we have established with our collaborative partners, allows for the expedited access to mental health, recovery services and housing services. The integration of these partner services has allowed for us to reduce, and in some cases, eliminate these external stressors, allowing for greater engagement in medical care services as well as increased access and adherence to ART.

Average Viral Load resulted in a **40% decrease** from baseline to time 3.

85% of Care Coached clients who remained engaged in care coach services for 24 months achieved viral load suppression (<200 copies/ml).

Average CD4 count increased by 13%
Project Description: Re-Link

- To expand on our Innovative Care Coach Model and employ a team approach to long term and intensive case management services and community resources capacity building.
- Improve coordination and linkages for criminal justice, public health, social services and primary care providers for the targeted reentry population
- Utilize a harm reduction model to increase access to public health, behavioral health, and other social supports.
- Reduce recidivism and continued involvement in the justice system
Questions or Comments

Contact
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Program Coordinator, Philadelphia Linkage Program

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Philadelphia, PA 19012

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Email: cpoerio@actionwellness.org
Transitional Care Coordination: a collaborative approach to facilitate continuity of care after incarceration

Alison O. Jordan LCSW
Senior Director, Reentry & Continuity Services
NYC Correctional Health Services
Rikers Island, NY
347-774-7170

Spring 2017
Comparison by Country

U.S. has highest per capita imprisonment rate

Prisoners per 100,000 Population - 2008


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The November Coalition
282 West Astor • Colville, WA 99114 • (509) 684-1550 • www.november.org

Courtesy of Barry Zack
### At A Glance

<table>
<thead>
<tr>
<th>Facilities</th>
<th>12 jails: 9 on Rikers Island (1 female facility, 1 adolescent facility), 3 borough houses, public hospital inpatient unit</th>
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</thead>
<tbody>
<tr>
<td>Average Daily Population</td>
<td>~10,800 (2014)</td>
</tr>
<tr>
<td>Annual Admissions</td>
<td>60,000 (2014)</td>
</tr>
<tr>
<td>Community Releases*</td>
<td>60,000 / year</td>
</tr>
<tr>
<td>Length of Stay</td>
<td>mean=37 days; median~7d</td>
</tr>
<tr>
<td>Electronic Health Record (adopted 2008-2011)</td>
<td>eClinical Works, customized for jail setting; care mgt templates; unidirectional interface with NYC DOC Inmate Information System</td>
</tr>
</tbody>
</table>

*Annual releases from NYC DOC Report of Discharges by zip code for CFY’14*
## DEMOGRAPHICS

<table>
<thead>
<tr>
<th>AGE</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>16 – 21</td>
<td>13.4%</td>
</tr>
<tr>
<td>22 – 31</td>
<td>32.8%</td>
</tr>
<tr>
<td>32 – 41</td>
<td>21.6%</td>
</tr>
<tr>
<td>42 – 51</td>
<td>21.8%</td>
</tr>
<tr>
<td>51+</td>
<td>10.2%</td>
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<table>
<thead>
<tr>
<th>GENDER</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>90%</td>
</tr>
<tr>
<td>Female</td>
<td>10%</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>RACE</th>
<th>Percentage</th>
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</thead>
<tbody>
<tr>
<td>Non-Hispanic, Black</td>
<td>57%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>33%</td>
</tr>
<tr>
<td>Non-Hispanic, White</td>
<td>7%</td>
</tr>
</tbody>
</table>
Prevalence by Diagnosis

- Substance abuse disorder: >50%
- Mental Illness: 30%
- Hepatitis C: 8%
- HIV: 5%
- Diabetes: 5%
- Tuberculosis: 5%
- Other Sexually Transmitted Infections: 6%
TWIN EPIDEMICS: MASS INCARCERATION & HIV

Number of Reentrants
- 0 - 38
- 39 - 99
- 100 - 199
- 200 - 341
- 342 - 624

Income Category
INCOME
- < 25 K
- 25 - 35 K
- 35 - 50 K
- 50 - 75 K
- 75 - 110 K

Number of New HIV Diagnoses
- 0 - 15
- 16 - 40
- 41 - 90
- 91 - 130
- 131 - 217

Number of Inmates Released
- 341 - 526
- 526 - 818
- 819 - 1363
- 1363 - 2552
- 2553 - 3917

