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ORIGINAL PAPER

Transitional Care Coordination in New York City Jails: Facilitating Linkages to Care for People with HIV Returning Home from Rikers Island

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Abstract New York City (NYC) jails are the epicenter of an epidemic that overwhelmingly affects Black and Hispanic men and offer a significant opportunity for public health intervention. The NYC Department of Health and Mental Hygiene instituted population based approaches to identify the HIV-infected, initiate discharge planning at jail admission, and facilitate post-release linkages to primary care. Using a caring and supportive 'warm transitions' approach, transitional care services are integral to continuity of care. Since 2010, over three-quarters of known HIV-infected inmates admitted to jails received discharge plans; 74 % of those released were linked to primary care. The EnhanceLink initiative's new Health Liaison, a lynchpin role, facilitated 250 court-led placements in medical alternatives to incarceration. Transitional care coordination programs are critical to facilitate continuity of care for people with chronic health conditions including the HIV-infected returning home from jail and for the public health of the communities to which they return.

Keywords Jail · HIV · Linkages · Discharge plan · Warm transitions · Care coordination

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Introduction

New York City (NYC) is the epicenter of the AIDS epidemic in the United States. It is estimated that over 110,000 people are living with HIV/AIDS in NYC; there are over 3,400 new infections annually and AIDS remains a leading cause of death among city residents [1]. NYC jails are at the crossroads of an epidemic that affects an already disadvantaged population, most notably Black and Hispanic men, through a cycle of poverty and incarceration [2]. A 2006 blinded serosurvey reported that 5.2 % (4.7 % of men and 9.8 % of women) of those in NYC jails are HIV-infected [3]. In 2011, 3.5 % self-disclosed their HIV positive status to medical providers on entry to jail and another 1.1 % were identified through follow up care and an opt-in HIV testing program. These rates are three to four times higher than the NYC general population.

Since over 70 % of those released from jail return to the NYC communities with the highest rates of health disparities and lowest socio-economic status [4] (Fig. 1), city jails are a significant opportune point for public health intervention [5–7]. In addition to higher rates of HIV infection (Fig. 2), those admitted to NYC jails also report higher rates of other chronic diseases and drug use compared to the city as a whole (Table 1) [8, 9]. The Chelsea neighborhood in Manhattan is the only exception in the overlay of HIV diagnoses and jail releases, an area where primarily White, higher income men who have sex with men (MSM) reside and which does not experience the same health disparities as the poorer, hard hit neighborhoods in northern Manhattan, central Brooklyn, and the south Bronx (Fig. 2).

This study provides: (a) an overview of the NYC experience with HIV-infected people entering jails, (b) a review of the methods used to provide services that facilitate continuity of care from jail to community primary

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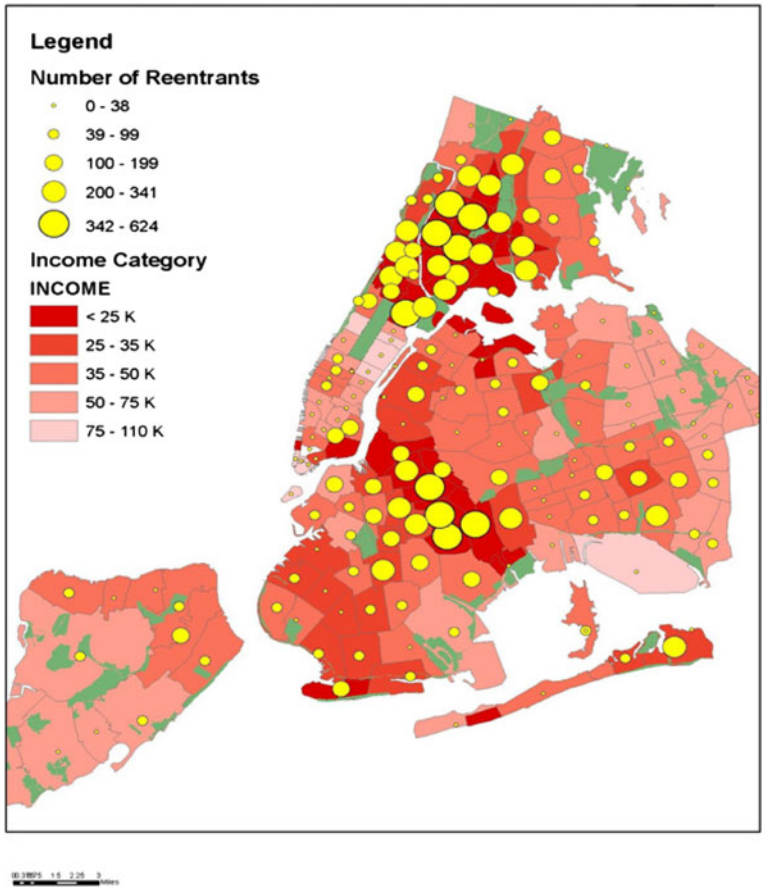

