



Re-Entry & HIV/AIDS Care

Easing the Transition for Recently-Incarcerated Persons

Ryan White National TA Call

An ongoing series to explore pressing HIV care issues

Summary and Abbreviated Transcript of June 16, 2009 TA Call
Health Resources and Services Administration, HIV/AIDS Bureau

Opening

Steven Young, MSPH, Director, DTTA, HRSA/HAB & Call Moderator

An HIV epidemic is occurring within our nation's correctional system but is not confined within those walls. It affects our most underserved communities, the world where the Ryan White HIV/AIDS Community does its work. We thus have a clear role to play in helping HIV positive ex-offenders engage in care upon release.

Approximately 2.3 million people are incarcerated in this country. About 50,000 are HIV infected, and the rate of AIDS cases in correctional facilities is three times higher than the general U.S. population. If you look at this retrospectively, we know that one out of every seven Americans infected with HIV were incarcerated at some point in their lives. It's about care for the HIV disease, but also much more. If you know or if you've worked with an HIV positive ex-offender, you know it's about a place to live, a job, a source of healthcare, treatment and counseling for drug abuse and mental health, as well as a way to avoid people in situations who might drag persons down again. With all these issues, the question is how Ryan White programs help can establish a link to care in the community.

The TA Call Format

This National TA Call outlined (1) policies under the Ryan White HIV/AIDS Program regarding HIV/AIDS services for incarcerated persons and those facing release from the corrections system and (2) insights from re-entry programs seeking to ease the transition and engage persons into care upon release. The 1.5 hour call included a panel comprised of a HRSA/HAB administrator, a consumer, and Ryan White grantees (i.e., several city and State programs, and grantees from a Ryan White's Special Projects of National Significance initiative investigating innovations in HIV care for incarcerated persons). The panel engaged in a discussion with the moderator. Two open mike segments provided for listener questions and feedback.

Consumer Perspective

Steven Young and Troy, a consumer

Steven Young: We're going to get grounded right away and we're going to talk to a client in one of our re-entry programs and also a member of the AIDS Care Group in Chester, Pennsylvania. On the line with us today is Troy. When you were incarcerated, can you summarize for us what your situation was like in managing your HIV disease and what you were getting on the inside?

Troy: It was real hard. The care wasn't that good. The medicine wasn't that good. It was a real tough time for me there. I got no support whatsoever. It was rare that you found anybody in there that was willing to open up to let you know that they have the HIV disease. The staff looks at you like you're not even there.

Steven Young: You obviously knew your release date coming up and were there certain things that you felt you needed most as your release date was coming up and you were thinking about going back out into the community?

Troy: Yeah, I really needed a lot of help. My health was real bad. The medicine that they were giving me in the prison wasn't sufficient enough. I really needed help. In helping me transition to the community, I came across the best people that I ever met, the AIDS Care Group. They provided medicine for me. They provided housing for me. They did everything that I guess they were made to do.

Steven Young: How are things going for you now?

Troy: Oh, I'm excellent right now. Let me put it to you this way, when I was discharged from jail, I was 150 pounds. I'm actually 234 now, solid, in good shape. I have a nice place to live and I'm actually working right now with the AIDS Care Group.

HRSA/HAB Perspective

Steven Young and Laura Cheever, MD, ScM, Deputy Director, HRSA/HAB

Steven Young: Let's next look at the big picture at the HRSA/HAB level and we're joined today by our Deputy Associate Administration Dr. Laura Cheever here at the HIV/AIDS Bureau. Could tell us a little bit about any data we might have on Ryan White programs and what it says about current service to the incarcerated.

Laura Cheever: Unfortunately, we really don't have very good data about incarceration backgrounds for our Ryan White clients. We do know from our 2007 data report that about 3% or 25,000 people in the data report resided in institutional settings. Now, this could be residential, healthcare or correctional facilities. We don't really know. We know that about 15% of our population is not permanently housed. It's very clear from the data that you presented initially that we gathered from other national sources that ex-offenders represent a significant part of the HIV infected patient population. The data you gave in 2005, one in seven infected

persons in the U.S. passed through a correctional facility that year, speaks to the need of this population to receive the kind of care that we give.

Steven Young: Can you give us a quick overview of our programs at the Bureau that work with ex-offenders living with HIV AIDS?

Laura Cheever: All of our Ryan White parts are involved in working with ex-offenders and many have developed uniquely targeted programs for this really vulnerable population. Regarding ADAP, with the advent of highly active antiretroviral therapy, many state ADAP programs worked very closely with correctional institutions to improve access to medications upon release and that's something that we still struggle with. We've also funded several Special Projects of National Significance, SPNS programs, in the last decade to look at innovative delivery systems. From 1999 to 2004, we ran an initiative with the CDC called a Corrections Demonstration Project to expand HIV related services to inmates and the recently released from various correctional settings, including jails, prisons and juvenile facilities.

