

# **TOOLS + TIPS FOR PROVIDING TRANSITIONAL CARE COORDINATION**

## **HANDBOOK**



# TOOLS + TIPS FOR PROVIDING TRANSITIONAL CARE COORDINATION HANDBOOK

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Final Report on the work of the *Transitional Health Care Consortium* under a grant award to NYC Correctional Health Services on behalf of the *THCConsortium*, funded through 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) “Enhancing Linkages to HIV Primary Care to Services in Jail Settings Initiative (EnhanceLink)” (2007–2012) [NOA: 1H97HA08538]

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The views in this handbook are those of the authors and do not represent the views of New York City Health + Hospitals, the *THCConsortium*, or any of its partner organizations or affiliates.

# A Three-Dimensional Action Plan to Raise the Quality of Care of US Correctional Health and Promote Alternatives to Incarceration

**By Homer Venters**

Chief Medical Officer and Assistant Vice President of the Division of Correctional Health Services,  
New York City Health and Hospitals

**T**he United States has the world's highest incarceration rate. Nonetheless, health care provided during approximately 12 million annual incarcerations remains disconnected from the rest of the nations' health apparatus. Care delivered to the incarcerated disproportionately impacts the poor, people of color, and those with behavioral health problems. The scope and quality of this care is inconsistent and often directed by security leadership, not health professionals. Additionally, vital information gathered in these settings is rarely used to coordinate care with community providers or consider alternatives to incarceration. To increase the quality and coordination of correctional health care, three key areas must be addressed: the funding model, the scope of services, and correctional health staff.

## The Funding Model

Health care has been a legal right for the incarcerated because of the US Supreme Court Decision *Estelle v. Gamble* in 1972.<sup>1</sup> However, these health services are generally not Medicaid-reimbursable, and except for the Federal Bureau of Prisons, costs fall on cities, counties, and states. Despite widespread litigation and investigation regarding correctional health, deficiencies remain even in settings with comparatively more resources and attention.<sup>2,3</sup> For Sheriffs and Departments of Correction, who oversee virtually all correctional health care in the United States, spending on health costs must be weighed against security staffing and other institutional commitments. Despite some public health models in larger cities, the most common model of correctional health care in the US consists of for-profit vendors with contracts designed and monitored by security authorities.<sup>4</sup> Accrediting organizations, such as the National Commission on Correctional Health Care, may promote evidence-based practices; however, participation is voluntary and performance is unrelated to funding. One new source

of the Centers for Medicare & Medicaid Services (CMS) funding is newly available “Meaningful Use” funds to help correctional health providers implement electronic medical records (EMRs) in an evidence-based manner.<sup>5</sup> This funding can help correctional settings adapt community EMRs to promote evidence-based care while also increasing transparency on health outcomes for the incarcerated.

A key funding opportunity could involve Medicaid waivers to reimburse provision of chronic care inside jails and prisons that was initiated in a community setting, particularly for aspects of care that can reduce after incarceration morbidity and mortality. For example, the high prevalence of patients with HIV, hepatitis C, and substance use disorders in correctional settings could render funding of cost-effective treatments for these conditions worthwhile to CMS. Such an approach would not only benefit these individual patients, but the community health systems and CMS, which bear the financial and management burdens of treatment interruptions and after incarceration mortality and morbidity.<sup>6</sup> In the case of hepatitis C, jails routinely admit patients during the course of their CMS-funded hepatitis C treatment.<sup>7</sup> Local jail pharmacy budgets will not be able to continue this costly care under the current model, and the CMS investment for the community portion of the regimen (typically tens of thousands of dollars) may be lost.

