

Special Points of Interest:

- Less than 1/3 of HIV+ releasees are filling their ART prescription within 60 days.
- Only 17% of releasees are able to maintain continuous treatment
- 67% of releasees need assistance to obtain housing
- 60% require case management services
- 45% require medication for some type of chronic disease
- 30% need assistance in obtaining substance abuse treatment programs

“Transitional HIV care with antiretroviral therapy substantially extends life expectancy and reduces infectiousness to others.”

TRANSITIONAL CARE COORDINATION: SUPPORTED TRANSITIONS

This policy brief describes the transitional care coordination process for people living with HIV in correctional settings, reviews its potential impact on continuity of care, and suggests steps for initiating an appropriate program. By using existing resources, leveraging available funding, and building collaborations, such a program can enhance

continuity of care for persons with HIV leaving jails, leading to improved health outcomes and a positive impact on community public health. Leadership for this approach may come from jail administrators, local health departments, correctional health providers, community health providers, AIDS service organizations, and other



community organizations committed to working with the formerly incarcerated.

MAKING THE CASE: NEED FOR TRANSITIONAL CARE COORDINATION

The care provided in correctional settings can have a substantial personal and public health benefit by screening and treating infections such as STDs, HIV, and TB (Glaser & Gleifinger, 1993; Hammett, Gaiter, & Crawford, 1998; Freudenberg, 2001). Transitional assistance for HIV-positive persons leaving jail can extend and amplify these benefits by improving post-release access to medical care and other services (Rich et al. 2001).

For persons living with HIV, treatment with antiretroviral therapy (ART) substantially extends life expectancy (Harrison, Song & Zhang 2010) and reduces

infectiousness to others (Castilla et al. 2005; Cu-Uvin et al. 2000; Donnell et al. 2010; Harrison, Song & Zhang 2010; Porco et al. 2004; Quinn et al. 2000; Tovanabutra et al. 2002; Vernazza et al. 1997). When ART is interrupted, not only are its benefits compromised, but drug-resistant strains of HIV may develop that are difficult to treat (Burman et al. 2008; Dearing, Meyer & Rogers 1994).

Optimal use of ART requires 95% adherence to medication regimens, a significant challenge for those going home from correctional settings (Karus et al. 2007). One study found that less than one-third of HIV-positive

people released from jail filled a prescription for ART within 60 days of release and only 7% filled a second prescription in time to avoid a treatment interruption, with the average interruption exceeding the clinically-indicated two week period (Baillargeon et al. 2009). Another study followed hundreds of HIV-positive detainees on ART for an average of 31 months, and found that only 17% were able to maintain continuous treatment (Pai et al. 2009). A study that examined reentry experiences of HIV-positive people recently released from South Florida jails found that many said they needed assistance in obtaining housing (67%),

case management (60%), medication (45%), and substance use treatment (30%) (Fontana & Beckerman 2007).

While transitional care programs can improve post-release retention in HIV treatment, and some programs have even shown reduced recidivism rates (National Center on Addiction

and Substance Abuse report, 1998; Rich, et al. 2001; Wilmott & Olphen, 2005), jails often may be hard-pressed to fund such activities.

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FUNDING THE GAP: RYAN WHITE CARE SERVICES SUPPORT RE-ENTRY

To address this service gap, correctional health providers and community-based organizations may form a partnership and together seek Ryan White funds. These funds can be used for short-term, transitional social support and primary care for persons leaving jail who are eligible for Ryan White HIV/AIDS program services (HRSA 2009). Since Ryan White funds should not be

used to pay for services that the correctional system legally is expected to provide, jail administrators and their partners in transitional assistance should first determine what health services are not covered by the correctional system (HRSA 2009).

To garner additional support for HIV-related transitional services, collaborations can



be formed to apply for grants that specifically require partnerships between community groups and government agencies.

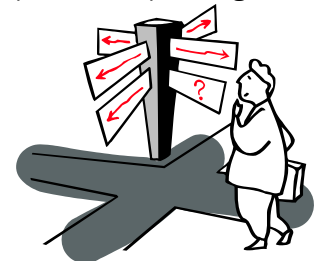
MANAGING THE TRANSITION: FROM JAIL TO COMMUNITY HEALTH

Transitional case management services funded by Ryan White can be a key element of discharge planning as the incarcerated person living with HIV prepares to return home. Activities would include identifying at jail admission those living with HIV (Avery & Murphy 2010), formulating a discharge plan, and transitioning the HIV-positive person from jail-based to community-based care. In addition to seeing a physician, care in the community may include medication, housing, substance abuse treatment, medical case management, and other services intended to stabilize patients and support adherence to ART (see Porter

& Strauss 2010). Other examples of transitional care coordination include providing an interim supply of medication along with a prescription for medication to coincide with the first post-release medical visit, a letter with the patient’s latest laboratory test results, processing AIDS Drug Assistance Program (ADAP) or Medicaid insurance applications, and developing mechanisms for sharing health information between providers.

