**Policy Brief**

**ENHANCING LINKAGES TO HIV PRIMARY CARE AND SERVICES IN JAIL SETTINGS INITIATIVE: HIV TESTING IN CORRECTIONAL FACILITIES**

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**CURRENT STATE OF AFFAIRS**

Over 1 million individuals in the United States are infected with HIV and approximately twenty percent are unaware of their infection. New infections occur daily, primarily as a result of undiagnosed infection. Routine HIV testing has been recommended for over a decade for all pregnant women and has nearly eliminated infections passed from mother to child. In 2006, CDC expanded recommendations to include routine testing at least once for every one 13-64 years old and annually for those with high risk behaviors. The 2009 guidelines recommend implementation of routine HIV testing in correctional facilities.

Screening for HIV infection has similar health benefits as screening for high blood pressure and diabetes, and should be included in routine health screenings. Similar to so many other health issues, minorities are disproportionately affected. Nearly 75% of HIV infections occur in men and HIV affects minority men more than any other subgroup of the population. Among women, African American women have five times the rate of infection as their Caucasian counterparts.

Correctional facilities offer a unique opportunity to address the health status and lives of the individuals that pass through them. Individuals, for the first time may address their health needs, substance abuse treatment, mental health issues and screening for STDs, HIV and hepatitis. Given the significant overrepresentation of minorities among the incarcerated and among individuals with HIV, it would be expected that the prevalence in jails would be notably higher than it is among the general population.

**BACKGROUND**

HIV rates vary geographically, however, among the general US adult population HIV prevalence is currently 0.5 percent. Individuals living with HIV interact with correctional facilities at a far greater rate than the general population… Correctional facilities offer a unique opportunity to affect the health status and lives of those that pass through them.

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Over 1 million people in the United States are HIV+

Over 20% of individuals with HIV are not aware of their infection

1 in 7 HIV+ individuals pass through corrections annually

In 2006, CDC expanded recommendations to include routine testing at least once for everyone 13-64 years old and annually for those with high risk behaviors.

"Individuals living with HIV interact with correctional facilities at a far greater rate than the general population… Correctional facilities offer a unique opportunity to affect the health status and lives of those that pass through them."

HIV rates vary geographically, however, among the general US adult population HIV prevalence is currently 0.5 percent. Individuals living with HIV interact with correctional facilities at a far greater rate than the general population. Furthermore, the Bureau of Justice Statistics bulletin reports the HIV prevalence among state and federal prison inmates averages 1.5% with notably higher rates in some areas such as New York. Although there is no standard report for HIV rates among jails, when HIV programs exist, the prevalence are usually similar to their prison counterparts.

Most prison inmates have previously spent time in jail. In fact, 95% of detainees just pass through a jail and do not move on to a prison. It has been noted that 1 out of 7 HIV+ individuals pass through a correctional facility each year. However, HIV testing in correctional settings varies from mandatory to nonexistent with most facilities somewhere in the middle. When HIV testing programs have been initiated, they have been accepted by inmates and staff at far greater rates than anticipated.
BENEFITS OF ROUTINE HIV TESTING IN CORRECTIONS

Effective treatment of HIV in prisons has dramatically decreased AIDS-related mortality. Identification of HIV offers cost savings to correctional facilities by avoiding costly complications and hospitalizations of individuals with unrecognized and untreated disease. HIV testing in correctional facilities offers at-risk individuals the opportunity to address a treatable chronic disease both while incarcerated as well as upon release to the community.

Life saving medication is available to individuals diagnosed with HIV and allows them to lead productive and healthy lives while decreasing their infectiousness to others. Awareness of one’s HIV infection often results in safer behaviors such as decreased number of sexual or needle sharing partners, safer sex, as well as self imposed abstinence. This combination of medical treatment and behavior modification interrupts transmission among those aware of their infection and makes both the correctional facility and the community safer places.

This same life saving medication prevents transmission when occupational exposures occur thus providing a benefit to correctional staff. As officers often collide, sometimes violently with detainees, knowledge of an inmate’s HIV status would improve the care and lessen a time lapse in treating the wounded officer appropriately for an occupational exposure if HIV status is known.

In addition to improving the health and safety of the community, once an individual is identified as HIV+, local health departments will locate his or her partners and provide testing and referral services so that affected members of the community may also access life saving treatment and disease related education. This type of communication service further extends the benefit of HIV testing in jail into a benefit for the community.