Fig. 1 Number of discharges to the community from NYC jails by zip code and socioeconomic status for 2004

care, and (c) an assessment of the program outcomes of the transitional care coordination program.

Background/History

The NYC jail system has 12 operating facilities; nine on Rikers Island, one in lower Manhattan, one in Brooklyn, and one jail barge off the coast of the Bronx. The NYC Department of Correction (DOC) reports approximately 100,000 incarcerations of 60,000 individuals each year with an average daily census of 13,000; 10–12 % are women. Of these, 80 % are detainees awaiting trial [10]. The average length of stay is 50 days, but short stays are the norm; 28 % are released to the community within 72 h and more than half are released within a week [11].

Within 24 h of transfer from police to NYC DOC custody, each person receives a medical intake and physical exam including a voluntary universal offer of a rapid HIV test through the NYC Department of Health and Mental Hygiene's Correctional Health Services (CHS). Opt-in testing now accounts for approximately 34,000 tests annually, with new admission testing representing three-quarters of all tests performed in jail. CHS provides comprehensive HIV care to all HIV-infected persons including treatment adherence counseling to the 350–400 people taking antiretroviral (ARV) medication on any given day [12]. Transitional care coordination services are available for all HIV-infected patients and others at high risk. Of the 400–500 HIV-infected persons in NYC jails on any given day, 10–12 % are considered medically frail and are placed in medically supported housing.

In 2005, CHS reviewed the services available for the HIV-infected during their stay in city jails and found many organizations provided a variety of services through an uncoordinated system with no centralized tracking. There was duplication of effort, fragmented service delivery, and unknown outcomes. In 2006, CHS made structural changes to the existing system, adopting a population based approach and centralizing responsibility for transitional care coordination services for people known to be living with HIV within one program. This led to the establishment of program goals for those incarcerated in NYC jails to: (a) know their HIV status prior to release from city jails, (b) receive comprehensive community standard of care during their stay in jail, (c) have at least one face-to-face

