Mitigating the impact of incarceration on housing and employment

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ACOJA CONSULTING

OPENING DOORS...MAKING A DIFFERENCE

Disclosure and Disclaimer

Option 1: “I do not have any relevant financial relationships with any commercial interests.”

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Educational Objectives

- Objective 1: Review the challenges of housing and employment after incarceration
- Objective 2: Discuss three evidence-based structural interventions designed to address incarcerated populations and community return.
- Objective 3: Provide functional assessment tool to complete, discuss and share next steps with their jurisdictions.

Special Projects of National Significance

Purpose of SPNS

Develop innovative models of HIV treatment

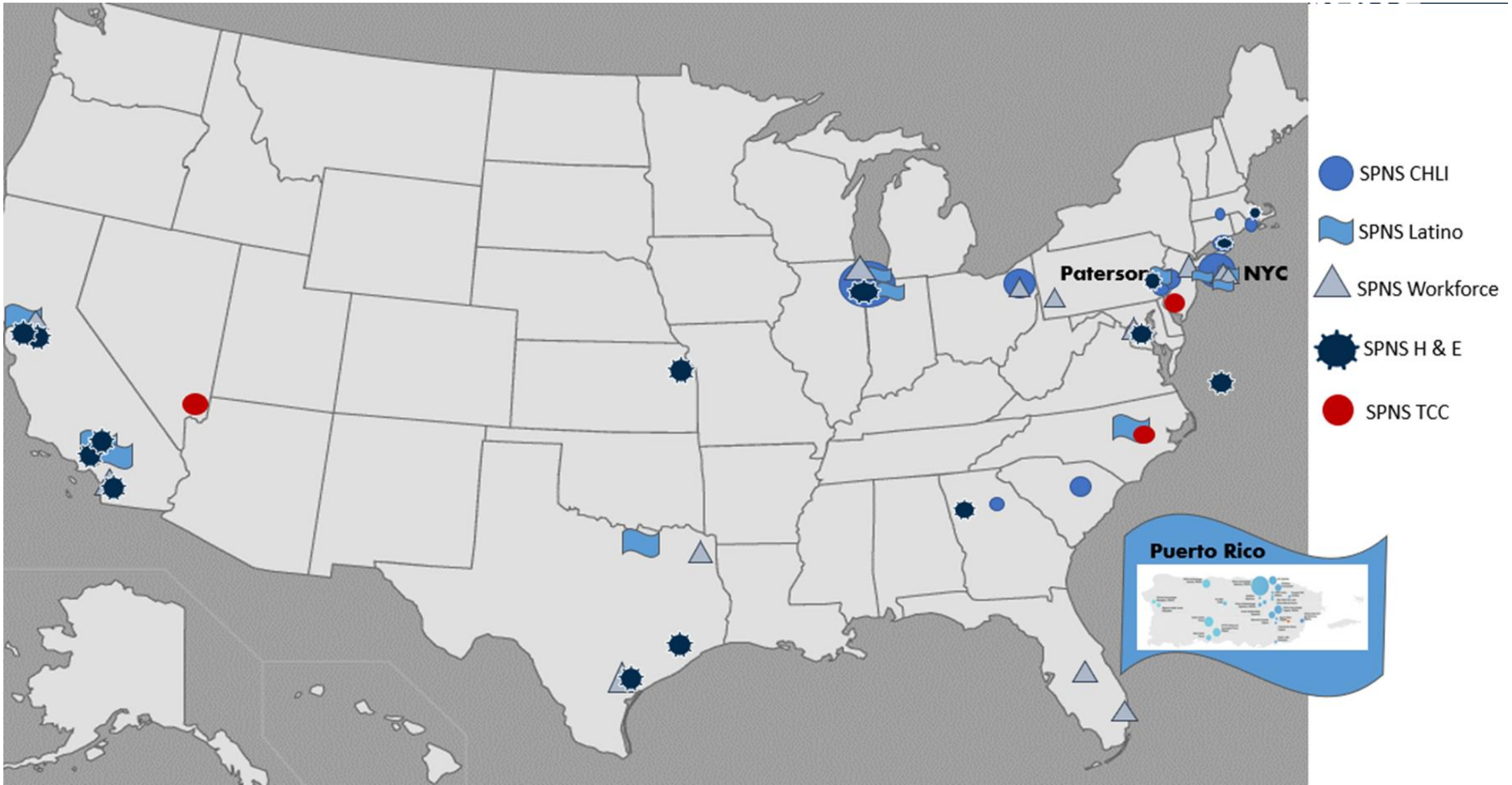
Quickly respond to emerging needs of clients

Source: Johanna L. Goderre, MPH

Key SPNS Initiatives

Correctional Health [2007-2012]	Ten sites found 79% of participants linked to care after incarceration; created Transitional Care Coordination New York City (TCC NYC).
Latino Initiative [2013-2018]	Most ethnic minorities in NYC jails of PR origin; facilitated culturally appropriate care and linkages after incarceration to enhance TCC NYC.
Workforce Capacity [2014-2018]	Built a community collaborative & adapted TCC NYC intervention to create Transitional Care Coordination Puerto Rico (TCC PR).
Dissemination of Evidence-Informed Interventions [2015-2020]	Developed Care and Treatment Interventions (CATIs) including dissemination of Transitional Care Coordination NYC in 3 locations: Camden NJ, Raleigh NC and Clark County NV
Housing & Employment [2019-2021]	Various interventions across the U.S. – all enrolled people with recent histories of incarceration; Paterson NJ adapted / enhanced TCC PR.