We are currently funding a SPNS initiative called Enhancing Linkage to HIV Primary Care and Services in Jail Settings. This is funded for 2007 through 2011 and the initiative focuses on jail settings with all of their challenges regarding rapid turnover of inmates that often result in really fragmented care. The project has introduced active HIV testing in jail settings and is examining innovative ways to improve linkages with the newly identified clients, as well as people that were previously known to be HIV infected as they had transitioned from jail back into the community. These demonstration sites have begun at this point to provide linkage case management into jails to ensure that access to medical care is released. On the panel today we're going to hear from a series of grantees who have worked with SPNS, as well as work in other parts regarding ex-offenders.

Steven Young: I want to talk policy for a minute and ask if you could give us an overview of the role of Ryan White programs in working with ex-offenders.

Laura Cheever: Our role with ex-offenders is the same as with all our Ryan White clients. We work to engage patients living with HIV/AIDS in medical care and to retain them in care over time. The data that you initially outlined at the top of the call shows how necessary it is for us to be working with correctional facilities and with ex-offenders.

The challenges of ex-offenders really vary quite a bit depending on where they were incarcerated. As I mentioned previously, in jails people are generally incarcerated for very short periods of time and released with very little notice, which poses a huge challenging for coordinating care. As they re-enter the community, their transitional needs to reconnect is really that reconnecting with care they've already had or establishing new linkages that haven't been in care. So it tends to be a little bit easier since they were there for a shorter period of time.

When people are in prison, they're usually incarcerated for much longer and they can be released either to their home community or even a completely different jurisdiction. Linking them with care in the community may be more complicated as they may be released to a brand new

location, or even if they're released into the same community they could have significantly different needs than they had prior to being incarcerated.

As for the Ryan White programs, as for Ryan White can exclusively can do to help inmates, I think I should be mentioning specifically the HAB Policy Notice 0704, the use of Ryan White HIV/AIDS funds for transitional social support in primary care services for incarcerated persons. The purpose of the policy is to provide grantees with as much flexibility as possible under the current Ryan White statute to be servicing people that are transitioning out of correctional settings. That flexibility is there so that grantees can provide the necessary and otherwise transitional primary care and social support services for incarcerated people at the local state or federal correctional system. This applies to inmates who are either nearing release or whose incarceration is a short duration.

I want to once again emphasize the term otherwise unavailable. It's crucial that Ryan White HIV/AIDS program funds can come into play with the correctional system is either not legally responsible for the need to care or doesn't provide such care. We can't be supplanting care that's being - that should be provided by the correctional facility.

Steven Young: Under that policy, I'm wondering if you can tell us any particular services that Ryan White can cover?

Laura Cheever: I'd urge people to look at the policies on our Web site—specifically, HAB Policy Notice - 07-04, The Use of Ryan White HIV/AIDS Program Funds for Transitional Social Support and Primary Care Services for Incarcerated Persons, at <http://hab.hrsa.gov/law.htm>

To quote the actual policy, Ryan White funds can be used for short term, transitional social support and primary care services for incarcerated persons who are eligible for Ryan White HIV/AIDS program services. These services will be part of an affective discharge planning as the person prepares to exit the correctional system. Ryan White should not pay for services that are legally expected to be provided within the correctional system. Grantees should work with the appropriate correctional administrators to determine what health services are not covered by the correctional system.

Steven Young: You mentioned the ADAP program before and the importance to ADAP. I was wondering if there's anything else you wanted to tell us about the specific role in terms of what can be provided under ADAP.

Laura Cheever: ADAP certainly provides a critical role here. There was an article published in February of this year in JAMA that highlighted the problem of accessing medications on discharge from correctional institutions. (Accessing Antiretroviral Therapy Following Release From Prison. JAMA. Vol. 301 No. 8, February 25, 2009.)

This study looked retrospectively over 2,000 inmates released from the Texas Department of Criminal Justice Prison System from 2004 to 2007, and found that only 5.4% of HIV infected inmates that had been on antiretrovirals were in prison had their prescriptions filled within 10

days of release. That would be from the time they needed so they didn't have a break in their medications. Only 30% had filled their antiretroviral prescription within 60 days of release. But importantly, those who received formal pre-release assistance and enrolling in ADAP were three times more likely to fill the prescriptions within 10 days. Having a structural ADAP system in place in Texas made a big difference for clients.

In terms of the role of ADAP, it really depends on coordinating with the correctional system to determine what services the system is paying for. The grantee needs to determine what gaps in the systems there will be in connecting the soon to be released inmate to services in the community. We don't define in the policy what seem to be released is, but we recommend that it not exceed 180 days prior to release.

Based on what is provided in the correctional setting and what is going to be provided in the community and the gaps that exist in between, for the grantee then determines what supplemental services should be provided during that transition period. Remember, once again, that Ryan White must be the payer of last resort here, and all the sources of funding must be expended first.

