Slide 1

Linkages to Care: From Jail to the Community

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Slide 2

Presenters' Disclosure

Paul A. Teixeira & Alison O. Jordan

The follow
ing personal financial relationships with commercial interests relevant to this presentation existed during the past 12 months:

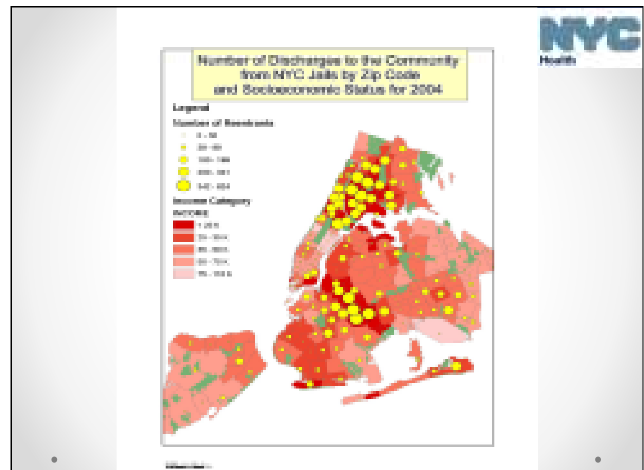
No relationships to disclose.

Slide 3

Rikers Island is New York City's main jail complex;
Other jails include the Manhattan and Bronx detention centers;
About 100,000 annual admissions and average daily census of ~13,000.

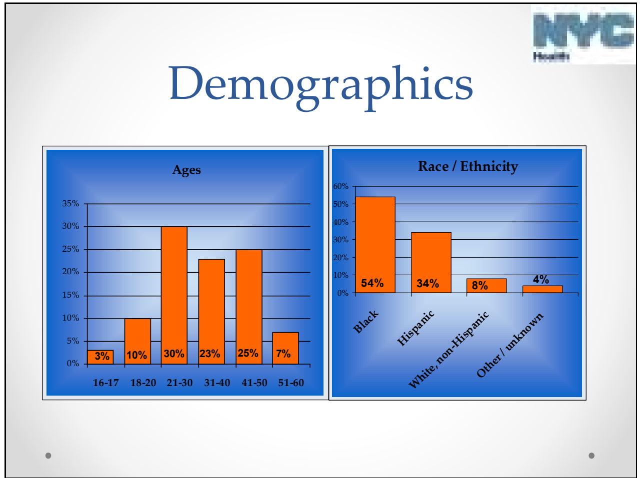
Slide

4



Slide

5



Slide

6

Background

- Correctional Health Services (CHS) oversees provision of care in the jails with over 78,000 visits monthly
  - 6,500 comprehensive intake exams
  - 50,000 medical and dental visits
  - 1,500 specialty clinic visits
  - 20,000 mental health visits
- All jail facilities utilize an electronic health record
- Transitional Health Care Coordination (THCC) provides discharge planning services to all living with HIV and the chronically ill at risk

Slide 7

Linkages to Care

- Intake and assessment
  - Discharge planners provide a plan
  - Treatment adherence / health education
  - Care coordination (in and out of jail)
- Appropriate referrals made
  - Residential programs
  - Outpatient programs
  - Nursing homes
- Link to community partners, including Rikers Island Transitional Consortium Partners

Slide 8

RITC Partners

- Rikers Island Transitional Consortium is comprised of THCC and our community-based partners: Exponents, Palladia, The Fortune Society, Women's Prison Association (WPA)
- Partners provide housing & case management
- The Fortune Society provides transportation as well

Slide 9

Follow-up

- All clients followed for 90 days post-release
  - Goal is to connect them in first 7 days to primary care
  - First 30 days critical
- Rely on community-based partners to follow clients referred to those partners
- THCC Home Visit Team follows up on clients who declined partner referral or who remain unconnected after 30 days post-release

Slide 10

Home Visit Team

- Community-based staff
  - Access to systems
  - In the field and in the courts
- Use all sources and means to locate and contact clients
  - Telephone
  - Certified letters
  - Home visits
- Once located, services are re-offered to the client
  - Case management
  - Transportation & accompaniment to appointments

