Common Themes for Successful Linkages and Experience in The Field

National Hepatitis Corrections Network

Atlanta, 2017
Outline:

• Legal & Ethical
• Models
  ▫ Who
    • NGO / CBO / FBO
    • Health Departments
    • Academic / Research
    • ....and combinations of the above
  ▫ What
    • Inside / Inside-Out / Outside
  ▫ Common Successful Elements...
  ▫ Project START+
The Evolving Standard of Decency: Postrelease Planning?
Jeff Mellow, PhD, and Robert Greifinger, MD

Journal of Correctional Health Care
Volume 14 Number 1
January 2008 21-30
© 2008 NCCHC
10.1177/1078345807309617
http://jchc.sagepub.com
Ethical Considerations
AMA Code of Ethics:

• Physicians have a **moral duty to attempt to provide continuity and coordination of care for their patients when their care is being transferred to others.** A release from a prison or jail is, in effect, a transfer of a medical home from the institution to the community.

• The physician may not discontinue treatment of a patient as long as further treatment is medically indicated, without giving the patient reasonable assistance and sufficient opportunity to make alternative arrangements for care.

• **The patient has the right to continuity of health care.**
NCCHC Position Statement on HIV Discharge Planning in Correctional Facilities

- HIV-positive individuals need to receive prevention, education, and treatment that continues upon release.

- It can be difficult for HIV-positive individuals to find health care services outside a correctional environment.

- Individuals on treatment inside need to have continuity of care upon discharge from jail or prison.

- Give sufficient supplies of medications at release (14-30 days).

- Provide instruction on the importance of medication adherence.
2011 - 2012 NIS

- Twenty-one percent of prisoners and 14% of jail inmates reported ever having tuberculosis, hepatitis B or C, or other STDs (excluding HIV or AIDS).

- About 66% of people in prison and 40% of people in jail have a current chronic condition that they are taking prescription medication.
Cycle of Incarceration

Community ➔ Jail ➔ Court ➔ Prison ➔ Community
HCV Services Continuum

• Prevention

• Testing

• Linkage to Care / Continuity of Care
Who’s doing what?

- **CBOs / NGOs / FBOs / etc.**
  - Don’t publish (typically)
  - Great unknown

- **Local and State Health Departments**
  - Focus is often on surveillance

- **Academic and other Research Institutions**
  - Theoretical-based intervention testing

- Collaborations of the above
Linkages to Care Spectrum

- Inside Only Model
  - Planning begins near release with continuation and support until release; released with referrals.

- Released Focused Model
  - Brief planning happens near release with case management after release.

- Outside Only Model
  - Meet you at the gate / office / clinic.

- Inside/Out Model
  - Ongoing planning and case management occur inside and continues in the community after release.
What Successful CoC Models Have in Common

1) Starting the intervention or program before release from custody, thereby developing a trusting and ongoing relationship between program staff and the client that continues postrelease;

2) Providing support and/or referrals to support services that address the competing priorities of housing, income, family reunification, obtaining government identification, addressing conditions of probation and parole, and other basic needs within the context of the CoC program model;
What Successful CoC Models Have in Common

3) Providing linkages to comprehensive health care that includes ART and other HIV treatment, and treatment for other chronic health conditions, substance use and mental health disorders;

4) Incorporating behavioral interventions that address medication adherence, sexual and drug-related risk reduction, and prevention of reincarceration.
Criminogenic factors are measures of risk associated with reincarceration, including:

- Housing
- Pro-Social Leisure/Recreation factors
- Antisocial behavior
- Antisocial personality pattern
- Antisocial cognition
- Family/Marital/Relationship factors
- School/Work/Income factors
- Substance Use Disorder
- Mental Illness
- Antisocial associates
Project START+

An HIV/STI/hepatitis risk reduction program for people returning to the community after incarceration
A Bridge to Success

- Is a short-term individual level program = 5 months
  - 2 months pre-release
  - 3 months post-release
  - Begins before release & continues in the community after release

- Helps clients to “bridge” from the “inside” to community-based services on the “outside” that support their HIV/STI/hepatitis risk reduction and transitional goals

- Does not replace longer term comprehensive systems of care
Basic Structure of Project START

• Enrollment plus six one-on-one sessions:
  ▫ Two sessions completed before release
  ▫ Four sessions completed after release

• Other sessions as needed.

• Required tasks per session.
  ▫ Risk assessment,
  ▫ Reentry needs
  ▫ Facilitated referrals
  ▫ Goal setting
  ▫ Strengthening motivation
  ▫ Providing condoms

• Supplemental exercises as needed.
Sessions 1-2 Overview (Pre-Release)

• Complete assessment process
  ▫ HIV Linkage to Care Assessment
  ▫ HIV, STI, Hepatitis Behavioral Risk Assessment
  ▫ Reentry Needs Assessment
• Develop personalized goal sheets (linkages, risk, reentry needs)
• Facilitate immediate release planning
• Facilitate post-release service referrals for housing, employment, substance use treatment, etc.
Sessions 3-6 Overview (Post Release)

- **Hold session 3 ideally within 48 hours** of release and at the community medical provider location
- Assist & **confirm linkage to community medical care**
- **Assure medications obtained** in community
- **Provide facilitated referrals** to treatment and other social service needs
- Review and **update goal sheets**
- **Provide risk reduction materials**
- **Link to longer-term system of care**
Post Release Sessions

• Session 3 ideally within 48 hours of release at the community medical provider location

• Assure medications obtained in community

• Ongoing facilitated referrals to treatment and other social service needs

• Review and update goal sheets

• Provide risk reduction materials

• Transition to longer-term system of care
Post-Release Sessions Overview (cont.)

• Focused activities include:
  ▫ Confirm linkage to community medical care
  ▫ Assure medications obtained in community
  ▫ Provide ongoing facilitated referrals to treatment and other social service needs
  ▫ Review and update goal sheets
  ▫ Provide harm reduction materials
  ▫ Link to longer-term system of care
  ▫ Provide closure with participant
Immediate Release Checklist

- HCV/HIV Care
- Transportation from the correctional facility
- Housing for first night out
- Money from personal account at facility
- Identification
- Basic needs (e.g., medications, clothing, toiletries, food)
- Required appointments (e.g., parole, medical)
- Connecting with family/partners/kids
- HIV/STI/hepatitis risk reduction supplies (e.g., condoms, clean drug using paraphernalia)
Adaptation for HIV+ Linkages to Care

- **Additional Session Inside**
  - Discharge planning (medication supply, medical records, prescription, adherence)
  - Benefits/ADAP
  - Linkage to community medical provider
  - Disclosure and living with HIV in the community

- **Post Release Follow-up**
  - Review discharge plan along with risk reduction plan (secondary prevention)

- **Pilot with MA Department of Public Health**
  - 71% of participants attended first medical appt after release (N=33)
Adaptation Pilot Results (N=28)

- 100% received their supply of medications upon release
- 75% received prescription for their medication
- 93% filled their prescription post release
- 96% linked to HIV care
- At one site:
  - 100% reenrolled (or reinstated) into ADAP
  - 57% enrolled in Medicaid
  - 53% enrolled in insurance
Global Efforts with Project START+

- Central Asia
  - 6 countries
  - HIV, HCV and TB
- Haiti
  - HIV
- Kenya
  - HIV
- Taiwan
  - HCV
- Thailand
  - TB