## Scope of Services

Most correctional health systems focus their work on brief intake screenings and responding to acute complaints. A small number of settings have secured funding for a correctional public health model, with expanded clinical services, Medicaid enrollment, and improved health outcomes associated with discharge planning.<sup>8-10</sup> In these settings, additional resources are dedicated to preventive and chronic care, not simply avoiding morbidity and mortality during incarceration.<sup>11</sup> One related innovation is that many states altered Medicaid eligibility so that persons experiencing short-term incarceration have their Medicaid coverage suspended, rather than terminated, to permit rapid reactivation.<sup>12</sup>

Aside from broadening the scope of in-jail services, correctional health can expand to the prearrest process, where newly arrested persons may be screened to determine their fitness to pass through to arraignment and incarceration. In these settings, correctional health staff can help triage care for the jail-bound (e.g., persons with a history of alcohol withdrawal), especially if they have access to the correctional EMRs. Health staff in the prearrest setting can also notify partner organizations about diversion potential for persons who meet criteria for local programs, including serious mental illness. This approach is being piloted in the New York City jail system, and one of the early lessons is the utility of the jail EMRs.<sup>13</sup> The

frequent incarceration of persons with behavioral health problems has resulted in a significant amount of their critical health information being held in jail health records, making the correctional health system a critical resource for acting on new diversion opportunities.

## Staff

Recruiting and retaining mission-driven health staff to work in jails and prisons is a core barrier to improving correctional health care.<sup>14,15</sup> Correctional health has sometimes been thought of as a career of last resort, and correctional health professionals provide care in extremely difficult settings, where their decisions are often questioned by patients and security staff alike. Correctional health staff often experience strong dual loyalty pressures that can impact the care they provide as well as their willingness to speak out when they encounter patient abuse or neglect.<sup>16</sup> The overwhelming pressures of working in a security setting lead some health staff to stop believing their patients, with dramatic impact on patient care and clinical outcomes. Without a willingness to engage and support staff in these and other areas of human rights, the daily realities of correctional health staff quickly become disconnected from outside perceptions about their ability or willingness to provide high-quality care.

Correctional health can also improve by recruiting a new generation of mission-driven physicians and other staff. The predominance of for-profit organizations in US correctional health is a clear concern for some who might otherwise be drawn to this area of work. The larger issues of mass incarceration, human rights, and social determinants of health are now woven into medical training, and a growing cohort of young doctors are eager to help remake a forgotten area of US medicine and public health. To entice them, new models may be required. Organizations like Doctors Without Borders and Partners in Health are able to recruit outstanding clinical staff to work in extremely challenging settings.<sup>17,18</sup> Staff who work for these organizations share a sense of mission and know that their organization supports them and their patients as part of a broad commitment to address health in a social context. Recruiting this caliber of staff to correctional health may require development of mission-driven, not-for-profit organizations that can address the quality void as well as assist partners to rethink conditions of confinement and opportunities for diversion.

## Transforming Correctional Health

Transforming correctional health will require local interest in improving care and national policy changes to allow for some efforts to expand reimbursement opportunities. If Medicaid waivers can be developed to allow some settings to explore reimbursement for aspects of care in jail or prison settings, then the potential cost and quality benefits can be explored. Similarly,

in settings where correctional and community health systems and state insurance programs forge partnerships to improve continuity of insurance, the benefits of access and coverage will be revealed. Also, working to establish a correctional health foothold in the prearrest setting will allow the entire criminal justice system in that city or county to explore the benefits of diversion based on reliable health information. Finally, correctional health must become viewed as a noble and rewarding career path for those who seek to bring high quality care to patients in dire need. While these three domains are not the only systemic concerns facing correctional health, they do represent an action plan that can improve the quality and coordination of care and inform opportunities for alternatives to incarceration.

