THE AMERICAN ACADEMY OF HIV MEDICINE www.aahivm.org MARCH 2017
Patient Care, Practice Management & Professional Development Information for HIV Care Providers

HIV Specialist

HIV Behind Bars

SPECIAL ISSUE

In partnership with the National Commission on Correctional Health Care

Community Reentry & HIV Continuity of Care

BY BARRY ZACK, MPH AND KATIE KRAMER, MPH, MSW

Effective advocacy for better care in correctional settings will help stop HIV, hepatitis and addiction epidemics in the U.S.

PRISONS AND JAILS PROVIDE ACCESS TO A POPULATION with an increased burden of infectious and chronic conditions.[1] Globally, Dolan and colleagues found higher prevalence of HIV, HCV, HBV and tuberculosis in prisons than in the general population, especially in imprisoned people with a history of injection drug use.[2] An estimated one in seven people living with HIV (PLWH) in the United States are released from a correctional facility each year.[3] In a recent analysis by Nasrullah and colleagues,[4] PLWH who were recently incarcerated for >24 hours in the past year, compared to PLWH who were not recently incarcerated, were more likely to have been uninsured or had a lapse in health insurance; used emergency department services in the past 12 months; been hospitalized in the past 12 months; and had any sex, and unprotected sex with a discordant or unknown status partner, in the past 12 months. In addition, recently incarcerated persons living with HIV were less likely to have achieved viral suppression.

Chronic medical conditions also are disproportionally faced by incarcerated people. In a Special Report[5] from the U.S. Department of Justice (DOJ), Bureau of Justice Statistics, it was estimated that 66% of people in prison and 40% of people in jail with a current chronic condition reported taking prescription medication.

BURLINGHAM/ SHUTTERSTOCK

Assuming that over 95% of people in jail or prison will be released to the community, with a majority of those receiving some level of correctional medical care, continuity of care is critical to maintain personal health and reduce the chance of both treatment interruption and the development of medication resistance.

In a prior publication, we highlighted the vital importance of collaboration between the criminal justice system (prison, jail, parole and probation) and the community public health system (social services, medical/health clinics, treatment programs, etc.), and several effective models exist.[6]

Building partnerships can help address public health issues while confronting the challenges of public safety and custody priorities. If the goal truly is to decrease rates of HIV, STIs and hepatitis and treat chronic conditions in the general public's health, then correctional health and public health systems must work together to create a seamless continuum that will improve prevention, care and treatment both inside prisons and jails, as well as in disproportionately affected communities.

Justification for HIV continuity of care

Sprague and colleagues identified "the HIV prison paradox," stating that prisons and jails have been depicted as unhealthy, yet they provide HIV services to incarcerated populations to engage and re-engage in HIV care.[7]

Furthermore, jails and prisons interrupt the cycles of substance use that individuals report as critical barriers to achieving stability in their lives, while at the same time supporting medication adherence. Iroh and colleagues conducted a literature review on HIV testing, engagement in care and treatment among incarcerated persons, and estimated the care cascade in this group. Their findings indicated that the HIV care cascade following diagnosis actually increased during incarceration and declined substantially after release, often to levels lower than before incarceration.[8]

Each year, some 12 million people are released from local jails and one million more from prisons. Though people incarcerated in the United States have a constitutional right to medical care, upon release this access to care rarely exists. Mellow and Greifinger address this "evolving

standards of decency" by arguing that the incarcerated patient has a right to continuity of care upon release, and that the physician has a moral obligation to support this continuity as "further treatment is medically indicated."[9]

Furthermore, recent court cases have concluded that a state has "a duty to provide medical services for a person leaving prison who is receiving continuing treatment at the time of his or her release for the period of time reasonably necessary for him or her to obtain treatment on his or her own behalf." This decision clearly defends the "evolving standards of decency."[10]

The Affordable Care Act (ACA) holds much promise to support people leaving prison and jail. Coverage under the ACA, particularly Medicaid expansion, provides opportunities to increase health coverage for this population, which would improve access to care, promote stability in people's lives and reduce reincarceration rates.[11] These ACA benefits are now in question if the law is repealed and forthcoming changes restrict access to medical care.

Key elements of effective continuity of care

There is evidence, concern and promise about creating continuity of care (CoC) programs that increase the likelihood of post-release linkage and retention to care and treatment. Ultimately, the goal is to achieve and maintain HIV viral suppression with ART prior to release from custody and to continue suppression post-release over the long term. Researchers have identified key elements of effective CoC programs.

Bracken and colleagues conducted focus groups with recently incarcerated PLWH to understand the factors that facilitated linkage to and retention in HIV care following their release. Four main themes emerged—interpersonal relationships, professional relationships, coping strategies/resources and individual attitudes.[12]

Hammett and colleagues conceptualize a single system of correctional health, community HIV care and the necessary links between them.[13] They interviewed correctional staff, community HIV care providers and other community service providers, as well as staff from state agencies. From these interviews, they made recommendations on key elements of a single system of care that ensures continuity of care.