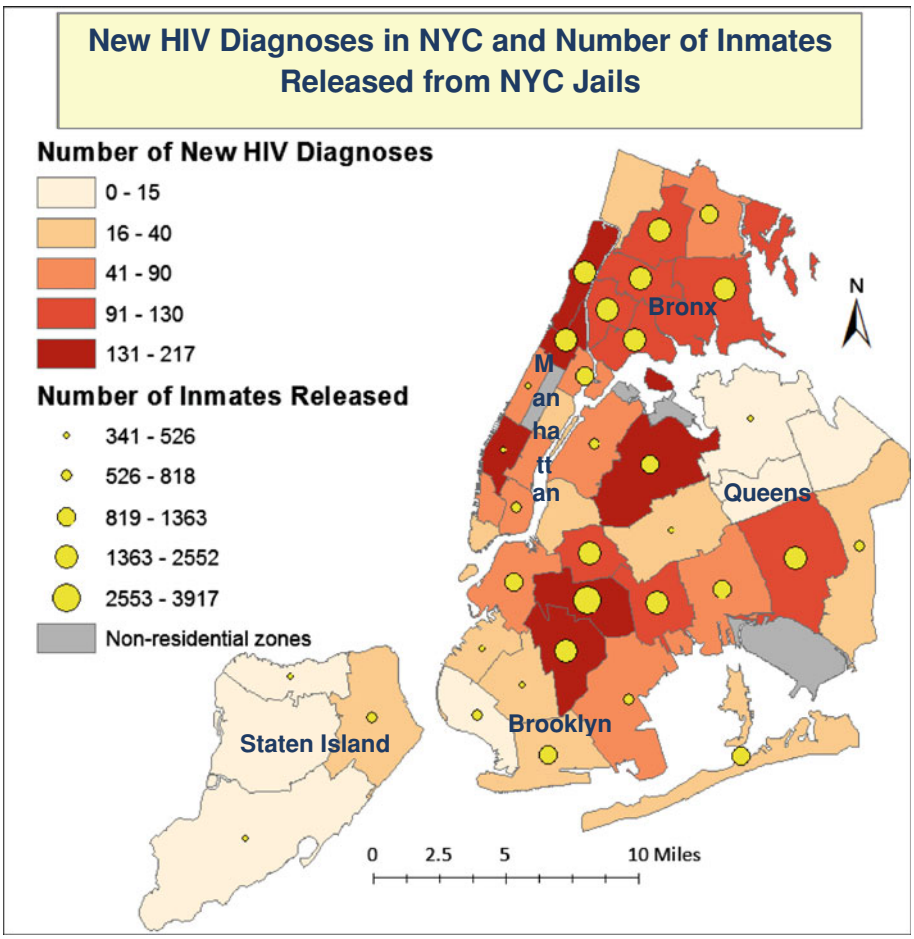

Fig. 2 New HIV diagnoses in NYC and releases from NYC jails

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 the FY 2010 (July 1, 2009 to June 30, 2010).

transitional services session prior to release, and (d) be linked to a community health provider within 30 days of release from jail [13]. The first two objectives are addressed by CHS medical staff and the latter two by the newly established transitional care coordination program.

Transitional care coordination programs are now an integrated, essential component of the continuum of care system for HIV-infected people returning to the community on release from NYC jails [14]. Funding for transitional care services is provided through the Health Resources and Services Administration (HRSA), Centers for Disease Control and Prevention (CDC), private foundations, Medicaid, and city funds.

Program Review

All people newly diagnosed with HIV are seen by a health educator for medical case management, counseling, and a comprehensive discharge plan including a scheduled primary care appointment in the community. As part of the medical intake process for jail admissions, those who report living with HIV are offered medical care and treatment including ARV, and clinical information is documented in their electronic health record (EHR).

Transitional care coordination programs for those at risk of and living with HIV are organized into three teams. Each Team Leader supports four jails and supervises a Facility Coordinator, six to eight jail-based Patient Care Coordinators (PCC), a Transition Coordinator, and a community-based PCC. Central administration and program support are provided by the Executive Director, Program Director, Grant Manager, Program Evaluator, Research Scientist, Contract Manager, Office Manager, and two Data Coordinators.

Each morning the Data Coordinators create a roster of newly admitted HIV-infected patients from the EHR. The jail-based PCC use this roster to initiate transitional services on the first day after admission to jail, engaging the client in the jail-based housing area and offering discharge planning services. PCC then arrange with DOC for the