Routine testing for HIV normalizes the disease and creates a safer environment for inmates who are aware of their status to disclose it to correctional healthcare providers.

MODELS FOR HIV TESTING IN JAILS

Currently, there are numerous models for HIV testing in corrections. A successful program depends on the availability of resources and the interest of stakeholders. All correctional facilities employ medical staff who could perform HIV testing but often they are overburdened with existing workload obligations. Frequently, healthcare workers who are less familiar with HIV testing perceive it to be more time consuming than it actually is once procedures are in place, and this may contribute to initial staff resistance.

In both large and small facilities, local health departments often provide support, which can range from comprehensive responsibility for the entire program to only providing HIV testing kits and training.

In addressing public health issues, HIV is a high priority for many local and state health departments. This makes them logical partners in garnering support for a testing program; however, potential funding from health departments can be unpredictable and most health departments would not be able to completely support a jail testing program.

Partnering with a community based organization (CBO) to provide HIV testing is another option. Community based health clinics and health service organizations often provide HIV prevention outreach and testing in the community and may even provide HIV related health care. A partnership with a CBO provides immediate expertise in the area as well as access to transitional health care needs upon release. Jails can utilize both their staff and outside staff to implement testing and care.
TESTING MODALITIES

Rapid testing is a “match made in heaven” for some jail environments, especially the smaller ones. Rapid test kits are administered on site and do not need a special license or extensive training. All types of rapid tests take 20 minutes or less from start to finish. This allows inmates to get their result immediately rather than requiring jail staff to track them down later. Most commonly, an oral swab or finger stick is done rather than a blood draw. Any reactive test still needs further testing but negative tests do not.

Traditional testing also remains a viable alternative to rapid testing. Traditional tests require a blood draw but may be processed in bulk on automated systems in certified labs. This testing usually is processed by an outside lab and typically, results are not available for at least several days. This modality may be preferred if testing is being done with inmates with expected stays of a week or more or if blood is already being drawn for other purposes.

The costs of rapid and traditional HIV testing may vary by region and institution but generally the costs are less than $20, and perhaps less than $10, per test depending on the type of testing performed.

LOCATION, LOCATION, LOCATION

Booking and intake are ideal places for systematic implementation of rapid testing and this is being done in many jails across the country. Limitations of testing at booking include detainees’ state of mind (possible inebriation, emotional distress, or not interested in being HIV tested at that time due to the turmoil of the incarceration) as well as the jail limitations in staffing and space.

The National Commission on Correctional Health Care and the American Correctional Association recommend that a health assessment be completed by day 14 from the booking date. This health assessment is another ideal setting for HIV testing, where HIV and other chronic illnesses may also be diagnosed and addressed. At this time, the legal and social issues may be less prominent and detainees may be more interested in their health status. On the other hand, many inmates will have been released by this time and would be missed if this is the earliest time the test is offered.

Finally, with the literacy and comprehension limitations of many detainees, many programs also have used in-reach and health education sessions as a strategy to increase HIV-related knowledge and offer testing.

“Booking and intake are ideal places for systematic implementation of rapid testing...[the] health assessment is another... All types of rapid tests take 20 minutes or less from start to finish. This allows inmates to get their results immediately...”
**Authors**

Ann Avery, MD is the Principal Investigator of the ATLAS program at Care Alliance Health Center in Cleveland, Ohio.

Dorothy Murphy is Co-Investigator of Enhancing HIV Care Linkages for Women in Jail at the University of Illinois at Chicago and Cook County Jail in Chicago, Illinois.

**About the Initiative:** Enhancing Linkages is a multisite demonstration and evaluation of HIV service delivery interventions for HIV+ individuals in jail settings who are returning to their communities.

The Enhancing Linkages Initiative is sponsored by:

- US Department of Health and Human Services
- Health Resources and Services Administration
- HIV/AIDS Bureau
- Special Projects of National Significance

**Anticipated Issues**

**Cost:** The cost of HIV testing personnel, medications and supplies may be prohibitive in many jurisdictions. Many jails, large and small, find it beneficial to partner with community based organizations and local health departments. These partner agencies may be able to support rapid testing programs through provision of test kits, personnel or direct funding. Once cases are identified, many areas have federally funded programs that care for individuals with HIV and these are invaluable resources for HIV medication and care, such as the Ryan White programs.