Locations


Paterson
NYC
Puerto Rico
SPNS CHLI
SPNS Latino
SPNS Workforce
SPNS H & E
SPNS TCC

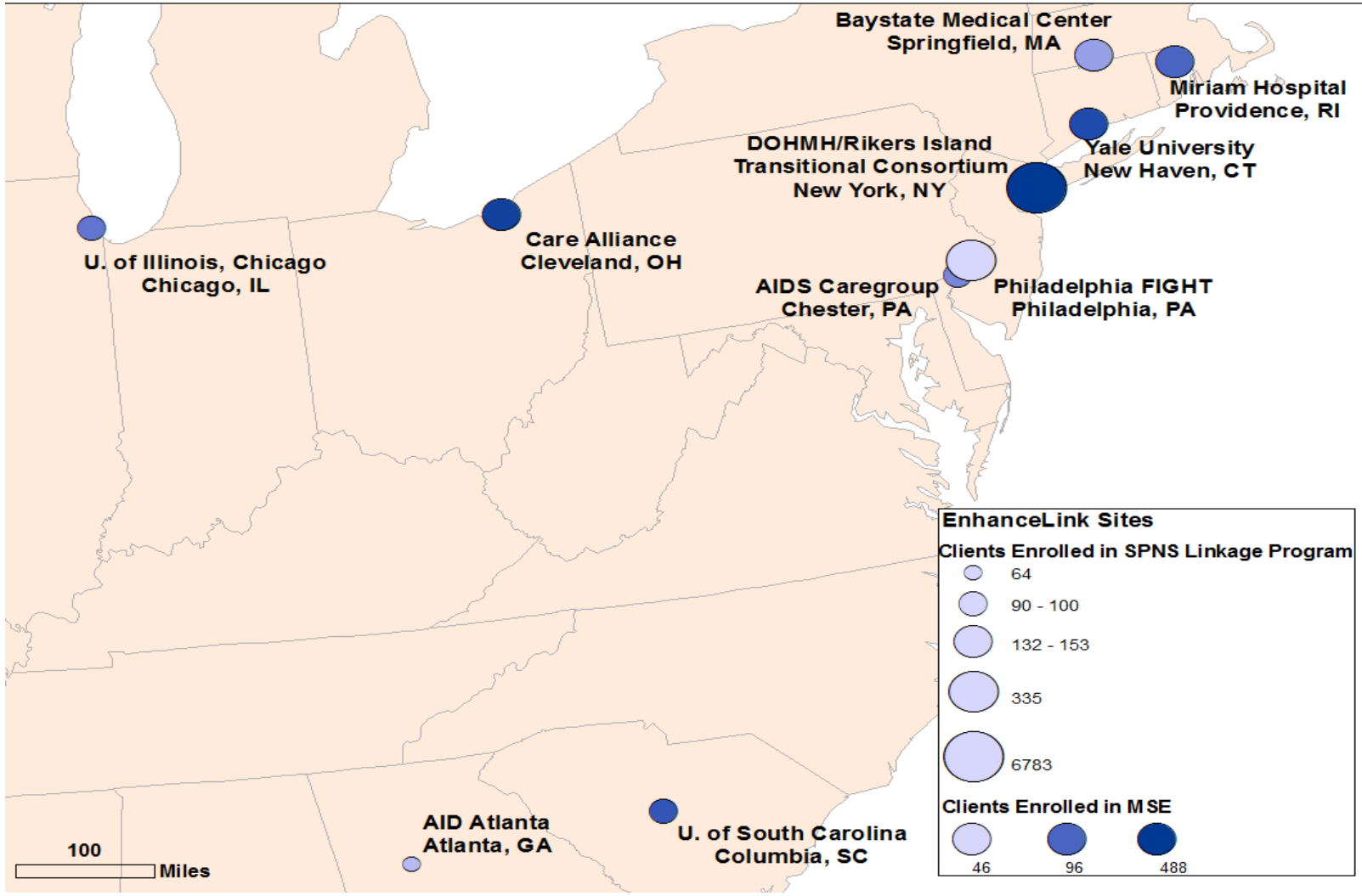
Correctional Health Linkages Initiative

Ten Demonstration Sites

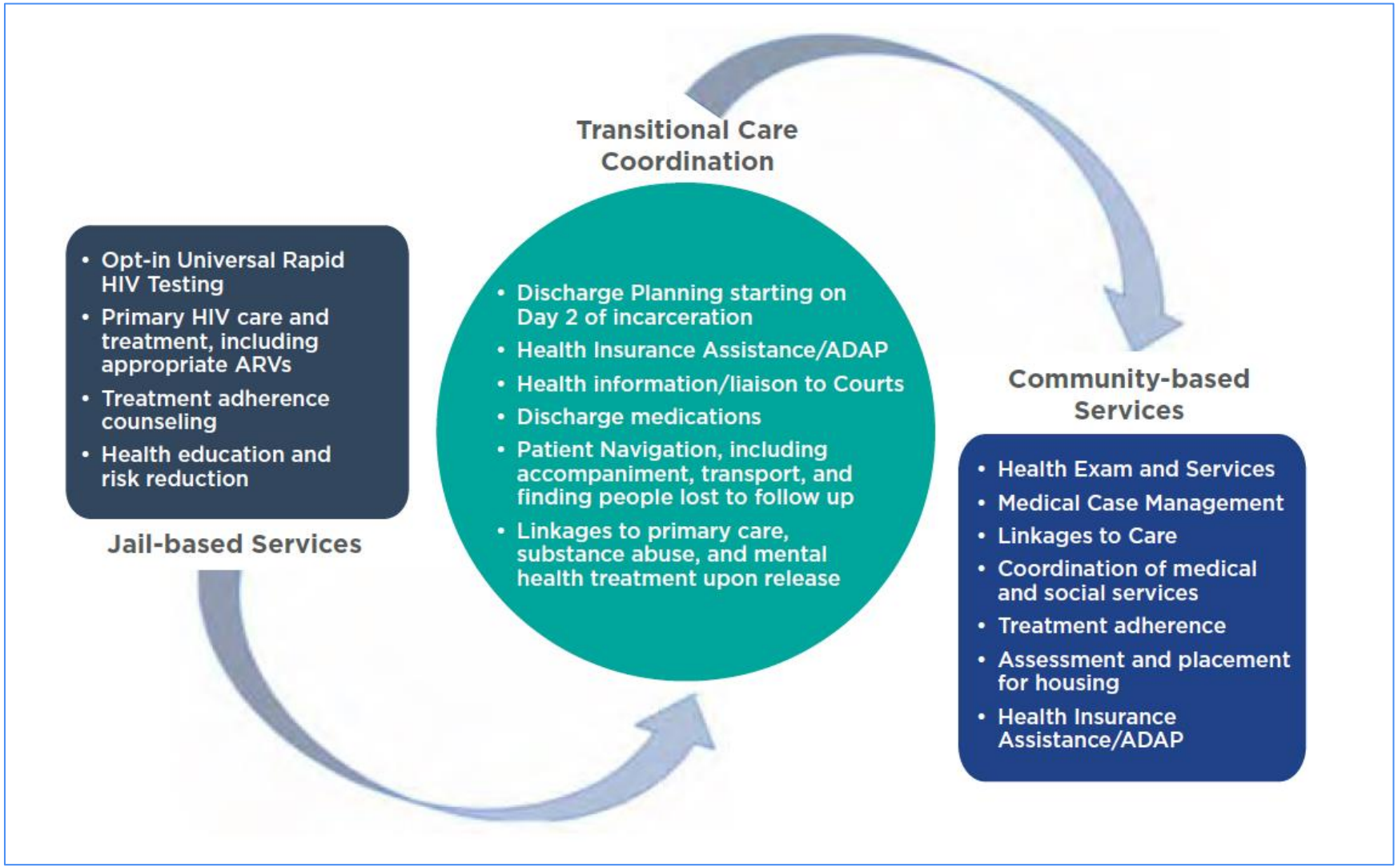
(2007-2012)

Facilitate linkage to primary care for HIV patients leaving local jails:

- Identify HIV patients in custody
- Initiate transitional services in jail
- Facilitate post-release linkage to primary care and community services.