Table 1 NYC general population and jail population demographics

Characteristic	NYC general population[a,b,c]	NYC jail population[d,e]	
	Total population 8,175,133	Total individuals admitted 2011 61,853	Total HIV-infected individuals admitted 2011 2,176
Age			
Range	Birth to death	16–84	16–68
Mean	34	34	45
Breakdown	15 < 19 6.6 %	16 < 21 13.4 %	16 < 21 1.3 %
	20 < 24 8.0 %	21 < 31 32.8 %	21 < 31 10.1 %
	25 < 44 31.0 %	31 < 41 21.6 %	31 < 41 18.6 %
	45 < 64 24.0 %	41 < 51 21.8 %	1 < 51 44.3 %
	65+ 12.0 %	51+ 10.2 %	51+ 25.4 %
Gender			
Male	47.5 %	89.0 %	78.3 %
Race			
Non-Hispanic Black	22.8 %	54.0 %	61.0 %
Non-Hispanic White	33.3 %	8.7 %	7.0 %
Hispanic	28.6 %	33.0 %	30.0 %
HIV			
HIV-infected	1.4 %	3.5 %	100.0 %
Other health barriers			
Reported current drug use	16 %	65 %	91 %
Tobacco use	16 %	71 %	n/a

[a] Population, Age, Race: NYC Census 2010, New York City Department of City Planning: Demographic Tables

[b] Chronic Health Conditions: DOHMH Epiquery: NYC Interactive Health Data System, 2009

[c] HIV: DOHMH Surveillance Slide Set: HIV/AIDS in New York City, 2009

[d] Population, Age, Race, HIV: DOHMH Rikers Island Intake System (RIIS) new admission records, 2011; current drug use likely underreported at medical intake

[e] Other Health Barriers: eCW Correctional Health Services electronic health record data, 2011; data collected during startup year

client to be escorted to a private office in the jail, or in the jail health clinic, based on space availability. The PCC interview the client, assessing needs and barriers to accessing primary care while maintaining auditory privacy during these voluntary sessions and keeping health information confidential.

Releases from jail are precipitous and can occur at any hour. In addition to providing 24-h medical and mental health services, CHS schedules PCC to work evening and weekend hours in order to initiate transitional services within 48 h of jail admission and provide a discharge plan prior to release. During the jail stay, staff 'begin where the client is' [15] and inquire about the client's post-release priorities. Each assessed need is addressed and documented in the discharge plan and community resources are identified. Discharge plans address each client's basic needs for secure housing, food security, and clothing along with primary care, health insurance and other community services and supports. Based on assessed needs, more than half of all discharge plans also include referrals for behavioral health treatment for substance use or mental illness; 30 % of discharge plans address needs for housing assistance. For those in need of mental health services, a separate program for mental health discharge planning coordinates service planning with the PCC and provides case management, support, and referrals for mental health services.

At the initial session and at each subsequent one, discharge plans are devised for two possible outcomes—whether the client remains incarcerated or is released to the community. Those who are detained are advised about the health insurance application process and efforts are made to gather required documentation prior to release. Those with a known release date are pre-screened and an application may be completed during their jail stay for public health insurance including Medicaid (available to single and childless adults up to 100 % of the federal poverty level on release) and the AIDS Drug Assistance Program (ADAP).

