Service Category Definition - DSHS State Services
September 1, 2017 - August 31, 2018

Local Service Category:	**Early Intervention Services – Incarcerated**
Amount Available**:**	**To be determined**
Unit Cost	
Budget Requirements or Restrictions **(TRG Only)**:	Maximum 10% of budget for Administrative Cost. No direct medical costs may be billed to this grant.
DSHS Service Category Definition:	Support of Early Intervention Services (EIS) that include identification of individuals at points of entry and access to services and provision of: • HIV Testing and Targeted counseling • Referral services • Linkage to care • Health education and literacy training that enable clients to navigate the HIV system of care These services must focus on expanding key points of entry and documented tracking of referrals. Counseling, testing, and referral activities are designed to bring people living with HIV into Outpatient Ambulatory Medical Care. The goal of EIS is to decrease the number of underserved individuals with HIV/AIDS by increasing access to care. EIS also provides the added benefit of educating and motivating clients on the importance and benefits of getting into care.
Local Service Category Definition:	This service includes the connection of incarcerated in the Harris County Jail into medical care, the coordination of their medical care while incarcerated, and the transition of their care from Harris County Jail to the community. Services must include: assessment of the client, provision of client education regarding disease and treatment, education and skills building to increase client's health literacy, establishment of THMP/ADAP post-release eligibility (as applicable), care coordination with medical resources within the jail, care coordination with service providers outside the jail, and discharge planning.
Target Population (age, gender, geographic, race, ethnicity, etc.):	Services are for people living with HIV incarcerated in The Harris County Jail.
Services to be Provided:	Services include but are not limited to CPCDMS registration/update, assessment, provision of client education, coordination of medical care services provided while incarcerated, medication regimen transition, multidisciplinary team review, discharge planning, and referral to community resources.
Service Unit Definition(s) **(TRG Only)**:	One unit of service is defined as 15 minutes of direct client services or coordination of care on behalf of client.
Financial Eligibility:	Due to incarceration, no income or residency documentation is required.
Client Eligibility:	People living with HIV incarcerated in the Harris County Jail.
Agency Requirements **(TRG Only)**:	As applicable. the agency's facility(s) shall be appropriately licensed or certified as required by Texas Department of State Health Services, for the provision of HIV Early Intervention Services, including phlebotomy services.

	Agency/staff will establish memoranda of understanding (MOUs) with key points of entry into care to facilitate access to care for those who are identified by testing in HCJ. Agency must execute Memoranda of Understanding with Ryan White funded Outpatient Ambulatory Medical Care providers. The Administrative Agency must be notified in writing if any OAMC providers refuse to execute an MOU.
Staff Requirements:	Not Applicable.
Special Requirements **(TRG Only)**:	Must comply with the Houston EMA/HSDA Standards of Care. The agency must comply with **the DSHS Early Intervention Services Standards of Care**. The agency must have policies and procedures in place that comply with the standards ***prior*** to delivery of the service.

FY 2019 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/14/18**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Steering Committee**		Date: **06/07/18**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Quality Improvement Committee**		Date: **05/15/18**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **HTBMN Workgroup**	Date: **04/25/18**
Recommendations:	Financial Eligibility:
1.	
2.	
3.	

EARLY INTERVENTION (JAIL ONLY)

Early intervention services (EIS) refers to the provision of HIV testing, counseling, and referral in the Ryan White HIV/AIDS Program setting. In the Houston Area, the Ryan White HIV/AIDS Program funds EIS to persons living with HIV (PLWH) who are incarcerated in the Harris County Jail. Services focus on post-incarceration care coordination to ensure continuity of primary care and medication adherence post-release.

(**Graph 1**) In the 2014 Houston Area HIV needs assessment, 7% of participants indicated a need for *early intervention services* in the past 12 months. 6% reported the service was easy to access, and 1% reported difficulty. 11% stated that they did not know the service was available.

(**Table 1**) When barriers to *early intervention services* were reported, the most common barrier type was accessibility (40%). Accessibility barriers reported include release from incarceration.

GRAPH 1-Early Intervention (Jail Only), 2016

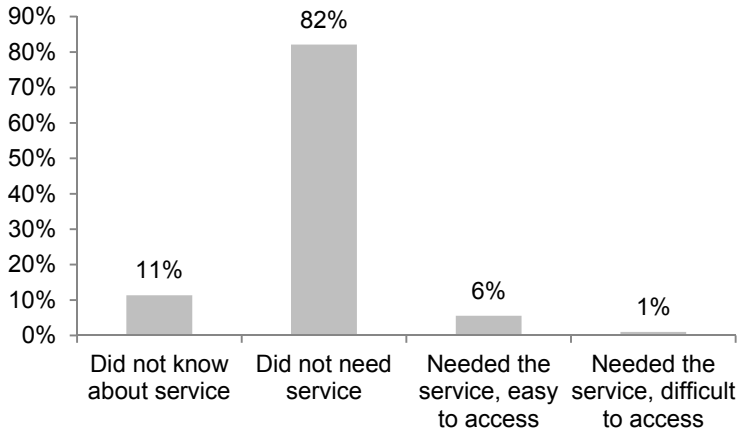

TABLE 1-Top 4 Reported Barrier Types for Early Intervention (Jail Only), 2016

	No.	%
1. Accessibility (AC)	2	40%
2. Interactions with Staff (S)	1	20%
3. Resource Availability (R)	1	20%
4. Transportation (T)	1	20%
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(**Table 2 and Table 3**) Need and access to services can be analyzed for needs assessment participants according to demographic and other characteristics, revealing the presence of any potential disparities in access to services. For *early intervention services*, this analysis shows the following:

- More males than females found the service accessible.
- More other/multiracial PLWH found the service accessible than other race/ethnicities.
- More PLWH age 25 to 49 found the service accessible than other age groups.
- In addition, more recently release and unstably housed PLWH found the service difficult to access when compared to all participants.

TABLE 2-Early Intervention (Jail Only), by Demographic Categories, 2016

	Sex		Race/ethnicity				Age		
Experience with the Service	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	12%	8%	13%	13%	7%	14%	4%	15%	7%
Did not need service	81%	86%	86%	80%	88%	43%	96%	77%	88%
Needed, easy to access	6%	5%	1%	6%	5%	43%	0%	6%	5%
Needed, difficult to access	1%	2%	0%	2%	0%	0%	0%	1%	1%

TABLE 3-Early Intervention (Jail Only), by Selected Special Populations, 2016

Experience with the Service	Unstably Housed[a]	MSM[b]	Out of Care[c]	Recently Released[d]	Rural[e]	Transgender[f]
Did not know about service	11%	12%	0%	26%	0%	9%
Did not need service	78%	82%	100%	26%	97%	86%
Needed, easy to access	9%	6%	0%	42%	3%	5%
Needed, difficult to access	2%	1%	0%	5%	0%	0%

[a]Persons reporting housing instability [b]Men who have sex with men [c]Persons with no evidence of HIV care for 12 mo.
[d]Persons released from incarceration in the past 12 mo. [e]Non-Houston/Harris County residents [f]Persons with discordant sex assigned at birth and current gender

EARLY INTERVENTION SERVICES - INCARCERATED
2017 CHART REVIEW REPORT

PREFACE

DSHS Monitoring Requirements

The Texas Department of State Health Services (DSHS) contracts with The Houston Regional HIV/AIDS Resource Group, Inc. (TRG) to ensure that Ryan White Part B and State of Texas HIV Services funding is utilized to provide in accordance to negotiated Priorities and Allocations for the designated Health Service Delivery Area (HSDA). In Houston, the HDSA is a ten-county area including the following counties: Austin, Chambers, Colorado, Fort Bend, Harris, Liberty, Montgomery, Walker, Waller, and Wharton. As part of its General Provisions for Grant Agreements, DSHS also requires that TRG ensures that all Subgrantees comply with statutes and rules, perform client financial assessments, and delivery service in a manner consistent with established protocols and standards.

As part of those requirements, TRG is required to perform annual quality compliance reviews on all Subgrantees. Quality Compliance Reviews focus on issues of administrative, clinical, consumer involvement, data management, fiscal, programmatic, and quality management nature. Administrative review examines Subgrantee operating systems including, but not limited to, non-discrimination, personnel management and Board of Directors. Clinical review includes review of clinical service provision in the framework of established protocols, procedures, standards and guidelines. Consumer involvement review examines the Subgrantee's frame work for gather client feedback and resolving client problems. Data management review examines the Subgrantee's collection of required data elements, service encounter data, and supporting documentation. Fiscal review examines the documentation to support billed units as well as the Subgrantee's fiscal management and control systems. Programmatic review examines non-clinical service provision in the framework of established protocols, procedures, standards and guidelines. Quality management review ensures that each Subgrantee has systems in place to address the mandate for a continuous quality management program.

In 2016, DSHS contracted with Germane Solutions to perform chart reviews of specific service categories. These chart reviews change from year-to-year and are determined at the beginning of each calendar year. TRG does not duplicate the chart reviews if a review was conducted Germane Solutions. Therefore, the chart review report for 2017 resulted in no chart review results. TRG will resume the monitoring process in 2018. However, to assist in the quality analysis of the EIS services, the 2016 data is presented below.

QM Component of Monitoring

As a result of quality compliance reviews, the Subgrantee receives a list of findings that must be address. The Subgrantee is required to submit an improvement plan to bring each finding into compliance. This plan is monitored as part of the Subgrantee's overall quality management monitoring. Additional follow-up reviews may occur (depending on the nature of the finding) to ensure that the improvement plan is being effectively implemented.

Scope of Funding

TRG contracts with one Subgrantee to provide Early Intervention Services in the Houston HSDA.

INTRODUCTION

Description of Service

Early Intervention Services-Incarceration (EIS) includes the connection of incarcerated in the Harris County Jail into medical care, the coordination of their medical care while incarcerated, and the transition of their care from Harris County Jail to the community. Services must include: assessment of the client, provision of client education regarding disease and treatment, education and skills building to increase client's health literacy, establishment of THMP/ADAP post-release eligibility (as applicable), care coordination with medical resources within the jail, care coordination with service providers outside the jail, and discharge planning.

Tool Development

The Early Intervention Services review tool is based upon the established local standards of care.

Chart Review Process

The collected data for each site was recorded directly into a preformatted computerized database. The data collected during this process is to be used for service improvement.

File Sample Selection Process

Using the ARIES database a file sample was created from a provider population of 927 who accessed Early Intervention Services in the measurement year. The records of 59 clients were reviewed (representing 6% of the unduplicated population). The demographic makeup of the provider was used as a key to file sample pull.

NOTE: DSHS has changed the file sample percentage which will result in a lower number of files being reviewed in 2016.

Demographics-Early Intervention Services

2015 Annual

Total UDC: 871 **Total New:** 293

Age	Number of Clients	% of Total
Client's age as of the end of the reporting period		
Less than 2 years	0	0.00%
02 - 12 years	0	0.00%
13 - 24 years	55	6.31%
25 - 44 years	464	53.27%
45 - 64 years	340	39.04%
65 years or older	12	1.38%
Unknown	0	0.00%
	871	100%
Gender	**Number of Clients**	**% of Total**
"Other" and "Refused" are counted as "Unknown"		
Female	157	18.03%
Male	700	80.37%
Transgender FTM	0	0.00%
Transgender MTF	14	1.61%
Unknown	0	0.00%
	871	100%
Race/ Ethnicity	**Number of Clients**	**% of Total**
Includes Multi-Racial Clients		
White	138	15.84%
Black	637	73.13%
Hispanic	90	10.33%
Asian	0	0.00%
Hawaiian/Pacific Islander	0	0.00%
Indian/Alaskan Native	6	0.69%
Unknown	0	0.00%
	871	100%

From 01/01/15 - 12/31/15

2016 Annual

Total UDC: 927 **Total New:** 279

Age	Number of Clients	% of Total
Client's age as of the end of the reporting period		
Less than 2 years	0	0.00%
02 - 12 years	0	0.00%
13 - 24 years	53	5.72%
25 - 44 years	492	53.07%
45 - 64 years	369	39.81%
65 years or older	13	1.40%
Unknown	0	0.00%
	927	100%
Gender	**Number of Clients**	**% of Total**
"Other" and "Refused" are counted as "Unknown"		
Female	148	15.97%
Male	766	82.63%
Transgender FTM	0	0.00%
Transgender MTF	13	1.40%
Unknown	0	0.00%
	927	100%
Race/ Ethnicity	**Number of Clients**	**% of Total**
Includes Multi-Racial Clients		
White	156	16.83%
Black	661	71.31%
Hispanic	106	11.43%
Asian	1	0.11%
Hawaiian/Pacific Islander	0	0.00%
Indian/Alaskan Native	3	0.32%
Unknown	0	0.00%
	927	100%

From 01/01/16 - 12/31/16

RESULTS OF REVIEW

Intake Assessment

Percentage of HIV-positive clients who had a completed intake assessment present in the client record.