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## References

1. *Estelle v. Gamble*, 429 U.S. 97 (1976).
2. Noble ADC. Council rejects \$66M contract proposal for prison's health care. *Washington Times*. April 14, 2015. Available at: <http://www.washingtontimes.com/news/2015/apr/14/dc-council-rejects-corizon-contract-proposal>. Accessed January 28, 2016.
3. Meisner J. Independent experts blast quality of medical care in Illinois prisons. *The Chicago Tribune*. May 19, 2015. Available at: <http://www.chicagotribune.com/news/ct-illinois-prison-medical-care-met-20150519-story.html>. Accessed January 28, 2016.
4. Royse D. Medical battle behind bars: big prison healthcare firm Corizon struggles to win contracts. *Modern Healthcare*. April 11, 2015. Available at: <http://www.modernhealthcare.com/article/20150411/MAGAZINE/304119981>. Accessed January 28, 2016.
5. Martelle M, Farber B, Stazesky R, Dickey N, Parsons A, Venters H. Meaningful use of an electronic health record in the NYC jail system. *Am J Public Health*. 2015;105(9):1752-1754.
6. Binswanger IA, Stern MF, Deyo RA. Et al. Release from prison—a high risk of death for former inmates. *N Engl J Med*. 2007;356(2):157-165.
7. Rich JD, Allen SA, Williams BA. Responding to hepatitis C through the criminal justice system. *N Engl J Med*. 2014;370(20):1871-1874.
8. Artiga S. Profiles of Medicaid outreach and enrollment strategies: the Cook County Early Expansion Initiative. Kaiser Family Foundation. 2014. Available at: <http://kff.org/medicaid/issue-brief/profiles-of-medicaid-outreach-and-enrollment-strategies-the-cook-county-early-expansion-initiative>. Accessed January 28, 2016.
9. Teixeira PA., Jordan AO, Zaller N, Shah D, Venters H. Health outcomes for HIV-infected persons released from the New York City jail system with a transitional care-coordination plan. 2014. *Am J Public Health*. 2014;105(2):351-357.
10. Morrissey JP. Cuddeback GS, Cuellar AE, Steadman HJ. The role of Medicaid enrollment and outpatient service use in jail recidivism among persons with severe mental illness. *Psychiatric Services*. 2007;58(6):794-801.



11. Parvez F, Katyal M, Alper H, Leibowitz R, Venters H. Female sex workers incarcerated in New York City jails: prevalence of sexually transmitted infections and associated risk behaviors. *Sex Transm Infect.* 2013;89(4):280–284.
12. Health Coverage and County Jails. Suspension vs. Termination. The National Association of Counties. 2014. Available at: [http://www.naco.org/sites/default/files/documents/Suspension-termination\\_2015.pdf](http://www.naco.org/sites/default/files/documents/Suspension-termination_2015.pdf). Accessed January 28, 2016.
13. Cloud D. Improving the health of arrestees: the pre-arraignment screening initiative. Vera Institute of Justice. Available at: <http://www.vera.org/project/improving-health-arrestees-pre-arraignment-screening-initiative>. Accessed January 28, 2016.
14. Chang C. Many doctors treating state’s prisoners have disciplinary records themselves. *The Times Picayune*. July 29, 2012. Available at: [http://www.nola.com/crime/index.ssf/2012/07/many\\_doctors\\_treating\\_states\\_p.html](http://www.nola.com/crime/index.ssf/2012/07/many_doctors_treating_states_p.html). Accessed January 28, 2016.
15. Toner C. Alabama prison doctors lost medical licenses following sexual conduct with patients. September 17, 2014. Available at: [http://www.al.com/news/index.ssf/2014/09/breaking\\_the\\_oath\\_alabama\\_pris.html](http://www.al.com/news/index.ssf/2014/09/breaking_the_oath_alabama_pris.html). Accessed January 28, 2016.
16. Glowa-Kollisch S, Graves J, Dickey N. et al. Data-driven human rights: using dual loyalty trainings to promote the care of vulnerable patients in jail. *Health Hum Rights.* 2015;17(1):E124–E35.
17. Westerhaus M, Finnegan A, Haidar M, Kleinman A, Mukherjee J, Farmer P. The necessity of social medicine in medical education. *Acad Med.* 2015;90(5):565–568.
18. Brauman R, Tanguy J. The MSF Experience. Doctors Without Borders. 1998. Available at: <http://www.doctorswithoutborders.org/msf-experience>. Accessed January 28, 2016.

# Introduction and Overview

**W**hen designing a service model for transitioning people from one system to another, in this case from jail to community health care, there are two key components: removing barriers and establishing relationships. Barriers exist within systems, organizations, and the individual's approach to problem solving. Establishing relationships and then maintaining them at each of these levels helps facilitate transitions and access to care.