Slide 11

HVT Outcomes

12 Month Period	Referrals	UTL[a]	Found	Rate
July, 2010	30	3	27	90%
August	106	13	93	88%
September	48	6	42	88%
October	59	6	53	90%
November	44	3	41	93%
December	40	5	35	88%
January	61	7	54	89%
February	54	6	48	89%
March	36	10	26	72%
April	94	33	61	65%
May	26	8	18	69%
June, 2011	60	8	52	87%
Totals:	658	108	550	84%

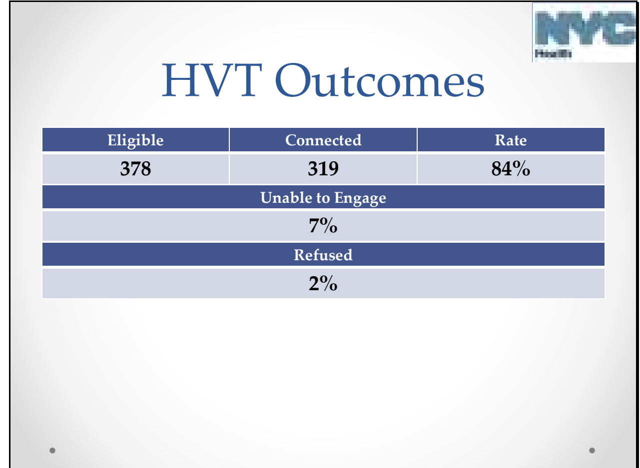
a) UTL =Unable To Locate; clients who could not be located in or out of the community.

Slide 12

HVT Outcomes

Referrals	Found	Rate
658	550	84%
Reincarcerated		
28%		

Slide 13



Eligible	Connected	Rate
378	319	84%
Unable to Engage		
7%		
Refused		
2%		

Slide 14

Multisite study: Enhancing Linkages to Care

- HRSA-funded SPNS grant
- Multi-site evaluation led by Emory Univ. & Abt Assoc.
- Identifying facilitators and barriers to community linkages

Slide 15

Preliminary results

	Mean values, n=99		
	Baseline	6-month f/u	p-value
CD4 cells	364 (267)	430 (275)	0.003
Viral load	69,034	11,600	0.011
On ART 7 days prior	0.59 (0.49)	0.97 (0.17)	0.001
ART adherence	79.3 (29.8)	92.2 (10.7)	0.001
Current Health (SF-12)	3.14 (1.09)	2.77 (0.81)	0.001
Homeless prior month	0.30 (0.46)	0.09 (0.28)	0.001
ED visits past 6 months	0.86 (1.55)	0.25 (0.69)	0.001

Slide 16

Why do this?

- Opportunity to find people who would have been lost
- Cost-savings implications
- Recognition that incarceration is a public health opportunity & correctional health IS public health

Slide 17

Next Steps

- Look at people connected by the HVT vs. others
- Use natural control group to do retrospective comparisons
- Look at recidivism for those who were followed-up in the SPNS study vs. those lost to follow-up

Slide 18

Questions?

Acknowledgements

- Home Visit Team: Cheryl Moorehead, Elena Flores, Darrin Henry, Robert Igoe, Richie Munoz, Evelyn Ortiz
- THCC: Jacqueline Cruzado-Quinones, Press Canady, Allison Dansby, Brenda Rosario, Sandy Diodunet, Carlos Caban, Maria Munyonyedi, Damita Owens, Marie Ross, Ilolochika Emuh, Naomie Hilaire, Traciah John, Delores Owens, Kenny Wu
- NYC DOHMH: Louise Cohen, Homer Venters, Eric Zimiles
- SPNS-multisite: Anne Spaulding, Cristina Booker, Meredith Pustell (enhancelink.org), funded by HRSA grant: H97HA08541
- HRSA: Adan Cajina, Melinda Tinsley, Jessica Xavier

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