These recommendations include:

- Hire healthcare providers who are affiliated with academic institutions or other entities independent of the corrections department.
- Develop a correctional medical organizational philosophy emphasizing a patient-centered, personal and holistic approach.
- Identify strong leadership with effective "champions."
- Establish a team approach that includes coordination, collaboration and integration throughout the system; mutual respect and learning between corrections and health providers; staff dedicated to reentry services; and effective communication and information sharing among providers.
- Provide comprehensive reentry supporting activities and services including HIV, mental health and substance use services inside prisons and jails; timely and comprehensive discharge planning with specific linkages and appointments made prior to release; supplies of medications on release; access to benefits and entitlements; and case management and proactive follow-up on missed appointments.
- Establish the commitment of clients to their own reentry plans.

Springer and colleagues identified five key factors to improve both individual and community health:[14]

- Adaptation of case management services to facilitate linkage to care.
- Continuity of anti-retroviral therapy (ART).
- Treatment of substance use disorders.
- Continuity of mental illness treatment.
- Reduction of HIV-associated risk-taking behaviors, all in the context of Maslow's hierarchy.

Other models stress these five core elements and prioritize the competing priorities of housing and income, along with the utmost need of a government issued photo identification, which is necessary to obtain vital services.

We also can learn from our academic partners in criminology who study evidence-based practices. The Department of Justice (DOJ) developed The Roadmap to Reentry that identifies five evidence-based principles guiding federal efforts to improve correctional practices and programs for those being released from custody. This DOJ report states that "reentry begins on Day One. And, just as important, our involvement does not end at the prison gates."[15]

Continuity of care models

Numerous CoC models are being implemented throughout the United States, many without published literature on their efforts or effects. Some have been adapted from research studies and others include local health departments or community agencies that are creatively implementing a "meet you at the gate" program. The following is a brief description of three CoC models, all of which have published results documenting their success.

The Transitional Care Coordination Program

The Transitional Care Coordination Program at New York City's Riker's Island jail is a HRSA Enhance Link program that aims to facilitate the linkage of PLWH to community-based care and treatment services after incarceration.[16,17]

Its intervention activities include identifying and engaging PLWH during the jail stay, identifying the "right fit" for community resources, developing a client plan for during and after incarceration, and coordinating activities needed to facilitate linkage to care after incarceration.

These activities occur quickly because jail stays often are brief and the uncertainty around discharge dates presents

a shorter window of opportunity to reach people leaving jail settings. Care is coordinated among partners, with correctional health staff assigning clients and tracking outcomes. Community providers assist with care linkage and coordination post-release. A universal client interview tool is designed to facilitate the sharing of complete health information with receiving community partners. A mutual consent form further advances continuity of care.

Community Care Coordinators (CC) meet clients in the jail to begin planning for release. Once released, the CC provides transportation and accompanies clients to primary care providers as needed, providing a warm hand-off to facilitate continuity of care.

In an effort to reengage clients who do not make it to their initial primary care appointments, CCs reach out to clients directly, including home visits. The CCs provide a safety net and, together with providers, act as "surrogate family" to provide support and facilitate linkage to care. This approach has proven to advance program goals with documented linkage to care rates at over 70%, as well as 80% maintenance in care rates at 90 days after the first appointment is kept.

Project START+

Project START Plus (PS+) is an HIV/STI/hepatitis linkage to care and risk reduction program for PLWH who are returning to the community after incarceration. It is based on research conducted with the original Project START intervention.[18]

The program provides six one-on-one sessions with each participant to serve as a "bridge" to their return to the community. Participants begin the program in the last two months of their incarceration and continue it in the community for three months. Two PS+ pre-release sessions focus on assessment and goal planning in four areas: 1) post-release linkage to HIV care; 2) broader reentry needs; 3) individualized HIV/STI/hepatitis risk behaviors; and 4) risk of reincarceration.

The four post-release sessions focus on supporting and confirming linkage to community HIV medical care, ensuring that medications are obtained by the participant in the community, providing ongoing facilitated referrals for other treatment and social service needs, reviewing and updating participant goal sheets, providing risk reduction materials and information (e.g., condoms, syringe cleaning supplies, syringe exchange referrals) as needed, and engaging participants in longer-term systems of care, medical homes, and other support.