**Stigma:** When HIV testing is provided in a primary care setting, along with other routine medical services, it may help to reduce stigma associated with targeted testing based on self-disclosed high-risk behaviors. This may be especially relevant in a correctional environment where there may be perceived harms to disclosing high-risk behavior information. For example, inmates may have concerns about the effects of disclosure on sentencing, court outcomes, response of custody staff and other inmates.

**Routine Testing**

Routine opt-out HIV testing in jails is feasible and improves the health and wellbeing of inmates both in and out of the correctional facilities. For the reasons above, it is supported by: The US Department of Health and Human Services/Centers for Disease Control * National Commission on Correctional Health Care * Society of Correctional Physicians * National Minority AIDS Council *

As well, for this reason, the US Department of Health and Human Services (DHHS) Health Resource Services Association (HRSA) has funded a four year project for ten demonstration sites to model programs of HIV testing and linkage to care. For details on the Enhancing Linkages project, see our website: www.EnhanceLink.org

This policy brief is written by persons associated with this project.

**References**


Enhancing Linkages to HIV Primary Care and Services in Jail Settings Initiative. Website. Available at: www.enhancelink.org


Policy Brief

Enhancing Linkages to HIV Primary Care and Services in Jail Settings Initiative: Linkage to Social Support Services

Special points of interest:

- Barriers to appropriate linkages include the conflicting missions of the correctional system and public health initiatives.
- System-wide barriers include: disease stigma, lack of knowledgeable personnel, lack of coordination between medical and social service providers.

“Social services effectively become a durable link for released inmates to gain entrance into and remain committed to coordinated HIV clinical care, supportive services, and risk reduction.”

Discharge to the Streets: Re-integrating the HIV+ County Jails

Ten sites in a Special Projects of National Significance (SPNS) Health Resources and Services Administration (HRSA) Initiative (funded September 1, 2007 to August 31, 2011) have initiated Innovative Demonstration Models of HIV Testing and Linkage to Care and are utilizing a variety of social service interventions to implement re-integration into community life for HIV+ individuals.

Social services effectively become a durable link for released inmates to gain entrance into and remain committed to coordinated HIV clinical care, supportive services, and risk reduction. The SPNS multisite evaluation study seeks to examine linkages to HIV-clinical care as one measure of successful outreach.

To ensure timely linkages into clinical care, social services are utilized and further enriched with enhancements that may include, but are not limited to, case management and outreach, substance abuse treatment, transportation, food, shelter, phone cards, and clothing.

Needs Assessment: Current Problems

Targeted county jails cannot meet all identified needs

Jails often lack the incentive or resources to deal with the multi-faceted needs of HIV+ inmates requiring appropriate discharge planning. Inmates are stigmatized; left with no supportive counseling for housing, mental health, substance abuse, HIV care and services or employment, HIV education, testing for HIV disease and linkages into medical care are either not available, sporadic in availability, linked to an accident or trauma, or openly avoided due to the resulting costs that HIV disease management may introduce into already strained budgets.

Barriers to care that predominate within the jail environments also exist upon discharge. Basic needs such as establishing identity; finding shelter, clothing, food, and

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transportation; dealing with mental illness or the stress of domestic chaos and ostracism overshadow the need for medical care. Pursuing a seamless continuum of adherence to HIV care with these unresolved stressors would be a miracle without designed and concerted efforts that are rooted in social networking through a variety of social management systems.

Critique of policy options

In an ideal world, HIV education, appropriate counseling, discharge planning, and reintegration programs for inmates from county jails would be structured and comprehensive. Corrections treatment team members, parole staff, discharge planners, case managers, clinicians, and other linked social support personnel would convene to develop discharge and reintegration work plans specific for the HIV+ inmate’s medical and social acuity. However, structured discharge and reintegration planning is often lacking. In an attempt to deal with the unexpected, this brief suggests the need for flexibility and resourcefulness among all professionals involved in an inmate’s discharge. It also encourages immediate responses to find alternative solutions when customary linkages are unavailable.

