Linkages and Care Engagement: From NYC Jail to Community Provider

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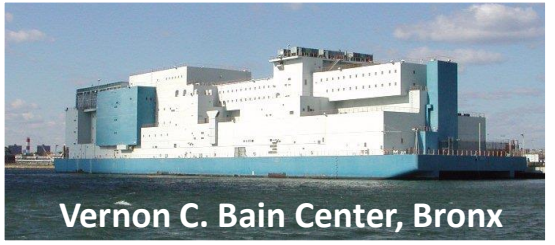
RIKERS ISLAND



Otis Bantum Correctional Center

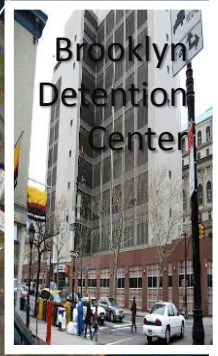
North Infirmary Command

James A. Thomas Center

George Motchan Detention Center

Rose M. Singer Center

George R. Vierno Center



West Facility

Anna M. Kross Center

Transitional Health Care Coordination

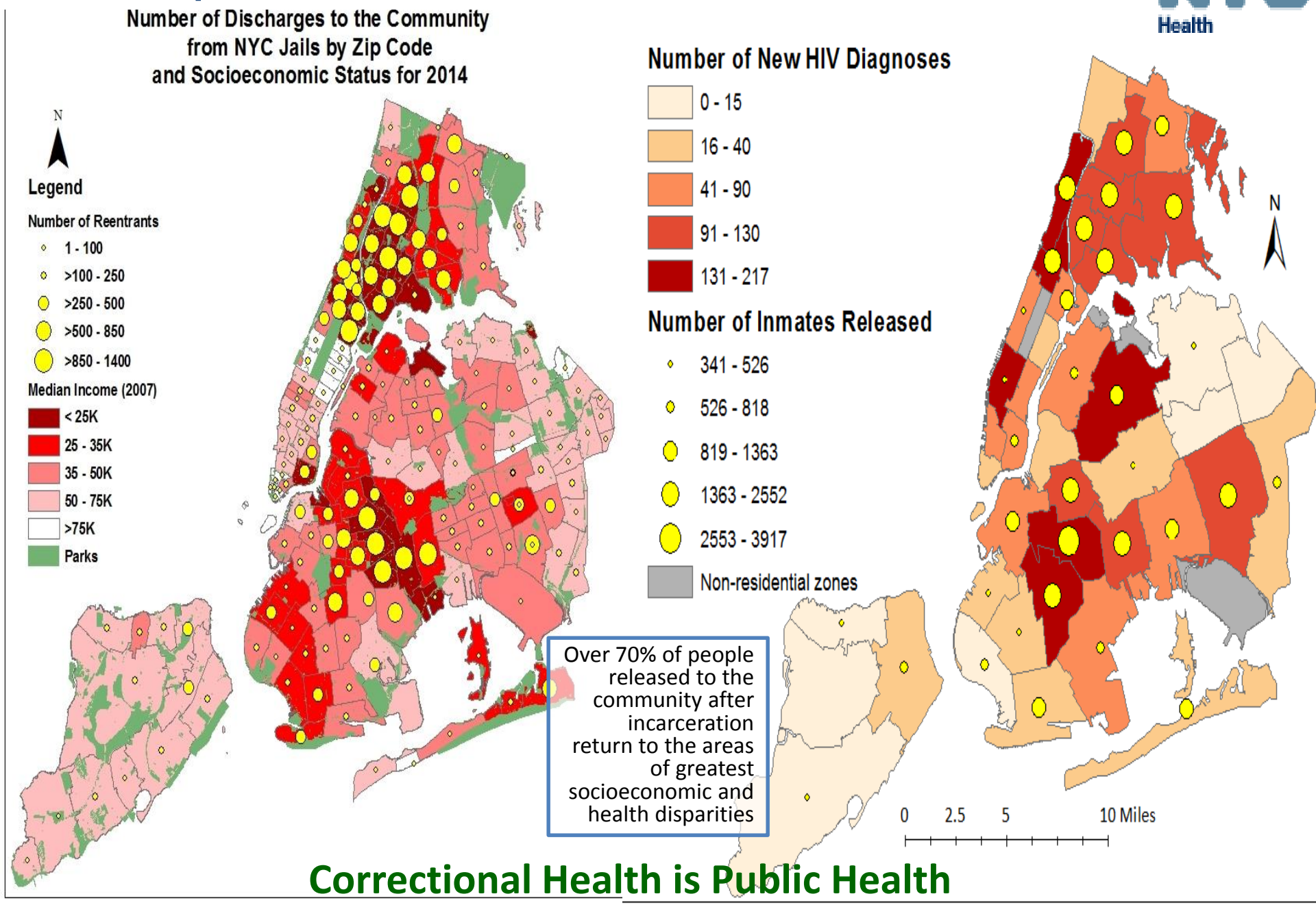
Eric M. Taylor Center

Adolescent Reception & Detention Center

Francis R. Buono Memorial Bridge

LaGuardia Airport Runway

Twin Epidemics: Mass Incarceration & HIV



Over 70% of people released to the community after incarceration return to the areas of greatest socioeconomic and health disparities