	Yes	No	N/A
Number of client with a completed intake assessment in the client record.	56	1	2
Number of HIV-infected clients in early intervention services that were reviewed.	57	57	59
Rate	**98%**	2%	-

Intake Assessment

Percentage of HIV-positive clients that self-reports being in care (attending a medical appointment) in the last 6 months prior to incarceration.

	Yes	No	Unknown	N/A (New Dx)
Number of client with a completed intake assessment in the client record.	40	10	3	6
Number of HIV-infected clients in early intervention services that were reviewed.	53	53	53	59
Rate	**75%**	19%	6%	-

Health Literacy and Education: Risk Assessment

Percentage of HIV-positive clients that had documentation of the client being assessed for risk and provided targeted health literacy and education in the client record (including receipt of a blue book).

	Yes	No	Partial (blue book only)	N/A
Number of client records that documented health literacy and education.	38	4	12	5
Number of HIV-infected clients in early intervention services that were reviewed.	54	54	54	59
Rate	**70%**	7%	22%	-

Health Literacy and Education: Medication Adherence

Percentage of HIV-positive clients who had documentation of discussion of medication adherence by the EIS case manager in the client record.

	Yes	No	N/A
Number of client records who had documentation of discussion of medication adherence by the EIS case manager in the client record	34	20	5
Number of HIV-infected clients in early intervention services that were reviewed.	54	54	59
Rate	**63%**	37%	-

Linkage: Newly Diagnosed

Percentage of newly-diagnosed clients (incarcerated 30 days or longer) that initiate care through the EIS program

	Yes	No	N/A
Number of newly-diagnosed clients (incarcerated 30 days or longer) that initiate care through the EIS program	6	0	53
Number of newly-diagnosed HIV-infected clients in early intervention services that were reviewed.	6	6	59
Rate	**100.0%**	0.0%	-

Linkage: Medical Care

Percentage of HIV-positive clients that accessed a medical provider and obtained an appointment.

	Yes	No	N/A
Number of client records that document linkage to a medical provider and access to an appointment	55	0	4
Number of HIV-infected clients in early intervention services that were reviewed.	55	55	59
Rate	**100.0%**	0.0%	-

Multidisciplinary Team Conference

Percentage of HIV-positive clients who received early intervention services that had at least one multidisciplinary team conference

	Yes	No	N/A
Number of client records that showed evidence of at least one multidisciplinary team conference.	0	55	4
Number of HIV-infected clients in early intervention services that were reviewed.	55	55	59
Rate	**0%**	100.0%	7%

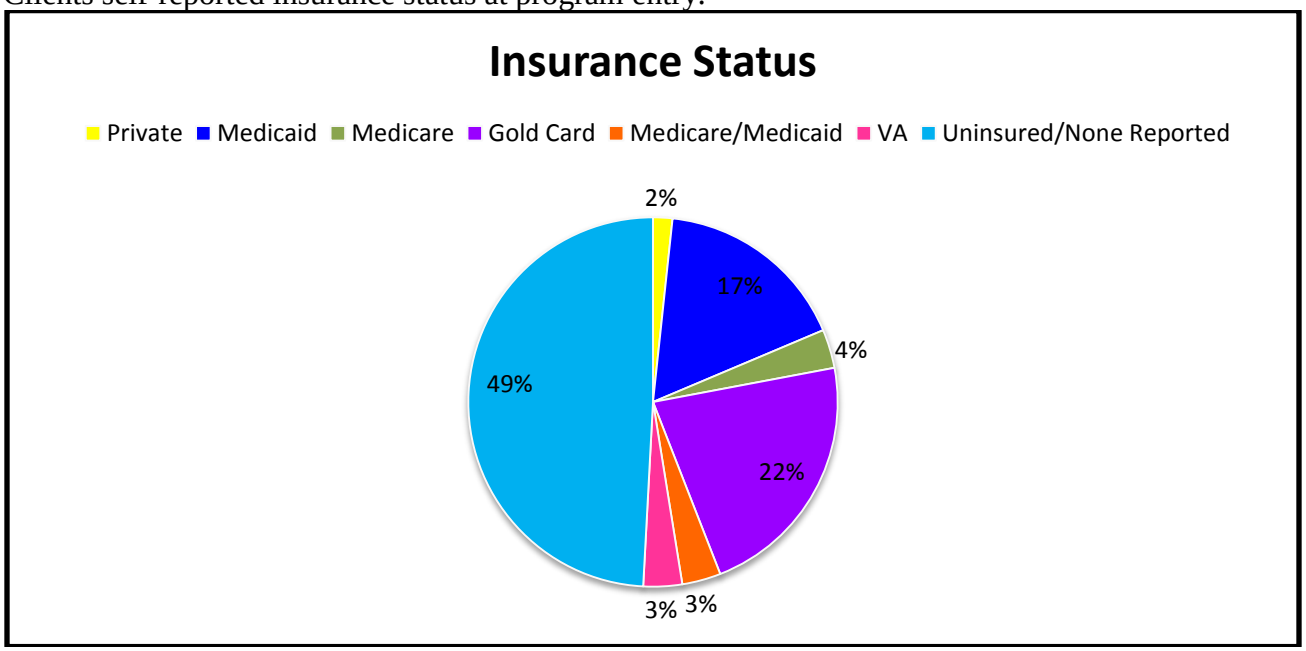
Discharge Planning

Percentage of HIV-positive clients who had a discharge plan present in the client record.

	Yes	No	N/A
Number of client with a completed discharge plan in the client record.	44	10	5
Number of HIV-infected clients in early intervention services that were reviewed.	54	54	59
Rate	**81%**	19%	8%

Insurance Status

Clients self-reported insurance status at program entry.



HISTORICAL DATA

Not applicable for 2016 Chart Review as this is the first time this service category has been presented.

CONCLUSIONS

Overall, quality of services is good. Through the chart review: 98% (56) of clients completed an intake assessment and 81% (44) developed a discharge plan. Of the clients enrolled into the EIS program 100% were linked accessed a care provider; with 100% (6) of the newly-diagnosed clients accessing care. However, only 50% (3) of the newly-diagnosed clients documented a discharge plan. 75% (40) of clients self-reported accessing medical care within the last six months of entering the EIS program and 51% (30) reported a third-party payer source (including the HCHD Gold Card)

Transitional Care Coordination

From Jail Intake to Community HIV Primary Care

DISSEMINATION OF EVIDENCE-INFORMED INTERVENTIONS

Intervention Summary

HIV Care Continuum

Collaborations between public health agencies, community-based organizations, and jail health services have implications for public health and safety efforts and have been proven to facilitate linkage to care after incarceration.[1] Medical screenings that happen for all inmates through the jail intake process offer an opportunity to implement such interventions, as do booking processes and intervention intake.[2,3,4] Jordan et al., introduce the concept of "Warm Transitions" as an integral part of implementing their HIV Continuum of Care Model by "applying social work tenets to public health activities for those with chronic health conditions including HIV-infection."[5] Absent "a caring and supportive warm transition approach," pre-existing barriers to care and other stressors that come with the experience of incarceration and cycling in and out of correctional facilities will continue or be exacerbated after incarceration.[6] Without transition assistance, people living with HIV who are released from jails are at risk of unstable housing; lack of access to health insurance and medication; overdose due to period of detoxification; exacerbation of mental health conditions due to increased stress; and lack of social supports, when exposed to the same high risk communities from which they were incarcerated.[7]

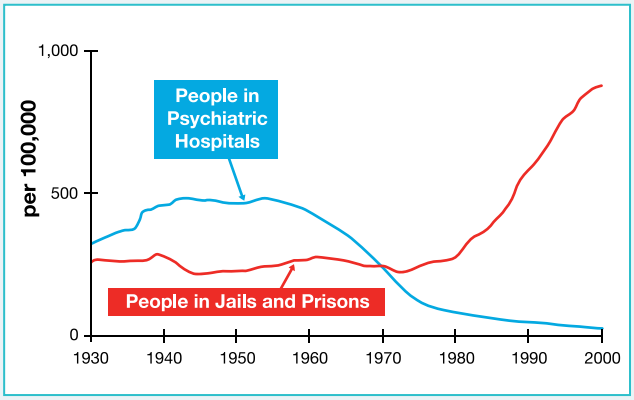
This intervention is intended for organizations, agencies, and individuals considering strengthening connections between community and jail health care systems to improve continuity of care for HIV-positive individuals recently released from jails. The following information is meant to provide an overview of the Transitional Care Coordination intervention to implement a new linkage program to for PLWH to support their care retention and engagement post-incarceration and as they re-enter the community.

Professional Literature

The United States has the highest incarceration rates of any industrialized country in the world.[8,9] Approximately 1 out of every 100 people in the United States is incarcerated;[10] and, if rates persist, 1 in 15 Americans will have been incarcerated at some point in their lives.[11]

The U.S. Criminal Justice System includes Law Enforcement (police, sheriff, highway patrol, FBI, and others), Adjudication (courts), and Corrections (jails, prisons, probation, and parole).[12] Most incarcerated individuals (85%) pass solely through jails. Yet most corrections spending is in state prisons, rather than in jails, which are dependent on local funding.[13,14]

FIGURE 1 **De-Institutionalization?**
Harcourt 2006



If rates persist,

1 in 15

Americans will have been incarcerated at some point in their lives.

Jails are often the *de facto* health provider of last resort where people with low income, mental illness, unstable housing, substance use issues, and a range of social and health problems are concentrated.[15,16] Further, while historic arrest rates tend to mirror the racial and ethnic demographics of the local community, the incarcerated population is predominantly men of color.[17,18]

Prior to jail admission, many individuals may have had barriers to accessing health care and support services due to structural inequalities, including poverty, unstable housing, limited educational attainment, and un- or under- employment.[19,20] Co-occurring health and behavioral health conditions (e.g., substance abuse and mental illness) further exacerbate access to care issues (see also Figure 1).[21,22] Additionally, people are less equipped to address health issues when faced with competing compelling needs related to survival, such as food and shelter.[23] In these same communities, health inequities lead to higher rates of both incarceration and HIV.[24] As a result, public health professionals working in jail settings have a unique opportunity to engage a population living with HIV and not engaged in care, in need of supportive services to access care after incarceration to achieve viral load suppression.[25,26,27]

Jail-based health services treat populations at high risk for acquiring HIV and offer people an opportunity to know their HIV status. They may also provide transitional care coordination to facilitate linkage and re-engagement with the health care system after incarceration.[28,29] Jail-based health services have the opportunity to:

- **Offer universal HIV testing**, particularly in jurisdictions with hyper endemic rates of incarceration, so that the offer of HIV testing in correctional health care settings mirrors that in community health settings;[30]
- **Implement interventions** to prevent HIV transmission among populations that move into, dwell in, or leave correctional facilities, while delivering general interventions that decrease intimate partner/sexual violence, promote harm reduction and medication adherence, and address substance use;
- Ensure that health services in jails follow **international guidelines** for HIV care, including for the management of HIV comorbidities that occur at high frequency in incarcerated populations;
- Promote 2-way, **comprehensive communication** between correctional and community HIV providers to ensure that there are no gaps in care, treatment, and supportive services as people transition to and from their communities and correctional facilities.