Questions from the Field

Richard Stewart, Tibotec

Richard Stewart: My question surrounds the fact that there's wonderful guidelines provided by both the Ryan White organizations, as well as the CDC, and the problem is they're exactly that; they're guidelines, they're not mandatory. Unfortunately most of the budgets are determined by county legislatures, by governors and because there's no federal funding, very often these patients are not linked to care because their questions are basically surrounding the fact that, well, who's going to pay for this. Consequently there's great discharge planning information, there's great guidelines that have been in existence for a long time. How can we, as consumers, as people who care, help get the information across? Guidelines are there but no one is mandated to follow them upon discharge.

Laura Cheever: Certainly in the context of Ryan White, usually in Part A, we have planning councils who are doing local planning. Having someone who is incarcerated on the planning council, or people who understand on the planning council the needs of the incarcerated is important in order to prioritize spending in this area.

You say there are no federal dollars available, I think Ryan White is one area where if the service doesn't exist and isn't happening and there's no mandate that it should be happening through the correctional system, that Ryan White entities can be paying for those services.

Questions from the Field

Sandra Miller, Lawndale Healthcare Center

Sandra Miller: How much or how many days is the jail or the prison mandated to supply the detainees or the discharge with medication?

Laura Cheever: You need to be working with your local officials because it varies dramatically from location to location and often the reality is in jails when people are discharged, they go before the judge and they're released directly from the courthouse, so they walk out with nothing. Other places, especially state institutions, may give 10 days or two weeks, but it varies and you really need to find out what's required in your area.

Questions from the Field

Mike Bryson, Marion County Health Department

Jinday Mabuea (Marion County Health Department, Indianapolis): Troy stated that his care was not good in prison and his medicine was not good. When he meant his care was not good, specifically was it that they didn't do the CD4 counts and the viral loads?

Troy: That's correct. They didn't do none of that. As a result I ended up hospitalized for almost three and a half weeks. The medicine that they prescribed for me wasn't the best and I ended up in the hospital for like three and a half weeks.

Jinday Mabuea: And the side effects?

Troy: Just the virus itself progressed a lot into me. They just didn't provide the right medicine that I needed.

Panel

Steven Young: We know that re-entry programs have to do many things at once, but that's nothing new to us in Ryan White. That's how we work. What I'd like to do now is go to our panelists and get a flavor of what these various reentry programs look like, what do they do, etc.

We have four Ryan White grantees on the line with us and they come from New York City, Oregon, Illinois and Wisconsin. I'm going to start with two of our panelists and ask them to give us a broad overview of their target group and their program so that we begin to get some perspective about what these programs look like.

First I'm going to turn to Portland, Oregon, and we have with us Amanda Hurley, and Amanda is the manager of housing services at the Cascade AIDS Project. She's also accompanied by one of her staff, Donna Standing Rock who is the housing case manager. Amanda, could you start us off?

Overview of Re-Entry Programs

Amanda Hurley, Cascade AIDS Project

Amanda Hurley: Cascade AIDS Project has several different programs that focus on people that are currently incarcerated or have criminal histories. One of those being the CareLink Program, which is a Ryan White funded program. It links people to medical care and medical case management for anyone that's newly diagnosed or has been out of care for more than six months. There is also a component that focuses on people that are currently incarcerated. The CareLink staff is able to work with people pre-released and make sure that they have access to medication and then also work with transition counselors to coordinate their transition plan. It allows us to coordinate services immediately after they are released. We are also able attend transition fairs that are inside the (Josen) prisons, so we're able to make contact with people that are currently incarcerated.

Another program is the HOPWA SPNS Program which is part of our support of housing program, where we work with people that are involved with corrections that are either recently released or just have a history of criminal activity. We do use the housing first model where we provide rental assistance and housing case management for support. We work with several landlords in the area to do housing placement. We also do home visits in order to provide eviction prevention services and try to connect people to mainstream services. We do a lot of work with community partners such as other AIDS service organizations and we work really closely with probation officers to ensure that people are meeting those requirements.

Steven Young: You mentioned HOPWA SPNS, so I'm assuming that you actually receive HOPWA funds to assist with some of the more permanent housing assistance. Let's shift over to the East Coast and I want ask Alison Jordan to provide us an overview. Alison is the Executive Director at New York City's project that's called Transitional Healthcare Coordination. Alison, could you give us an overview of your program?

Alison Jordan: Just to give you a little picture of Riker's Island, it's an island between Queens and the Bronx and there are about 14,000 incarcerated people there on any given day. We have a little bit over 4,000 people who self-report to us in a year that they're living with HIV. We have been trying to coordinate programs for them for a number of years and have recently worked on some new models that we're really interested in sharing with you all. I guess the major thing to remember with New York is that it's big, but in the end, we're dealing with one patient at a time just like the rest of the country.

Steven Young: I heard a couple of themes and we're going to probe on these themes around fundamental pieces of your programs. Discharge planning, obviously, stable housing, healthcare, partnerships with other agencies and even in a location with lots of clients taking it one at a time and building rapport and trust with clients. We are going to try to dissect some of these a little bit and maybe start with discharge planning and what's in a plan and how this all works.