The support provided by linkage to social support services helps to deploy case management and outreach worker models, which are community level interventions used to provide supportive services to the targeted county jails in order to address the needs of people with HIV disease who are currently incarcerated and reintegration efforts from the moment of discharge ("Connecting to Care: Addressing Unmet Need in HIV" AIDS Action Council, 2003). Key characteristics of this demonstration model are the outplacement, or deployment, of case managers and outreach workers to assess and refer HIV+ inmates to medical and community-based services in both urban and rural settings to insure successful reintegration back into independent living and community life. Funding may not always be available for ideal staffing, but working through a conceptual framework of the options may help to link the inmate into all of the needed services.

Strategies employed in the demonstration models

Be creative with your case managers. This can be within the jail setting or initiated in the transitioning process that exists between the jails and other AIDS service organizations at the point of discharge. Case managers within jail systems, or working with jail administrators during the inmate’s stay within the jails, help to monitor and link clients into appropriate medical care, substance abuse and mental health treatment, legal and parole requirements, and supportive services in their local communities. The goal of initiating social services at the point of discharge is to appropriately link multiple service providers to a client to achieve successful reintegration into the community; maintain healthy behaviors including adherence to HIV care; reduce risky behaviors; and reduce recidivism.

Strategies built upon prior experiences with the target population

Exposure to high-risk places, persons, and situations occurs over-night as inmates move from controlled environments to almost complete freedom, with few having developed relapse prevention skills during their incarceration to deal with these risks. Assessment and planning can be structured to address identified risks and provide coping solutions to reduce recidivism. This

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Successful reintegration depends heavily on the availability of treatment options and the ability to access those options within the community. Inmates with mental illnesses are more likely to have been homeless before incarceration and to be homeless upon discharge. The evolving triad of HIV disease, mental illness, and addictions is often complicated by other co-morbid health, social, and economic issues. Comprehensive reintegration planning can incorporate mental health assessment and treatment planning. Mental Health assessment and treatment planning ideally should take place prior to discharge and should be done by collaborations between jail primary care providers and the psychiatrist/consultant.

Employment opportunities are limited. Many communities will not hire ex-offenders, and felony convictions often preclude the newly released inmate to find employment. Illiteracy and lack of job skills can also put the ex-offender on the defensive when looking for employment. Efforts to link the discharged inmate with durable wage earning positions should deal with the medical acuity, substance abuse and mental health status, job readiness training and educational skills of the client, along with discrimination found among employers.

Family can be welcoming or the first barrier to reintegration. The psychosocial assessment for family reintegration should start during the period prior to discharge. Upon discharge the family can be the first link to durable housing and stability. Domestic chaos or the lack of compassionate family can set the stage for relapse into drug addictions or crime. Family issues need to be identified and addressed prior to discharge and/or throughout the reintegration process.

Housing may be the number one stumbling block if the released inmate lacks family contacts or economic capacity for rental units. Associations between lack of housing and lack of adherence with HIV medical care speak of the dire need to have clean, safe, and affordable housing for all clients living with HIV/AIDS. Homeless shelters may be the only resort for many former inmates in need of housing, but they too, are not always available.

“Housing may be the number one stumbling block [to reintegration] if the released inmate lacks family contacts or economic capacity for rental units.”
Authors

Jean Porter is the Principal Investigator and Program Manager of Enhanced Correctional Care (ECC) at AIDS Atlanta in Atlanta, Georgia.

Howell Strauss, DMD is Principal Investigator and Executive Director of AIDS Care Group in Chester, Pennsylvania.

About the Initiative:
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Recommendations to Address the Re-integration of HIV + County Jail Inmates into the Community

Summary of options

1. All released detainees are assessed for individualized treatment plans and linked to providers that offer a continuum of services under the observed and coordinating leadership of a deployed case manager.

2. The program model would be designed so that foreseeable barriers are minimized or eliminated to the point that is fiscally feasible and possible when merging systems with conflicting missions, e.g., corrections systems and public health initiatives.
   - Transportation is provided from the jail on day of release to transitional housing within the community that provides substance abuse treatment.
   - Utilize a non judgmental staff who are trained in cultural sensitivity to minimize and/eliminate discrimination.

3. Primary medical care is combined with dentistry and ophthalmology, two essential unmet needs of the targeted population. Coordination of care is used to promote easy access for consultation on complicated medical histories helping to expedite treatment planning. Programs should be efficient with minimal waiting time for all appointments.

4. Case managers collaborate with service providers to help keep all client records up to date and to ensure continuing access into care. The care settings are carefully chosen based on their level of service and commitment and sensitivity to the community.

5. There is coordination of care by the case managers to insure that their services are available during the reintegration process.