The CDC strongly recommends jail-based HIV testing.[31] Routine HIV screening in jails is also consistent with the National HIV/AIDS Strategy.[32] Nonetheless, many HIV positive persons in jails are unaware of their HIV status or were not in HIV primary care at the time of jail admission. The majority of people pass through jail and are never sentenced to prison but return to the communities that they left.[33,21,34] The transition period from incarceration back to the community is known to be a high risk period for: increased deaths,[35] discontinuity of care and treatment (including ART), unstable housing, and opiate overdose. The adverse health outcomes that occur in this high risk period further underscore the need for transitional care coordination and support services.[36,37,28,38] As such, health

departments, local healthcare providers, and community-based organizations have a vested interest in the provision of HIV testing, treatment, and linkage to both care and treatment during and after incarceration. It is useful for health care and correctional staff to view jails as part of the continuum of care rather than independently, since this approach may help encourage strategic retention-in-care planning.

Theoretical Basis

A behavioral change theory is a combination of, "interrelated concepts, definitions, and propositions that present a systematic view of events or situations by specifying relations amount variables, in order to explain or predict the events or situations."[39] By grounding an intervention in theory, the component parts are intentionally sequenced to build off of one another to facilitate a change in health behavior.

The original **Transitional Care Coordination** intervention was grounded in the Transtheoretical Model of Behavior Change (using Stages of Change to lead to behavior change).[40] The Stages of Change framework explains an individuals' readiness to change, and provides strategies at six levels of behavior change (**precontemplation**, **contemplation**, **determination**, **action**, **relapse**, and **maintenance**) to move the individual into adopting the new health behavior. The Transtheoretical Model of Behavior Change builds off of the Stages of Change by adding 10 processes of change that address the process of overcoming barriers, reducing internal resistance to change, and commitment to a new health behavior. These processes are consciousness raising, dramatic relief, self-reevaluation, environmental reevaluation, self-liberation, helping relationships, counter conditioning, reinforcement management, stimulus control, and social liberation. The Model also includes decisional balance (the benefits and costs of changing) and self-efficacy (confidence in the ability to change health behavior and temptation to engage in unhealthy behavior) as core constructs.

Intervention Components and Activities

The central aim of the Care Transitional Coordination intervention is to facilitate the linkage of a client living with HIV to community-based care and treatment services after incarceration. Intervention activities include identifying and engaging people living with HIV during the jail stay, identifying "right fit" community resources, developing a client plan for their time during and post-incarceration, and coordinating activities needed to facilitate linkage to care after incarceration. These activities need to occur quickly because jail stays are often brief and the uncertainty around discharge dates presents a shorter window of opportunity to reach people leaving jail settings.[41]

Transitional Care Coordination includes the following key activities while clients are incarcerated (pre-release):

1. HIV testing or self-disclosure information as well as mental health and substance abuse information after medical intake screening (occurring in the jail);
2. Recruitment (including informed consent) and enrollment into the intervention/program after medical intake screening;
3. Intensive case management intervention and individualized discharge plans (typically, within 24 hours and at least within 48 hours of medical intake);
4. HIV education, including risk reduction and treatment adherence counseling, ongoing during the jail stay;

5. Health Insurance and ADAP assistance for post-release submission;
6. Discharge medications / prescription scripts at the time of jail release, including arrangements for those released from court;
7. Providing a health liaison to the courts, which involves collaboration with court advocates, judges and prosecutors, to provide health information to facilitate placement in community programs (including skilled nursing facility, hospice, drug treatment program) and alternatives to incarceration programs;

Transitional Care Coordination includes the following key activities after the clients are released (post-release):

1. Patient navigation (accompaniment, home visiting, transportation assistance) and re-engagement in care after incarceration;
2. Intensive case management after incarceration to facilitate linkage to care for at least 90 days: address needs for food, clothing, and shelter; verify linkages to HIV primary care within 30 days of returning to the community; address ongoing mental health and substance abuse treatment needs, as assessed; consistent access to health insurance and medication; ongoing care management and social supports after 90 days.

Staffing Requirements

The following staff positions need to be developed and filled in order to successfully implement the intervention.

STAFF TITLE	DESCRIPTION
Linkage staff	
PROJECT MANAGER 	The **Project Manager** coordinates all aspects of the intervention with jail and community-based staff and community partners. The Project Manager is responsible for: ▸ being the point of contact for the intervention and providing oversight of the project; ▸ providing administrative supervision to the care coordinators and the data manager; ▸ serving as the health liaison to the courts; and ▸ serving as the liaison with local jail administration, the Dissemination and Evaluation Center (DEC), and the Implementation Technical Assistance Center (ITAC).
CARE COORDINATOR 	The care coordinator has five primary responsibilities: patient engagement, patient education, discharge planning, care coordination, and facilitating a warm transition to the community and linking a client to care. ***Patient engagement during incarceration.*** The Care Coordinator is responsible for: ▸ client engagement and assessment during the client's jail stay; and ▸ conducting care coordination with jail- and community-based organizations. ***Patient education.*** The Care Coordinator is responsible for: ▸ providing patient education on HIV, including treatment adherence, risk reduction as well as a range of other health-related topics (e.g. STI, hepatitis, and TB overviews; prevention strategies and safe sex negotiation; relapse prevention; symptoms evaluation, etc.). ***Discharge planning.*** The Care Coordinator is responsible for: ▸ assessing client needs; ▸ developing a plan with client to address basic needs; ▸ identifying resources to facilitate access to community health care; and ▸ scheduling initial linkage appointment.

Care coordination for care upon release. The Care Coordinator is responsible for:

- completing patient assessment and discharge plan to initiate the process of coordinating care upon release, meeting the person in jail and initiating follow-up to verify linkage to care after incarceration;
- arranging discharge medications and prescriptions; and
- obtaining consent to collaborate with external entities and individuals (e.g. community health providers, social service programs, courts).

Facilitating a warm transition to the community and linking a client to care. The care coordinator is responsible for:

- accompanying individuals who are newly released to appointments to ensure connection to care;
- coordinating community-based HIV care linkage services;
- providing home visits, appointment accompaniment, or transportation;
- conducting, arranging, or coordinating outreach activities to find individuals who fall out of care and facilitate re-engagement in community care;
- assessing and addressing basic needs like housing, food, clothing, etc.; and
- transitioning the client to the standard of care after 90 days post-incarceration.

CLINICAL SUPERVISOR

The **Clinical Supervisor** is responsible for:

- Participating in case conferencing (as needed);
- Providing monthly (or as requested) individual clinical supervision to care coordinators; and
- Providing monthly group clinical supervision to intervention team (as needed)

DATA MANAGER

This position is responsible for:

- Consenting patients into the study;
- Collecting and submitting data required for multi-site evaluation;
- Coordinating the collection of patient surveys, encounter forms, basic chart data abstraction, and implementation measures, and reporting them to the Dissemination and Evaluation Center (DEC); and
- Providing quality assurance reports and updates to intervention team about study referrals, enrollment retention, etc.

Staff Characteristics

All staff involved in the intervention need to be:

- able to deliver **culturally appropriate** services.
- **non-judgmental** and demonstrate empathy, professionalism, boundaries around personal philosophy/belief systems.
- genuinely **interested in working** with people incarcerated in jails.
- **reflective of racial and ethnic backgrounds** of client population with language ability as appropriate to meet client needs (as practicable).
- able to meet Department of Corrections' **security clearance** criteria.
- willing to conform to Department of Corrections' **policies** and are cognizant of **guidelines** regarding justice-involved persons working in jail.

Programmatic Requirements

The following are programmatic requirements that need to be addressed prior to implementation (prior to enrollment of clients in the jails) in order to facilitate a successful implementation:

- Establish relationships with the Jail and Department of Corrections to insure ongoing cooperation and support throughout implementation.
  - Assess what related work is already taking place within the jail.
  - Receive clearance for intervention implementation. Understand what materials and resources are or are not permissible within the jail and plan your program accordingly (for example, some jails do not allow laptops inside).
  - Invite corrections to join the collaboration and obtain a commitment for correction officers to provide escort services. Ideally assigned and dedicated officers will work in partnership with the team.
  - Negotiate for dedicated space to conduct intervention activities. Appropriate work space is essential to maintain patient confidentiality.
  - Determine role of jail security staff in project implementation and involve them in planning.
- Visit jail facilities to conduct a flow analysis. Walk through the health services unit and other relevant spaces to learn where services are delivered to identify space amenable to your program.
- Strengthen existing relationships with community-based organizations that are willing to work with HIV-positive individuals leaving jail.
  - Address need for telephone or in-person case conferences with community-based organizations during the jail stay (to facilitate a warm transition).
  - Develop mutual Memorandum of Understanding (MOU) Linkage Agreement with each community partner that includes a commitment to provide data that verifies linkage to care.
  - Assess organizational capacity at community-based organizations to insure their ability to consistently provide culturally competent transitional social supports to each inmate post-incarceration.
- Identify how access to health records and any Electronic Health Record (EHR) systems (including RSR data).
  - Establish a process for communication and information sharing of participating Ryan White care providers during and post-incarceration to streamline the client process and activities each client engages in. Providers should be prepared to address the operational issues involved in working with multiple jail-based and community-based providers of health care as patients are frequently transferred among jails, between jails and prisons, from jail to court, and from jail to the community.
- Additionally, DEII performance sites must assess their capacity to conduct process and outcome evaluation activities during the funding period.

Costs

The SPNS Jail Linkages projects were deemed cost-effective from a societal perspective[42] with an average cost per client at $4,219. In an analysis of nine sites, the mean cost to sustain linkage to care post-incarceration for 6 months was $4,670.[43] Health outcomes impacting costs (reductions in ED use and self reported unstable housing and hunger when compared to themselves at baseline and at 6 Month follow up) were found under the Transitional Care Coordination intervention including a reduction in emergency department use and homeless shelter stays[13, 14]

Resources

OVERVIEW OF PRIOR SPNS INITIATIVES

- Enhancing Linkages to HIV Primary Care and Services in Jail Settings
  www.hab.hrsa.gov/abouthab/special/carejail.html
- Enhancing Linkages: Opening Doors for Jail Inmates. *What's Going on @ SPNS*:
  www.hab.hrsa.gov/abouthab/files/cyberspns_enhancing_linkages_may_2008.pdf
- HRSA Consultation Meeting. Enhancing Linkages to HIV Primary Care in Jail Settings:
  www.hab.hrsa.gov/abouthab/files/enhancinglinkages.pdf
- HRSA/CDC *Opening Doors: Corrections Demonstration Project for People Living with HIV/AIDS:*
  www.hab.hrsa.gov/abouthab/files/openingdoors.pdf

CREATING A JAIL LINKAGE PROGRAM: TOOLS FROM THE INTEGRATING HIV INNOVATIVE PRACTICES PROGRAM

- Training Manual:
  https://careacttarget.org/library/creating-jail-linkage-program-training-manual-0
- Curriculum: https://careacttarget.org/library/creating-jail-linkage-program-curriculum-manual
- Pocket Guide: https://careacttarget.org/library/best-practices-hiv-interventions-jails-pocket-guide
- Webinar series: https://careacttarget.org/library/hiv-and-jails-public-health-opportunity

EVALUATION RESOURCES

- Enhancing Linkages to HIV Primary Care and Services in Jail Settings implementation guide and evaluation instruments www.enhancelink.org

PEER-REVIEWED ARTICLES PROVIDING BACKGROUND INFORMATION ON WORKING IN JAILS AND LINKING INMATES TO CARE

- Adherence to HIV Treatment and Care among Previously Homeless Jail Detainees.
  www.ncbi.nlm.nih.gov/pmc/articles/PMC3325326/
- Contribution of Substance Use Disorders on HIV Treatment Outcomes and Antiretroviral Medication Adherence Among HIV-Infected Persons Entering Jail.
  www.ncbi.nlm.nih.gov/pmc/articles/PMC3818019/

