

Corrections and Community for Continuity of HIV Care Upon Re-entry

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CONFERENCE
ON HIV CARE & TREATMENT

Background

- Facilitating continuity of care for persons re-entering the community from incarceration prior to release is critical for reducing community transmission.
- The prevalence of HIV/AIDS among those incarcerated is higher than the general population.¹
- Of the 31,630 living with HIV in Maryland in 2019, there were 2.3% in a correctional facility at diagnoses.²

DATA MATTERS

- SOAR client data tracked in CAREWare
- SOAR data barriers in RWHAP are:
 - Timely information from Department of Public Safety and Correctional Services (DPSCS)
 - Transitioning from Excel tracking sheet into CAREWare
- Inadequacy of data entered / reported in CAREWare
- Generic data errors

1. Kassira, E.N., Bauserman, R.L., Tomoyasu, N., Swetz, A., Solomon, L. June 2001. *HIV and AIDS Surveillance Among Inmate In Maryland Prisons*. Journal of Urban Health: Bulletin of the New York Academy of Medicine. Vol. 78, No. 2. <https://doi.org/10.1093/jurban/78.2.256>
2. Maryland Department of Health. 2019. *Corrections Fact Sheet*. <https://phpa.health.maryland.gov/OIDEOR/CHSE/Pages/statistics.aspx>



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Method Model

SOAR (Support Outreach And Re-entry) MODEL FUNDING

- The Baltimore City Health Department (BCHD) funds sub-recipients under RW Part-A Minority Aids Initiative (MAI) grant.
- Ryan White provides SOAR program funding to four (4) sub-recipients.
- SOAR provides services to clients in facilities throughout all regions of Maryland:
 - Baltimore Region (10 facilities)
 - Cumberland Region (2 facilities)
 - Eastern Region (4 facilities)
 - Hagerstown Region (3 facilities)
 - Jessup Region (9 facilities)