Correctional Health is Public Health

Jail Discharges to NYC Communities by Zip Code and Socioeconomic Status (2004)

New HIV Diagnoses as reported to NYC DOHMH HIV/AIDS Registry (HARS) by June 30, 2011
Number of Inmates Released reported by NYC DOC.
All reports for CFY2010 (July 1, 2009 to June 30, 2010)
Correctional Health Services

- NYC Correctional Health services oversees the healthcare of people in all NYC jails.
- Goals: Improve the health of incarcerated individuals, promote human rights and improve public health.
- Correctional Health Services oversees medical care in the jails with over 78,000 medical visits monthly
  - Medicaid prescreening: 6k; Medicaid applications: 1,400
- Discharge Planning – Population-based for mentally ill (13k); HIV-infected (2.5k); others at high risk (1.5k)
- All jails use electronic health record
Background / History

- 1989: First Drug Court established Miami, Florida
- 2004: NYC CHS creates medical discharge planning program
- 2005: NYC CHS creates HIV Continuum of Care Model (HCCM)
- 2007: HRSA SPNS Jail Linkages funds NYC HCCM using Health Liaison
- 2008: NYC CHS & Drug Court representatives establish collaborative
- 2012: 2,734 Drug Courts operating in every U.S. state and territory
- 2015: HRSA SPNS seeks to replicate the HCCM using Health Liaison
CONTINUUM OF CARE MODEL

Jail-based Services

- Medical screening on admission
- Health Insurance screening
- Primary care and treatment
- Treatment adherence counseling
- Health education and risk reduction

Care Coordination

- Discharge Planning
- Health Insurance Assistance
- Health information / liaison to Courts
- Discharge medications
- Patient Navigation
- Linkages to primary care, mental health and substance use treatment upon release
- Transportation from jail to community

Community-based Services

- Primary Care / Mental Health Treatment
- Community Case Management
- Health promotion
- Patient Navigation: accompaniment, home visits, and re-engagement in care
- Linkages to Care
- Treatment adherence
- Housing assistance and placement
- Health Insurance Assistance / ADAP

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Warm Transitions

- An approach to linkages to care
- Applies social work tenets to public health activities
- Used to connect those with chronic health conditions including HIV-infection to community healthcare and services.
Social Work Tenets Applied

- Begin where the client is
  - Inquire about the client’s priorities.
- Address basic needs
  - Secure food, clothing
  - Stable housing
- Use “warm fuzzy” attention to reinforce positive behavior (not “cold, prickly”)
Public Health Principles Applied

- Ask good questions
  - Rather than “What’s your address?” try “How may I reach you in the community?”
  - Rather than “Who is your emergency contact?” ask “Where shall I send laboratory results?”

- Facilitate access to healthcare and return to care:
  - Health insurance
  - Transportation
  - Medication
CRITICAL SKILLS

- Community Health Workers
- Health Dept.
- Courts
- Health Insurers
- Hospitals
- Corrections
- Funders
- Health providers
- Staff
- Parole
- Probation
- Criminology
- Health providers

Skills:
- Communicate
- Negotiate
- Connect
- Advise
- Oversee
- Provide
- Assist
- Maintain
- Support

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Transitional Care Services

- Identify population – use electronic health records
- Engage client – access to housing areas
- Conduct assessment – universal tool
- Coordinate post-release plan – Primary care, social service orgs, Courts, attorneys, treatment providers
- Screen for Benefits – DSS as a partner
- Continuity of medications – discharge meds 7 days + Rx
- Facilitate continuity of care
  - Transfer summary / use RHIOs / ePaces
  - Make appointments / walk-in arrangements
  - Arrange transportation / accompaniment
Creating a Jail Linkages Program

Expect the Unexpected

- **Client Level:**
  - Begin Where the Client is; harm reduction model.
  - Plan for both options: Stay or Go

- **Program Level:**
  - Hire staff who care, clear security, culturally aware, bilingual
  - Train staff: Motivational Interviewing
  - Partner Agreements
  - Systems Level:
    - Track outcomes
    - Arrange transitional services
    - Partner with community health centers; walk-in hours
Federally Funded Program Evaluations