Once a community partner has been authorized to work in the jail, the corrections administrator, jail health provider, and community

partner need to establish a system for identifying eligible patients, accessing those patients, communicating regularly, and sharing health information in ways that address patient confidentiality and willingness to participate in pre-release planning.



When a system is established, transitional care coordination activities with the client would include:

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meeting the client and assessing their engagement in care before being incarcerated (HRSA 2006), managing care in jail, and providing support services that address barriers to accessing care in the community. Ideally this phase would begin within 24-48 hours of incarceration. The

discharge plan should document when the patient was last in care prior to incarceration, the patient's sources of social support and housing options, and potential obstacles to appropriate post-release care, along with strategies to address these obstacles. Given the unpredictability of patient

stays in jail, each discharge plan needs to identify a mechanism for the patient to access care in the community in the event that their first session with the discharge planner or care coordinator is also the last session prior to release (HRSA 2009).

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BUILDING THE MODEL: COLLABORATIONS

The very nature of providing transitional services requires collaboration to achieve continuity of care, avoid duplication of effort, and facilitate a streamlined and coordinated service delivery system. The project coordinator should, therefore, maintain strong ties and ongoing relationships with both jail-based and community-based service provider networks. Collaborations may include representatives from government, legal services, community-based organizations, and researchers from diverse disciplines including criminal justice, health care, mental health and substance abuse treatment, housing, social services, employment, and reentry.

Shared knowledge of community resources and good working relationships between jail-based and community-based front line staff are keys to a successful program. Those conducting client assessments should be

familiar with the stages of engagement in care (HRSA 2006) and with motivational interviewing techniques (Miller & Rollnick 2002). Ryan White case management staff working in a correctional setting need to understand and take into account the features and specific requirements of jail systems and be familiar with issues common to those who cycle in and out of jail. Case managers should also have socioeconomic, cultural, and language competencies for working with the incarcerated populations.

A variety of community-based service providers may be helpful partners in correctional settings, including existing Ryan White service programs, volunteer groups such as 12-step programs, faith-based organizations and churches, and community-based organizations committed to working with the formerly incarcerated. An ideal community partner may be one that 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.

Activities such as documenting service relationships using memoranda of understanding, and being an active participant in collaborative events help to create a body of meaningful resources to draw upon that are likely to be far more effective than relying on printed service directories which are often out-of-date shortly after publication. Team-building activities are useful, and one that is of particular utility is the development of universal forms that can be shared between the jail and community providers to streamline enrollment into services and avoid duplicate questioning of participants by case managers.

“By establishing and nurturing collaborative relationships, partners will be better able to build an effective and efficient transitional program that benefits people living with HIV, the correctional system that houses them, and the communities to which they return.”

MAINTAINING THE MODEL: AN INTEGRATED APPROACH TO CONTINUITY OF CARE

Once relationships and resources are established they need to be maintained and nurtured to successfully support transitional services and reduce barriers to patient engagement in primary care in the community. Ongoing communication is essential and requires leadership to creatively support collaborations. Some examples of ways to support productive relationships with front line staff and to enhance communication between corrections officers and community-based providers include:

- Health service providers organizing a health and wellness event for correction officers where, for example, blood pressure testing or flu shots are provided. The focus of the health fair could also be informed by the correction department’s employee health services.
- Correction administrators asking a community partner to provide brief health education sessions at roll call that address common areas of concern (e.g., transmission of HIV through saliva).
- The collaboration partners integrating staff development and training efforts by presenting a program overview to each others’ existing staff and new recruits and later providing ongoing updates and trainings.
- Enjoying the rewards of establishing a collaboration by arranging a retreat where staff at all levels design the agenda, discuss issues openly with each other and supervisors, and have an opportunity to socialize outside of their regular work environment.
- Correction administrators providing security orientation sessions to introduce community-based providers to the issues faced by officers and inmates.
- Each organization in a collaboration inviting the others to attend planned staff events such as brown bag lunches, cultural heritage celebrations, and picnics.
- Collaborations arranging an employee recognition event where representatives of all member organizations receive certificates of appreciation.

When planning collaborative events, think about the messages you would like to convey, such as why knowing one’s HIV status is important to public health or how the collaboration has helped reduce instances of violence. Resist the impulse to plow into the most recent case study or communication mishap and keep the focus on the activities of the day. Following the event, solicit feedback and ask for suggestions for next steps. Never underestimate the importance of simple things, like saying please and thank you. Always plan to give more than you receive.

By establishing and nurturing collaborative relationships, partners will be better able to build an effective and efficient transitional program that benefits people living with HIV, the correctional system that houses them, and the communities to which they return.



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About the Initiative:

Enhancing Linkages is a multisite demonstration and evaluation of HIV service delivery interventions for HIV+ individuals in jail settings who are returning to their communities.

The Enhancing Linkages Initiative is sponsored by:

- US Department of Health and Human Services
- Health Resources and Services Administration
- HIV/AIDS Bureau
- Special Projects of National Significance

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