- Correlates of Retention in HIV Care after Release from Jail: Results from a Multi-site Study. www.ncbi.nlm.nih.gov/pmc/articles/PMC3714328/
- An Exploration of Community Reentry Needs and Services for Prisoners: A Focus on Care to Limit Return to High Risk Behavior. www.ncbi.nlm.nih.gov/pubmed/21663540
- Gender Disparities in HIV Treatment Outcomes Following Release From Jail: Results From a Multicenter Study. www.ncbi.nlm.nih.gov/pmc/articles/PMC3953795/
- Gender Differences in Baseline Health, Needs at Release, and Predictors of Care Engagement Among HIV-positive Clients Leaving Jail. www.ncbi.nlm.nih.gov/pmc/articles/PMC3758427/
- Health outcomes for HIV-infected persons released from the New York City jail system with a transitional care-coordination plan. www.ncbi.nlm.nih.gov/pubmed/25521890
- Jail: Time for Testing. Yale University School of Medicine www.enhancelink.org/EnhanceLink/documents/Jail%20-%20Time%20for%20Testing.pdf
- Linking HIV-positive Jail Inmates to Treatment, Care, and Social Services After Release: Results from a Qualitative Assessment of the COMPASS Program. www.ncbi.nlm.nih.gov/pmc/articles/PMC3005089/
- Post-Release Substance Abuse Outcomes among HIV-infected Jail Detainees: Results from a Multisite Study. www.ncbi.nlm.nih.gov/pmc/articles/PMC3600070/
- Rapid HIV Testing in Rapidly Released Detainees: Next Steps. http://journals.lww.com/stdjournal/Fulltext/2009/02001/Rapid_HIV_Testing_In_Rapidly_Released_Detainees_.9.aspx#
- Transitional Care Coordination in New York City Jails: Facilitating Linkages to Care for People with HIV Returning Home from Rikers Island. www.ncbi.nlm.nih.gov/pubmed/23128979
- Understanding the Revolving Door: Individual and Structural-level Predictors of Recidivism Among Individuals with HIV Leaving Jail. www.ncbi.nlm.nih.gov/pmc/articles/PMC4049299/

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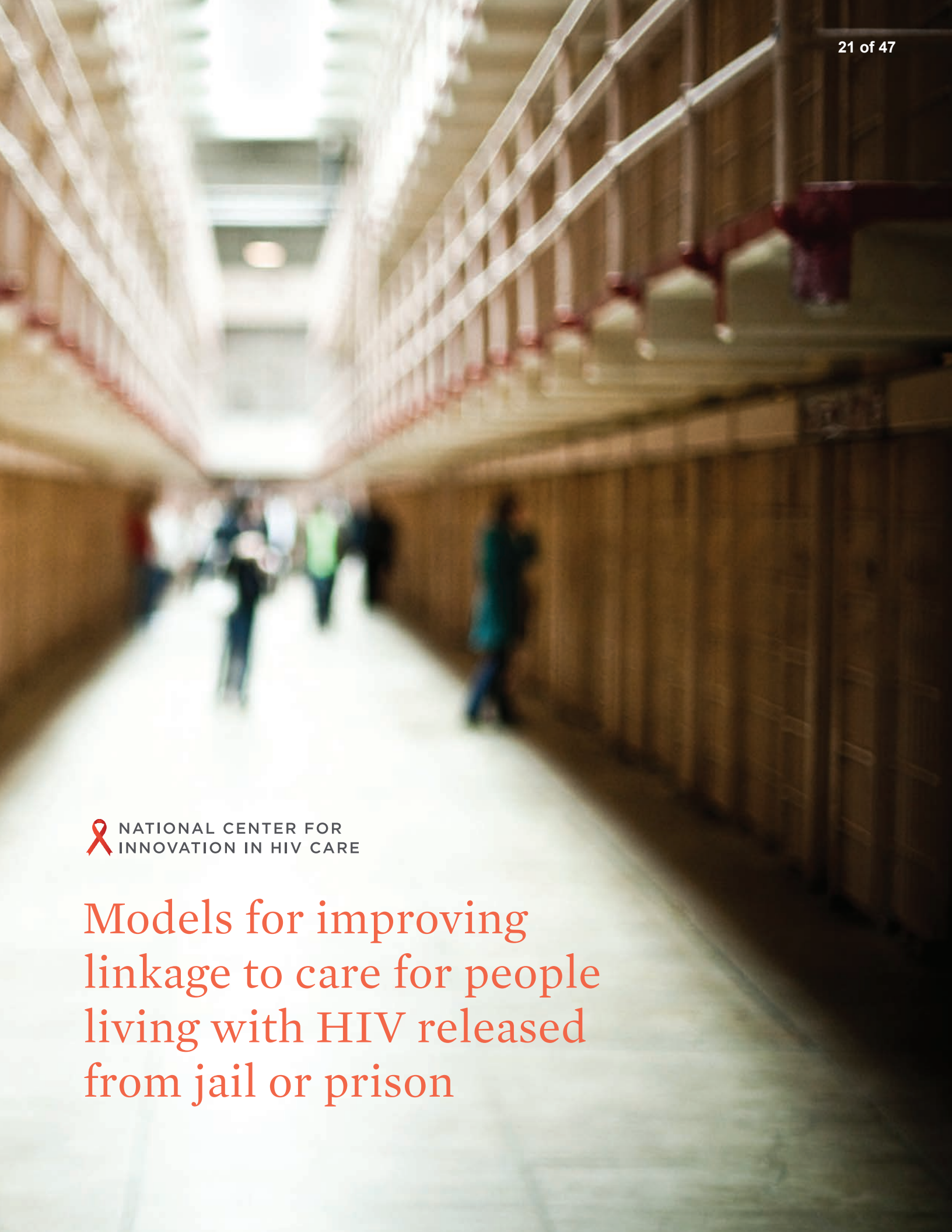


NATIONAL CENTER FOR
INNOVATION IN HIV CARE

Models for improving linkage to care for people living with HIV released from jail or prison

Table of Contents

Summary

This is a resource guide for Ryan White HIV/AIDS Program (RWHAP) funded organizations to provide care to people living with HIV (PLWH) who are leaving prisons and jails and reentering society after incarceration. It describes proven models for linkage to care programs that can help PLWH access healthcare upon release in order to stay healthy, treatment adherent, HIV virally suppressed, and reduce their changes of recidivism.

With HIV prevalence among state and federal prisons more than three times higher than the general population (1.3% compared to 0.4%),[1] correctional facilities offer a unique opportunity to engage with PLWH and offer care. For many PLWH, this time during incarceration may be the only time they have access to HIV care. For others, due to intense stigma against HIV and homosexuality[2] in hypermasculine[3] corrections settings, incarceration may interrupt HIV treatment they were previously receiving in the community. It is essential that AIDS service organizations (ASOs) and community-based organizations (CBOs) work with newly released PLWH to ensure continuity of care for incarcerated PLWH as they reenter society.

The HIV care continuum involves five sequential steps: (1) diagnosis of HIV infection, (2) linkage to care, (3) retention in care, (4) receipt of antiretroviral therapy (ART), and (5) achievement of viral suppression.[4] Barriers to accessing care can include lack of stable housing, poverty, mental health and/or substance use disorder issues, and lack of access to culturally competent care.[5] Formerly incarcerated individuals often struggle with various issues, including: substance use disorders, mental health, family estrangement, lack of support, lack of employment and housing after being released back into their communities.[6] Thus, continuity of care for incarcerated PLWH is particularly important. Interventions that address barriers to engagement in care are vitally important.

This resource guide summarizes effective models and best practices of linkage to care programs for PLWH who are leaving jail or prison and reentering society. It is based on project reports, training manuals and resource guides on post-incarceration linkage to care programs, including the HRSA-CDC Corrections Demonstration Project, HRSA HIV/AIDS Bureau's (HRSA HAB's) Special Projects of National Significance Program (SPNS): Enhancing Linkages to HIV Primary Care & Services in Jail Settings Initiative (EnhanceLink), The Bridging Group's Project START Plus, ActionAIDS' Philadelphia Linkage Program's Care Coach Model, and the Change Team Model in Delaware Study.

Each of these programs is briefly summarized below. At the end of this guide a troubleshooting Q&A can be found to address common questions and concerns.

Corrections Demonstration Project (CDP)

The HRSA/CDC CDP was a five-year project (1999–2004) that addressed HIV testing and continuity of care for incarcerated individuals living with HIV. Seven state departments of health were funded to support projects that developed effective linkage to care models. It attempted to establish linkages between existing correctional and community health services while addressing other social service needs. Effective models used a combination of health services including HIV surveillance, medical and behavioral screening and assessment, prevention education and counseling, primary healthcare, and referral linkages. Information is summarized from their report, *Opening Doors*[7], and *EnhanceLink's Consultancy Report* (see next paragraph).[8]

EnhanceLink

The HRSA, HABs, and SPNS: Enhancing Linkages to HIV Primary Care & Services in Jail Settings Initiative (EnhanceLink) built upon the CDP. From 2007–2012, ten grant recipients were funded, representing 20 separate jail sites. From this pilot project, a training manual was developed that illustrates the effectiveness of jail linkage work, information on components of effective jail linkage programs, best practices, and necessary information to replicate and implement the work of EnhanceLink. The EnhanceLink project highlighted important considerations for starting a successful linkage to care program, such as research and preparation, data collection, HIV testing, implementation of programs, and reintegration of formerly incarcerated individuals back into the community. Information is summarized from their training manual.[9]

Project START Plus

The Bridging Group's Project START Plus was an adaptation of Project START, an individual-level, multi-session linkage to care and risk reduction program for PLWH returning to the community after incarceration. The program provides tools and resources to increase awareness and reduce risk of HIV, STI, and Hepatitis. The program consists of six sessions with each client, working with them one-on-one to serve as a "bridge" for their return to the community. The program begins up to 2 months pre-release and continues for 3 months post-release, focusing on linkage to care through referrals, social healthcare services support, and transitional needs support. Information is summarized from their fact sheet.[10]

Philadelphia Linkage Program's Care Coach Model

This was a linkage to care program that includes two key staff positions: care coach and care outreach specialist. The care coach has smaller caseloads of typically 25 clients, and works one-on-one with clients during incarceration and post release. Care coaches assisted in the transition from jail-based medical care to community-based care. The care outreach specialist worked with a care coach, and served as an advocate, medical escort, and health educator. This model delivered multi-tiered services with the engagement of community partners. Information is summarized from their report, *Securing the Link*.[11]

Change Team Model in Delaware Study

This was a model used in the National Institute on Drug Abuse-funded Criminal Justice Drug Abuse Treatment Studies HIV Services and Treatment Implementation in Corrections protocol in the state of Delaware. Research centers teamed with criminal justice organizations to identify where improvements needed to be made on the HIV care continuum in their local facilities. The change team consisted of a change team leader and a team of key staff and personnel, including representatives from correctional and community agencies. Identifying linkage to care as the area for improvement, the Delaware change team worked to increase communication between HIV community providers and Department of Corrections medical supervisors, decrease administrative burden, and improve HIV testing and educational material at medical intake. Information is summarized from the article, *Improvements in Correctional HIV Services: A Case Study in Delaware*.[12]

In the following pages, information from each program is summarized in-depth. For further guidance, links to the original reports and studies are provided throughout this report.

Introduction

Each year, approximately 17% of all people living with HIV in the U.S. will spend some time in prison or jail.

The United States incarcerates over 20% of the world's prisoners despite having less than five percent of the world's population.[13] The U.S. incarceration rate is over four times the world average, with a rate of 693 incarcerated individuals per 100,000 residents in 2014, and a total prison population of over 2.2 million.[14]

According to a 2015 Bureau of Justice Statistics report, the prevalence of HIV among state and federal prisoners is 1.3%, which is more than three times higher than the prevalence in the general population (0.4%).[15] In 2010, the rate of diagnosed HIV infections among prisoners was more than five times greater than the rate among those not incarcerated.[16] Each year, approximately 17% of all PLWH in the U.S will spend some time in prison or jail[i].[17] Most incarcerated individuals acquire HIV in their communities, prior to incarceration.[18] For many with PLWH, their time in prison or jail is the only time they have access to care, treatment, and support. For this reason the corrections system is a key site of engagement with some PLWH and an important place to find PLWH who have never been diagnosed or who have been diagnosed but lost to care. This provides a unique opportunity for public health professionals to access this population to provide not only acute care, but a continuity of care that extends back to the community, where 90% of people in correctional facilities will return.[19]

The fact that nearly one in five PLWH cycles through the jail or prison system in any given year, and that the vast majority of incarcerated individuals will return to society and their partners, spouses and families demonstrate the linkage between prisons, communities, and the overall HIV epidemic. The public health sector is increasingly recognizing the opportunity within corrections to contribute to a more successful reentry process for former incarcerated citizens into the community. It has been shown that promoting health during incarceration promotes health in communities post-release. For example, in a study examining the effects of jail sexually transmitted infection (STI) testing on neighborhood chlamydia rates, neighborhood clinics in areas with higher jail testing density found a seven times greater reduction in chlamydia rates (from 16.1% to 7.8%) compared to neighborhood clinics in areas with lower jail testing density.[20] A comprehensive approach that includes not only standard HIV treatment and education but also enhances continuity of care is essential to reducing HIV in correctional facilities and our communities.[21] The following are successful programs and models that use this comprehensive approach.