Correctional Health is Public Health

Correctional Health Services

At A Glance	
Facilities	12 jails: 9 on Rikers Island (1 female facility, 1 adolescent facility), 3 borough houses, public hospital inpatient unit
Average Daily Population	11,827
Annual Admissions	81,758
Community Releases	60,000 / year
Length of Stay	mean=53 days; median~8d
Electronic Health Record (adopted 2008-2011)	eClinicalworks, customized for jail setting; care mgt templates; unidirectional interface with NYC DOC Inmate Information System

Sources: NYC Department of Corrections Mayoral Report – 2013 http://www.nyc.gov/html/doc/downloads/pdf/MMR-FY2013.pdf
Annual releases from NYC DOC Report of Discharges by zip code for CFY'14

Demographics

Age	ALL	HIV
Range	16 - 84	16 - 68
Mean	34	45
Break down	16<21 (13.4%)	16<21 (1.3%)
	21<31 (32.8%)	21<31 (10.1%)
	31<41 (21.6%)	31<41 (18.6%)
	41<51 (21.8%)	41<51 (44.3%)
	51+ (10.2%)	51+ (25.4%)

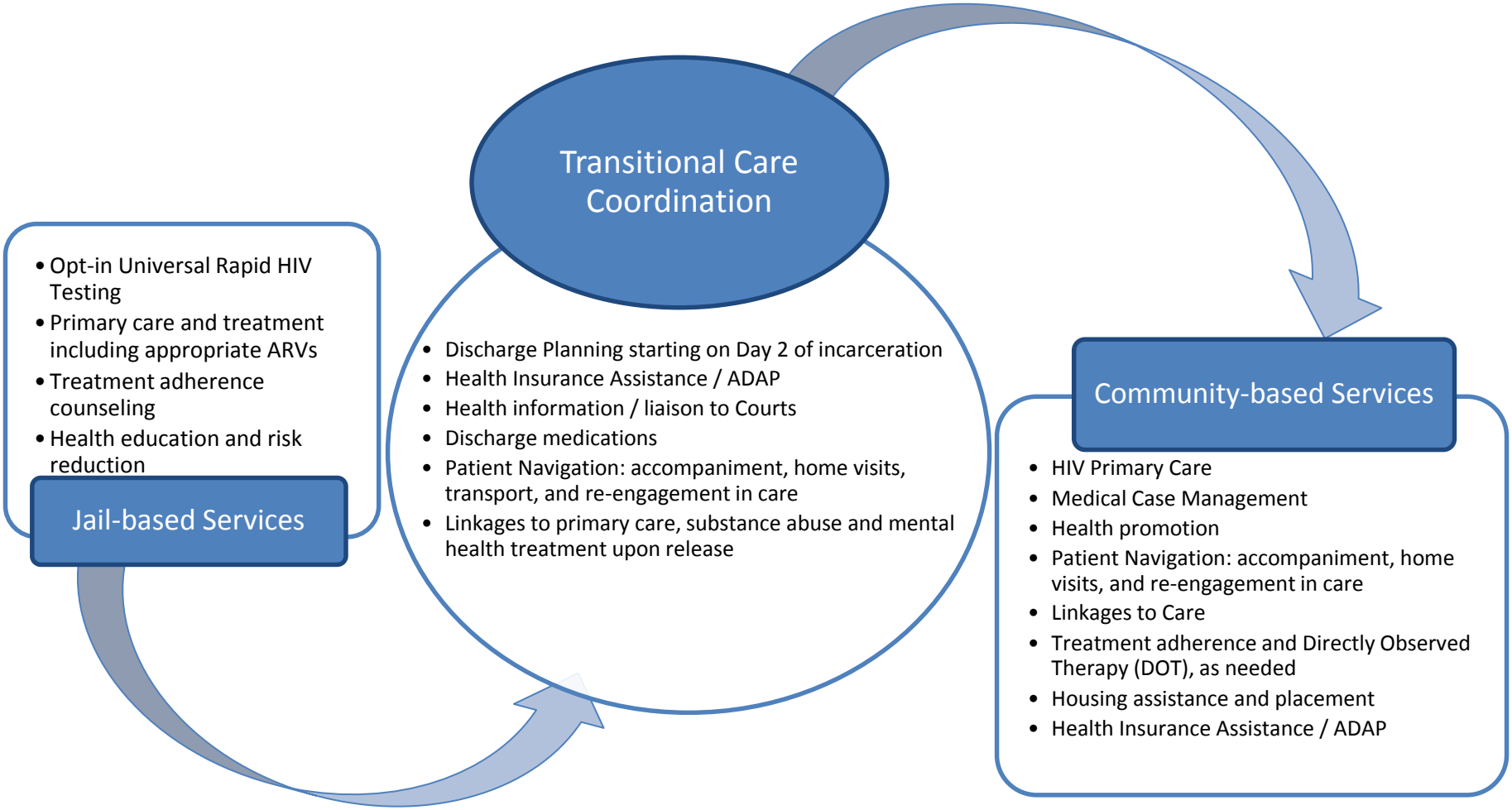
Race	ALL	HIV
Non-Hispanic Black (%)	54.0%	61.0%
Hispanic (%)	33.0%	30.0%
Non-Hispanic White (%)	8.7%	7.0%
Gender	**ALL**	**HIV**
Male (%)	89.0%	78.3%