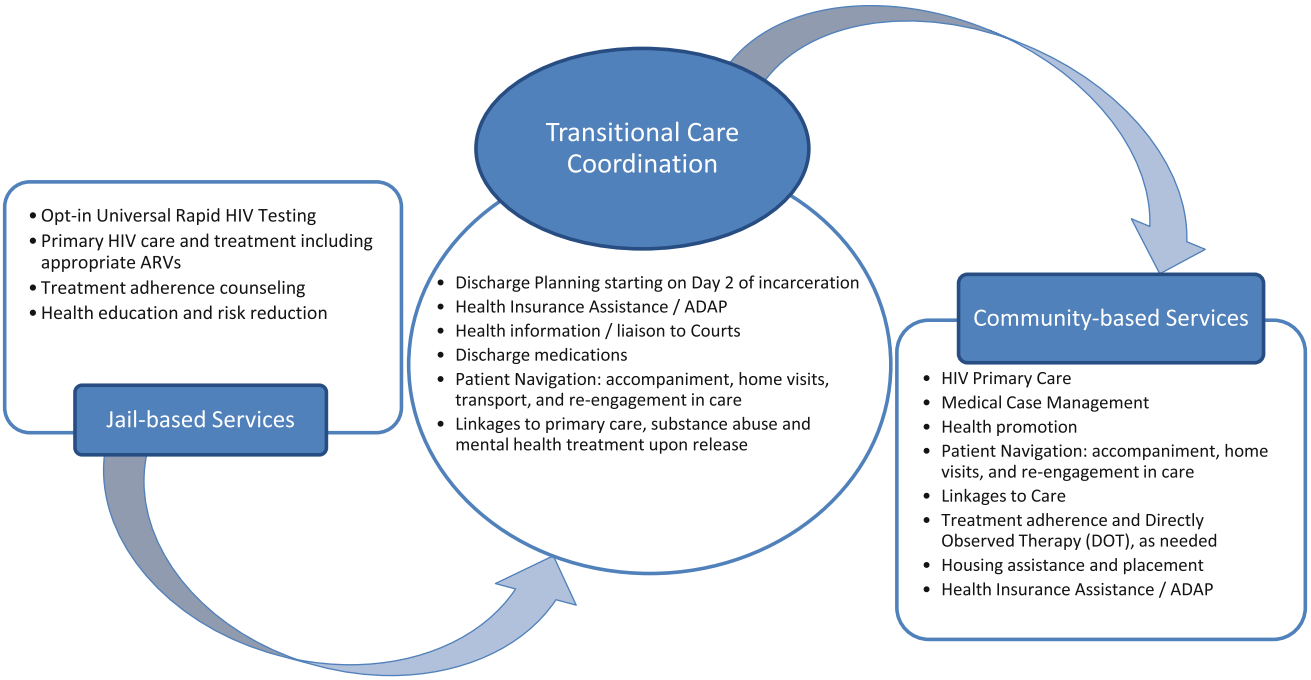

Fig. 3 NYC HIV continuum of care model

Managing the high risk time between jail release and linkage to community care includes case conferences with the client, PCC, and contracted community case managers (CCM) to transition the helping relationship. Facility Coordinators keep track of each client throughout the transitional care coordination process, from initial intake and discharge plan, through transfers among jail facilities and court appointments, to release. Court dates are noted and medical appointments and transportation arrangements are made in anticipation of release from court, as two-thirds of detainees are likely to be released to the community following a court hearing.

An after-care package is prepared including a medical summary and each HIV-infected patient taking ARV medication in jail receives a 7 day supply of medications and 21-day prescriptions at the time of release. All those leaving jails are provided a discharge kit including condoms, a health passport [13], a listing of STD clinics and syringe exchange programs in the community, a pocket guide to services designed for the criminal justice involved [16], and key words to use ("Jail Release Services") when calling 3-1-1, the NYC service telephone line. Transportation and accompaniment to initial primary care appointments are provided on release as needed by contracted CCM and patient navigators. Transition Coordinators reach out to the community primary care provider to verify linkages to care, confirming the client and provider met and documenting this outcome in the EHR.

The community-based PCC conduct home visits and attempt to locate those not confirmed to have met with a primary care provider within 30 days of release. To locate the client, community PCC use their knowledge of the local areas where formerly incarcerated people are likely found and visit locations the client provided during their jail stay to contact family and social supports. For those found in the community who did not yet meet with a primary care provider, PCC act as patient navigators to facilitate linkage to primary care.

Directors and Team Leaders review monthly summary reports prepared by Data Coordinators that include the number of HIV-infected people: newly admitted to jail, PCC attempted to contact in jail, identified after the admission date, offered a transitional care coordination session, seen for ongoing transitional services, released to the community, and linked to care in the community. These data are compiled and reviewed as part of the ongoing program evaluation process.

An extensive network of community resources and linkage agreements with hundreds of community providers are deployed to facilitate linkages to primary care for those leaving Rikers Island jails. These resources are coalesced using various approaches. For half of those released from jails, reentry service providers with dedicated CCM, funded as Ryan White Part A DOHMH sub grantees, collaborate with federally qualified health centers and Designated AIDS Centers to facilitate linkages to primary care. DOHMH also contracts with 28 Ryan White Part A sub grantees to provide care coordination services by deploying CCM to provide medical case management and patient

navigation to facilitate linkages to care for those referred to HIV primary care health centers [17], including those released from NYC jails. Every effort is made to identify community health centers where no appointment is needed and walk-in hours are available. CCM also provide referrals for social services, mental health and substance abuse treatment, and housing assistance (Fig. 3).