6. Treatment plans are designed to improve the patient’s HIV medical status and address social service needs.

7. Intense relapse prevention efforts should be utilized through the use of consult/liaison psychiatry and substance abuse counseling.

8. The case managers and outreach workers meet clients on their turf to “sell the service”.

9. The project administrators and educators market their program to other providers including known collaborating agencies. Medical and dental society meetings, informational gatherings; AIDS Education and Training Centers lectures; local AIDS consortia; social service agencies; and religious groups should all be targeted to disseminate information about the available services.

Summary of Points

In brief, reentry back into society for HIV+ inmates is a complex undertaking that requires collaboration between county jail systems, AIDS service organizations, substance abuse treatment centers, the medical community and the community at large in order to successfully reintegrate the inmate. Reintegration also requires creative, knowledgeable, flexible and resourceful staff to navigate the myriad of systems in out of county jails. Reintegration is only as strong as the weakest link provided to the client. Missing and/or deficient supportive services have direct consequences resulting in poor outcomes: loss of social stability and incapacity to remain free in a world with complex health and social systems.
**Policy Brief**

**STRATEGIES TO ENHANCE LINKAGES BETWEEN CARE FOR HIV/AIDS IN JAIL AND COMMUNITY SETTINGS**

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**Introduction to Enhancing Linkages Program (ELP)**

The purpose of this policy brief is to describe the participating linkage programs for clients the ELP project will serve nationally, and illustrate the range of linkage strategies that are being implemented. This brief also reviews assumptions about jail populations, mechanisms for community linkages and desired outcomes, such as 1) increased identification of HIV, 2) increased adherence to HIV treatment, 3) linkages to other support services, and 4) reduced reincarceration. (Please see the full paper for further information.)

In 2007, HRSA awarded grants to 10 organizations to implement and evaluate innovative models of care and treatment for persons with HIV leaving jail. The ELP sites are concentrated in the northeastern and southeastern regions of the U.S.:

- AID Atlanta (Atlanta, GA)
- AIDS Care Group (Chester, PA)
- University of Illinois Chicago (Chicago, IL)
- Yale University (New Haven, CT)
- Baystate Medical Center (Springfield, MA)
- New York City Department of Health & Mental Hygiene (NYC, NY)
- Care Alliance Health Center (Cleveland, OH)
- Philadelphia FIGHT (Philadelphia, PA)
- Miriam Hospital (Providence, RI)
- University of South Carolina Research Foundation (Columbia, SC)

Major activities within these ELP sites include the enhancement of HIV screening and diagnosis, and linking HIV-positive individuals to HIV primary care and other support services.

The Rollins School of Public Health at Emory University and Abt Associates, Inc. were funded as the Evaluation and Support Center (ESC) to design and implement a multi-site evaluation, client-level outcomes, program-level summary data, and a cost analysis of ELP interventions. The role of the ESC is to provide programmatic and evaluation technical assistance to ELP sites and to disseminate research findings.

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**Improving HIV Detection and Care in Jails**

The high number of incarcerations in the U.S. has reached a rate of 13 million annual admissions, of whom 9-10 million are "unique persons" (3).

These individuals may be living with HIV/AIDS and other health issues like mental illness, tuberculosis, viral hepatitis and substance use disorders.

Jails can play an important role in HIV prevention in the U.S., but strategies are needed to adapt and implement evidence-based interventions in an effort to...
address the 56,000 estimated new HIV infections that occur in the United States each year (4).

Jails differ from prisons in many ways. Jail stays vary considerably but most are brief in comparison to prison stays, making jails more porous than prisons. As such, health programs in jails have a need for rapid assessment due to quick turnover.

The criminal justice system is slow to adopt health programs due to costs; ideology; and lack of coordination, expertise, and political will due to the negative status of prisoners in society.

Nevertheless, the CDC recommends expanding routine HIV testing within prisons and jails. Notable pilot programs (5, 6, 7) in the past, although they demonstrated effective testing strategies, have not been widely implemented. Recent trials confirm that HIV testing should be done within 24 hours of intake to avoid attrition from jail (12, 13).

Major issues involving routine HIV testing include the cost of screening and whether or not it is cost-effective to society. Additionally, the program must aim to better determine who is incapable of “opting out”. Also, logistical constraints of who performs the test, and how and where it is done also pose some challenges (8, 12, 19).