[i] According to the Bureau of Justice Statistics: "Jails are locally-operated, short term facilities that hold inmates awaiting trial or sentencing or both, and inmates sentenced to a term of less than 1 year, typically misdemeanants. Prisons are long term facilities run by the state or the federal government and typically hold felons and inmates with sentences of more than 1 year." https://www.bjs.gov/index.cfm?ty=qa&iid=322

Programs & Projects

HRSA/CDC Corrections Demonstration Project

From 1999 to 2004, the Corrections Demonstration Project (CDP) addressed HIV testing and continuity of care for incarcerated individuals living with HIV by funding projects that developed effective linkage to care models. It attempted to establish linkages between existing correctional facilities and community health services while addressing other social service needs. The CDP published a 2007 report that describes the development, implementation, barriers, and recommendations from the different models used in the projects. EnhanceLink, a later project that built upon the CDP, created a consultancy report that provides an overview of the CDP. This report discusses general related issues and challenges, data elements, ethical considerations, and an overall summary of lessons learned and best practices. Information from both reports, *Opening Doors: the HRSA-CDC Corrections Demonstration Project for People living with HIV/AIDS*[22] and *EnhanceLink's Consultancy Report*[23] as it relates to the CDP, is summarized below.

The major objectives of the CDP included:

- Increasing access to HIV primary healthcare and prevention services;
- Improving HIV transitional services between corrections and the community; and
- Developing organizational supports and linked networks of comprehensive HIV health and social services.

The goal of the CDP was to develop and evaluate models for linking networks of health services and correctional facilities for replication by other programs, institutions, and organizations. Effective models included activities such as clinical evaluation and treatment, prevention education, peer education, disease screening, counseling and testing, staff development and training, discharge planning, continuity-of-care case management, and prevention case management.[24] Through these various activities, CDP attempted to develop effective collaborations between three systems: corrections, the community, and public health.

Collaboration in Project Management

HIV services in correctional facilities must include collaboration and partnership building between corrections, community providers, public health, and most importantly, incarcerated individuals. Getting participation from incarcerated individuals in program design may be difficult, but it provides valuable insight into the services that are truly needed within and outside of corrections. Strategies for building partnerships with the community include leveraging pre-existing relationships between the state's department of health and community health providers and identifying CBOs that are able to consistently engage in the project. All in all, a review of the CDP programs showed a recurring theme: the most successful project management structures were those where one of the collaborating partners led program implementation, and a single individual within the lead organization was in charge of coordinating all project activities. The success of the collaboration heavily relied upon the commitment of those in leadership positions, such as the warden or medical director, at the partnering correctional facility.

Program Design

Within the CDP, all seven participating states implemented successful continuity of care programs in a variety of settings, in-

cluding state prisons, local jails, and youth service centers. One important finding from the successful continuity of care programs was that HIV was often not the most pressing issue for the incarcerated individuals. Other issues like housing, family reunification, employment, substance use disorders, and mental health treatment had to be addressed before participants were willing to consider HIV treatment and management. Programs must be holistic and address and prioritize the social issues participants face. Additionally program design must consider the myriad of policies that affect transition into the community, such as housing and employment prohibitions for ex-offenders who are felons. Public Housing Agencies are permitted to prohibit admission into the program for history of drug-related criminal activity, violent criminal activity, or other criminal activity that may threaten health, safety or right to peaceful enjoyment of the premises.[25] There is significant stigma related to hiring someone with a criminal record. Many employers ask if potential employees have been arrested or have a criminal record, and may decide not to hire someone based on that response. This common practice and stigma makes it difficult for previously incarcerated people with histories of nonviolent crimes to find employment.

For implementing the continuity of care programs, the seven grant recipients used a basic model that included the following elements:

1. One or more community-based organizations (CBOs) worked in the jail and in the community to link HIV-infected incarcerated individuals to services.
2. Case managers split their time between the jail and the community, or one set of case managers worked in the jail and another set worked in the community.
3. The case manager met with incarcerated individuals living with HIV at the jail at least one time before release to assess post-release readiness, and whether or not there were existing relationships with community providers, or if new connections were necessary.
4. The case manager developed a discharge plan that prioritized the particular services that the incarcerated individual needed and made appointments (ideally) or referrals (minimally) with providers in the community. If there was no time to make pre-release appointments for services, appointments for post-release case management were made.
5. In programs where there were two case managers, one in the jail and one in the community, the community case manager came to the jail to meet the incarcerated individual.
6. When possible, the case manager met the incarcerated individual at the jail gate at the time of release and escorted him or her to the first appointments or housing.
7. The community case manager worked with the previously incarcerated individual in the community to follow up on the discharge plan or make additional linkages to community services.

Each grantee designed its program to reflect their own individual local conditions and existing relationships. Some grant recipients used innovative strategies, including developing of a transitional housing program for three months of post-release housing, forming a partnership with shelters and transitional housing programs to ensure access to beds, collaborating with a major health center to establish a weekly clinic, and establishing diverse teams of social workers, case managers and peers to provide services.

It is important to consider the scope of the new project, including what services are already being offered and what services are available in the community. It is crucial to not over-promise what services can be delivered, as this can create or worsen a general distrust of service providers. Provided below is a checklist from the *Opening Doors* report for project development that takes these issues into consideration:

- What is the big picture?
- Who is already advocating for incarcerated individuals living with HIV?
- What is already being done for incarcerated individuals living with HIV?
- How is the jail organized?
- What existing community and criminal justice resources and structures can you tap into to strengthen your program?

CDP Project Spotlight: Massachusetts Department of Public Health

The CDP provided funding to the Massachusetts Department of Public Health HIV/AIDS Bureau (Massachusetts HAB), which implemented the Transitional Intervention Project (TIP). TIP built on the Massachusetts HAB-supported, pre-existing HIV-related services such as prevention, education, counseling, testing, and case management. TIP focused on the following activities:

- Intensive, community-based transitional case management for all previously incarcerated people living with HIV.
- Creation of a bridge between HIV services within correctional facilities and existing HIV services in community.
- Evaluation of the utility and feasibility of the TIP reintegration model.
- Provision of and improvement to chlamydia surveillance and treatment.
- A comprehensive, peer-led prevention and education program focusing on HIV, STIs, TB and hepatitis.
- HIV counseling and testing in juvenile corrections facilities, and referrals to appropriate community HIV services.

TIP services also included assistance with obtaining safe housing, establishing post-release medical treatment, obtaining health insurance, counseling on HIV treatment adherence, and locating mental health and substance use disorder services. Massachusetts HAB contracted with CBOs in six different service regions, and provided management, oversight, training, technical assistance and evaluation support. Massachusetts HAB worked with the CBOs to create eight TIP teams comprised of jail coordinators, infectious disease nurses, case managers and other correctional facility staff. TIP teams referred clients to the program during incarceration and then focused on establishing rapport with clients to develop relationships, assess their release needs, and implement client-specific service plans. Barriers to the utilization of TIP included the lack of privacy in utilizing the services during incarceration, fear of being "outed" and resulting repercussions of stigma and rejection by others, the complexities associated with medication adherence, underutilization of services and retention difficulties within TIP due to substance use disorder relapse, and territorial issues between community programs.

Recommendations for success from the TIP program include:

- Transitional case management is effective in meeting multiple needs, such as housing, substance use disorder treatment, etc., for successful transition to the community.
- Accessibility of case managers is important: ensure open access.
- Client retention and continuity is reinforced through program flexibility.
- Avoid gaps in services, which act as a barrier to care and can result in loss of clients.
- Due to high prison staff turnover, ongoing education of staff is necessary.
- Participation and support from parole officers is needed to explain the role of TIP case managers among incarcerated individuals.
- Attention must be paid to the emotional and support needs of case managers.
- According to clients, having a nonjudgmental, respectful, and accessible case manager is important to the success of the program.

Barriers to utilization of TIP:

- Lack of privacy in utilizing services during incarceration;
- The complexities of medication adherence;
- Fear of being "outed" and the repercussion of stigma;
- Substance use disorder relapse;
- Territorial issues between community programs.

To learn more about the CDP, see:

http://www.enhancelink.org/EnhanceLink/documents/ConsultancyReport_update012907.pdf

https://www.careacttarget.org/sites/default/files/file-upload/resources/openingdoors.pdf

Enhancing Linkages to HIV Primary Care (EnhanceLink)

Building upon the HRSA/CDC Demonstration Project, The Enhancing Linkages to HIV Primary Care & Services in Jail Settings Initiative (EnhanceLink) was a project launched by the HRSA, HAB, SPNS Program. It sought to fill the research void of evidence-based interventions for identifying high-need clients and best practices for linkage to care. It was funded to design, implement, and evaluate innovative methods for linking incarcerated PLWH into primary care. From 2007–2012, 10 grantees were funded, representing 20 separate jail sites. EnhanceLink tested 210,267 incarcerated individuals for HIV and 1,312 individuals tested positive. Of those 1,312 that tested positive, EnhanceLink enrolled 1,270 participants. From this pilot project, a training manual was produced that illustrates the effectiveness of jail linkage work, best practices, and necessary information to replicate and implement the work of demonstration models funded under the EnhanceLink initiative. That information is summarized below.[26]

Tips for Preparation: Laying the Groundwork

It is essential to lay the groundwork for a successful jail linkage program. Those interested in starting a new jail linkage program should first:

- Explore existing programs and other organizations working within the jail/prison to avoid duplication or starting an intervention without the capacity to complete it.
- Understand the culture of corrections: what is and is not permissible in those environments, cultural competency with incarcerated individuals, building trust, challenges to adhering to the Health Insurance Portability and Accountability Act (HIPAA), and implications to the proposed program.
- Secure buy-in and create partnerships:
  - Engage entire staff, first targeting high-level decision makers.
  - Host education sessions with corrections administrators about HIV.
  - Find and collaborate with key supporters like opinion leaders in the community (e.g., RWHAP Planning Council, consortia, consumer advisory board members, etc.).
  - Share information and goals up front to allow all parties a voice.
  - Use memorandums of understanding (MOUs) to document services, relationships and reportorial structures, paired with ongoing conversation and collaboration.
  - Tailor programs to your community and jail settings.
- Determine how data will be collected, stored, and analyzed.
  - Significant challenges to data collection include staff attitudes, chaotic jail environment during intake, criteria for testing, and timing of testing.

There are also important issues that need to be considered specifically when dealing with HIV testing and linkage programs in jail settings. Five central questions regarding privacy and cultural competency that need to be considered include:

1. How will testing be performed in a voluntary manner, in light of the new CDC recommendations that suggest incorporating testing into routine medical services?
2. How will testing be performed in a manner that is sensitive to the psychological impact of an incarcerated individual's learning for the first time his or her HIV status?
3. How will confirmatory testing be delivered within a brief time period, given the slightly higher false positive testing rate of rapid testing?
4. How will adverse events be monitored?
5. How will protected health information be shared in a manner that facilitates linkages but does not violate the Health Insurance Portability and Accountability Act (HIPAA)?

Tips for Getting Started

The EnhanceLink evaluation center identified strategies for building a strong and successful program. Appropriate and effective information sharing is critical to successful programs, and this includes having appropriate space for the program in the jail, coordinating the new programs with existing services, authorizing CBOs and health departments to work in the facility, and meeting security requirements. Major components of EnhanceLink activities included:

Appropriate Staffing

It is very important to have a non-judgmental and culturally competent staff because of the sensitive nature and stigma surrounding HIV status. EnhanceLink recommends that the staff include any pre-existing mental health staff and housing counselors in the jail, a health liaison or court advocate if possible, and someone to begin the process of coordinating care upon release and accompany clients to appointments. EnhanceLink also recommends that an effective referral system between medical staff and staff at partnering CBOs be established.