Supplementary funding under the HRSA Special Projects of National Significance (SPNS) Enhancing Linkages to Primary Care for People with HIV Leaving City Jails initiative (EnhanceLink) supported a multisite evaluation of the existing NYC transitional care coordination program as well as the enhancement of a Health Liaison to the courts. The Health Liaison enhanced the model by assisting the courts in placing non-violent detainees (including those held on technical parole violations), in behavioral health treatment programs, primarily residential substance use treatment, or specialized medical care (such as skilled nursing and hospice programs) as medical alternatives to incarceration. This collaborative process requires client consent, defense attorney and court support, and community resources that meet the needs of all parties. PCC identify potential candidates from those detained awaiting the next court date. With client consent, PCC: (a) contact attorneys, prosecutors, and court liaisons; (b) identify health care resources; and (c) obtain program acceptance from health services providers. The Health Liaison brings documentation to the court including a letter from the medical director, EHR summary reports, and program acceptance letters. Upon court order and client agreement, a CCM or patient navigator accompanies the client and arranges transportation from court to the program.

Skills and qualifications of the ideal PCC candidate include compassion for people living with HIV, a desire to work in jail, a non-judgmental attitude, cultural and linguistic competency, as well as the ability to establish relationships and remove barriers to facilitate continuity of care. CHS' transitional care coordination programs are managed and supervised by licensed certified social workers who provide training (such as motivational interviewing techniques [18] and stages of engagement in care [19]) and implement program goals and objectives.

While not required for the positions, most PCC, Facility Coordinators, and Transitional Coordinators have bachelor degrees (two earned bachelor degrees while incarcerated). Others have pursued bachelor and master degrees during their employment, with internships arranged on-site; two Directors are certified MSW field instructors. Several jail-based PCC are Certified Alcohol and Substance Abuse Counselors. Preferred skills and experience include: knowledge about the public health issues affecting the NYC communities to which inmates return, bilingual in English and Spanish, familiarity with HIV/AIDS, and personally impacted by criminal justice issues. The racial, ethnic, and cultural backgrounds of transitional care coordination staff are reflective of the client population; 90 % are Black or Hispanic and more than half live in communities to which inmates return. The DOHMH transitional care coordination program had an average voluntary turnover rate of 3.6 % over the past 3 years; the Program Director and five of the six Team Leaders/Facility Coordinators were promoted from within. Transitional care coordination staff are trained to use a 'warm transitions' approach to linkages, applying social work tenets to public health activities for those with chronic health conditions including HIV-infection.

Program Outcomes

In the 3 years from January 2009 to December 2011, a monthly average of 291 admitted to NYC jails reported HIV-infection and an average of 221 were held at least 48 h—sufficient time to be offered a discharge plan. A monthly average of 195 discharge plans were developed to facilitate linkages to HIV primary care on release. The annual number of discharge plans provided to those infected with HIV has increased from 2,218 in 2009 to 2,519 in 2011 (Table 2), while the overall jail census has declined [11]. In the same 3 year period, a monthly average of 135 were released to the community with a discharge plan and 73 % (monthly mean = 98) were linked to primary care (Table 2). The rate of release from NYC jails with a discharge plan increased from 60 % in 2009 (1,345 released of the 2,218 with a discharge plan) to 72 % in 2011 (1,824 released of the 2,519 with a discharge plan). In addition, there was a 42 % increase in the annual number of linkages to primary care from 941 in 2009 to 1,336 in 2011 (Table 2).