Data collected at two organizations piloting PS+ demonstrated that 100% of participants had received their supply of medications upon release from custody, 75% received a prescription for medication, 93% filled their prescriptions in the community, and 96% were linked to HIV care. At one site, 100% were reenrolled (or reinstated) into the federally funded AIDS Drug Assistance Program, 58% enrolled in Medicaid and 53% enrolled in insurance.[19]

Bronx Transitions Clinic

The Bronx Transitions Clinic (BTC) in New York City is an innovative model for primary care linking formerly incarcerated people with chronic health conditions to medical care within two weeks after release.

The BTC is a collaboration between Montefiore Medical Center, a Federally Qualified Health Center (FQHC), and the Osborne Association, a community-based organization serving people with criminal justice system involvement. The BTC provides a medical home with open access scheduling at the FQHC. It uses community health workers (CHW) who were formerly incarcerated themselves to provide patient navigation. Staffing is with clinicians experienced in caring for people with criminal justice involvement.

In an effort to reengage clients who do not make it to their initial primary care appointments, community care coordinators reach out to clients directly, including home visits.

The intervention begins within correctional facilities, with health education and recruitment provided by the Osborne Association. After release, the CHW meets with new patients to complete clinic registration forms, apply for Medicaid, and help them access other social services. The CHW also calls patients with reminders about their appointments and provides transportation assistance. The clinical services available at the BTC include include primary and HIV care, as well as substance use and mental health treatment.

The BTC is integrated into the FQHC's normal work flow and provides care two half-days per week with a voluntary physician. All other services offered at the FQHC, including social work, Medicaid enrollment, and pharmacy services, also are available to BTC patients.

An evaluation of the BTC documented results of the main goals of the program. Median time to initial medical visit

BURLINGHAM/ SHUTTERSTOCK

was 10 days. Retention was high after six months for PLWH (86%), but lower for people with opioid dependence (33%), hypertension (45%) and diabetes (43%). At six months, 54% of PLWH had a suppressed viral load.[20]

What Successful CoC Models Have in Common

- Starting the intervention or program before release from custody, thereby developing a trusting and ongoing relationship between program staff and the client that continues post-release.
- Providing support and/or referrals to support services that address the competing priorities of housing, income, family reunification, obtaining government identification.
- Addressing conditions of probation and parole, and other basic needs within the context of the CoC program model.
- Providing linkages to comprehensive health care that includes ART and other HIV treatments.
- Treatment for other chronic health conditions, substance use and mental health disorders.
- Incorporating behavioral interventions that address medication adherence, sexual and drug-related risk reduction, and prevention of reincarceration.

As concluded by Springer,[21] "Innovative solutions [to complex correctional and community health care problems] are urgently needed that involve partnerships between all existing stakeholders, including people who are incarcerated, the criminal justice system (law enforcement, the courts and the correctional setting) and communities to overcome existing impediments."

Thus, collaboration between the criminal justice system and the community public health system is critical if effective linkage to care and continuity of care for persons with HIV post-incarceration is to be accomplished. **HIV**