In 2004, New York City's (NYC's) correctional health conducted a functional assessment of HIV care and treatment in jails, finding a fragmented system that lacked cohesion, with limited communication between organizations, including four reentry service agencies, the NYC Department of Correction (DOC), and the correctional health vendor. These groups offered a range of services, including:

- substance use and HIV services;
- housing services;
- transportation assistance;
- child welfare, domestic violence, and trauma services;
- primary health care; and
- HIV testing and medication treatment adherence counseling.

Service providers individually applied for grants based on organizational capacity, and grant awards were provided based on the budget available and the number of clients that could be served by each staff person. Each organization had its own forms, processes, and service targets. All counted the number of plans developed, and none were obligated to track and report the

outcomes of referrals made to one another or community providers.

To streamline the system, the organizations unified to create a partnership—now known as the Transitional Health Care Consortium (*THCConsortium*). It was a challenging endeavor and required pooling resources to serve the entire HIV and chronic disease population known in the jail. By building on the existing system, the *THCConsortium* was able to introduce a new approach and work collaboratively, focusing on one specific outcome: documented linkage to primary care and services in the community for all those released with a transitional care plan.

To move to a continuum of care model, three goals were established:

1. All clients who come into jail know their HIV status.
2. All clients receive a 1:1 session within 48 hours.
3. All clients released with a plan are connected to care.

The continuum of care model required that all partners work together at each level. Care was coordinated among partners,

## History of Our Collaborative

The collaborative relationships among and between correctional health services, the correction agency, and the *THCConsortium* have evolved over the years—adapting as needs and innovations arise. For example,

- In the 1980s, a condom distribution policy for the correctional agency was initiated through the local health agency, alongside CDC-funded health education and risk-reduction services, based on a medical model.
- By the 1990s, a consortium comprising representatives from the correctional agency, correctional health, and community reentry and treatment providers began providing HIV discharge plans under Ryan White Part A funding.
- In 2003, correctional health initiated chronic care discharge planning for the sickest patients, demonstrating the need for collaboration before, during the transition period to the community, and after incarceration.
- In 2004, correctional health was invited by the correctional agency to establish the Visitors' Health Station to reach family members and friends as a form of early intervention.
- In 2005, correctional health became the lead organization of what is now known as the Transitional Health Care Consortium (*THCConsortium*), aligning HIV and other medical discharge planning services under one umbrella; home visiting was added to reengage HIV patients in care after incarceration.
- In the years thereafter, grants, such as the Health Resources and Services Administration (HRSA), HIV/AIDS Bureau (HAB), Special Projects of National Significance (SPNS) Enhancing Linkages to HIV Primary Care to Services in Jail Settings Initiative grant, and others, built upon years of practice and enabled correctional health and the *THCConsortium* to conduct population-specific studies. These have ranged from HIV patients, Latino populations, young minority men who have sex with men, and others.

Today, HIV patients are served using a population-based approach that is being adapted for substance users. Correctional health and the *THCConsortium* have made great strides in adapting and modifying its HIV discharge planning approach to serve medical and substance-use patients in jail and to provide warm transitions with verified linkages to care and continued care management after incarceration.

with correctional health assigning clients and tracking outcomes. A universal client interview tool was designed to facilitate the sharing of complete health information with the receiving of community partners. Later, a mutual consent form was added to further advance continuity of care.

Care coordinators (housed in the jail) meet clients in the jails to begin planning for release. Drop-In Center services were moved upstream, engaging the client during the jail stay, meeting the client at the time of jail release to link to care and services, following the plan established while in jail, and modifying the plan to meet client needs as they presented after incarceration.

In an effort to reengage clients who do not make it to their initial primary care appointments after incarceration, a Community-based care manager (CCM) reaches out to the client directly, including through home visits, to engage the client around the importance of reengaging in HIV Primary Care after incarceration.

The CCM conducts outreach for patient reengagement and accompany clients to primary care providers as needed. They provide a warm hand-off to clients to facilitate continuity of care after incarceration. The CCM acts as a safety net and, together with the reentry providers, act as “surrogate family” to provide support and facilitate linkage to care. This also helps advance program goals and targets and is key to achieving an over 70% linkage-to-care rate as well as an 80% maintenance-in-care rate 90 days after the first appointment is kept after incarceration.