Intervention #1 Transitional Care Coordination NYC



Transitional Care Coordination New York City is listed in the CDC Compendium of Evidence-informed Structural Interventions

TOOLS + TIPS FOR PROVIDING TRANSITIONAL CARE COORDINATION HANDBOOK

www.targethiv.org/ihip/tools-tips-providing-transitional-care-coordination

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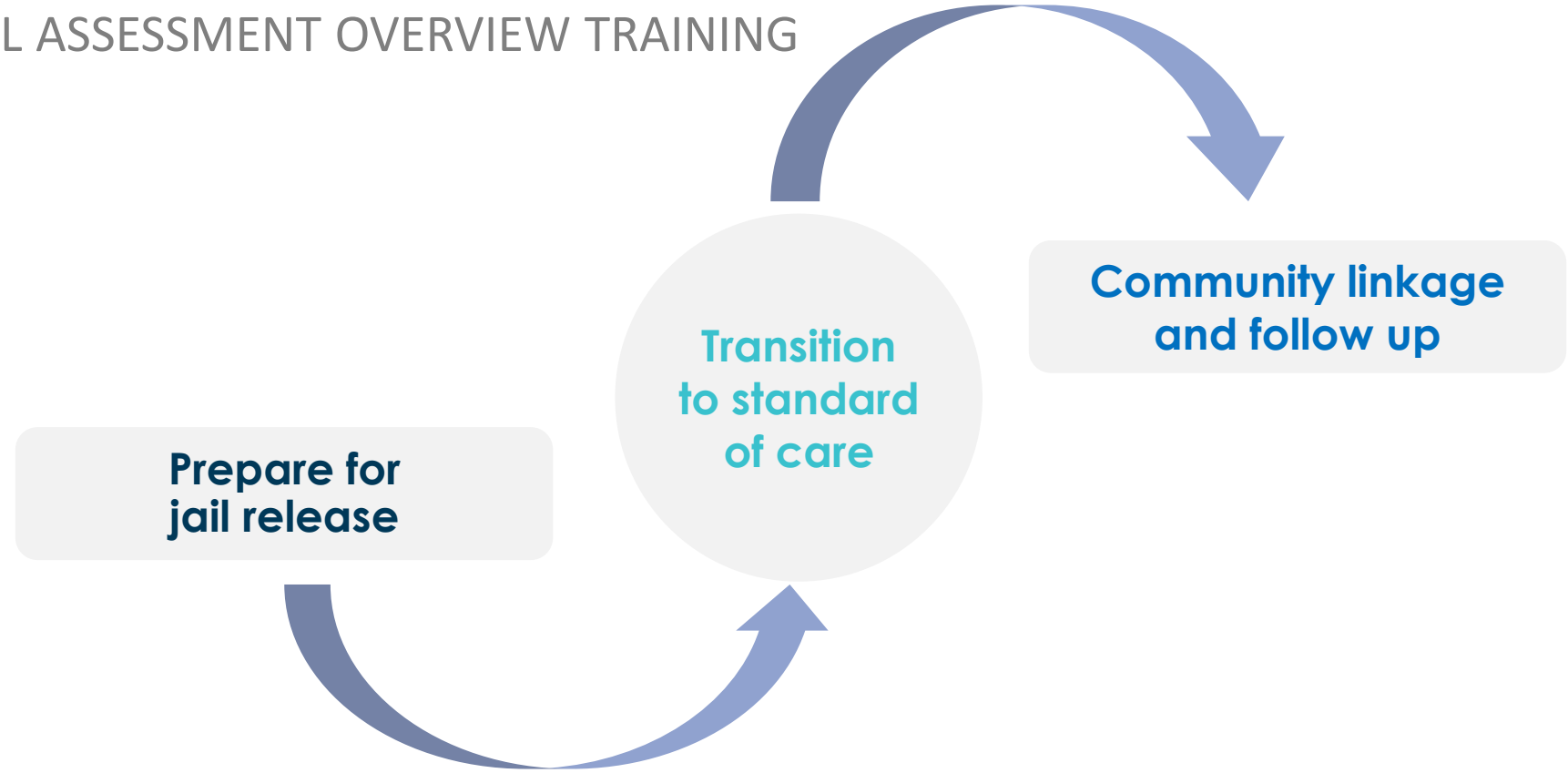
TRANSITIONAL CARE COORDINATION:

FUNCTIONAL ASSESSMENT OVERVIEW TRAINING



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TRANSITIONAL CARE COORDINATION MODEL

Functional Assessment Instructions

- **Assess roles and responsibilities for each activity associated with the 5 CORE ELEMENTS. Each activity is currently listed in blue and each core element is listed in green.**
- **Determine which organization will perform each activity. Change the font colors on each listed activity using the Functional Assessment Tool to reflect:**
  - Performance site
  - Performance site partners
  - Community standard of care
  - To be determined
- **Identify gaps as well as inconsistencies and any strategic adjustments that may facilitate:**
  - Start up
  - Integration of model
  - Maintenance of model
- **Use the Goal Setting Tool to reflect changes or updates that are needed for implementation**

TRANSITIONAL CARE COORDINATION MODEL

Prepare for jail release

- Medical intake (day 0), including rapid HIV testing
- Primary HIV care and treatment, including appropriate HIV antiretroviral medication
- Treatment adherence counseling

Initial client contact

- Intake assessment
- Health insurance assistance/AIDS Drug Assistance Program (ADAP)
- Health education and risk reduction

Transitional care plan

- Health liaison to court
- Identify community resources

Transition to standard of care

Facilitate a warm transition

- Discharge medications
- Accompaniment/transport from jail to community provider.
- Verify linkages to primary care, substance use, and mental health treatment upon release

Community linkage and follow up

Appropriate follow-up through 90-days post-release

- Implement the transitional care plan
- Linkages to care and services
- HIV primary care
- Treatment adherence and directly observed therapy (DOT), as needed
- Health education/promotion
- Housing assistance and placement
- Health Insurance Assistance/ ADAP
- Patient navigation: accompaniment, home visits, and re-engagement in care

Ongoing medical case management

CORE ELEMENTS IN GREEN

TOOLS + TIPS FOR PROVIDING TRANSITIONAL CARE COORDINATION

HANDBOOK

Synthesizes program planning, implementation, and lessons learned, offering strategic approaches to:

- implement, expand, and refine care coordination work.
- negotiate and form partnerships to improve health outcomes.
- identify medical alternatives to incarceration.
- improve continuity from jail to community healthcare.
- benefit health and hospital care, public health, HIV services, substance use and mental health, and jail health.

It can take just one individual to initiate improvement and one team to sustain it.

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Transitional Care Coordination NYC

- 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 through community outreach; 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."

– Alison O Jordan, LCSW & Lawrence Ouellet, PhD

SPNS Correctional Health Linkages Initiative

Outcomes

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

Indicator	NYC Health		All 10 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%)

Improving Health Outcomes

Transitional Care Coordination results:

- **Fewer visits to the emergency department,** from 0.60 per person in the 6 months prior to baseline to .20 visits at follow-up
- **Housing instability and food insecurity decreased** from over 20% at baseline to less than 5% at follow-up.
- Individuals also self-reported **feeling in better general health.**

(see Teixeira et al 2016)

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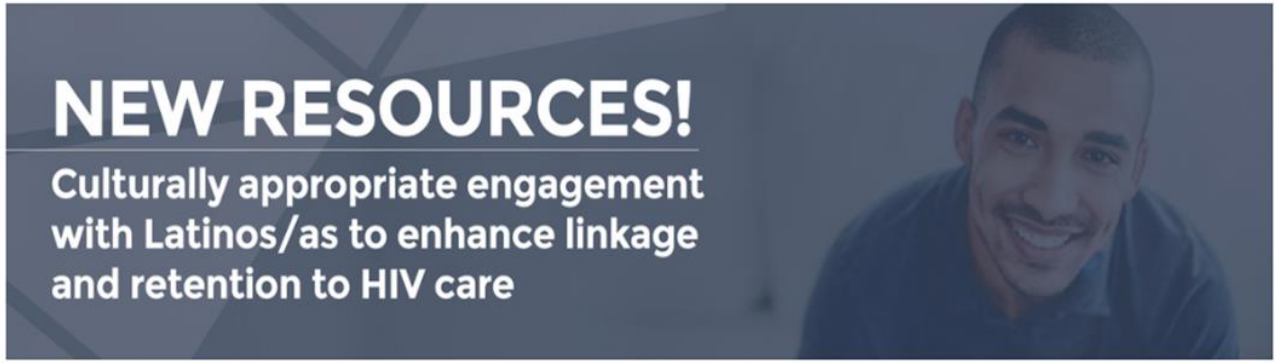
Intervention #2 SPNS Latino Initiative in NYC

Culturally Appropriateness Training

Key Topic Areas

- Transnationalism
- Puerto Rican & Latino Culture
- Cultural Competency
- Strategies for Improving Care
- Also: Interactive activities

This webinar series is available for health and social service professionals!
http://www.bxconsortium.org/cewebinarseries.html



A webinar series about Culturally Appropriate Engagement and Service Delivery with Latino/as to Enhance Linkage and Retention to HIV Primary Care – including a Transnational Case Study for Puerto Ricans is now available for health and social service professionals! This Continuing Education activity is for physicians, nurses and Certified Health Educators, as well as other health and social service professionals. Accreditation for physicians, nurses, and Certified Health Educators as well as general CE is available (CME, CNE, CHEC and CEU).

