

NYC Health

Health outcomes for HIV-infected people released from NYC jails: Results from the SPNS Jails Initiative

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RIKERS ISLAND, NY

About 100,000 annual admissions and average daily census of ~12,500

NYC Department of Correction (DOC) operates Rikers Island (9 jails) and 3 borough facilities. NYC DOHMH provides health and mental health care for all in DOC custody.

Jail Discharges to NYC Communities by Zip Code and Socioeconomic Status 2004

Over 70% of those released from NYC jails to the community return to the areas of greatest socioeconomic and health disparities.

NYC Health

Legend

Number of Reentrants

- 0 - 38
- 39 - 99
- 100 - 199
- 200 - 341
- 342 - 624


Income Category

INCOME

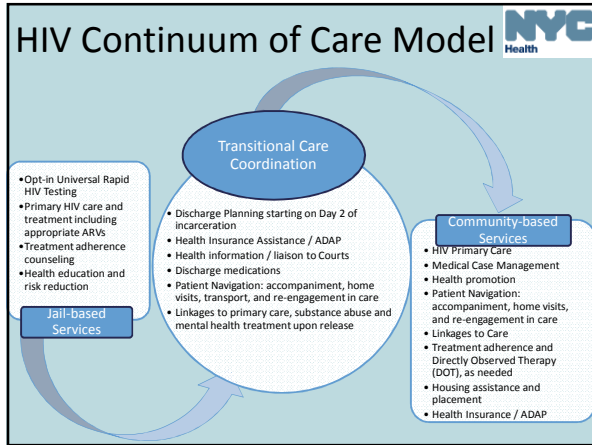
- < 25 K
- 25 - 35 K
- 35 - 50 K
- 50 - 75 K
- 75 - 110 K

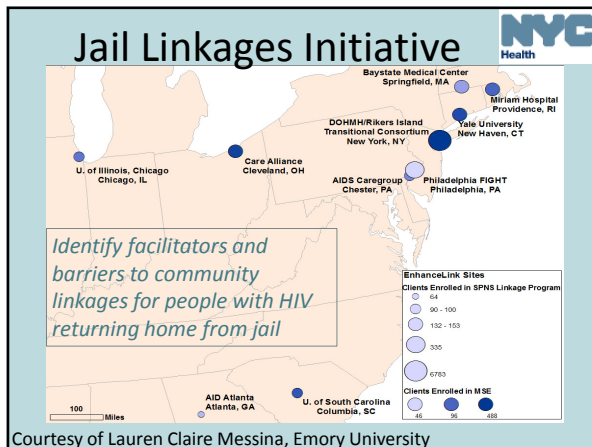
Correctional Health is Public Health

Background



- Correctional Health Services oversees medical care in the jails with over 78,000 medical visits monthly
 - 6,500 comprehensive intake exams
 - 50,000 medical and dental visits
 - 1,500 specialty clinic visits
 - 20,000 mental health visits
- Discharge Planning – Population-based for mentally ill (13k); HIV-infected (2.5k); others at high risk (1.5k)
- All jails use electronic health record





NYC JL Study Protocol

- **Enrollment:** all NYC participants enrolled during jail stay
 - Inclusion criteria: 18+ HIV-infected
 - Exclusion criteria: newly diagnosed, receiving mental health discharge planning, likely to have long sentence (>1year)
- **Baseline survey:** initiated at index incarceration
- **Jail chart review:** most recent clinical data at time of release
- **Post Release Services:** linkage determined 30 d post-release
- **C6M (6-month follow up):** by RITC CBO partners
 - Encountered participants pre-release
 - Followed post release with check in at 90 d and survey at 6 m
 - Recorded clinical data gathered from clinicians at 6m

NYC JL Participants

Demographics	Baseline (n=555)	C6M (n=243)
Male	431 (78%)	208 (86%)
Female	111 (20%)	33 (14%)
Transgender	13 (2%)	2 (1%)
White	40 (7%)	17 (7%)
Black	302 (55%)	124 (51%)
Latino	201 (36%)	91 (38%)
Age, <30	20 (4%)	4 (2%)
30-39	76 (14%)	30 (12%)
40-49	267 (48%)	112(46%)
50+	192 (34%)	97 (40%)

