Transitional Care Coordination Overview

Our Program and Population at a Glance

NYC HEALTH+ HOSPITALS | Correctional Health Services

New York City has a well-established Transitional Care Coordination program.

The Transitional Care Coordination model is built on a strong foundation of public health and criminal justice partnership building, as well as an unwavering commitment to the incarcerated population.

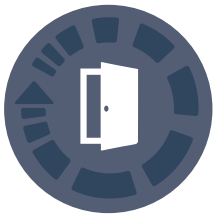
Transitional Care Coordination has demonstrated public health benefits, from decreased ED visits to improved HIV viral load suppression and improved self-management skills.

Demographically, the jail population mirrors that of the NYC communities hardest hit by healthcare and socioeconomic disparities.

2nd largest
jail system in the country

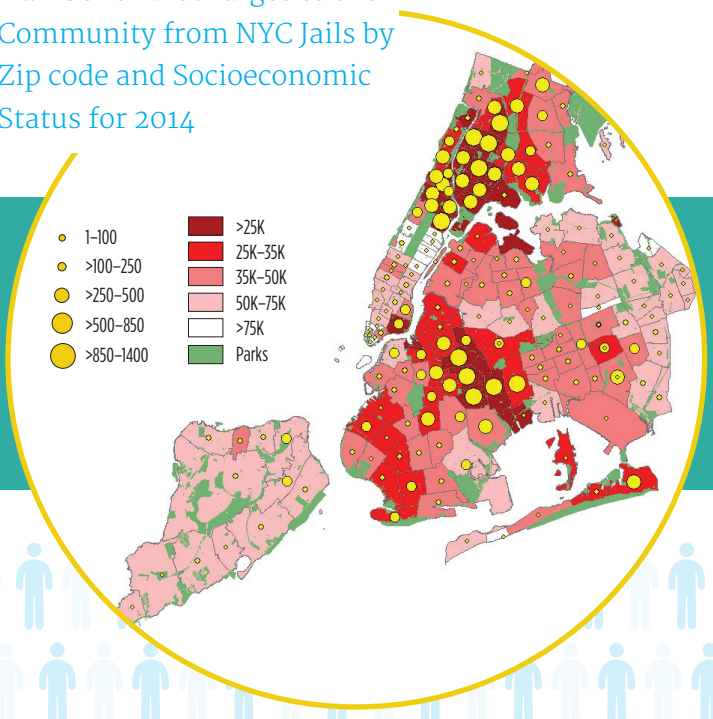
5%
of NYC jail population is self-reported HIV-positive

All individuals detained for at least **24 hours** receive medical intake and mental health screening



Within **48 hours** individuals receive a discharge plan

Number of Discharges to the Community from NYC Jails by Zip code and Socioeconomic Status for 2014



Individuals linked to care within **30 days** have greater retention/health outcomes

More than 70%
of clients released from jail return to communities of the greatest socioeconomic and health disparities

10,000 average daily jail census

Why Jails?

Transitional Care Coordination effectively reduces barriers and improves linkage to care. A jail intervention needs to happen quickly because jail stays are often brief and the uncertainty around discharge dates presents a small window of opportunity to reach people. However, given the higher rates of sexually transmitted infections, including HIV, as well as viral hepatitis, tuberculosis, substance abuse, chronic health conditions, mental health issues, and history of trauma among incarcerated people, a jail intervention offers a unique opportunity to engage a high-need population who may have had no or previously intermittent interaction with the healthcare system.

Intended to house only those deemed to be a danger to society or a flight risk before trial, jails have become massive warehouses primarily for those too poor to post even low bail or too sick for existing community resources to manage. ■

When leaving jails, individuals often return to the communities from which they came and subsequently face competing needs related to survival, such as food and shelter, and which may preclude their ability to link to care. **Engaging these individuals while in the jail setting and effectively connecting them to the healthcare system offers important implications on community and public health**. NYC's warm transition, active linkage, and consistent follow-up offer a lens through which to examine this important work.

Transitional Care Coordination Aligns with Federal Priorities

Transitional Care Coordination, facilitating linkages to care, aligns with federal priorities ranging from the HIV Care Continuum, the Affordable Care Act, the National HIV/AIDS Strategy, the Action Plan for the Prevention, Care & Treatment of Viral Hepatitis, and more. Transitional Care Coordination work meets the Centers for Disease Control and Prevention (CDC) recommendations for using **"combinations of scientifically proven, cost effective, and scalable"** prevention interventions.

EnhanceLink Study

NYC Correctional Health Services participated in the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), HIV/AIDS Bureau (HAB), Special Projects of National Significance (SPNS) EnhanceLink study. The study examined jail care coordination and HIV. Findings included the following:

- Meeting with an HIV provider **within 30 days of release** from jail was associated with having an **undetectable viral load** 6 months after release from jail.

At the NYC site there were statistically significant improvements among the group that attended **at least one case management meeting** within 6 months' post-release. This group, for example, was found to have the following healthcare improvements:

- **Fewer visits to the emergency department**, from 0.60 per person in the 6 months prior to baseline to 0.20 visits at follow-up.
- **Food insecurity decreased** from 20% at baseline to less than 2% at follow-up.
- Individuals also self-reported feeling **in better general health**.

To access the full handbook, visit
careacttarget.org/ihip

Health Liaison to the Courts

Transitional Care Coordination includes a Health Liaison to the Courts function that supports inpatient and outpatient substance use treatment, skilled nursing, hospice care, or hospital-based programs as medical alternatives to incarceration. Placements may be made through traditional alternatives to incarceration (ATI) or Alternatives to Sentencing or merely as medical placements in lieu of incarceration with court-ordered time served in correctional facilities for eligible clients living with HIV or other chronic illnesses. Compassionate release is also pursued where appropriate. This approach puts a public health lens on issues affecting jails and people who are incarcerated.

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