This curriculum explains how to use four key frameworks which, when integrated, allow for the development of a provider-level strategy to improve the HIV primary care patient outcomes for Latinos/as who are incarcerated or have a history of incarceration. The case study provides a sub-analysis of transnationalism among Puerto Ricans.

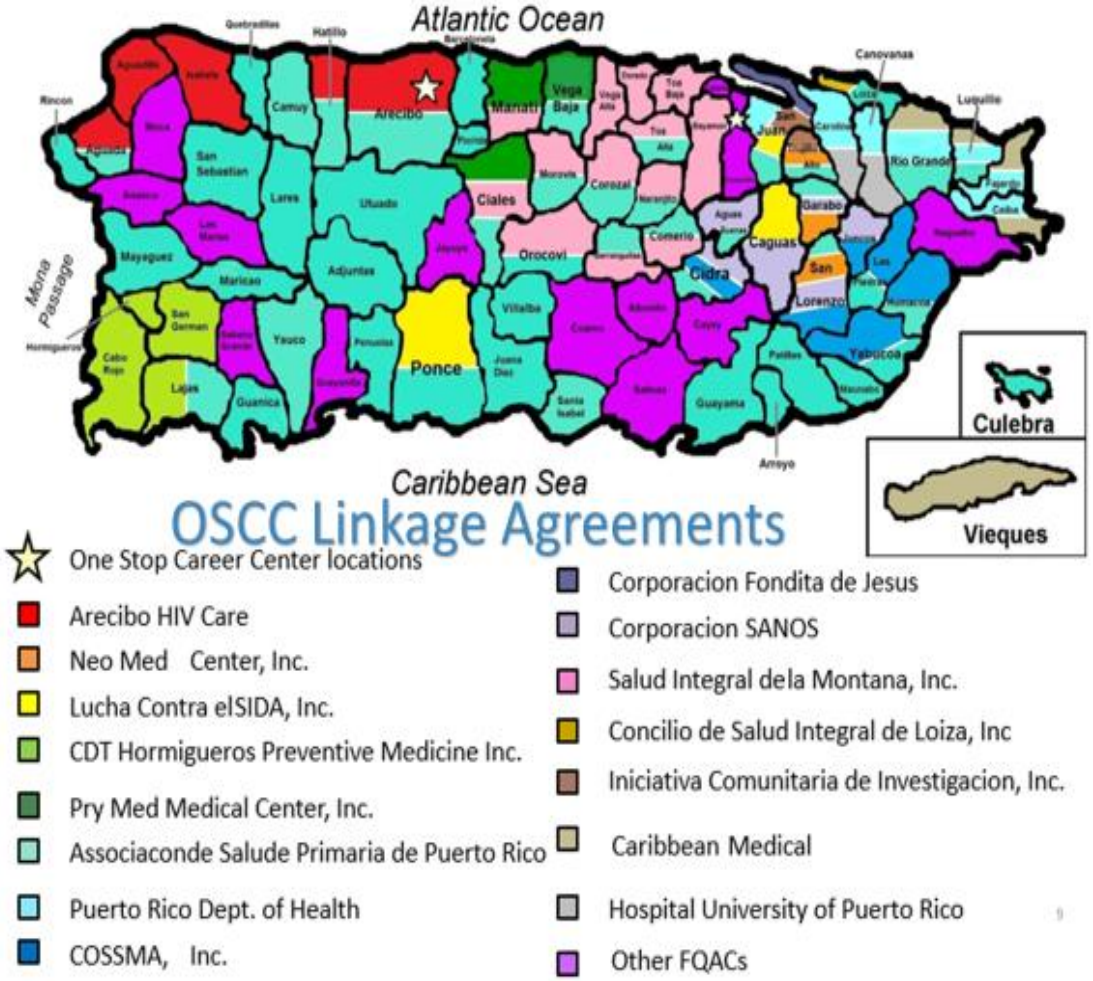
These frameworks include:

1. **Cultural Formulation,** which analyzes cultural factors that affect clinical encounters, especially when the healthcare provider does not share the same cultural background as the patient.
2. **Transnationalism,** which represents the process by which immigrants forge and sustain multi-stranded social relations with their country/place of origin. It affect the social field of individuals, which includes their group identity, daily activities, neighborhoods/communities, economic opportunities, and social and political behaviors.
3. **DECIDE**, a six-step process for decision making.
4. **Shared Decision Making**, a strategy where patients and providers build a consensus on the treatment plan and agree on the steps necessary to implement it.

Collaboration Outcomes

Community Resource Identification

- Over **60 MOUs** with service providers across PR to address housing, primary care, employment, and other social services
- Government and community partners launched Island-wide consortium to address needs of HIV+ clients transitioning to community after incarceration
  - **Community providers** – medical care, including HIV Primary Care, housing, substance use treatment, syringe exchange, support services, care management.
  - **Federal agencies** – Ryan White, US DOJ
  - **PR Department of Correction and Rehabilitation**



Primary Care in Puerto Rico

Intervention #3 Pay It Forward

One Stop Career Center of Puerto Rico, Inc. (OSCCPR) is a private non-profit organization (501) (c) (3), incorporated in November 2000, with state and federal tax exemption. We offer services to young people and adults across the island with a commitment to develop and help strengthen community structures.