Discharge Planning

Dr. Frank Graziano, University of Wisconsin Hospital and Clinics

Steven Young: Could give us a little bit of an overview and specifically start to focus in on how you handle discharge planning in your locality.

Frank Graziano: We are obviously a smaller state from the standpoint of number of infections that we have. We have at least 10 state prisons. The University of Wisconsin has a contract with these state prisons so that we see all of the prisoners for all of their healthcare, but HIV certainly is one of those problems that we see. We see all of the patients from the State Prison System in our clinic at the university, which is very nice that we have this closed clinic so that we can see them.

There is always a concern about security so we have cameras in the room as a suggestion. I don't know if that can be done. The State actually helped us with that security issue so that the guards don't have to be in the room. I think this is a very personal issue and this is how we take care of our patients.

As far as discharge planning, we start this very early. We try and find out when someone is going to be discharged. We understand that the biggest challenge is when is that date is, because it can change. They can just be released soon, so this is an issue that we have to deal with.

One of the things that we have done is we've been able to partner, as a Part C grantee, with Part B, the State, so that they have given us one person who we call the Prison Case Liaison person who helps and really deals with all of the re-entry issues. What this person does is they make sure that the person has an appointment, they make sure that they have an adequate supply of their medications (in this state it's from 10 to 25 days supply). We actually have a person who will try and help us with re-entry of these individuals into the community. We partner with one of the AIDS network places in Wisconsin and across the state so that we make sure that there's housing for those people and there are appointments that these people are going to have.

Steven Young: You use this term there when you were providing your overview; you referred to a closed clinic. Can you provide to our listeners what you meant by that?

Frank Graziano: All our patients who are seen here at the University of Wisconsin and what we do is since there are security issues with that and we worry and they worry about security, we have two rooms that are set aside in our clinic. All of the patients come to the clinic, two rooms are set aside and there's security in there. The state prison system actually put two cameras in the rooms; one for each room, so that security people can stay outside and we can see the patients inside with closed ability to talk to the patients about various problems they have.

Alison Jordan: It's important to engage the client as soon as possible. We try within the first two days - within the first 24 hours everyone who comes in New York City jails receives a complete

intake history physical exam and they have the opportunity to self report their HIV status. We also identify folks who are interested in a voluntary rapid HIV test; about 25% agree to that.

We identify folks who need care as soon as possible and then we'll actually engage them in the housing area, which is a benefit we have from being Department of Health in a correctional setting, but we're mandated by law to actually provide the care for inmates, which I think is pretty unique nationally. We bring t-shirts and toothpastes and underwear and socks and say good morning and we'd very much like to talk with you about some health service issues that you may have and start the conversation real early.

I think the discharge plan itself needs to have four major components. One would be primary care, second, housing, the third is treatment and that can be substance abuse or mental health and the fourth is some kind of other services; job - some kind of cash income to sustain a person in the community.

We have found recently that as far as techniques that are used for motivation and interviewing, really brief interventions have been really useful in helping staff conduct focused interviews with clients.

Steven Young: A number of our SPNS projects on a variety of topics have used motivational interviewing as part of their intervention so it's good to hear that.

Donna Standing Rock (Cascade AIDS Project): Regarding the discharge plan and the process of what we do here in Portland, we don't have the advantage of being able to have our staff directly in the correctional facility. We have been able to create partnerships and develop relationships with discharge planners in each of our institutions. Each of those institutions then have a primary contact, kind of their medical manager of their discharge planners, and they then send all of their known positive referrals to their head nurse and then she then in essence sends that back out to us over at our agency. That usually occurs within about three to six months prior to their discharge. At that point in time, that's when we're going to start trying to work with them; find out if they've ever had a provider here in our community before. If we're able to get them connected back up to that provider, we're going to try to reconnect with that relationship just based on - if they can go back to where they had some normalcy in their life prior to their incarceration, we're going to try to work on that.

Rather than a medical first model, we work on a housing first model. We believe that housing is healthcare. In order for us to save like somebody's mental health - their medical conditions, some of their psycho-social support, we have to have the foundation of housing. We try to place our clients as quickly as we can, whether it be into a transitional service program or whether it be into our HOPWA SPNS (unintelligible) programs which is our re-entry program.

One of the challenges I think that we've come into here is that a lot of inmates may not be reporting to health services that they're living with HIV. Some of that is very dependent upon their length of stay and their health conditions upon entering into the system. One of the tactics that we've been trying to in developing that trust and that credibility within the population is

we're trying to go directly into the culture club. I do an HIV/AIDS awareness program for peer mentors that are in our prison so that they all know that there is a resource for HIV positive inmates, that they can look at this housing plan as a discharge plan prior to getting released and they can incorporate it as a safer place for them to live when they get out.

Transitioning People to Care in the Community

William Moran, Illinois Department of Public Health

Steven Young: Describe your State Health Department approach in terms of transitioning folks to care in the community.