- Health Resources and Services Administration’s Special Projects of National Significance (SPNS)
  - Jails Initiative (2007-2012)

- Office of Minority Health (OMH)
Ten Demonstration Sites
(2007-2012)
Facilitate linkage to primary care for HIV patients leaving local jails:
• Identify HIV patients in custody
• Initiate transitional services in jail
• Facilitate post-release linkage to primary care and community services.
SPNS Jails Initiative

**Local Study Protocols**

- **Enrollment:** adult HIV patients enrolled during jail stay
  - Exclusion criteria: newly diagnosed, receiving mental health discharge planning, likely to have long sentence (>1 year)
- **Baseline survey:** initiated at index incarceration
- **Jail chart review:** most recent clinical data at time of release
- **Post Release Services:** linkage determined 30 d post-release
- **C6M (6-month follow up):**
  - Followed post release with regular check in and survey at 6m
  - Recorded clinical data gathered from clinicians at 6m
### Baseline Socio-Economic Factors

<table>
<thead>
<tr>
<th>Indicator</th>
<th>NYC Health n=555</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never completed high school</td>
<td>47%</td>
</tr>
<tr>
<td>H.S. Diploma / GED</td>
<td>38%</td>
</tr>
<tr>
<td>Job / skill training</td>
<td>58%</td>
</tr>
<tr>
<td>Some College +</td>
<td>15%</td>
</tr>
<tr>
<td>Employed 30 days prior</td>
<td>10%</td>
</tr>
<tr>
<td>Committed relationship</td>
<td>30%</td>
</tr>
<tr>
<td>Age &lt;18 years at first arrest</td>
<td>50%</td>
</tr>
<tr>
<td>Proportion of Lifetime spent incarcerated (mean)</td>
<td>9%</td>
</tr>
<tr>
<td>Arrests (mean)</td>
<td>26</td>
</tr>
</tbody>
</table>
### SPNS JAILS Initiative

**Baseline Medical & Services Accessed**

<table>
<thead>
<tr>
<th>NYC Baseline Co-morbidities</th>
<th>n=555 (%)</th>
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<tbody>
<tr>
<td>Active / other medical problem</td>
<td>76%</td>
</tr>
<tr>
<td>Hepatitis C virus</td>
<td>40%</td>
</tr>
<tr>
<td>Medical Insurance</td>
<td>91%</td>
</tr>
<tr>
<td>History of Heroin Use</td>
<td>56%</td>
</tr>
<tr>
<td>History of Methadone</td>
<td>39%</td>
</tr>
<tr>
<td>Alcohol / drug treatment ever</td>
<td>23%</td>
</tr>
<tr>
<td>Troubled by Drug use, last 30d</td>
<td>66%</td>
</tr>
<tr>
<td>SF-12 Physical Composite Score</td>
<td>47.5 (SD: 10.6)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NYC Services Accessed (30 days post release)</th>
<th>% (n=402 )</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV primary care</td>
<td>71%</td>
</tr>
<tr>
<td>Other medical care</td>
<td>37%</td>
</tr>
<tr>
<td>Alcohol/Substance use treatment</td>
<td>52%</td>
</tr>
<tr>
<td>Housing</td>
<td>32%</td>
</tr>
</tbody>
</table>
Post Release Services

Along with primary medical care, Jail Linkages clients were also connected to:

- Medical case management (53%)
- Substance abuse treatment (52%)
- Housing services (29%)
- Court advocacy (18%)

Approximately 65% of clients accept the offer of accompaniment and/or transport to their medical appointment.

85% of those who were not known to be linked to care were found by DOHMH Home Visit team; finding 30% re-incarcerated.

"An ideal community partner offers a ‘one-stop’ model of coordinated care in which primary medical care is linked with medical case management, housing assistance, substance abuse and mental health treatment, and employment and social services."