HIV Testing

Most EnhanceLink grant recipients were already engaged in HIV testing within jails using rapid HIV testing. However, organizations not already involved in HIV testing but looking to initiate a program should consider some important questions, included in a guide by an EnhanceLink grant recipient, Yale University School of Medicine:

- Is there a medical exam at intake or shortly after?
- Is there an opportunity to discuss HIV testing at orientation?
- Are there policies that would impede your ability to implement a new way of doing testing?
- Is there space to do the testing and to store supplies?
- Who will feel threatened by what are you doing? What can you do to minimize the sense of threat?
- How and where will they get their results?

Timing of Services and Interventions

With the short average length of stay, HIV testing should ideally be done within 24 hours of intake, or at least within 48 hours. As such, it is important to understand barriers and facilitators to HIV testing in correctional settings. The staff should be familiar with state laws surrounding HIV testing and informed consent. Policies where incarcerated individuals have to opt-out of testing rather than opt-in yield greater rates of testing. Privacy and confidentiality should be prioritized in order to make incarcerated individuals feel comfortable getting tested. Staff should determine private locations within the jail where HIV test results can be disclosed. If permitted, providing basic items like toothbrushes or socks can go a long way in increasing client willingness to participate, but testing must be voluntary and no one should ever feel coerced into it. If one incarcerated individual receives items, all incarcerated individuals should receive the same items. Before offering testing, EnhanceLink recommends that incarcerated individuals be asked about their HIV status in a private and sensitive manner to allow for self-disclosure. Those who do self-disclose should be engaged in a follow-up discussion about treatment.

HIV testing should ideally be done within 24 hours of intake, or at least within 48 hours.

Treatment and Adherence

Due to the short nature of jail stays, patients may not be placed on antiretroviral therapy (ART) until after release. However, even with the short-stay nature of jails, ART should be started as soon as possible, as immediate initiation is the standard of care.[27] If incarcerated individuals will not be able to start ART prior to release, they should receive education about ART before being released. If a patient is placed on ART, complex regimens with large pill burdens should be avoided. To avoid drug-drug interactions, the patient's other prescriptions should be examined and discussed with patients and medical providers. EnhanceLink recommends that the following topics be discussed when initiating treatment with incarcerated individuals:

- Benefits of HIV medication.
- Misconceptions about treatment.
- How medications work.
- Integrating regimens into daily life.
- Importance of adherence and consequences of nonadherence.
- Common side effects and how to manage them.
- Dosing and names of medications.
- Any food requirements and the effect of nutrition in medication absorption.

Risk-reduction Education

Risk-reduction education is important for those at high risk of infection but who may not be aware they are at risk, or for those who have little knowledge of HIV. Providing this education pre-release is important since the time following release has a higher likelihood for engaging in high-risk behaviors.[28] This education can be a formal curriculum or incorporated into support groups that are open to all incarcerated individuals to protect patient confidentiality. Considering that jail stays can be short, it may be best to condense topics into fewer sessions. Basic topics to cover include:

- HIV, STI, hepatitis and TB overviews.
- Strategies for prevention and safe-sex negotiation.
- Coping techniques.
- Communication strategies for talking with care providers and family.
- Conflict resolution.
- Nutrition information.
- Symptoms evaluation.
- Relapse prevention.
- Advance directives.
- Job training.
- Wellbeing, including exercise, journaling and spiritual needs.

Discharge Planning

For a successful connection to care post-release, it is important that action is taken from the beginning of the release process. Pre-release case management, retention strategies, and interaction with transitional services need to be prioritized. EnhanceLink recommends the following tips for effective discharge planning:

- Treat each session like it is the last; discharge within jails can be unpredictable.
- Listen closely to person's concerns and address them, especially triggers associated with poor decision-making. Use motivational interviewing techniques to prepare incarcerated individuals for release.
- Draft a discharge plan that documents needs and a plan to address each one. Once the release date is known, help the person complete an application for health insurance if needed.
- Some EnhanceLink participants found it useful to have a "to do" list included in their discharge plan that includes resources, partner organizations, important tasks, and relevant contacts.
- Collect multiple ways of reaching clients post-release. This can include the client's support system, information about where they hang out, their "street name" or nickname, and any identifying tattoos/markers.

Treat each session like it is the last; discharge within jails can be unpredictable.

Linkage Services

An important aspect of continuity to care is linkage services, which include post-release referrals to care, intensive case management, and follow-up. Formerly incarcerated individuals have many competing needs, to which HIV care may be a low priority. Successful interventions recognize that basic needs such as food, clothing, safe housing, and drug treatment and mental health support are priorities, and as such, they promote access and linkage in programs that address those needs. EnhanceLink makes the following recommendations:

- Formulate and strengthen relationships with community resources, creating supportive relationships between jail and community staff, and know what resources are available. These resources can include healthcare, housing, mental health and substance use disorder treatment, transportation assistance, food services, legal services, employment services and support groups.
- Case managers should offer more intensive and individualized services based on client need. This could mean focusing on housing, legal support, or securing identification.
- Case managers should meet releasees at the gate and provide transportation to appointments or transitional housing, as well as following up with them post-release.
- For those with substance use disorder, consider discussing risks of sharing needles and overdose prevention. Connect them with appropriate therapy such as inpatient or outpatient care or sober homes.
- If a client is lost-to-follow up, check re-incarceration first, and then shelters, drug and alcohol facilities, mental health facilities, hospitals, coroner's office, or where they live/hang out (depending on what they consented to).

Case managers should meet releasees at the gate and provide transportation to appointments or transitional housing.

10 recommendations from the EnhanceLink evaluation center to address re-integration into the community

1. All released individuals should be assessed for individualized treatment plans and linked to providers.
2. Program model should be designed to minimize or eliminate foreseeable barriers. For example:
   a. Transportation on day of release to transitional housing should be provided.
   b. There is utilization of a nonjudgmental staff that is trained in cultural sensitivity.
3. Primary medical care should be combined with dentistry and ophthalmology — two essential, unmet needs.
4. Case managers should collaborate with service providers to ensure continuing access to care.
5. Care settings should be chosen based on level of service, commitment and sensitivity to the community.
6. There should be coordination of care by case managers to ensure availability of services.
7. Treatment plans should be designed to improve patient's HIV medical status and address social service needs.
8. Intense relapse prevention efforts should be utilized through use of psychiatry and substance use disorder counseling.
9. Case managers and outreach workers should meet clients on their turf to "sell the service."
10. Project administrators and educators should market their program to other providers and collaborating agencies to disseminate information about available services.

For more information, see:

HIV/AIDS Bureau, Special Projects of National Significance Program. Training manual: creating a jail linkage program. Rockville, MD: U.S. Department of Health and Human Services, Health Resources and Services Administration; 2013. https://careacttarget.org/sites/default/files/file-upload/resources/Jail%20Linkage%20Program%20IHIP%20Training%20Manual.pdf

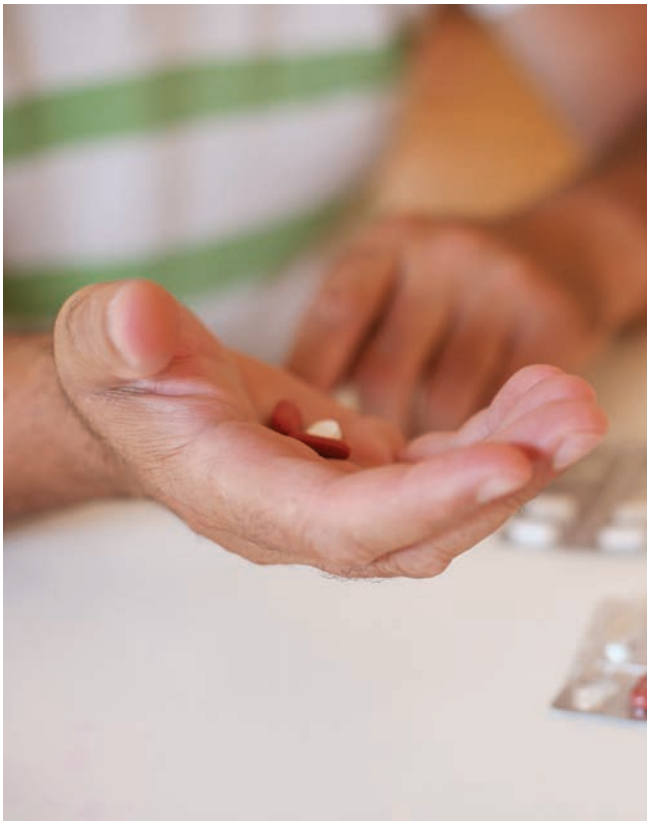
Project START Plus

Project START Plus is an adaptation of Project START, an individual-level, multi-session linkage to care and risk reduction program for PLWH returning to the community after incarceration. It is based on the conceptual framework of incremental risk reduction and provides tools and resources to increase awareness and reduce risk of HIV, STI, and Hepatitis.[ii] Pilot studies demonstrated that 100% of participants received their supply of medication, 75% received a prescription for their medication, 93% filled their prescriptions, and 96% were linked to HIV care in community. A fact sheet was produced, and key points are summarized below:[29]

Project START Plus began two months before release and continued for three months post-release.

Key Points

The Project START Plus program consisted of six one-on-one sessions with each client to help them smoothly reintegrate into the community and maintain HIV treatment. The program began two months before release and continued for three months post-release. The pre-release sessions focused on linkage to care, transitional needs, individualized risk behaviors and criminogenic factors (situations or factors that are likely to cause criminal behavior). Sessions included information and assistance with enrolling for health insurance, obtaining medical documentation for medications and prescriptions, referrals to social services, individual goal sheets, needs assessments, and post-release follow-up scheduling. The post-release sessions included meeting with participants within 48 hours of release at their community medical provider's location, assuring medication was obtained, assisting in making ongoing referrals and linkages to CBOs, reviewing and updating goal sheets, providing risk reduction educational materials, and transitioning the participants to longer-term care.



For more information, visit:

http://www.thebridginggroup.com/project_start.html

[ii] One quarter of HIV-infected persons in the U.S are also co-infected with Hepatitis C virus (HCV), and among HIV-infected injection drug users, HCV is common with 50-90% prevalence. HCV is one of the most important causes of chronic liver disease in the U.S, and liver damage progresses more rapidly in in HIV-infected individuals. The U.S Public Health Service/Infectious Diseases Society of America guidelines recommend that all HIV-infected persons be screened for HCV infection. (https://www.cdc.gov/hepatitis/populations/hiv.htm)

Philadelphia Linkage Program's Care Coach Model

With a focus on building relationships with clients, health providers, the criminal justice system, and community agencies, this ActionAIDS model was a linkage to care program that included two key staff positions: care coach and care outreach specialist. The care coach had smaller caseloads of typically 25 clients, and worked one-on-one with clients during incarceration and up to 24 months post-release, with services tailored to individual needs. Care coaches assisted in the transition from jail-based medical care to community based care and communicate with parole/probation officers to ensure client understanding of the legal parameters of their release. The care outreach specialist worked with a care coach, and served as an advocate, medical escort, and health educator, ensuring consistent collaboration between clients, care coaches and medical providers. The Care Coach Model delivered multi-tiered services with the engagement of community partners. Information from their report, Securing the Link, is summarized below.[30]

Considerations for Program Development

For the success of any correctional linkage-to-care program, it is crucial to establish relationships with key correctional facility staff and administrators. It is important for interested organizations to discuss how the proposed service program could be helpful, and should provide concrete research, program outcomes, and epidemiological data with these key staff and administrators. ActionAIDS, the Philadelphia ASO that created and coordinated the program, developed relationships with the following personnel:

- City commissioner of jails
- Chief of medical operations of the correctional facility
- Wardens, private contracted medical providers
- Infectious disease doctor of the correctional facility
- Jail social services
- Chaplain services
- Re-entry committee

It is also important to identify and develop relationship with community agencies and key community stakeholders:

- Community HIV medical providers
- Office of adult parole and probation
- Specialized courts within jurisdiction
- Local public health departments
- Substance use disorder treatment and recovery
- Mental health services
- Housing services

Programs should consider their existing HIV testing protocol and personnel who will be involved in the testing. It may also be helpful to consider hosting monthly collaborator meetings to create stronger ties among the partnering agencies. ActionAIDS utilized these monthly meetings, where the group spent approximately one hour discussing a client anonymously. This allowed the care coach to use this information to create a more in-depth service care plan. These meetings also led to stronger ties and expedited client appointments within the collaborating agencies. Transparency and clear program parameters are also two important components of program design and implementation, as well as understanding training and security clearance protocols and developing a standardized data collection system.