Our initiatives aim to impact the areas of greatest need of the population such as housing, education, employment, health and legal services. Offering service programs that can integrate and offer alternatives to communities in need.

In addition, we believe in the importance of collaborations between organizations, with the aim of bringing more and better services to the participants.

SPNS Latino & Workforce Capacity Initiatives

One Stop Career Center of Puerto Rico (OSCC)

- Partnership with PR Department of Correction supports individuals coming home after incarceration
  - Job training and placement
  - Clear criminal records
  - Case management
  - Housing assistance
  - Eviction prevention
  - Life skills training

Transitional Care Coordination Puerto Rico is listed in the CDC Compendium of Evidence-informed Structural Interventions

- SPNS Latino Initiative partnership with NYC Correctional Health Services identified community health care and services to support individuals coming home after incarceration – from Puerto Rico facilities and across the Air Bridge
- SPNS Workforce Capacity Initiative partnership with NYC Correctional Health Services expanded HIV outreach and education in jails / prisons to
  - Transitional Care Coordination adapted for housing & employment organization
  - Mapping linkages to healthcare as well as housing, employment and other services
  - Interactive Resource Guide builds in sustainability for collaborative

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Steps to Implementation

Identify staff:

- ✓ Train staff in TCC
- ✓ State certified HIV counselors

Transportation:

- ✓ Transportation Service
- ✓ Identify sustainable funding

Coordinate with Corrections:

- ✓ Access to correctional facilities
- ✓ Patient health records

Engage Key Stakeholders:

- ✓ Establish Linkage Agreements and a Consortium
- ✓ Sustain using Resource Guide

Transitional Care Coordination – Puerto Rico

- Build on SPNS CHLI & Latino Initiatives to enhance collaboration and coordination among providers
- Train employment and housing specialists in Transitional Care Coordination
  - HIV education and risk reduction
  - Outreach & engagement
  - Transitional care planning
  - Coordination with service providers
  - Patient navigation after incarceration
- Conduct SPNS local evaluation
- Secure reliable transportation for clients
- Sustain collaborative and service delivery

TCC Puerto Rico Program Outcomes

- OSCC staff working in 13/32 correctional facilities in PR
- Prevention education/risk reduction sessions provided at jail orientations to identify potential clients (n=360)
- 69 enrolled and completed baseline
  - All received transitional care coordination
  - 10 additional served as part of pilot
- 58 returned to community after incarceration
  - 54 of 58 eligible (93%) linked to HIV primary care and other services after incarceration
  - All 10 (100%) pilot participants linked to care