REFERENCES

1. Maruschak, L., Berzofsky, M., and Unangst, J. Special Report: Medical Problems of State and Federal Prisoners and Jail Inmates, 2011-2012. Bureau of Justice Statistics, October 2015.
2. Dolan, K., Wirtz, A., Moazen, B., Ndeffo-mbah, M., Galvani, A., Kinner, S., Courtney, R., McKee, M,., Amon, J., Maher, L., Hellard, M., Beyrer, C., and Altice, F. Global burden of HIV, viral hepatitis, and tuberculosis in prisoners and detainees. *The Lancet* , Volume 388, Issue 10049, 1089–1102 DOI: http://dx.doi.org/10.1016/S0140-6736(16)30466-4.
3. Spaulding, A., Seals, R., Page, M., Brzozowski, A., Rhodes, W., Hammett, T. HIV/AIDS among inmates of and releasees from US correctional facilities, 2006: declining share of epidemic but persistent public health opportunity. *PLoS One*. 2009 Nov 11;4(11):e7558. doi: 10.1371/journal.pone.0007558.
4. Nasrullah, M., Frazier, E., Fagan, J., Hardnett, F., Skarbinski, J. The association of recent incarceration and health outcomes among HIV-infected adults receiving care in the United States. *International Journal of Prisoner Health*, Vol. 12 Iss: 3, pp.135–144 (2016) DOI http://dx.doi.org.ucsf.idm.oclc.org/10.1108/IJPH-04-2016-0010.
5. Maruschak, L., Berzofsky, M., Unangst, J. Special Report: Medical Problems of State and Federal Prisoners and Jail Inmates, 2011–12; Bureau of Justice Statistics, October 2016.
6. Zack., B., Kramer, K., What is the role of prisons and jails in HIV prevention? http://caps.ucsf.edu/uploads/pubs/FS/pdf/revincarceratedFS.pdf
7. Sprague, C., Scanlon, M., Radhakrishnan, B., Pantalone, D. T*he HIV Prison Paradox Qualitative Health Research*, First published date: October-14-2016. 10.1177/1049732316672640.
8. Iroh, P., Mayo, H., Nijhawan, A. The HIV Care Cascade Before, During, and After Incarceration: A Systematic Review and Data Synthesis; July 2015, Vol 105, No. 7. *American Journal of Public Health* doi:10.2105/AJPH. 2015.302635.
9. Mellow, J., and Greifinger, R. The Evolving Standard of Decency: Postrelease Planning? *Journal of Correctional Health Care*, 2008; 14:21 DOI: 10.1177/1078345807309617.
10. Lugo v. Senkowski, 114 F. Supp. 2d. 111 (N.D.N.Y. 2000).
11. Gates, A., Artiga, S., Rudowitz, R. The Henry J. Kaiser Family Foundation, The Kaiser Commission on Medicaid and the Uninsured; Health Coverage and Care for the Adult Criminal Justice-Involved Population. September 2014 | Issue Brief.
12. Bracken, N., Hilliard, C., McCuller, W., Harawa, N., Facilitators of HIV Medical Care Engagement among Former Prisoners *AIDS Educ Prev.* 2015 December ; 27(6): 566–583. doi:10.1521/aeap.2015.27.6.566.
13. Hammett, T., Donahue, S., LeRoy, L., Montague, B., Rosen, D., Solomon, L., Costa, M., Wohl, D., Rich, J. Transitions to Care in the Community for Prison Releasees with HIV: a Qualitative Study of Facilitators and Challenges in Two States *Journal of Urban Health: Bulletin of the New York Academy of Medicine*, Vol. 92, No. 4 doi:10.1007/s11524-015-9968-x 2015.
14. Springer, S., Spaulding, A., Meyer, J., Altice, F. Public Health Implications for Adequate Transitional Care for HIV-Infected Prisoners: Five Essential Components. Clinical Infectious Diseases 2011:53.
15. US Department of Justice, Roadmap To Reentry. April 2016. https://www.justice.gov/reentry/roadmap-reentry
16. Target Center, Tools + Tips For Providing Transitional Care Coordination, HRSA HIV/AIDS Bureau January 2017.
17. Teixeira PA, Jordan AO, Zaller N, Shah D, Venters H. Health outcomes for HIV-infected persons released from the New York City jail system with a transitional care-coordination plan. *Am J Public Health* 2015; 105: 351–57.
18. Wolitski, R. and the Project START Writing Group, for the Project START Study Group. Research and Practice: Relative Efficacy of the Multisession Sexual Risk-Reduction Intervention for Young Men Released from Prisons in 4 States. *American Journal of Public Health* 1854–1861 Vol 96, No 10; October 2006.
19. Zack, B., and Kramer, K. *From Incarceration to Linkage to Care: Adapting Project START for PLWH.* Abstract: 1292. National HIV Prevention Conference, Atlanta, 2015.
20. Fox, A., Anderson, M., Bartlett, G., Valverde, J., Starrels, J., Cunningham, C. Health outcomes and retention in care following release from prison for patients of an urban post-incarceration transitions clinic; J Health Care Poor Underserved. 2014 ; 25(3): 1139–1152. doi:10.1353/hpu.2014.0139.
21. Springer, S., Spaulding, A., Meyer, J., Altice, F. Public Health Implications for Adequate Transitional Care for HIV-Infected Prisoners: Five Essential Components. *Clinical Infectious Diseases* 2011:53.

ABOUT THE AUTHORS:

Katie Kramer, MPH, MSW, is the Co-Founder and CEO of Corrections, Communities & Families for The Bridging Group in Oakland, CA. For the past 25 years, she has focused on the development, implementation, and evaluation of social service and health programs that serve individuals, families and communities affected by the criminal justice system through working with governmental, non-governmental organizations and research institutions throughout the U.S. and globally. In addition, Ms. Kramer is the Statewide Director for the California Reentry Council Network and currently serves on the Executive Editorial Board as a Criminal Justice Expert for the Journal of Clinical Research in HIV/AIDS and Prevention.

Since 1986, **Barry Zack, MPH**, has engaged in comprehensive public health programming and research in prison and jail settings. He has extensive experience in the development, implementation and evaluation of complex cross-cultural collaborative dynamics of academic, community, correctional, and public health research projects. He is the Co-Founder and CEO, Corrections & Health at The Bridging Group, on the Editorial Board of the Journal of Correctional Health Care and an affiliated Associate Clinical Professor in the Department of Social and Behavioral Science, University of California, San Francisco.

Founded in 2008, The Bridging Group has provided training, technical assistance, and evaluation and research for governmental, non-governmental organizations and research/academic institutions working in correctional facilities and/or in community reentry in over 33 States and 14 countries.