Few systems exist to respond to irregular patterns of release and delivery of care in each setting (10). The particular pattern of the timing of releases impacts how an AIDS Service Organization can deliver services in a specific jail (11). Detection and treatment of HIV in jail remain remarkably unexplored.

More effective mechanisms are needed to notify partners of HIV infected inmates. Recent findings have shown that there are very few (<1.0%) newly diagnosed infections determined during routine HIV testing (5, 6, 7, 12, 13). Data are necessary to support the significant numbers of new infections that can be identified to meet cost-effective thresholds (>1.0%).

Challenges to Providing Effective HIV Treatment

Obstacles to providing effective HIV treatment in jail settings can include confirming past medical history and current medications. During a jail stay, it is a challenge to effectively deliver HIV medications and avoid any interruption in continuity HIV medication. Additional hurdles include delayed laboratory testing, limited availability of HIV specialty services and other barriers.

Challenges to Ensuring Continuity of Care after Release

The limitations of case management programs include challenges such as linking HIV infected persons to medications (15), medical services (20) and maintaining non-detectable HIV-1 RNA levels after release (15, 16).

Linkage Strategies and Outcomes

The ELP grantees have developed strategies that fit within the social, political, and economic contexts of their community and jail environments. Few offer universal HIV testing in jails, but most have increased the availability of testing within and sometimes after release from jail. Nearly all sites offer a variety of case management programs for pre-and post-release.

Each program at the individual ELP sites is shaped by the opportunities for change and innovation unique to its community.
Moving Towards Broader Implementation of Strategies

Political Will and Service Capacity

Policymakers and program leaders in public health and criminal justice need to address HIV testing and linkage to care as a public health priority. When collaborations between public health and criminal justice agencies are stronger, the potential support for building these linkages and services are greater. Success has been found in aligning criminal justice goals with health goals to address substance use disorders.

The capacity of service systems within and outside the jails is central to creating effective linkages. For example, several factors may enhance linkages to care for releases: 1) the extent of current HIV testing in jail, 2) timeliness of delivering HIV test results, 3) greater capacity to provide health services in jail, 4) extent of coordination of outside services, and 5) program involvement to facilitate more favorable treatment in court will enhance the link to care once released.

Policy and System Constraints

There are a myriad of political, organizational, and safety concerns that constrain testing and linkage. These concerns include the involuntary nature of the jail stay; in addition, many advocates and providers believe the criminal justice system sets people up to fail, thereby reinforcing social and health disadvantages through incarceration (17). It is difficult for some to see this system as providing helpful resources.

Some medical providers are wary of initiating HIV treatment while someone is incarcerated for fear that it will not be continued upon release thus complicating later treatment. Other concerns and barriers to care for releases include lack of basic needs, such as personal identification, housing, money, transportation and employment. The lack of access to these basic needs may present additional barriers to care because mental health and substance abuse services are often dependent upon proof of residence and identification.

Another concern is that identifying detainees with HIV infection may lead to more out-of-pocket expense for the jail system. Historical abuse by the medical establishment and subsequent mistrust have left some communities of color wary of medical care. Some detainees may be preoccupied with obtaining release that HIV testing may not be a priority.

Conclusion and Implications

Universal testing for HIV in jails is still not a common policy in U.S. jails. Despite the constraints reviewed in this brief, the ELP sites will demonstrate how local jail and health systems can undertake efforts to increase HIV testing or access to testing, while building linkages for HIV care and services after release of clients across the ten sites. The period immediately after jail release has significant potential health risks for releases, some specific to HIV. Effective HIV testing and follow-up can serve the goal of reducing this post-release risk while assisting vulnerable individuals who are incarcerated and leaving jails.

ELP sites will not only provide data on testing, linkages and outcomes, but also demonstrations of how programs engage varied strategies to expand HIV testing and linkage. These demonstrations provide an array of opportunities to test the effectiveness of these strategies with scientifically rigorous evaluations.
REFERENCES


TRANSITIONAL CARE COORDINATION: SUPPORTED TRANSITIONS

This policy brief describes the transitional care coordination process for people living with HIV in correctional settings, reviews its potential impact on continuity of care, and suggests steps for initiating an appropriate program. By using existing resources, leveraging available funding, and building collaborations, such a program can enhance continuity of care for persons with HIV leaving jails, leading to improved health outcomes and a positive impact on community public health. Leadership for this approach may come from jail administrators, local health departments, correctional health providers, community health providers, AIDS service organizations, and other community organizations committed to working with the formerly incarcerated.