William Moran: We have a pilot project in Southern Illinois among multiple programs focused on local jails; county jails. The pilot is with the Jackson County Health Department (a Ryan White grantee) is designed to increase a number of positive referrals to care. In Illinois we're broken into eight different regions, and the first contact for care would be through one of these eight regions. To help that, we've launched a Web site (<http://www.hivcareconnect.com>) which allows discharge planners to know how to contact one of our eight regions. Depending on if they were to be released locally or if their destination is another part of the state they would be able to get a hold of that facility of the other end of where they're going to.

Another one is to test inmates that are scheduled for release prior to release so they would at least know their HIV status. Within the Illinois Department of Corrections, it's strictly a voluntary procedure to be test upon pre-release. Every six months inmates can request an HIV test or if there's any type of altercations within the facility, they would also be HIV tested. Another objective for the program would be overall general HIV transmission knowledge and how to reduce the risk and HIV healthcare referrals. What the project has done is worked through local parole offices as well as the reentry planners at specific field facilities down state.

They started a program called Healthy Beginnings which initially was a mandatory drug screening event planned and provided by parole agents in southern Illinois, and the Jackson County Health Department was able to partner with this particular program and be able to get a change in how this operated. In the past the parole officers went to each of the individual inmates' residence to conduct mandatory drug screens and other mandatory tests that needed to be done. Working with the Department of Health in Jackson County they were able to convince the parole officers to take advantage and be able to run, more or less, all these mandatory drug screens, other types of health screens, HIV screening at one particular location on a particular day. This was a big buy-in that the parole officers liked. They could conduct their mandatory screens without going from home to home and have it all done under one roof, and also be able to test them for HIV and refer as needed.

This pilot will conclude at the end of this month and at that time we will be working on putting together a binder for other facilities around the state. Financially it's supported by a mixture of Ryan White dollars as well as general revenue; state dollars.

Steven Young: We've heard a number of different innovative ideas and potential interventions. It really gets your head spinning a little bit in terms of how you really effectively coordinate care as they're being released and transitioning back to the community. Is there anything we may have missed with some of our specific questions that any of our panelists may want to raise in terms of coordinating a person's care, who you're connecting with and working with in the community in terms of other services and other agencies?

Frank Graziano: The prison case liaison manager is a person in our clinic. It's not someone in the prison system who works with the prison system. We really try and make sure that we're with the prison system and understand what's going with the patients there.

Amanda Hurley (Portland): We've really tried to work with some of the transitional housing programs that are outside of Cascade AIDS Project supportive housing programs, mainly to help with some of the immediate housing concerns. A lot of the transitional housing programs offer alcohol and drug free housing or more support around mental health and those types of things. Then once somebody has engaged in a transitional housing program we're also able to help do some permanent housing planning.

Allison Jordan: What we do could not happen without our community partners. There are over 200 organizations that we have agreements with, as well as a core group of consortium members who are - four organizations Palavia, Exponents, The Fortune Society, and Women's Prison Association, who come in to actually provide care coordination from jail, over the bridge, and into the community. I think that agreement along with other Ryan White providers who actually do case management in the community, COBRA case management, and other such things. We've been able to arrange for them to come to the jail prior to someone's release or to arrange a phone call with the person prior to their release, to actually begin the intake and really transfer the relationship that we have with the person to the community provider.

The two things that I think you hear over and over again from the callers is that this is about establishing relationships with existing groups to the extent possible, building on those new collaborations, and then the other piece is removing barriers.

People being released from jail have the greatest health disparities in our communities. From an epidemiology perspective this is the right place and the right time to talk with folks. As a social worker, if you're starting with people who are at their lowest point and trying to engage them in new behaviors this is really an opportunity not to be missed. I think that the care in coordination is absolutely essential with our population.

Allison Jordan: We created with our partners one universal tool that we all share so that when we begin our intake it then gets transferred on to the next provider, so whatever we haven't completed they have the opportunity to. And we did it as a consortium so I'm happy to share. I think it may be SPNS enhancing linkages Web site. See www.enhancelink.com

Donna Standing Rock: Because both of the states that represented - it sounds like they've been working their programs for a really really long time and over here and Portland our efforts have

just begun within the last couple of years to be able to be working directly with corrections for re-entry projects. We're at the challenging state and I'm assuming that maybe some of our callers might be in that same situation. The inmates inside of the institution are not aware of our programs that are on the outside. For us, there's not really a guarantee that if we develop the relationships with the administrators or the health service groups that inside the prison that the inmates are actually going to get the information. Our tactic is really to get the information about our services to the inmates is to get to the inmates first.

Frank Graziano: Our relationship with the state prisons and also our state public health, our HIV program here, has been ongoing for years and we had all of the anxieties and problems that you could think of to try and get these programs going. It really does take time. I think that's important that you understand that. It takes some time and it takes some effort on your part to work with these organizations. But at least here in Wisconsin we've been able to get a very good relationship with them and to have these programs now ongoing. That's a very important point.