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NYC Jails Initiative Program Outcomes 2008-2012

n=17,010 self-reported HIV-positive admissions to NYC jails (2008-2012)

- Offered a Plan: 2,700
- Received a Plan: 2,456
- Released with a Plan: 1,910
- Linkage to Primary Care: 1,420

Percentage:
- Offered a Plan: 89%
- Received a Plan: 91%
- Released with a Plan: 78%
- Linkage to Primary Care: 74%
## SPNS Jails Initiative Outcomes

From Prior to Incarceration to 6 months Post Release

**79% of those released with a plan linked to primary HIV care**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>NYC Health</th>
<th>All Sites</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clinical Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CD 4 (mean)</td>
<td>↑ (372 to 419)</td>
<td>↑ (416 to 439)</td>
</tr>
<tr>
<td>vL (mean)</td>
<td>↓ (52,313 to 14,044)</td>
<td>↓ (39,642 to 15,607)</td>
</tr>
<tr>
<td>Undetectable vL</td>
<td>↑ (11% to 22%)</td>
<td>↑ (9.9% to 21.1%)</td>
</tr>
<tr>
<td><strong>Engagement in Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td># Taking ART</td>
<td>↑ (62% to 98%)</td>
<td>↑ (57% to 89%)</td>
</tr>
<tr>
<td>ART Adherence</td>
<td>↑ (86% to 95%)</td>
<td>↑ (68% to 90%)</td>
</tr>
<tr>
<td>Avg # ED visits p/p</td>
<td>↓ (.60 to .2)</td>
<td>↓ (1.1 to .59)</td>
</tr>
<tr>
<td><strong>Basic Needs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Homeless</td>
<td>↓ (23% to 4.5%)</td>
<td>↓ (36.2% to 19.2%)</td>
</tr>
<tr>
<td>Hungry</td>
<td>↓ (20.5% to 1.75%)</td>
<td>↓ (37.4% to 14.1%)</td>
</tr>
</tbody>
</table>
Infections averted suggest societal cost savings
Program Enhancements

- Increased acceptance of follow up rapid testing
  - Acceptance rate increased from 30% to 60%
- Increased acceptance of service plans
  - Acceptance rate increased from 85.4% to 92.8%
- Health Liaison to the Courts
  - Release rate increased by 20%
- Long-term Follow up
  - Over 100 followed for 12 months post-release
- Integrate with EHR
  - Case management templates implemented 5/13
- CHS pilots with 2 NYC-based Health Homes
  - 10% of people NYC jails appear on a Health Home Roster
Program Sustainability

✓ Improve access and engagement in care
✓ Health Liaisons to the Courts
✓ Alternatives to mass incarceration
✓ Cost saving at a societal level
✓ Integration with Health Homes
✓ Additional funding/investors
✓ Papers published in peer-reviewed journals
✓ National and International Conference Presentations

HOW VALUE ADDED
Health Liaison to the Courts

- Health-based court advocacy to facilitate
  - community alternatives to incarceration including substance use / mental health treatment
  - compassionate release to skilled nursing/hospice care
- Service plan addresses health and service needs of the client while addressing public safety.
- Health information, records/letters from MD
- Coordinate with
  - prosecutors, courts, defenders,
  - care coordination agencies, community treatment providers
  - nursing homes, hospice programs and
  - supportive/transitional housing service network
Health Liaison Outcomes

- In 2014, 737 received Health Liaison services:
  - 387 diverted to alternatives to incarceration
  - 113 placed in non-mandated treatment programs
  - 113 restored to parole
  - 83 granted compassionate release
  - 41 term reduced in the interest of justice.
- At least 350 (47%) would have remained incarcerated.
- Providing information to the courts improves health outcomes and reduces the impact of incarceration on communities with the greatest health disparities.
Health Home Collaborations

- CHS currently receives rosters from 9 NYC-based Health Homes
  - On average, about 10% of those currently incarcerated in a NYC jail are on one of the health home rosters
  - CHS is currently partnering with 2 NYC-based Health Homes to actively link those currently incarcerated with their health home care management organization
  - Bronx Health Home supports a Project Officer and PCC for their assigned patients
  - South Brooklyn HH outstations two Project Liaisons to coordinate care for their patients receiving MH services
Health Home Collaborations: Next Steps

- **Program Evaluation:**
  - Evaluating ED use and hospital admission rates
  - Opportunities for examining community survival
  - Linkage to care
  - Value of patient education and HH awareness

- **Replication & Dissemination**
  - Expand the model to other health homes
  - Help other jurisdictions think about CJ HH
Why Partner with Us?