To evaluate community PCC activities, we analyzed the outcomes for the 12 months beginning July 2010. During

Table 2 Correctional Health Services outcome summary report

HIV-infected in NYC jails:	2009	2010	2011
Self-reporting HIV-infection on admission	3,897	3,236	3,068
Incarcerated for 48+ h	3,512	3,014	2,869
Seen for transitional care coordination	2,218	2,295	2,519
Releases to the community	1,345	1,676	1,824
Linkages to community primary care	941	1,259	1,336
% Linkages to primary care/releases to the community	70 %	75 %	73 %

Report based on admissions to NYC jails each year. NYC Department of Corrections reports an average of 1.4 incarcerations per person admitted to jails each year

this timeframe, 289 people released from jail were not confirmed to have seen a medical provider and thus referred to community PCC; 80 % were located ($n = 231$). Of these, 32 % ($n = 75$) were reincarcerated and 68 % ($n = 156$) were found in the community. All 156 remaining in the community were offered services including patient navigation; 128 (82 %) were linked to primary care. (Note: Linkages to care made by community PCC are included in Table 2 totals).

The EnhanceLink initiative, a longitudinal program evaluation looking at social and clinical outcomes is being conducted [20]. Several studies highlight the multi-site evaluation (MSE) client level findings which include 448 enrollees from the NYC site, 35 % of the 1,270 MSE enrollees from ten demonstration sites [21]. Since 2010, the NYC Health Liaison funded through the EnhanceLink initiative led to 250 placements to court-facilitated medical alternatives to incarceration. This includes placements in residential substance abuse treatment programs that offer on-site primary care and support services.

Discussion

Transitional care coordination is critical to facilitating continuity of care from jail to the community. Despite rapid releases and short lengths of stay [22], transitional care coordination services, including discharge planning, can be successfully initiated in a jail setting with pre-trial detainees as long as face to face sessions begin right away [23]. The unpredictability of working with pre-trial detainees who have yet to meet bail requirements can be mitigated by PCC acting as if each session with the client is the last and each court date is a release date. It is important to emphasize with the client the importance of ongoing care and ARV treatment in the community [24] during weekly transitional care coordination sessions. Caring, non-judgmental staff familiar with the needs of the population and the communities to which they return are at the heart of the program approach [25–27].

Although HIV treatment is extraordinarily effective, improved clinical outcomes cannot be realized until the barriers to ongoing care are removed. Barriers to HIV care for those released from jail are multifaceted [5, 28]. Structural changes to create a transitional HIV care program can have a dramatic impact on access to care. Focusing on the outcome of linkage to care within 30 days of release led, for example, to identifying and encouraging community health centers to create, expand and enhance clinic hours where appointments are not required and to provide one stop services where housing, substance use treatment and case management services are integrated with primary care [29, 30]. While it is a limitation that we record post-release outcomes for linkages to primary care and not for other referrals (such as those for housing, substance use treatment, and social services), this is somewhat mitigated by prioritizing the use of one stop service providers. Other structural barriers to immediate access to primary care on release from jail are reduced by: (a) obtaining pre-authorization for residential substance use treatment, transitional housing, and skilled nursing care; (b) pre-screening eligibility for health insurance; and (c) providing health information to the courts to facilitate medical alternatives to incarceration.

Health advocacy with the courts has allowed for a proactive and planned approach to our transitional care coordination services for those with non-violent charges. This not only facilitates access to needed medical care and substance use treatment, but can lead to earlier and more predictable release by courts [20]. While extensive collaborations are required, medical providers, District Attorneys, and the courts have found the Health Liaison provides a lynchpin role in the court-led jail diversion process that meets both the public health and public safety interests of the community.

Conclusion

A coordinated approach to transitional care coordination services, integrated with correctional, legal, social, and health systems, is critical to bridge the gap period from jail to community care. Managing the transition from jail to the community is important to the individual as well as to public health, particularly in areas disproportionately affected by HIV and other chronic and behavioral health conditions. Discharge plans need to address each client's basic needs for housing, food, and clothing along with medical and social services in order to successfully facilitate linkages to care. Transitional care coordination programs are critical to facilitate continuity of care for people with chronic health conditions including the HIV-infected returning home from jail and for the public health of the communities to which they return.

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