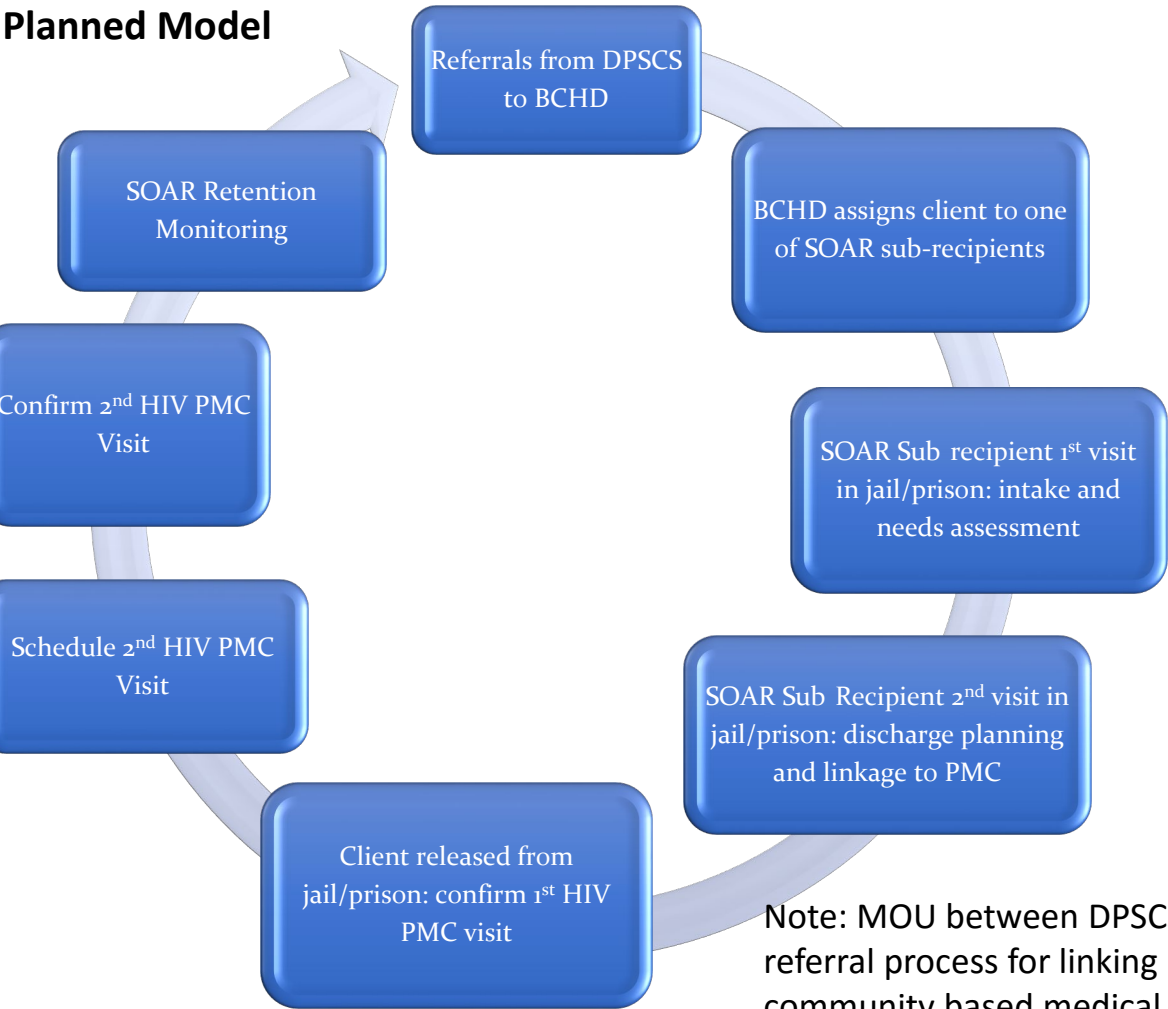
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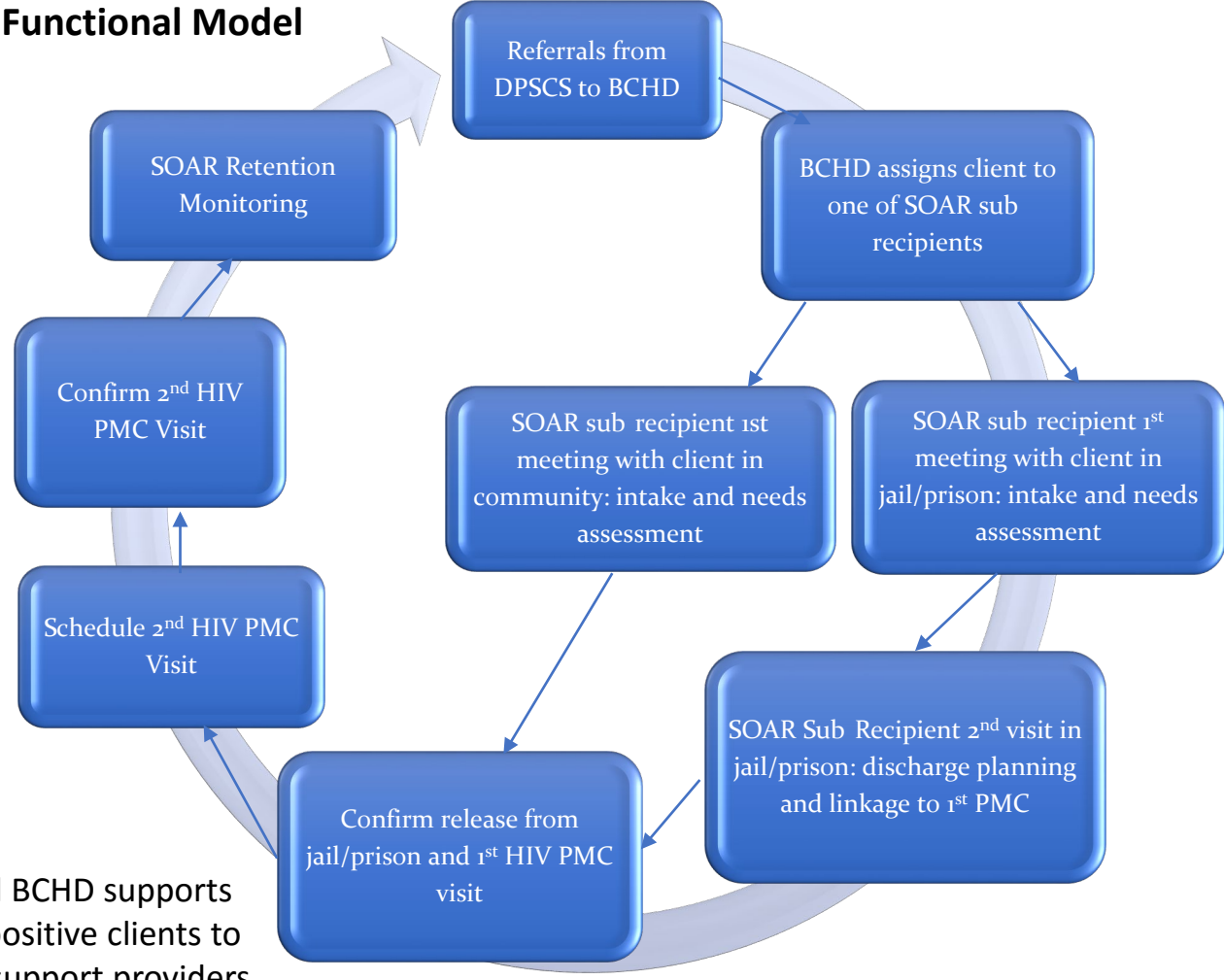
Method & Material

OBJECTIVES
To demonstrate and document how correctional system community health provider partnerships can increase HIV care linkage.

Planned Model



Functional Model



Note: MOU between DPSCS and BCHD supports referral process for linking HIV positive clients to community based medical and support providers.