Housing & Employment

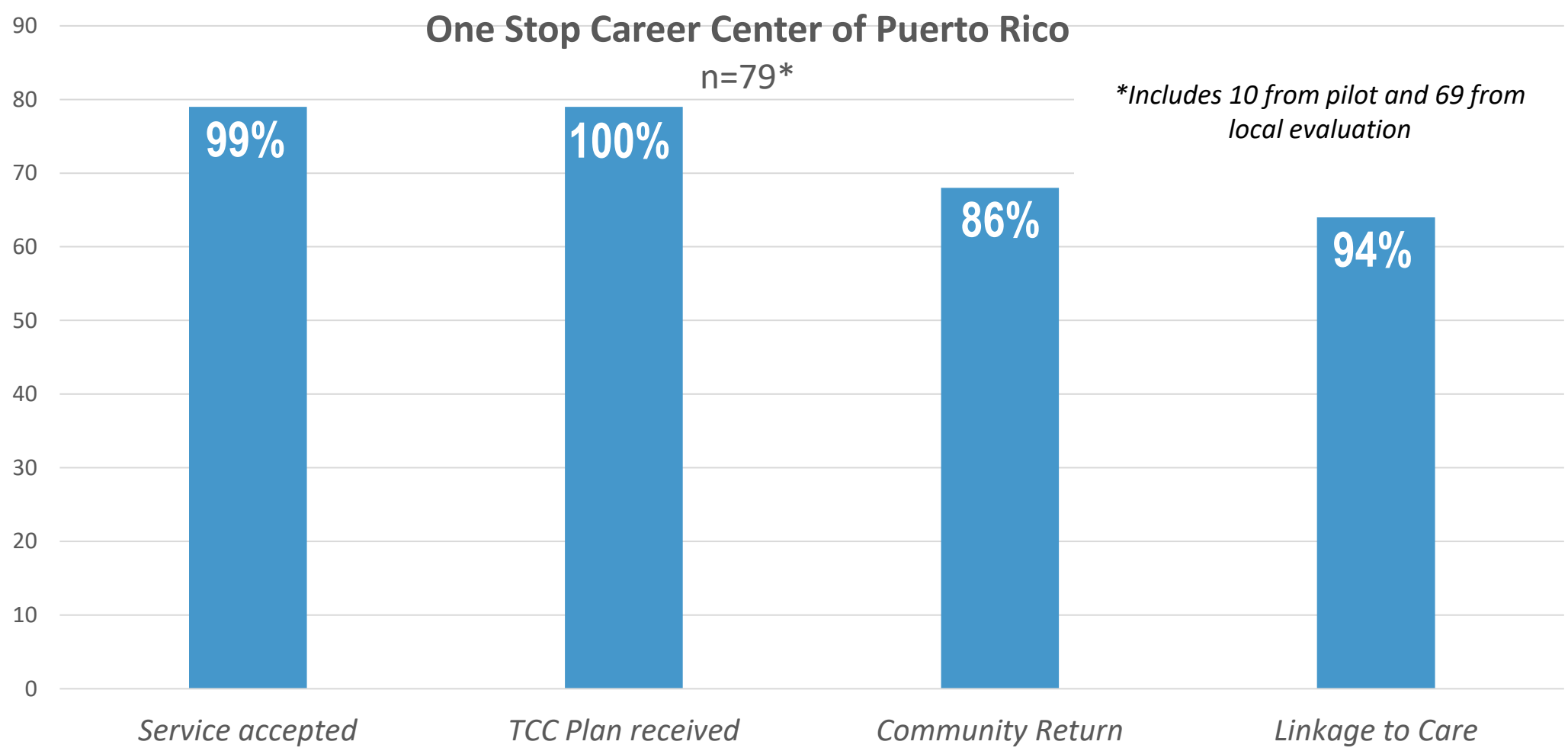
Housing: 22

- 19 transitional
- 5 permanent

Job readiness: 15

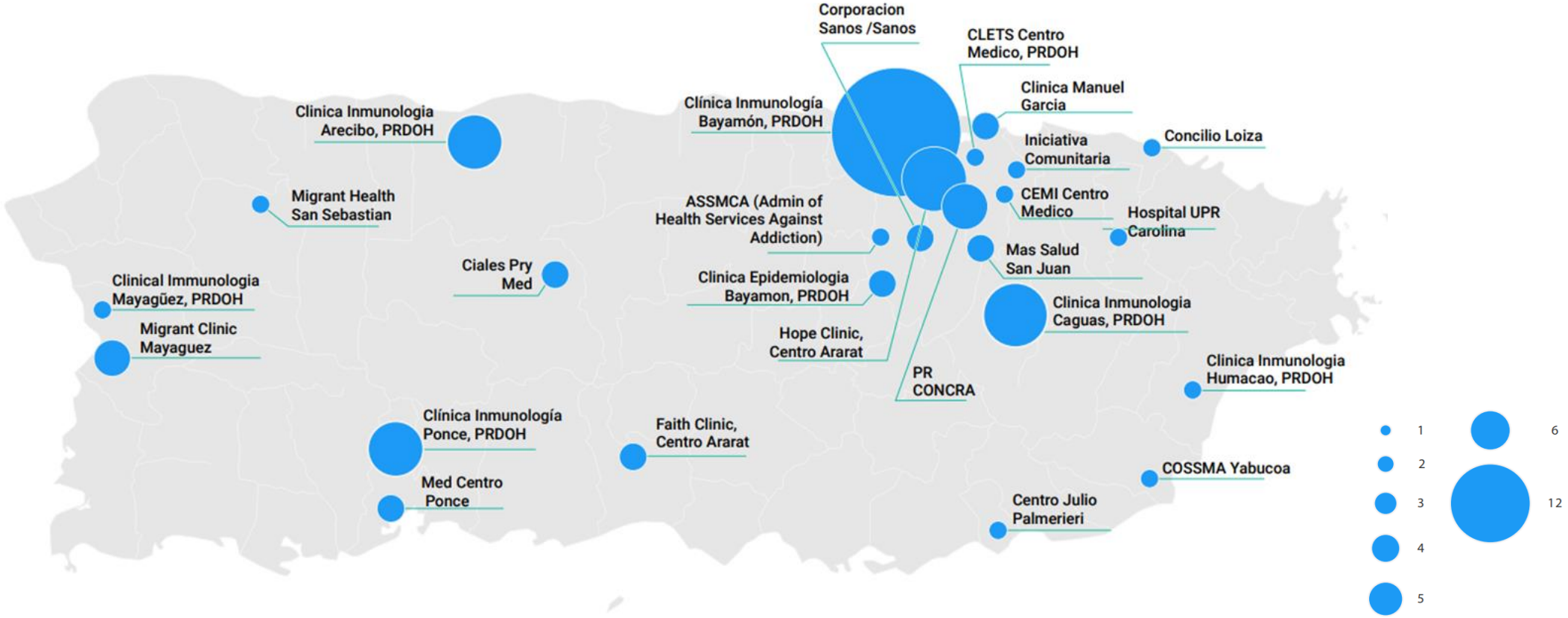
- 12 employed;
- 1 volunteer;
- 2 seeking employment