MAKING THE CASE: NEED FOR TRANSITIONAL CARE COORDINATION

The care provided in correctional settings can have a substantial personal and public health benefit by screening and treating infections such as STDs, HIV, and TB (Glaser & Gleifinger, 1993; Hammett, Gaiter, & Crawford, 1998; Freudenberg, 2001). Transitional assistance for HIV-positive persons leaving jail can extend and amplify these benefits by improving post-release access to medical care and other services (Rich et al. 2001).

For persons living with HIV, treatment with antiretroviral therapy (ART) substantially extends life expectancy (Harrison, Song & Zhang 2010) and reduces infectiousness to others (Castilla et al. 2005; Cu-Uvin et al. 2000; Donnell et al. 2010; Harrison, Song & Zhang 2010; Porco et al. 2004; Quinn et al. 2000; Tovanabutra et al. 2002; Vernazza et al. 1997). When ART is interrupted, not only are its benefits compromised, but drug-resistant strains of HIV may develop that are difficult to treat (Burman et al. 2008; Dearing, Meyer & Rogers 1994).

Optimal use of ART requires 95% adherence to medication regimens, a significant challenge for those going home from correctional settings (Karus et al. 2007). One study found that less than one-third of HIV-positive people released from jail filled a prescription for ART within 60 days of release and only 7% filled a second prescription in time to avoid a treatment interruption, with the average interruption exceeding the clinically-induced two week period (Baillargeon et al. 2009). Another study followed hundreds of HIV-positive detainees on ART for an average of 31 months, and found that only 17% were able to maintain continuous treatment (Pai et al. 2009).

A study that examined reentry experiences of HIV-positive people recently released from South Florida jails found that many said they needed assistance in obtaining housing (67%).
case management (60%), medication (45%), and substance use treatment (30%) (Fontana & Beckerman 2007).

While transitional care programs can improve post-release retention in HIV treatment, and some programs have even shown reduced recidivism rates (National Center on Addiction and Substance Abuse report, 1998; Rich, et al. 2001; Wilmott & Olphen, 2005), jails often may be hard-pressed to fund such activities.

**FUNDING THE GAP: RYAN WHITE CARE SERVICES SUPPORT RE-ENTRY**

To address this service gap, correctional health providers and community-based organizations may form a partnership and together seek Ryan White funds. These funds can be used for short-term, transitional social support and primary care for persons leaving jail who are eligible for Ryan White HIV/AIDS program services (HRSA 2009). Since Ryan White funds should not be used to pay for services that the correctional system legally is expected to provide, jail administrators and their partners in transitional assistance should first determine what health services are not covered by the correctional system (HRSA 2009).

To garner additional support for HIV-related transitional services, collaborations can be formed to apply for grants that specifically require partnerships between community groups and government agencies.

**MANAGING THE TRANSITION: FROM JAIL TO COMMUNITY HEALTH**

Transitional case management services funded by Ryan White can be a key element of discharge planning as the incarcerated person living with HIV prepares to return home. Activities would include identifying at jail admission those living with HIV (Avery & Murphy 2010), formulating a discharge plan, and transitioning the HIV-positive person from jail-based to community-based care. In addition to seeing a physician, care in the community may include medication, housing, substance abuse treatment, medical case management, and other services intended to stabilize patients and support adherence to ART (see Porter & Strauss 2010). Other examples of transitional care coordination include providing an interim supply of medication along with a prescription for medication to coincide with the first post-release medical visit, a letter with the patient’s latest laboratory test results, processing AIDS Drug Assistance Program (ADAP) or Medicaid insurance applications, and developing mechanisms for sharing health information between providers.

Once a community partner has been authorized to work in the jail, the corrections administrator, jail health provider, and community partner need to establish a system for identifying eligible patients, accessing those patients, communicating regularly, and sharing health information in ways that address patient confidentiality and willingness to participate in pre-release planning.