Demographics

Age	Percent	Race/Ethnicity	Percent	Gender	Percent
24 & Under	3%	Black/African American	72%	Male	85%
25-44	62%	Caucasian/White	10%	Female	9%
45-64	34%	Hispanic	1%	Trans M-F	4%
65+	1%	Other	1%	Trans F-M	1%
		Not Specified	1%		

Race by Gender	Male	Female	Trans MtF	Trans FtM
Black/African American	74%	50%	100%	0%
Caucasian/White	9%	33%	0%	0%
Hispanic	2%	0%	0%	0%
Other	2%	0%	0%	0%
Not Specified	14%	17%	0%	100%

- FY21 Population (n) = 68
- 96% of clients were between ages 25-64
- Males made up 85% of the clients in the data period
- Black / African American was the largest race documented in data

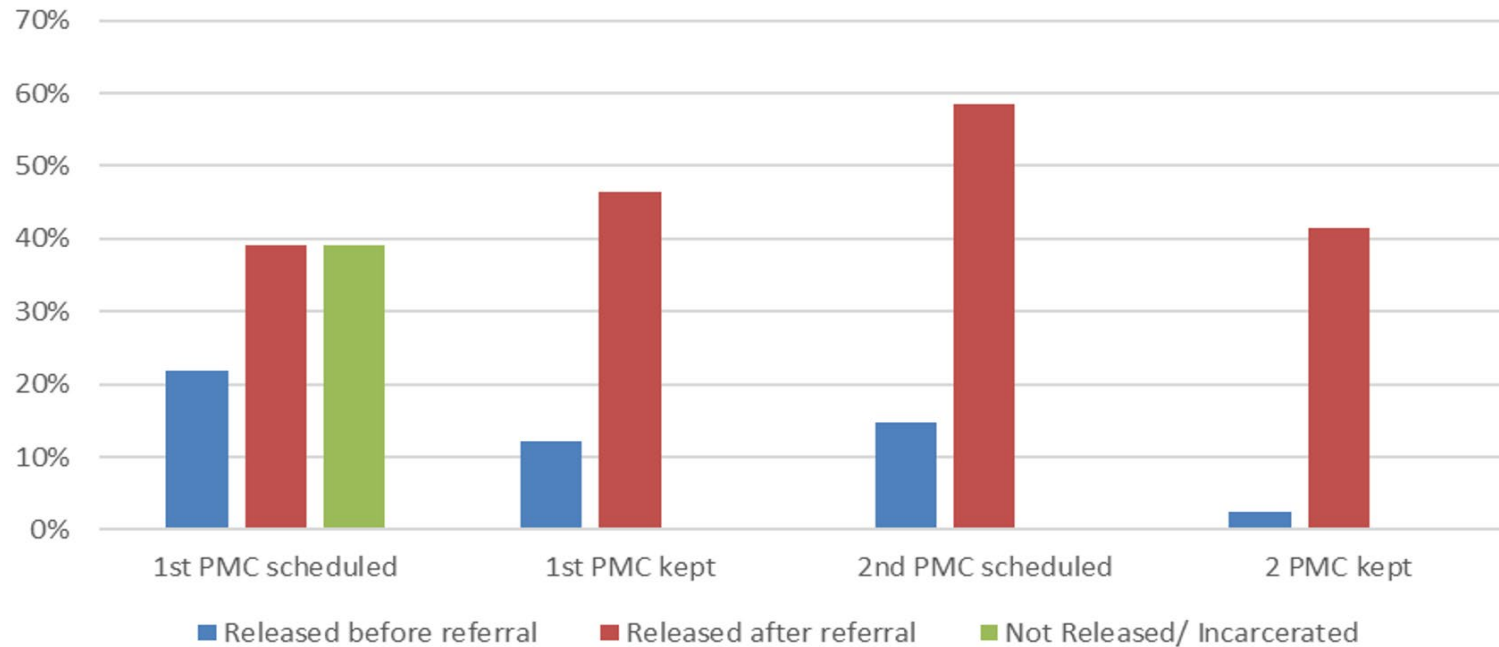


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Results

Continuity of Care Upon Re-entry



Clinical Outcomes

SOAR clients linked to outpatient ambulatory providers in the EMA were identified by clinical data and outcomes.

- **Retention in HIV medical care: 23/45 = 53%**
 - Clients with two or more metrics of care at least 90 days apart (outpatient visit, viral load, or CD4 count)
- **Viral Load Suppression: 29/40 = 72.5%**
 - Last viral date and result ≤ 199 copies m/L



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Conclusion

Lessons Learned

- Clients that were referred to SOAR before being released from incarceration had greater linkage to PMC in the community.
- The referral model required modification to include clients that are released from detention prior to the request completed.
- Adjusting the model to engage persons released prior to DPSCS completing referrals to BCHD helps with successful PMC linkage.

Challenges / Barriers

- Referrals for linkage sent to SOAR from jails/prisons after persons are release.
- Initial intakes and discharge plans occurred by conference call and/or virtual meetings due to COVID.



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