Continuum of Care for Persons with HIV in City Jails

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Inmates in U.S.

- 6x more likely to have AIDS than general public
- 2-3x more likely to be mentally ill or chemically dependent
- 5-15x more likely to have tuberculosis
- 5x more likely to have Hepatitis B
- 10x more likely to have Hepatitis C
Correctional Health in NYC

- 110,000 new admissions through correctional system each year
- ~14,000 incarcerated at any given time
- Correctional health services provided each month:
  - 8,000 intake screenings
  - 60-70,000 medical visits
  - 2,500 specialty clinic visits
  - 18,000 mental health visits
7/1/03 Contract Transfer Back to DOHMH:

- Improved accountability, coordination, and monitoring
- Significant improvements needed, particularly in areas of:
  - HIV/AIDS
  - Mental health
  - Chemical dependency
- Increased public health focus
Challenges

- Short-term stays are norm
  - 28% of inmates leave in 2-3 days
  - 52% leave within 7 days
- Limited time to diagnose
- Limited time to start treatment, ensure continuity of care
Recent Correctional Health Initiatives

1. HIV/AIDS and other STDs
2. Discharge planning
3. Substance abuse / Buprenorphine
4. Visitor Health Station
Other STDs

Gonorrhea/chlamydia testing
- Used epidemiology to target care
- Now all new admission males age 35 and under as well as women
- Information provided to access transitional health and DOHMH STD clinics to facilitate treatment post release
Discharge Planning

- Improved comprehensive discharge planning and transitional health care
  - Established Transitional Health Care Coordination
  - Assumed responsibility for Forensic Behavioral Health (FBH) to strengthen links between FBH and Correctional Health
  - Implemented mental health provisions of Brad H. consent decree
Substance Abuse

- Accreditation of methadone program
  - Second jail-based program in country to achieve this new accreditation
- Introduced buprenorphine treatment for heroin/opioid users
- Identifying resources for detox
Visitor Outreach

- Provide public health information to visitors of Rikers inmates
  - Health education literature
  - Screen for health insurance, provide information on obtaining
  - Provide information on community health resources
  - Health screening (blood pressure tests, BMI measurement, NRT for smoking cessation)
1999 City jail serosurvey found high HIV positivity rate:

- 8% of men and 18% of women

Estimated numbers annually (assuming 100,000 inmates; 91% male):

- 7,280 men; 1,620 women
Current HIV/AIDS Service Structure

- HIV Testing 100% offered at intake
- Provided by over 60 staff in seven units
- Some services coordinated through Rikers Island Transitional Consortium
- Similar questions asked multiple times
- Multiple units may serve same client
- Many patients with HIV are not served
- Minimal accountability or tracking
Goals

- All Know HIV Status prior to release
- All HIV positive patients receive state-of-the-art medical care
- All HIV positive patients connected to community care upon release.
Proposed Model

- Determine HIV status (*Day 1*)
- Offer Rapid Test (*Day 1, ongoing*)
- Patient Care / Treatment Adherence (*Day 1 to release*)
- Patient Care Coordination (*Day 2*)
- Transitional health care coordination and Health Education (*Day 7 to release*)
- Connected to Community Care (<30 days post-release*)
Determine HIV Status

- Ask every patient their HIV status
  - Status Unknown, Offer Rapid Testing
    - Preliminary positive – receive immediate counseling and case management throughout stay
  - Status: negative - Harm and risk reduction education and condoms
  - Status: known positive – identify treatment regimens, provide ongoing care according to protocol and provide transitional health care coordination

- Track through Electronic Intake/EHR
Ongoing Rapid HIV Testing

- For those without a documented HIV status in their chart, re-offer at all clinic visits:
  - follow-up (first 72 hrs.)
  - sick call (on-going)
  - chronic care clinic
  - on request by patient
- Reinforce importance of knowing status
Newly identified PLWHA

- 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
Patient Care Coordination

All known positive patients, on 2\textsuperscript{nd} day, receive individual education and counseling session:

- Standardized interviewing tool
- Initial resource identification, appointments
- Assigns discharge planner
- Tracks progress
- Case conferencing, as necessary
Discharge Planning

- Use standard checklist and reporting
- Identify / review service needs
- Screen for benefits (HASA, ADAP, Medicaid)
- Arrange discharge medications
- Identify / confirm community providers
  - Aftercare letters/transfer medical information
  - Make appointments/walk-in arrangements
  - Arrange transportation
Proposed Service Structure

- Designed to achieve goals
- Provides comprehensive services to all clients with HIV
- Coordinated / targeted approach from jail to community