NYC JL Health History

Self-reported History	Baseline (n=555)	CGM (n=243)
H.S. Diploma / GED	256 (46%)	94 (38%)
Some College +	295 (53%)	139 (56%)
Other Chronic Illness	422 (76%)	185 (76%)
Hepatitis C virus	222 (40%)	118 (49%)
History of Heroin Use	311 (56%)	153 (63%)
History of Methadone	215 (39%)	118 (49%)
Troubled by Drug use, last 30d	367 (66%)	31 (13%)
Ever Psychiatric In/Outpatient	163 (29%)	59 (24%)
Ever Psychiatric Distress	315 (57%)	96 (40%)
Psychiatric Distress, last 30d	259 (47%)	40 (16%)

NYC JL Key Results

Indicator	Baseline (n=555)	C6M (n=243)	p-value
On ART 7 days prior	63%	95%	<0.01
Ever on ART	86%	95%	<0.01
ART adherence	80%	93.3%	<0.01
ED visits past 6 months	32%	12%	<0.01
Homeless prior month	26.8%	3.9%	<0.01
Food Instability	25.0%	1.6%	<0.01
SF-12 –PCS	47.5	50.4	<0.01
Physical Composite Score	(SD: 10.6)	(SD: 8.1)	<0.01
SF-12 –MCS	43.9	47.5	<0.01
Mental Composite Score	(SD: 10.2)	(SD: 7.0)	<0.01

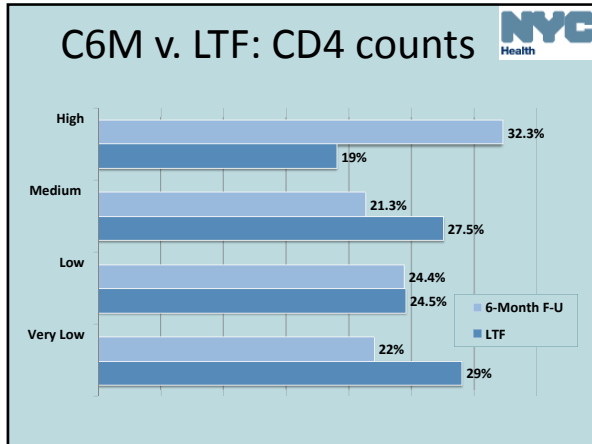
NYC JL Clinical Outcomes

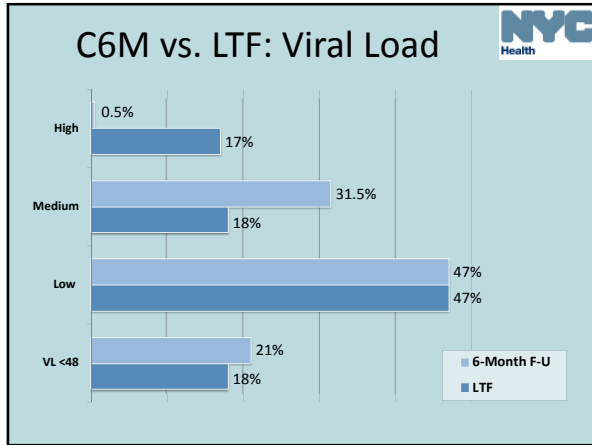
Clinical Indicators	Baseline (n=555)	C6M (n=243)	p-value
CD4 cells	402	417	<0.01
Viral load	49,097	13,923	0.011
CD4 <200	138 (25%)	55 (22%)	
CD4 201-350	120 (22%)	62 (25%)	
CD4 >351	285 (53%)	130 (53%)	
Undetectable Viral Load (<48)	59 (11%)	53 (22%)	

NYC JL C6M v. LTF

**Post-Release Comparisons:
Survey at 6-months (C6M) v. Lost to Follow up (LTF)**

	C6M (n=243)	LTF (n=164)	p-value
Mean CD4 count	417	349	= 0.054
Mean Viral Load	13,923	40,444.6	<0.0001





Discussion

- Using available surveillance data, we were able to compare study enrollees seen at the 6-month follow-up (C6M) with those considered lost to follow-up.
- Although 20% of JL enrollees were women, they comprised 1/3 (32%) of the lost to follow up group.
- Approximately 1/3 (32%) of all those in the LTF group had their 6-month labs drawn at a correctional facility.
- On average, the LTF group had higher viral load and a lower CD4 count, suggestive of interruptions in treatment and care.

Conclusions



- NYC JL participants who completed a 6-month follow-up survey showed significant improvements in ARV adherence, clinical markers, self-reported current physical and mental health, as well as reductions in housing instability, food insecurity and ED utilization.
- Most folks (95%) considered 'Lost to follow-up' (i.e., they didn't complete a 6-month follow up survey) did have a HIV care visit ~6-months post-release.
- We believe that transitional care services facilitate linkages to community-based care leading to improved health outcomes.

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Questions?



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