Steven Young: I want to ask all four of our panelists the evaluation question. You're all doing critical and very difficult work and I'm curious whether, you're objectively seeing the results of that work either in terms of retention in primary care in your clinic or in terms of decreased rates of re-incarceration and things such as that. Any of our panelists have any evidence to share?

Frank Graziano: We here in Wisconsin are trying to evaluate this and see what there is in an outcome. We have a much smaller population than almost anyone - I think than anyone on this call -- at least on the panel. We've been able to track some of this. What we've done is we've gone out a month and we've tried to see with the ARCW how many people were actually keeping their appointment. Amazingly so it was something like 85% of the people who were in this re-entry program were keeping their appointment. Now this was the first month. What we would like to do now is go out six months and see if this program is having the same type of success.

William Moran: In Illinois, even though this is a pilot project we're working on, we have seen some success in some of the outreach that has been done. In one of the events there were 79 offenders that were tested during a mandatory drug-screening event. Seventy-nine were provided services for employment and other things. Based on one session it seems like the program, did touch base with a number of offenders.

Amanda Hurley: For our CARE Link program as well as for our supportive housing program we have to do three, six and twelve month follow-up, and that's for engagement and medical care as well as stable housing. We always fall within the 85% to 90% stability rate of people that are engaged in medical care and continue to be stably housed.

Questions From the Field

Barry Zack: First, and for full disclosure, I'm the federal investigator of a role out community - a research project called Project Start that we've just translated the community. It is an effective correction to community behavioral prevention intervention. We've just pilot tested this with people with HIV and the data looks very promising. Though the data that people just shared

with (Corcoran) and Portland is 85% plus retention at six months and a year. That's amazing and we really need to look at that.

We've looked at access and utilization of medical appointments, but obviously a lot more that we need to look at. I guess my question is there are some great groups out there and, everyone on this call is well aware of the priority - be it funders or foundations that people are looking at evidence based. I know Project Start - we're ready to roll that out, but are there other behavioral interventions with the re-entry population? As Stephen said earlier, a question that you posed to the panelists as far as what kind of data people are collecting and what are their evaluations?

Let me squeeze in one second question for the panelists and anybody else on the call. That is because of the data coming out of Texas and ADAP about the work everyone is doing is how do providers represent themselves inside of a jail, being so HIV specific? I think one thing that we can all share with each other are strategies so that we are not outing our clients. You know, everybody with HIV come over here. I know, hopefully, no one's doing that, but what are some of the strategies inside of an institutional setting. How people are dealing with this? Thank you very much.

Frank Graziano: We give education to the staff in the prison systems where we will yearly hold a prison conference so that people know where we're coming from and the issues that we're dealing with. We also try and do is we have a newsletter that's available not only to the people that are HIV infected in the prison but to the whole prison staff. They are put in areas where the prisoners can actually look at them too so that we can look at obviously anonymous things that have been written by prisoners, etcetera. That sort of eases some of the tension, but boy that is a very important issue about outing a prisoner if they're HIV positive because that can have very big consequences for them.

Donna Standing Rock (Portland, Oregon): We partner with our Oregon State Health Department in an effort that's been in our main Oregon State Facility for the last like ten years. That's called our HIV Awareness Program where we invite anybody who's interested. We meet once a month and it's a peer curriculum based type of project. People can be - and by peers it's inmates, not just positives. There's a combination of people that can come - that are interested in learning more about HIV, learning to become a peer educator, learning, you know, more about the sharing and disseminating of accurate information within inside the prison system. That's one way that I think we've made an approach, in dealing with nondisclosure.

Allison Jordan (New York City): One of the things that we do is part of our funding is not HRSA HIV but rather CDC prevention. We have other programs that we run for folks with chronic health conditions. To the extent possible we try to present ourselves as working for the health department without regard to whether the person we're working with is living with HIV or not. To the extent that, you can work from a public health model or a community health perspective, I think that that actually has helped a lot in terms of both getting people to speak to us and also to maintain that confidentiality and not be known as the HIV ladies.

Your other point about the behavioral interventions, I'd be very interested as well in any evidence-based strategies that could be applied to our setting. We do have a treatment readiness program we've been running. It's called, A Road Not Taken. It's a sixteen module treatment readiness program that has been validated. Initial results are promising and we're waiting hear more about that.

I also wanted to share with you that we're providing somewhere between 150 and 200 discharge plans each month. About 100 people each month are released from Rikers Island and we're having connections to primary care within the first 30 days of release running at or about 75% to 80%. We don't really believe in appointments -- I have to tell you all -- because we never know when people are leaving. Because our short stays are the norm, people leave before we really have a chance to know what their appointment should be. We try to work with our community health centers to use walk-in hours and to make plans that are really more of a warm transition as far as transport than it is an appointment on a piece of paper.

Steven Young: Troy I was wondering if you had any experience with the whole issue that Barry raised about dealing with an HIV specific program and kind of outing yourself within the prison system. Did you have any experience with that either positive or negative with a thing that you had to work through?

