



The City of New York
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Continuum of Care for Persons with HIV in City Jails

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NYC
Health



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



DOHMH and Correctional Health

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)



HIV/AIDS in City Jails

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 2nd 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**