The team acts as a “surrogate family,” providing a warm transition to the community and second chances to clients who would have otherwise been lost to follow-up.

## Why Transitional Care Coordination?

The majority (85%) of individuals pass through jail and never move on to prison but, rather, return to the communities from which they left. While jails are dynamic environments, with people going to and from court and with unpredictable releases, they provide a window of opportunity to test, diagnose, and treat high-risk populations and offer marginalized people an opportunity for contact with the healthcare system. Prior to entering jail, most clients are out of care and face a disproportionate number of social, mental, and healthcare challenges;

In social work school, they teach you that people are most likely to change when they are at their lowest point, and so today, we have 10,000 opportunities to make a difference.

—Alison O. Jordan,  
Executive Director,  
Transitional Health Care Consortium

however, by working together, health agencies, community-based organizations, and jails can provide a public health intervention that effectively promotes continuity of care for a highly vulnerable population.<sup>1,2,3,4,5,6</sup>



When people return to the community after incarceration they often face the same challenges they had prior to arrest. In NYC, the majority of people who are incarcerated are from—and return to—the areas with the greatest health and socioeconomic disparities in the city. This transition period from incarceration back to the community represents a time of particular vulnerability and further underscores the need for Transitional Care Coordination services.<sup>7</sup>

<sup>1</sup>Spaulding AC, Perez SD, Seals RM, et al. Diversity of release patterns for jail detainees: implications for public health interventions. *Amer J of Public Health*. 2010;1010(S1):S347–52.

<sup>2</sup>Draine J, Ahuja D, Altice FL, et al. Strategies to enhance linkages between care for HIV/AIDS in jail and community settings. *AIDS Care*. 2011;23(3):366–77.

<sup>3</sup>Avery AK, Ciomcia RW, Lincoln T, et al. Jails as an opportunity to increase engagement in HIV care: findings from an observational cross-sectional study. *AIDS Behav*. 2013. Suppl 2: S137–44.

<sup>4</sup>Rapp RC, Ciomcia R, Zaller N, et al. The role of jails in engaging PLWHA in care: from jail to community. *AIDS Behav*. 2013. Suppl 2:S289–99.

<sup>5</sup>Frank L. Prisons and public health: emerging issues in HIV treatment adherence. *J Assoc Nurses AIDS Care*. 1999;10(6):24–32.

<sup>6</sup>Spaulding AC, Seals RM, Page MJ, et al. HIV/AIDS among inmates of, and releases from, U.S. correctional facilities, 2006: declining share of epidemic but persistent public health opportunity. *PLoS One*. 2009;4(11):1–8.

<sup>7</sup>deVoux A, Spaulding AC, Beckwith C, et al. Early identification of HIV: empirical support for jail-based screening. *PLoS One*. 2012;7(5):1–7.

## What is this Handbook and How is it Organized?

This handbook synthesizes the Transitional Care Coordination intervention model, including program planning, implementation steps, and lessons learned. It also outlines the correctional health approach to identifying people who are incarcerated but better served in medical placements.

This handbook is meant to train staff; inform implementation, expansion, and refinement of jail-related care coordination work; and help organizations strategize how they approach these activities. It provides insight into negotiating and forming partnerships with other organizations in order to find common ground and advance organizational missions, while maximizing and improving patient health outcomes.

When efforts for mutual goals and outcomes are combined, everyone benefits.

## Who is the Intended Audience?

This handbook can assist anyone interested in improving continuity of health care by transitioning clients from jail to community health care. The network of organizations that may participate in a Transitional Care Coordination model include health and hospital care, public health agencies, community-based organizations, AIDS service organizations, Ryan White HIV/AIDS program grantees and providers, substance use and mental health providers, jail health administrators, and others.

This document can be used by those inside correctional departments, as well as those outside the system, as long as they demonstrate a caring and nonjudgmental approach and dedication to do this work. It can take just one individual to initiate improvement and one team to sustain it.