Troy: Well I think that, somebody should provide a staff member from each agency inside one of the prisons. That would help the prisoners get along more better with opening up, letting people know that they are positive because people like hide their situations so well in prison that, you know, it just - I can't explain this. It's a real hard situation to explain. We really need somebody on the inside to conversate with the prisoners.

Frank Graziano: But I think this is important because this is what we hear from the prisoners all the time that this is a huge issue for them - from the other prisoners, from the guards, other staff, and it's something that I think we have to face. Again, we're a smaller community here so it's a little bit easier for us. This is Wisconsin, but that is a major issue for the prisoners.

Troy: And maybe the prison staff you can get along a little bit more better.

Kathleen Davis: I heard you mention that part of the plan is for a job or cash income. I am working in employment services for recently released with HIV and I'm wondering about strategies for securing employment. Are there any models in the country which have proven placement and retention rates? And for the entire panel, what's the most important factor in preventing recidivism? Thank you.

Allison Jordan: We work with community based organizations including Centers for Employment Opportunities and the Fortune Society, and they have had some very successful models. We also hire formally incarcerated people for our program and folks who've been impacted by HIV. I think that that helps folks see that, you know, what the next step could be. But there are some good resources in New York I'm happy to share with you.

Donna Standing Rock (Portland): The recidivism I think - like I said, our program is still pretty young yet and so we've still had a pretty decent success rate. What I see as particularly a better success rate with our individuals that are coming out of the state correctional facilities versus the individuals that are jumping in and out of jail. I think I see more recidivism in that population than I do with the folks that I work with that are coming directly out of the corrections system.

Part of what I do to work with individuals is acknowledging that they are coming out. There are so many changes depending upon how long they've been in. What kind of cultural shock are they going to come into just within the area that they live in? Some folks are coming out and have never even seen a cell phone before. So trying to meet that person exactly where they're at; what is their comfort level, how far can they go today, what are they going to be able to do next week, and who else is engaged in all of their reentry process and helping them to try to prioritize some of that.

One of the other things I think is just being really up front with our program policies is that, we also say, "This is a great opportunity for you. We don't know how long this opportunity is going to be around but, our goals are for stable permanent housing placement." We do intensive case management services with our client and that again is based on the client need. We can see a client up to, you know, one to three times a week if we need to or we can see them once every three months. We take that individually with each one of our clients and work through their problems or the challenges of what might be able to cause recidivism

In the past when I've been working here prior to this program, because I worked here at our agency for about seven years with this particular population, and what I saw previously was that the biggest recidivism issue was not having a place to live. In our area and in our program I can see why just having that housing first model has been an excellent source of being able to reduce recidivism and the case management support that goes along with it.

Amanda Hurley: I'd also like to add that we do stay connected to probation officers so that the client can hear from the probation officer as well as from the case manager about what the probation requirements are. Both people can come from a different angle and make sure that the person is meeting those requirements.

Donna Standing Rock: We also provide advocacy as a kind of buffer between our clients and the probation officer if so needed; doing that motivational interviewing to encourage good communication behavior between people that are involved in their lives.

Frank Graziano: Recidivism is a problem. We've had people who come back to prisons who did everything that we said; they went to their medical appointments, they got housing. I. Everything seems to be stable but there are still issues that they can have. I think we have to be aware of that.

Gisele Hudson (Arkansas Department of Health): We're trying to start a program in Little Rock and we need to know what we do first.

Steven Young: Well that's actually a segue to a question I was going to ask right at the end. Let me ask all four panelists. Each of you give me one thing that you think that a program just starting out should do first.

William Moran: One of the big things is if you haven't started out in working with your state department of corrections. You have got to learn about how they operate within their facilities and at kind of programs they have going all ready. In Illinois part of the things that came out of this pilot project was a re-entry summit that we were not aware at the time that these were going on. But they are going on within our IDOC every six months in which different community organizations and businesses actually come in to facilities and provide information for inmates that are scheduled for release. It was a key program to be able to jump start our pilot.

Frank Graziano: What's important is that you start up and get good relationships with the state corrections for sure. That's something that we really worked hard at. Your local organizations - we have a very good relationship with the ARCW and the AIDS Network. I think those are key, and also the HIV program here in this state. At least for us, those were the three key areas which we thought were important. We started very - quite a while ago to really make these relations solid. It takes some time but you can make those relations solid. If you do then you're going to see that these other people are going to want to help you.

Steven Young: Besides the relationships is there a service you need to have available right away?

Allison Jordan: I think going out to meet with your community health centers. You do have community health centers out in Arkansas, according to Google, and I think they're really valuable organizations particularly in the areas of greater need, because the likelihood is that they're sharing patients with you from the folks that are leaving jail. I think having that resource will help open the door for you when you go to meet with the jail health people.

Amanda Hurley: I would say the first step would be to identify what gaps there are in the system. Whether that be within the community or within the correction system, but that would involve talking to community partners and talking to clientele, the people that have actually been incarcerated, and hearing some of the challenges that they've heard or that they've experienced.