When a system is established, transitional care coordination activities with the client would include:

“Optimal use of ART requires 95% adherence to medication regimens, a significant challenge for those being released from correctional settings.”
meeting the client and assessing their engagement in care before being incarcerated (HRSA 2006), managing care in jail, and providing support services that address barriers to accessing care in the community. Ideally this phase would begin within 24-48 hours of incarceration. The discharge plan should document when the patient was last in care prior to incarceration, the patient’s sources of social support and housing options, and potential obstacles to appropriate post-release care, along with strategies to address these obstacles. Given the unpredictability of patient stays in jail, each discharge plan needs to identify a mechanism for the patient to access care in the community in the event that their first session with the discharge planner or care coordinator is also the last session prior to release (HRSA 2009).

**BUILDING THE MODEL: COLLABORATIONS**

The very nature of providing transitional services requires collaboration to achieve continuity of care, avoid duplication of effort, and facilitate a streamlined and coordinated service delivery system. The project coordinator should, therefore, maintain strong ties and ongoing relationships with both jail-based and community-based service provider networks. Collaborations may include representatives from government, legal services, community-based organizations, and researchers from diverse disciplines including criminal justice, health care, mental health and substance abuse treatment, housing, social services, employment, and reentry.

Shared knowledge of community resources and good working relationships between jail-based and community-based front line staff are keys to a successful program. Those conducting client assessments should be familiar with the stages of engagement in care (HRSA 2006) and with motivational interviewing techniques (Miller & Rollnick 2002). Ryan White case management staff working in a correctional setting need to understand and take into account the features and specific requirements of jail systems and be familiar with issues common to those who cycle in and out of jail. Case managers should also have socioeconomic, cultural, and language competencies for working with the incarcerated populations.

A variety of community-based service providers may be helpful partners in correctional settings, including existing Ryan White service programs, volunteer groups such as 12-step programs, faith-based organizations and churches, and community-based organizations committed to working with the formerly incarcerated. An ideal community partner may be one that offers a “one stop” model of coordinated care in which primary medical care is linked with medical case management, housing assistance, substance abuse and mental health treatment, and employment and social services.

Activities such as documenting service relationships using memoranda of understanding, and being an active participant in collaborative events help to create a body of meaningful resources to draw upon that are likely to be far more effective than relying on printed service directories which are often out-of-date shortly after publication. Team-building activities are useful, and one that is of particular utility is the development of universal forms that can be shared between the jail and community providers to streamline enrollment into services and avoid duplicate questioning of participants by case managers.

“An ideal community partner may be one that offers a ‘one-stop’ model of coordinated care in which primary medical care is linked with medical case management, housing assistance, substance abuse and mental health treatment, and employment and social services.”
MAINTAINING THE MODEL: AN INTEGRATED APPROACH TO CONTINUITY OF CARE

Once relationships and resources are established they need to be maintained and nurtured to successfully support transitional services and reduce barriers to patient engagement in primary care in the community. Ongoing communication is essential and requires leadership to creatively support collaborations. Some examples of ways to support productive relationships with front line staff and to enhance communication between corrections officers and community-based providers include:

- Correction administrators providing security orientation sessions to introduce community-based providers to the issues faced by officers and inmates.
- Each organization in a collaboration inviting the others to attend planned staff events such as brown bag lunches, cultural heritage celebrations, and picnics.
- Collaborations arranging an employee recognition event where representatives of all member organizations receive certificates of appreciation.
- Health service providers organizing a health and wellness event for correction officers where, for example, blood pressure testing or flu shots are provided. The focus of the health fair could also be informed by the correction department’s employee health services.
- Correction administrators asking a community partner to provide brief health education sessions at roll call that address common areas of concern (e.g., transmission of HIV through saliva).
- The collaboration partners integrating staff development and training efforts by presenting a program overview to each others’ existing staff and new recruits and later providing ongoing updates and trainings.
- Enjoying the rewards of establishing a collaboration by arranging a retreat where staff at all levels design the agenda, discuss issues openly with each other and supervisors, and have an opportunity to socialize outside of their regular work environment.

When planning collaborative events, think about the messages you would like to convey, such as why knowing one’s HIV status is important to public health or how the collaboration has helped reduce instances of violence. Resist the impulse to plow into the most recent case study or communication mishap and keep the focus on the activities of the day. Following the event, solicit feedback and ask for suggestions for next steps. Never underestimate the importance of simple things, like saying please and thank you. Always plan to give more than you receive.

By establishing and nurturing collaborative relationships, partners will be better able to build an effective and efficient transitional program that benefits people living with HIV, the correctional system that houses them, and the communities to which they return.

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REFERENCES