## Other Resources That Accompany This Handbook

Readers may also wish to review the NYC *AIDS Behavior* article<sup>8</sup> and *American Journal of Public Health* article.<sup>9</sup>

*Creating a Jail Linkage Program* training manual and curriculum were created as part of a 5-year project, for which the *THC Consortium* was one demonstration site.<sup>10</sup> An associated Webinar training series is also available and includes a NYC Transitional Care Coordination presentation. These resources can be found at: <https://careacttarget.org/ihip/jails>

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<sup>8</sup> Jordan AO, Cohen LR, Harriman G, et al. Transitional care coordination in New York City jails: facilitating linkages to care for people with HIV returning home from Rikers Island. *AIDS Behav.* 2013;Suppl 2:S212-9.

<sup>9</sup> Teixeira PA, Jordan AO, Zaller N, et al. Health outcomes for HIV-infected persons released from the New York City jail system with a transitional care-coordination plan. *Am J Public Health*; 2015;105(2):351-7.

<sup>10</sup> The 5-year project was funded by the Special Projects of National Significance (SPNS) program under the U.S. Department of Health and Human Services (HHS), Health Resources and Services (HRSA), HIV/AIDS Bureau (HAB). SPNS funds innovative and replicable models of care. The training manual, curriculum, and other jail linkage-based resources are part of the SPNS Integrating HIV Innovative Practices (IHIP) project to garner increased attention to and uptake of SPNS best practices.



# Transitional Care Coordination Overview

## Our Program and Population at a Glance

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.



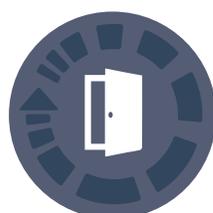
2<sup>nd</sup> largest jail system in the country



of NYC jail population is self-reported HIV-positive



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



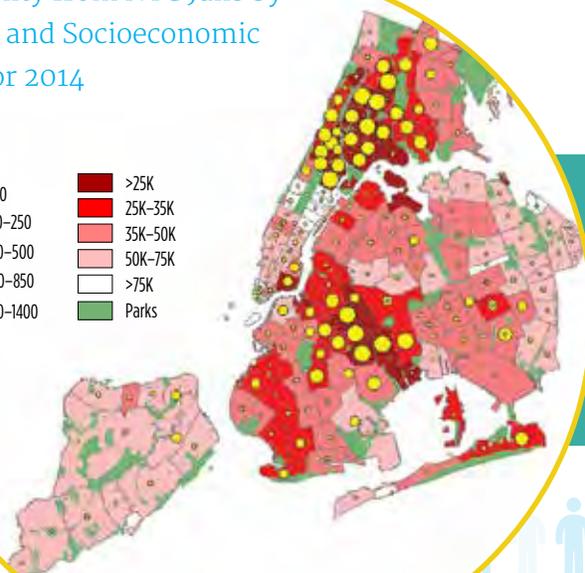
Within **48 hours** individuals receive a discharge plan



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

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

- 1-100
- >100-250
- >250-500
- >500-850
- >850-1400
- >25K
- 25K-35K
- 35K-50K
- 50K-75K
- >75K
- Parks