Donna Standing Rock: I think that the staffing of the project is also very important and especially starting from the get-go. I think that it's - and I don't know how other folks would feel about this, but I think part of what we've been more successful with is that administratively we've been working more with the administration of the department of corrections, and then having another person that goes in to see the inmates. Everybody's involved but yet the inmates see us as their liaison. They see that front line worker as we're there representing them, we're there for them, and we're going to consistently be there. I think staffing - It's the important choice of staff, who you put in the position.

Dr. Orrs (Alameda County Sheriff's Office): Two questions: One, what impact do we anticipate that the economic situation is going to have on the availability of Ryan White funds? Two, what innovative concepts can you present for an urban city jail in terms of transfer of information

when inmates come into the jail, inmates released- to getting information providers -- private providers and/or community health care centers. What kind of significant links are you able to have - has anyone developed that enhances the transfer of information?

Laura Cheever: Yes. As I pointed out when I was talking was that Ryan White is a payer of last resort. Ryan White is really the fill in gap - so the safety net. As the safety net gets thinner and thinner as programs are cut due to local budgetary constraints then Ryan White is trying to cover more and more. That does make it tough in some - certain things in Ryan White need to get prioritized and cut. As groups choose to prioritize, basic medical care over support services then it makes it much more complicated to run these types of programs. One thing is the decisions that are made at the local level.

Amanda Hurley: We do have a formalized referral system with the medical staff that work within the jails and the prisons. They do have a release of information which were added on that release of information so they can fax that to us directly so that we can make immediate contact with the inmate.

Allison Jordan: We're working on electronic health records and we're hopeful that through our primary care information project we will have a health information exchange. They call them (RIOS). I'm not sure what the acronym means but it is sort of a resource where a number of providers share health information and we're hoping to link into those in the coming years.

In the short term what we've been able to do is establish linkage agreements. We use this universal way of transferring information. As the local provider of health care in the jails, it's made one of the things really easier in establishing the relationships is that we do come with the information that people are needing for programs, like the results of a TB test and the last CD-4 count and viral load. I think that having that information go back and forth electronically is really just the future of working these programs through.

Michael Patia (Palladia Incorporated, New York City): I just wanted to just quickly say that I think something that I'm not really hearing addressed is the idea of drug treatment, residential and outpatient treatment. I think that would be one of the things that would be very helpful in terms of the recidivism rate. Having said that - thank you Allison for acknowledging the community-based partners that are partnering with the New York City Department of Health - one. Also from the the panel, are you guys looking at substance abuse treatment as a priority for your reentry process?

Allison Jordan: You should all know that one of the 12 jails on Rikers Island is primarily geared toward those who have treatment needs and that Michael works with us in connecting people to residential and other outpatient drug treatment programs in the community. One of our enhancements to the traditional model that we've been talking about is to have court advocacy linked to alternatives to incarceration. That includes residential drug treatment programs, which we think give that extra step from jail to the community in a transitional way. We're looking forward to seeing whether or not this court advocacy and placement in residential treatment programs can be successful. Thanks for the opportunity.

William Moran: In the Illinois pilot we have one component called Treatment Alternative for Safer Communities and this is a program that provides health care and treatment services for those that are incarcerated for drug offenses. Part of the pilot is to develop its ongoing educational programs for counselors and parole officers that are involved in this particular program.

Steven Young: Thank you William. I think given the time we're going to have to close this out now. Again, I want to remind folks that if we did not get your questions please call it in to us at 301-443-0067. And we will try to get a response to your question. You can also email it in through the TARGET Center Website. I'd like to thank all of our listeners as well as our panelists for their participation in this important call. And we're going to close.

Wrap Up Comments

I'm going to ask each of our five panelists - going to give them 15 seconds and have them share with us one parting piece of advice they have regarding doing this reentry work. William?

William Moran: I have three areas, or one major one, is really to investigate those organizations that are all ready involved in some type of prison outreach. These can be faith-based organizations, CBOs and there are different types of prison ministries that go around, at least in the state of Illinois, and they can be important partners in your development of your programs.

Troy: Just investigate that person that you're going - your client. Because he has a lot of secrets and he really needs to gain somebody's trust if you want a successful program.

Amanda Hurley: I would say have open communication with all parties involved. That includes community partners, clients, and the department of corrections. Open communication is really key to keeping the partnerships going.

Frank Graziano: Well I think Troy said it very well. And that's one thing we strive for is to make sure that we have the trust of the inmate, and that really is very helpful. The second thing is your relationships with your - the community-based organizations. I think that's very important.

Allison Jordan: I think none of this would work if we didn't have staff who care. I think if you can hire someone who's been impacted by HIV that would be useful. If you can't, make sure you hire people who care.

Steven Young: Thank you all to our listeners and our panelists. With that we're going to wrap up this National Technical Assistance conference call. I look forward to engaging with you sometime in the near future around another topic of importance to the Ryan White Community.