TCC Cascade in Puerto Rico

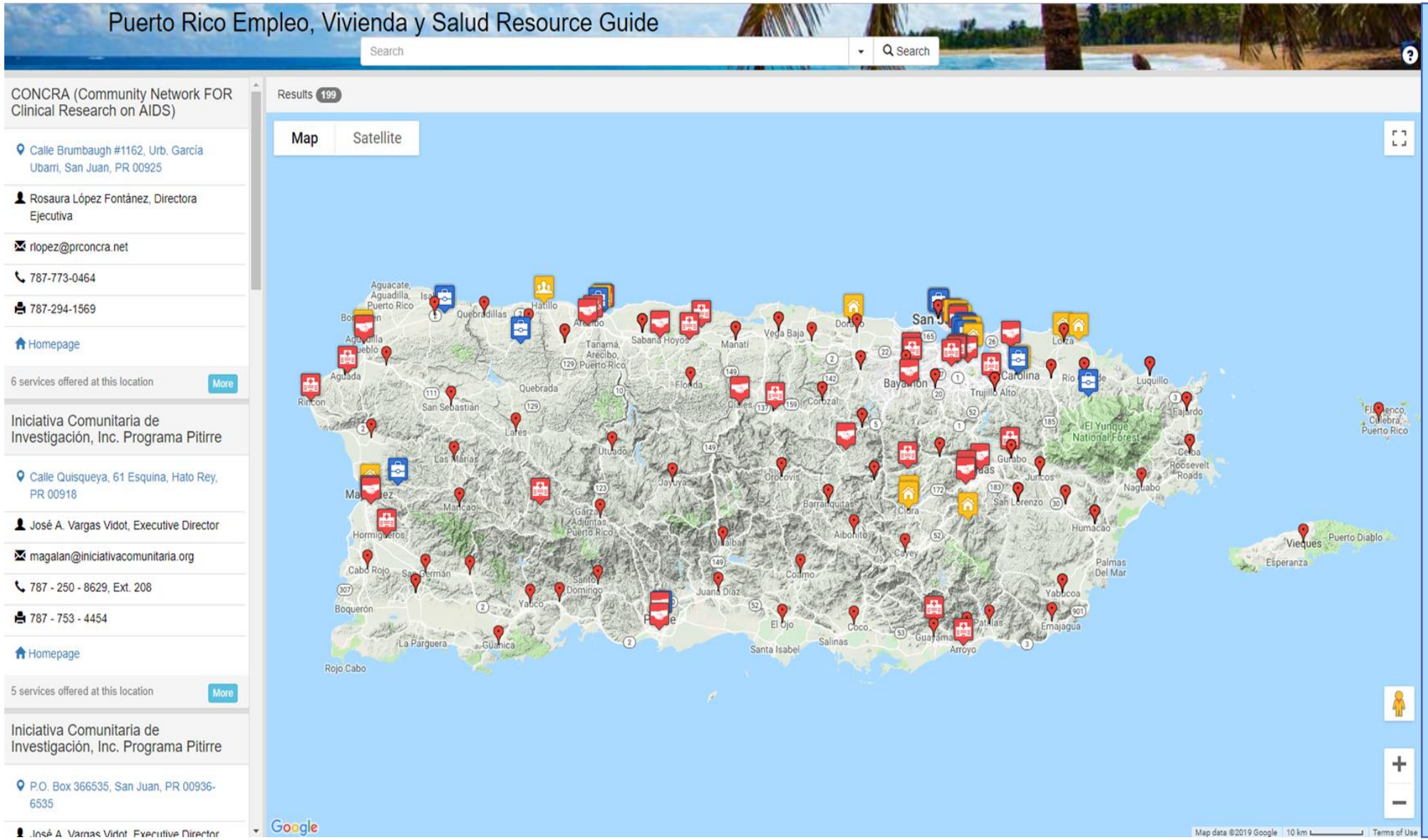


Mapping Linkages to Care in Puerto Rico

94% of people returning home with a transitional care plan linked to care after incarceration (n=80)



Most people linked to care after incarceration were seen at Ryan White Part B and C clinics, with others followed by Federally Qualified Health Centers. Access to care was facilitated in all regions across Puerto Rico.



The Puerto Rico Employment, Housing and Health Resource Guide is available at no cost to network providers through RDE eCOMPAS and includes icons that depict available services, such a hospital for medical care, a house for housing and a suitcase for employment services and a handshake for care coordination.

https://nrg.e-compas.com/pr/

Implementation Challenges

- Identifying right fit programs: personal relationships v. formal expertise
- Proposal evaluation methodology favors existing programs
- Formal authority/documents from predecessors are insufficient to gain buy-in
- Culture of corrections varies by location/jurisdiction
- Opening/closing of programs absent formal communication system
- Frequent turnover and changes in local government leadership
- Poor local economy, lack of affordable housing/shelters
- Hurricane Maria…

Hurricane Maria Relief Efforts

OSCC received hurricane relief funding and found clients after Hurricane Maria to assess need and arrange for:

- Medications
- Housing
- Food, drinking water, clothes and other needs
- Assistance with FEMA application
- Placement in transitional housing / treatment

OSCC Executive Director and staff secure & distribute food and essentials

Overcoming Challenges

Manati

After Hurricane Maria

February 2019

TCC Puerto Rico
Lessons Learned & Recommendations

1. Networking with other agencies & jurisdictions identified core organizations and champions
2. Local community/ faith-based organization (CBO) leadership pooled resources + worked with government staff to establish best practices to facilitate continuity of care
3. Coordination & collaboration between Ryan White service network and local CBOs improved access for those out of care.
4. Pre-established relationships led to formal agreements & created synergy among medical and support service providers (housing, employment, substance use)
5. OSCC participation on HIV Planning Council facilitated coordination with key stakeholders
6. Annual convening of stakeholders helped create strategies to address population needs
7. Maintain relationships and linkage agreements
8. Transitional Consortium maintained core leadership, supported relationships & leveraged resources to coordinate care
9. Engaging client during incarceration fosters relationships to endure after incarceration
10. Transportation access ensures linkage to care after incarceration

One Stop Career Center of Puerto Rico Service Menu

Advisory Agency and Financial Capacity

Advice for first purchase, prevention of loss and reverse mortgages.

LEGAL SERVICES

Legal advice and representation for people over 50 years of age who are in the process of losing their home or at risk of losing their home.

Job Placement and Retention

Training in social and labour integration and job placement for persons who have had problems with the justice system or have been displaced. The removal of criminal records, if it qualifies.

TRAINING

Short-term workshops and training

HEALTH

Case Management Services and connection to health services for people who have committed a crime and are HIV patients.

HOUSING COUNSELING PROGRAM

One Stop Career Center of PR in coordination with the Department of Housing of Puerto Rico provides advisory services to people affected by hurricanes Irma and/or Maria.

Strengthening Collaborations | Fortaléciendo Enlaces Across the Islands of Puerto Rico

Jesse Thomas

Jesse Thomas

Tirado-Mercado V, Rodriguez-Diaz CE, Cosme-Pitre C, Cruzado-Quiñones J, Jordan AO. Fortaleciendo Enlaces: Strengthening Collaborations to Build Institutional Capacity for Re-Entry Services for Incarcerated People with HIV in Puerto Rico. (2017). Puerto Rico Health Sciences Journal, University of Puerto Rico Medical Science Campus vol 36 (1): 47.

Thank you for your time!

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