Steps to Program Implementation

Step 1: Program Referral Protocol

The ability to identify potential clients quickly is important for the success of a linkage to care program, due to the sometimes quick processing and release cycles. A program should develop a referral protocol that reflects the type of facility and average length of stay, and allows adequate and realistic time from referral to intake. Pre-release visits should also be coordinated to link individuals to case management services before release. In some cases, Compassionate Release referrals may be needed if hospice/palliative care would be more appropriate for an individual. Referrals to the Philadelphia Linkage Program were primarily made within jails through:

- Infectious disease doctors.
- Electronic medical records.
- Health services administrations.
- Jail social services.
- Hospice.

Referrals received from the community included:

- Community medical providers.
- Public defenders' offices.
- Medical case managers from other agencies.
- Family members and partners.
- Client self-referrals.

Step 2: Intake and Assessment

Upon referral, staff should conduct an intake session with the client at the correctional facility to introduce the program and staff, complete forms, and conduct a risk assessment. During the

intake session, the program staff should also review the service agreement and get ensure that the required client consent forms and agreements are completed. ActionAIDS developed the Acuity Vulnerability Screening (AVS) tool to refer clients to appropriate services and allocate services to those most in need. It was used to identify those with the highest need who were then subsequently placed in the longer-term Care Coach Model service. Those with less need were assigned to short-term linkage services. This assessment is conducted prior to release and repeated every six months for 24 months while the client is engaged in care services.

Step 3: Client Engagement and Pre-Release Visits

Correctional linkage-to-care programs are dependent on pre-release meetings with clients. Engagement between clients and staff builds a supportive relationship and facilitates conversations and change. It is optimal to prepare for release one to two months prior to release, but due to a lack of predictability, it is best to foster a relationship during every visit. It is important to have a clear and goal-oriented plan, and obtaining appropriate releases of information and completed applications will help expedite client's linkage-to-care upon release. In anticipation of possible high-risk activities clients may engage in upon release back into the community, case managers can facilitate discussions about harm reduction, overdose education, and secondary prevention during incarceration.

Step 4: First Day-Out Planning

The most important issue to address on the first day out is housing, and knowing what resource are available immediately is the key to ensuring linkage to care. The Care Coach Model provides the following considerations when planning for the first day of release:

- What is the correctional facility's release plan?
- Does the client have an appropriate and safe environment to go following release?
- What is the plan for follow-up with staff after release?
- Does the client need immediate food and clothing resources?
- Planning for access to medication at release, especially over the weekend, helps clients remain adherent to medications. Accessing a pharmacy that is familiar with your program and population can make this process easier.

Step 5: Immediate Post-Release Follow-up

It is essential for staff to make an immediate connection with clients post-release. They should meet with clients in their home communities or neighborhoods, or encourage walk-ins to the office. If the assigned case manager is not available, there should be a backup case manager or intake worker to see the client as soon as possible. The Care Coach Model provides 24-hour access to case management services through emergency, on-call coverage, ensuring that clients can be connected to services during evenings or weekends.

Step 6: Care Outreach Services

In the Care Coach Model, each client is also assigned a care outreach specialist. These are community health workers who serve as advocates, medical escorts, and health educators. They serve as a liaison between the client, case manager, and medical providers. Once the client is in care, the care outreach specialist completes their core appointments in 30 days. These include:

- Department of Public Welfare application.
- Social Security Insurance benefits application.
- Court cost and fines payment plan.
- Residency information obtainment.
- Identification obtainment.

Other services that may be necessary include phone services, mental health assessment and insurance navigation.

Step 7: Transitioning to Longer-Term Systems of Care

Successful and comprehensive linkage to care programs help PLWH transitions into long-term systems of care. The Care Coach Model works with clients for up to 24 months to be able to link them to more services and support their retention in care and medication adherence, until they are eventually transferred to general case management. Closure can be difficult, but it should be woven in to all sessions. It is helpful to have closure guidelines to best serve the client's needs.

For more information on considerations for program development and the steps of program implementation, see the ActionAIDS and AIDS United report *Securing the Link*:

https://www.aidsunited.org/data/files/Site_18/Resources/Securing%20Link/SIF16_SecuringtheLink_final.pdf

Change Team Model In Delaware Study

In 2008, the Criminal Justice Drug Abuse Treatment Studies (CJ-DATS) was launched by the National Institute on Drug Abuse (NIDA) to better understand the organizational issues that affect implementation of evidence-based services in correctional settings.[31] In response to NIDA's priority of HIV care improvements in correctional facilities, the HIV Services and Treatment Implementation in Corrections (HIV-STIC) protocol was developed.[32] This multisite research program conducted randomized trials to test the effectiveness of a change team process improvement model for improving HIV services in correctional settings, compared to a control that solely received a directive from correctional administrators to improve HIV services.[33] Both experimental and control groups received baseline training about the HIV service continuum, HIV prevalence and issues among offenders, and evidence-based HIV services in corrections for HIV prevention, testing, and linkage to care.

The project was composed of nine research centers each linked with a criminal justice partner organization. The criminal justice partner (typically an administrator from the criminal justice organization) decided on which aspect of the HIV services continuum needed the most improvement in their local system, such as prevention, education, and testing while incarcerated, and linkage to HIV care upon returning home. Guided by a modified NIATx (Network for Improvement of Addiction Treatment) process improvement strategy, a local change team consisting of frontline staff who work directly with the HIV services needing improvement was developed. The change process was facilitated by an "external coach" who was trained in the NIATx treatment model.[34] Among the participating organizations were the Center for Drug and Health Studies (CDHS) at the University of Delaware and the Delaware Department of Correction (DE DOC). These organizations decided to focus on improving linkage to HIV care for individuals returning home after release. The findings and lessons learned from their study, as found in *Improvements in Correctional HIV Services: A Case Study in Delaware*, are summarized below.[35]

The Change Team Model, Process, and Procedure

After the baseline training, the research staff, criminal justice partner, corrections facility sponsor (typically a DOC administrator), the head nurse for the contracted DOC medical provider and the NIATx coach came together to select the change team leader (CTL) and other members. According to the HIV-STIC protocol, the suggested qualities and credentials of the CTL include the ability to interact with all levels of management, lead-

ership, communication, delegation skills, experience making changes, energy, enthusiasm, ability to instill optimism, and a goal-oriented and systematic approach. For this site, the head nurse was chosen as the CTL, and other members of the change team included staff from a contracted substance use disorder treatment facility, other nurses, and representatives from a community-based HIV treatment organization.

The change team was then presented the NIATx model by the external coach. An important element to the NIATx approach is a "walk-through" of the service that the change team is seeking to improve.[36] This provides the opportunity to improve their understanding of what the client experiences when trying to access and participate in services. Experiences and findings from the walk-through were presented to the change team and information was then used to inform goals and develop strategies for improving service delivery.

Another important element of the NIAtx approach and the change team model was the rapid cycle testing approach, which included monthly meetings to discuss changes being made to address barriers using the "Plan-Do-Study-Act" concept:

- Plan: Team brainstorms ideas for a strategy to improve a process or service.
- Do: Team takes those ideas to action and works on implementing change.
- Study: Team tracks barriers, facilitators, and progress
- Act: Teams adopts, adapts or abandons changes depending on studied results.

The goal of these meetings was to engage in discrete and obtainable short-term process goals, which could be achieved in less time and burden. Once goals are met and progress is being made, meetings were reduced to once every other month.

Outcomes and Implications for the Future

During the study period, only five PLWH were released, making it difficult to measure improvement at the client level. However, the change team and walk-through led to improvements of the process for linking PLWH care upon release. Two successful outcomes included: (1) increased communication between the Department of Corrections (DOC) medical provider and the community HIV provider through a communication form containing information on individuals being discharged with HIV, their appointments in the community, and re-incarceration, and (2) significantly reduced discharge paperwork through the creation of a standardized form. The original six-page linkage to care discharge form mimicked exactly the forms the community HIV provider used. The change team was able to condense it into a one-page, specific form, usable by both the DOC and the HIV provider. Simple and efficient, this form was ultimately written into DOC policy.

The change team introduced an opt-out question for HIV testing to the medical intake packet, which substantially increased the number of HIV tests conducted.

Additionally, the change team introduced an opt-out question for HIV testing to the medical intake packet, which substantially increased the number of HIV tests conducted. These improved HIV testing procedures were not put into DOC policy, and thus staff training and buy-in of the new procedure is important for those facilities that do not have it as protocol.

Finally, the change team found that the HIV educational packet given to individuals at medical intake was outdated and written at a reading level that was too technical and advanced. The change team was able to update the material, format it to be appropriate for a fifth-grade reading level, and translated it to Spanish. These changes greatly increased access to the HIV educational materials. The updated packet was added to the required medical intake packets at each facility.

In conclusion, the NIATx model for implementing change provided participants with a process to implement changes, and evaluate changes from the start. The walk-through and change team process led to putting the community HIV provider and DOC medical provider in direct contact, which ultimately led to a more efficient and standardized process of linking incarcerated individuals with HIV to care in the community upon release. The walk-through and collaborative meetings opened the opportunity to identify barriers and improve them, such as expanding access to HIV testing and education.

Troubleshooting Q&A

What is the role of ASOs and CBOs in linkage to care programs?

As seen throughout this report, ASOs and CBOs played an integral role in all linkage to care programs and projects. For some, like Philadelphia's Linkage to Care program, the ASO Action-AIDS created and coordinated the program. In the change team model program, staff of ASOs were members of the teams and assisted with transitional needs assessments and linking clients to community providers. In the EnhanceLink project, the grant recipient varied; some were ASOs and some were departments of health. In the latter case, those organizations and facilities contracted with ASOs for varying needs such as transitional services such as housing or drug use disorder treatment programs, or for staff to act as case workers for the clients. Whether heading the creation and coordination of the program, or contracting with facilities or departments of health, ASOs and CBOS play an integral role in linking released individuals to the HIV care they need.

Linkage to care programs can be costly, how can we control costs and ensure cost effectiveness?[37]

The EnhanceLink interventions were found to be cost effective at an average cost of $4,219 per client. Some cost-effective practices proven by EnhanceLink:

- Have a case manager work closely with jail medical staff and engage in cross-cutting. For example, obtaining medical records from community clinicians to reduce lab work duplications and diagnostic evaluations.
- If a client is pre-trial, case managers be able to negotiate to have their home HIV medications to be given in jail.
- Coordination of medical records. By examining client's past charts and determining if they had been seen in the community previously, a case conference can be established between the community doctor and jail medical director to provide specialty care in collaboration.

The EnhanceLink interventions were found to be cost effective at an average cost of $4,219 per client.

What role should local or state departments of public health (DPH) play?[38]

An effective linkage program should be based on clarifying the role of the local DPH. Roles will vary depending on whether or not DPH provides primary care. If DPH is a health service provider, then it may be best to have DPH coordinate discharge planning.[39] In the case that DPH is not a health service provider, it may be more appropriate to have a community health center or AIDS service provider coordinate the incarcerated individual's discharge planning. However, key personnel within local DPH may be instrumental to program success by helping to provide connections to community-health service providers and providing epidemiological and surveillance data.[40]

What if the prevalence of HIV in communities and jails/prisons is low in my area?[41]

Areas with low prevalence will not be able to identify a large number of new PLWH in jails/prisons nor link a large number to care. However, the majority of jails across the country are small with low HIV prevalence, so it would be wise to develop models that work in those settings. One strategy may be to cluster jails or develop a consortium of jails that apply for a grant together.