*2011 Correctional Health Services new admission records (N=61,853)

PREVALENCE BY DIAGNOSIS

- Substance abuse: >50%
- Mental Illness: 30%
- Hepatitis C: 8%
- HIV: 5%
- Diabetes: 5%
- Tuberculosis: 5%
- Other Sexually Transmitted Infections: 6%

HIV Continuum of Care Model



SPNS Jail Linkages Outcomes

From Prior to Incarceration to 6 months Post Release

79% of those released with a plan linked to primary HIV care.

Indicator	NYC Health	All Sites
Clinical Care		
CD 4 (mean)	↑ (372 to 419)	↑ (416 to 439)
vL (mean)	↓ (52,313 to 14,044)	↓ (39,642 to 15,607)
Undetectable vL	↑ (11% to 22%)	↑ (9.9% to 21.1%)
Engagement in Care		
# Taking ART	↑ (62% to 98%)	↑ (57% to 89%)
ART Adherence	↑ (86% to 95%)	↑ (68% to 90%)
Avg # ED visits p/p	↓ (.60 to .2)	↓ (1.1 to .59)
Basic Needs		
Homeless	↓ (23% to 4.5%)	↓ (36.2% to 19.2%)
Hungry	↓ (20.5% to 1.75%)	↓ (37.4% to 14.1%)

Post Release Services

- Along with primary medical care, Jail Linkages clients were also connected to:
  - Medical case management (53%)
  - Substance abuse treatment (52%)
  - Housing services (29%)
  - Court advocacy (18%)
- Approximately 65% of clients accept the offer of accompaniment and / or transport to their medical appointment.
- 85% of those who were not known to be linked to care were found by DOHMH Home Visit team; finding 30% re-incarcerated.

"An ideal community partner 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."

Process Improvements

- Improve acceptance of follow up rapid testing
  - Acceptance rate increased from 30% to 60%
- Improve acceptance of service plans
  - Acceptance rate increased from 85.4% to 92.8%
- Health Liaison to the Courts
  - Release rate increased by 20% and in 2013, 735 received Health Liaison services
- SPNS Jail Linkages Program Evaluation
  - Over 100 followed for 12 months post-release
- Integrate with EHR
  - Case management templates implemented 5/13
- CHS is currently partnering with 2 NYC-based Health Homes
  - On average, about 10% of those currently incarcerated in a NYC jail are on one of the health home rosters

HEALTH HOME PILOT PROJECTS

Goal: Facilitate continuity of care

- Network / collaborate with HH and its CMO
- Identify and case conference with shared clients
- Begin care coordination during the jail stay
- Actively link people to care after incarceration

CHS concurrently runs two Health Home pilots:

- Bronx HH funds a Project Director and two care coordinators to serve their assigned patients
- Brooklyn HH hired a Project Director and Liaison (out-stationed at CHS offices) to coordinate care for their patients receiving MH services

PRELIMINARY HH PILOT OUTCOMES

Health Home	# Eligible	# Linked to Care / CMO	Linkage Rate
Bronx	190	93	49%
Brooklyn	204	95	47%
Total	**394**	**188**	**48%**

Removing barriers

References

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