*Jail population is:*
- Sicker and has greater health disparities than general population
- More likely to use ED and have resulting hospitalizations

*CHS has:*
- Demonstrated, evidence-based approach to linkages to care
- Agreements with extensive network of NYC service providers

*Through our partnerships we can:*
- Remove barriers to engagement in care
- Avoid unproductive outreach
- Help patients address basic needs during critical reentry period
What a Team!
INDIVIDUAL AND GROUP LEVEL:

AIMM MINORITY YOUNG MSM

Personalized Cognitive Counseling (PCC)
- **Population**: Minority HIV MSM (ages 20-29)
- **Intervention**: Individual counseling session about recent unprotected anal sex encounter
  - **Launch**: 5/19/15
  - **Evaluation**: Baseline before session, post-session survey, 90-day post-release interview

Choosing Life: Empowerment, Action, Results [CLEAR]
- **Population**: HIV infected or at-risk men (ages 20-29)
- **Intervention**: Series of 4 small group educational sessions
  - **Launch**: 6/1/15
  - **Evaluation**: Baseline before session, post-session survey, 90-day post-release interview

**Contact**: Janet Wiersema
347-774-8259
**PROGRAM LEVEL: SPNS LATINO INITIATIVE**

**Population:** HIV PR adults

**Interventions:**
1) Jail/Community Provider training
2) Match PR care coordinator to PR client

**Evaluation:** Baseline in jail
Follow up: 6 12 18 and 24mos

**Target Enrollment:** 200 (100 pre- and 100 post-intervention)

**Training Launch—October 2015**
1) Grand rounds (60-90 minutes)
2) Mid-level staff (half day)
3) Care managers/support staff

**Multi Site Evaluation (UCSF)**
First 100 surveys completed

**Local Evaluation:**
1) Transnational checklist (pilot)
2) Provider evaluation:
   NYU/Vincent Guilamo-Ramos
3) Qualitative:
   Pre-intervention client interviews completed (n=14)
   Post-intervention client interviews
   Provider interviews
## Systems Level: Workforce Capacity

<table>
<thead>
<tr>
<th>One Stop Career Center of PR</th>
<th>Damian Family Care Centers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Population</strong>: People incarcerated in Puerto Rico</td>
<td><strong>Population</strong>: People incarcerated in Bronx jail</td>
</tr>
<tr>
<td><strong>Intervention</strong>: Replicate NYC HIV Continuum of Care Model in PR</td>
<td><strong>Intervention</strong>: Replicate Hampden County PH model for correctional health; mid-level clinician and community-worker to provide care in both jail and community</td>
</tr>
<tr>
<td><strong>Evaluation</strong>: Baseline in jail, follow-up in the community; UPR</td>
<td><strong>Evaluation</strong>: Baseline in jail, follow-up in the community</td>
</tr>
<tr>
<td><strong>Launch</strong>: Fall 2015</td>
<td><strong>Launch</strong>: Fall 2015</td>
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On-line Resources

- Creating a Jail Linkages Program Training Manual & Curriculum Webinar Series
  
  http://www.careacttarget.org/ihip

- Journal of AIDS and Behavior Supplement 2s October 1, 2013
  
  http://link.springer.com/search?query=enhancelink

- SPNS Enhancelink Multisite Evaluation Tools and Policy briefs
  
  http://www.enhancelink.org/

- Jail Administrator Toolkit for HIV Testing Program
  
  http://www.jjay.cuny.edu/Jail_Admin_Toolkit.pdf

- Overview of Reentry Services in NYC
  
  http://www.jjay.cuny.edu/NYCMappingHeathCare.pdf
Program Evaluations

Inform and inspire:

- Best practices
- Cost analysis
- Cross site visits & presentations
- New friends

Marry Creative Ideas & Practical Solutions to Wicked Problems

Ancillary cost benefit far exceeds grant awards!
References

- HRSA HAB Special Projects of National Significance Program Creating a Jail Linkage Program, Training Manual and Curriculum, September 2013 [www.careacttarget.org/ihip](http://www.careacttarget.org/ihip)
References


- Thank You!
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  - Rikers Island, NY
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