How can we ensure successful data collection?[42]

There are many strategies that can minimize burden and help ensure complete, accurate data submission on the effectiveness of the implemented linkage to care programs:

- Consider and reduce burden to both incarcerated individuals and providers.
- Train providers to collect the data (develop a training curriculum, have update trainings, use train-the-trainer models).
- Make instruments similar in content and format to forms currently in use (as simple as possible).
- Compile list of frequently encountered problems with the completion of forms.
- Establish open communication directly with the providers.
- Secure buy-in and participation from all project partners.
- Establish consequences for the evaluators of incomplete data submission
- Ensure full access to medical records for program staff while simultaneously ensuring confidentiality: provide only information that necessary.
- Consider whether to provide monetary incentives for participants.
- Create a "culture of compliance" with evaluation protocols with support from funders.

What are some strategies to support individuals upon release?[43]

The time immediately following release is when clients are most vulnerable. It's important to address their priorities, and offer support. To avoid relapse, risk-taking behaviors, and ensure a continuity of care, EnhanceLink recommends:

- listening to their stories and concerns.
- asking open-ended questions.
- being nonjudgmental and encouraging patients to be honest about behaviors.
- understanding where patients are "coming from" and their priorities.
- providing transportation services where possible.
- providing referrals to necessary services, such as healthcare, food, housing, and clothing.
- scheduling a meeting with a case manager at the time of release, if possible.
- accompanying patients to their first medical appointment.
- supporting patients in meeting parole and probation requirements"

Post-release can get complicated, what are the first steps to take?

From Philadelphia's Linkage Program[44], some sample first steps that Care Coaches took after release are as follows:

- Call Correctional Health Services administrator to request client's discharge paperwork, including:
  - medication list, including current prescription of ARTs
  - discharge photo identification
- Update client locator information with current information, such as address and phone number.
- Schedule (or confirm) a medical appointment with the community medical provider.
- Submit prescriptions to client-preferred pharmacy, along with method of payment (Ryan White HIV/AIDS Program AIDS Drug Assistance Program (RWHAP ADAP), pharmaceutical patient assistance program, etc.)
- Check insurance status (through the use of your state's eligibility verification system).
- Submit applications for health insurance/RWHAP ADAP as needed.
- Complete RWHAP certifications and/or other applicable certifications for region.
- Link client with food and clothing resources.
- Link client with emergency shelter, if needed.
- Link client with substance use disorder and mental health treatment as needed.

Initial intake assessments have been made, and post-release plans have been established. What should be done during the remaining time the client is incarcerated?

Once all post-release plans are in order, during the period of incarceration case managers can facilitate educational discussions with clients as part of standard education in anticipation of possible engagement in high-risk activities upon release. Issues to focus on will be specific to each individual, but common topics include: ART medications, adherence, drug and alcohol resources, overdose prevention, mental health and trauma recovery, disclosure of HIV diagnosis, referrals for vocational services or General Educational Development (GED) programs.[45]

Internal precautions need to be taken within the correctional facility to protect the confidentiality of all individuals when they are called down for medical care services.

What are some ways we can take HIV and stigma into consideration?

If an ASO is coordinating the linkage to care program within corrections facilities, consider naming the program independently of the ASO, especially if your agency is identified as a community provider for PLWH, or has the words "HIV" or "AIDS" in the name. For example, ActionAIDS is a community-based ASO in the Philadelphia area. It called its jail services program the "Philadelphia Linkage Program" and all printed materials provided do not indicate that it is a program of ActionAIDS. Additionally, internal precautions need to be taken within the correctional facility to protect the confidentiality of all individuals when they are called down for medical care services.[46]

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Disclaimer

This publication was produced by the National Center for Innovation in HIV Care, The Fenway Institute, Fenway Health with funding under cooperative agreement #U69HA27176 from the U.S. Department of Health and Human Services, Health Resources and Services Administration, HIV/AIDS Bureau. The contents of this publication are solely the responsibility of the authors and do not necessarily represent the official views of HHS or HRSA.

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HIV AND AIDS CRIMINAL JUSTICE JAILS AND PRISONS

In Prison, Women Are 9 Times More Likely to Be HIV-Positive

The disparity between infection rates in incarcerated and non-incarcerated women highlights the deeply unequal state of our criminal-justice system.

By Akilah Wise

NOVEMBER 24, 2017

A woman sits handcuffed after arriving at the Los Angeles County women's jail. *(Reuters / Lucy Nicholson)*

Men are roughly four times more likely to be diagnosed HIV-positive than women in this country. Unique in the world, the United States HIV crisis still primarily affects gay and bisexual men, particularly young, black, gay men. In 2014, gay and bisexual men accounted for an estimated 70 percent of the 37,600 new HIV infections in the United States, according to the Centers for Disease Control and Prevention. Women, on the other hand, account for only about one in five new HIV diagnoses.

The one place where women's HIV prevalence reaches and sometimes exceeds that of men is in our jails and prisons. Though the percentage of women in state and federal prisons with HIV has been on the decline for nearly two decades, the rates still far outpace the national averages: According to the most recent numbers from the Bureau of Justice Statistics, which collects data from inmates in state and federal correctional facilities, 1.3 percent of female inmates are HIV-positive. If that doesn't sound high,

consider that the HIV infection rate for the general female population is only 0.14 percent. That means that women in state and federal correctional facilities are over nine times more likely to be HIV-infected than women on the outside.

And those numbers don't even account for what can be higher rates of HIV infection among women in jails. While prisons generally hold people convicted of felonies for sentences that are longer than one year, jails—the roughly 3,000 county or municipality-run detention facilities in communities across the country—temporarily hold people arrested but not yet convicted of a crime. Most incarcerated women today are in jails, and jails are transient places, with people constantly moving in and out. HIV-prevalence rates are often much higher in jails than they are in prisons—one study that reviewed jail health records from 2009–10 found that 9 percent of newly incarcerated women in New York City jails were HIV-positive.

"Jails and prisons are places where a disproportional number of HIV-infected women end up, primarily because both HIV and incarceration target those who are poor," says Dr. Anne Spaulding, an infectious disease physician who has provided care for women and men with HIV and hepatitis C in prisons and jails for the past two decades.

What accounts for this glaring disparity? For one thing, the number of women in jail, prison, and on probation is ballooning. More women than ever before are being sent to jail and prisons, and the growth has largely impacted the most socially and economically disadvantaged: black women, Latina women, and women living in poverty.

Women in jails are now the fastest-growing incarcerated population in the country. Among women, rates of state and federal imprisonment were highest for adult black women ages 30–34 years (264 per 100,000), followed by Latina (174 per 100,000), and white women (163 per 100,000). Black women were between 1.6 and 4.1 times as likely to be imprisoned as white women of any age group. Thanks to stricter drug-enforcement laws and expanding law-enforcement efforts, the case of incarcerated women and HIV is truly one in which social, economic, racial, and gender inequity have created multiple, intersecting challenges for women who often lack robust social safety nets in the first place.

The types of activities and circumstances that are putting more women into contact with law enforcement are the same ones that are also putting them at increased risk of HIV infection. Women in state and federal prisons are more likely to be incarcerated for drug and property offenses than their male counterparts. Incarcerated women are more likely to have substance-abuse issues and report more frequent drug use and use of harder drugs compared with incarcerated men, according to the Bureau of Justice Statistics. Needless to say, substance abuse has been linked to HIV through several mechanisms, most notably through shared needles among injection-drug users.

Women who exchange sex for money, food, shelter, or drugs are also at a greater risk of being arrested, street-based workers much more so. According to one study of women in Rhode Island Department of Corrections facilities, 27 precent of respondents reported having engaged in sex work. This study found that prior sex exchange was also linked to

physical abuse, injection-drug use, and crack cocaine use—all of which are associated with an increased HIV-infection rate.

Systematic inequities are therefore at the root of incarceration and HIV for women. The behaviors that lead women to incarceration and HIV are rooted in poverty, traumatic childhoods, and sexual and physical abuse at the hands of sexual partners, who are often at risk of HIV infection too. Studies suggest that illegal activity, like sex work and drug use, are often introduced by male partners in intimate relationships. According to the report by the Vera Institute of Justice, 86 precent of women in jails have experienced sexual violence in their lifetime. Black women experience elevated domestic violence rates compared with their white and Latina peers, at a rate that is 20 precent higher than white women.

Abusive partners can force low-income women to lose employment and housing through battery and harassment. With an abusive partner, it's very difficult to negotiate a healthy sexual relationship that would prevent a sexually transmitted disease like HIV. Women who have been incarcerated are also more likely to have had sexual partners who have also been incarcerated. I was one of a team of researchers at the Centers for Disease Control and Prevention who published a study in this year's *Journal of Acquired Immune Deficiency Syndromes* that found that women with a history of incarceration were more likely to have partners who had been incarcerated too.

Because we have for decades used our criminal-justice system to handle the mental-health needs of the most vulnerable Americans, our incarcerated population as a whole is disproportionately burdened with a slew of chronic diseases and mental illnesses. But women in the criminal-justice system are much more in need of mental and general health services compared with men. For women, HIV is just the tip of the iceberg of elevated rates of physical and psychiatric conditions, which several studies indicate are higher than among men. The same study that found such high rates of HIV among female inmates in New York City jails also found high rates of chlamydia (6.2 percent) and gonorrhea (1.7 percent), in which sex workers (6.5 percent of the sample) had more than twice the odds of having chlamydia.

The fact that our most disadvantaged women can be found in jails and prisons, physically and mentally ill, represents a deep failure on the part of the United States. Nearly 80 percent of women in jails and over half of women in prison are mothers—providing quality rehabilitation for women who need it most would benefit these women, their families, and their communities. "When you incarcerate a person, you're affecting their family as well," says Dr. Spaulding.

Unfortunately, most women's correctional facilities are underfunded, and the type of care that inmates receive while in jail and prison varies widely from facility to facility. "Although incarcerated people have a constitutional right to health care, there are no mandatory standards of care and no mandatory oversight," says Dr. Carolyn Sufrin, assistant professor in gynecology and obstetrics at Johns Hopkins Medicine. Sufrin, whose research focuses on reproductive-health care for incarcerated women, says that "with any health care service, including HIV care, how it is dealt with in prisons and jails

depends on which prison or jail you are at. Every prison and jail has its own approach to screening, treatment, counseling, continuity, and comprehensive care."

Many facilities are therefore increasingly abrogating their rehabilitative responsibilities, especially when it comes to assisting newly released inmates in returning to their communities.

"Some prison systems try to save money by decreasing the number of weeks of medications they provided to people with HIV at discharge—from four weeks' worth to two weeks'," says Dr. Spaulding. "That's penny-wise and pound-foolish, especially in a community where the wait for a new appointment in an HIV clinic can take up to several months."

So how do we fight this crisis? Diverting women who have experienced the unfortunate confluence of poverty, trauma, and substance abuse to mental-health and drug-treatment services can minimize their risk of being incarcerated at the outset. Providing impoverished women and their families with adequate housing and social services can mitigate the relationship between poverty and hazardous, illegal activities.

For women who are already in jail or prison, high-quality comprehensive health and education services can simultaneously promote HIV-risk reduction and treat HIV-infected women. Initiatives that promote drug and mental rehabilitation and healthy reentry into communities can reduce recidivism.

"From the perspective of virus suppression, people with HIV can do quite well when inside [jail or prison]," says Dr. Spaulding. "What needs more attention is when they get out, the transition from jail or prison back to the community—that needs more attention from public health. On a systems-level, health-care planners can think more about how health care transitions occur."

Cooperation between community clinics and correctional facilities could facilitate healthy reentry into communities for released inmates who are HIV-infected, which can ensure they are able to continue their anti-retroviral treatment and reduce further transmission.

We can't expect this problem to go away by continuing to lock up the vulnerable and the needy. The money we're spending on incarcerating women would be much better spent on efforts to prevent their initial introduction to the criminal-justice system, and reduce their risk of HIV infection: adequate housing, robust responses to domestic violence, and social services that provide hope for their future.

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