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

**10,000** average daily jail census

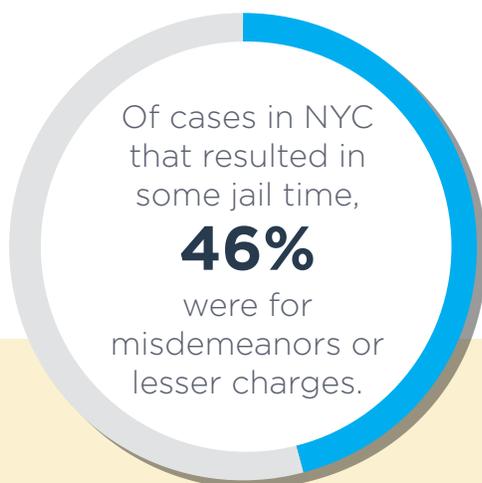


## Why Jails?

**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**.

## 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.

- Sources:** Jordan AO. New York City Correctional Health Services. Linkages and Care Engagement from NYC Jail to Community Providers. September 16, 2015. [Presentation.] Available at: [www.health.ny.gov/diseases/aids/ending\\_the\\_epidemic/docs/webinar\\_series/cjs/linkages\\_and\\_care.pdf](http://www.health.ny.gov/diseases/aids/ending_the_epidemic/docs/webinar_series/cjs/linkages_and_care.pdf).
- Teixeira PA, Jordan AO, Zaller N, et al. Health outcomes for HIV-infected persons released from the New York City jail system with a transitional care-coordination plan. *Am J Public Health*. 2015;105(3):351-7.
- New York City Criminal Justice Agency, Annual Report 2013 (New York: New York City Criminal Justice Agency, 2014), 30.
- de Voux A, Spaulding AC, Beckwith C, et al. Early identification of HIV: empirical support for jail-based screening. *PLoS One*. 2012;7(5):1-7.
- CDC. New high-impact approach to HIV funding for health departments advancing the national HIV/AIDS strategy. Fact Sheet. 2011.
- Spaulding AC, Seals RM, Page MJ, et al. HIV/AIDS among inmates of, and releases from, US correctional facilities, 2006: declining share of epidemic but persistent public health opportunity. *PLoS One*. 2009;4(11):1-8.
- Flanigan TP, Zaller N, Beckwith CG, et al. Testing for HIV, sexually transmitted infections, and viral hepatitis in jails: still a missed opportunity for public health and HIV prevention. *JAIDS(Suppl)*. 2010;55(2):S78-S83.
- Draine J, Ahuja D, Altice FL, et al. Strategies to enhance linkages between care for HIV/AIDS in jail and community settings. *AIDS Care*. 2011;23(3):366-77.
- Jordan AO, MacDonald R, Cruzado-Quinones J. Warm transitions: linkages to care for people with HIV returning home from Rikers Island Jails. 2012. [Presentation.]

# Getting Started: Building a Transitional Care Coordination Model

**T**alk to the experts—staff and partners are already working in the jail setting with the target population. To connect with these individuals, consider

- Researching which individuals and organizations are working in the jail.
- Listening to staff and partner concerns. Map out the existing model and identify barriers to achieving the goals. Ask staff and consortium members for potential solutions and what service gaps your organization may be able to fill.
- Identifying organizations and staff with whom you have existing relationships and build on them. Additionally, carve out time to foster new relationships.
- Asking correctional staff “how can we help?” Use that information to identify areas with potential for mutual benefit.
- Meeting with the biggest skeptic in the room. They may become your biggest supporter in the end.

## Developing a Jail Continuum of Care Collaboration: Key Aspects



Establishing Relationships	
At all levels:	Within the correctional setting:
Greet with a smile and a handshake.	Know the chain of command, including formal and informal roles.
Listen first; then ask key questions, such as <ul style="list-style-type: none"> <li>• How do things work now?</li> <li>• What do you need?</li> <li>• Can you help me?</li> </ul>	Identify a champion of this work within the jail administration.
Be clear and set realistic, measurable, and achievable goals.	Identify the benefit you're providing to the jail and to jail personnel (e.g., service gaps you may be filling, programs leading to reduced violence).
Begin where you can.	Acknowledge additional work for correctional staff (e.g., escort/transport, ensuring your staff's safety).
Build trust by <ul style="list-style-type: none"> <li>• Starting with winnable battles</li> <li>• Sharing at least five positive messages before any negative one</li> <li>• Setting up individuals to succeed</li> <li>• Setting clear expectations and delivering on them.</li> </ul>	Demonstrate your accessibility by <ul style="list-style-type: none"> <li>• Visiting often and becoming a familiar face and</li> <li>• Knowing who to approach for jail access, security training, and space in jail to interview clients.</li> </ul>
Align expectations with abilities.	Recognize that you are a civilian in a jail and be respectful of the policies and procedures in place.
Expect to give more than you receive.	Invite input from jail administrators as a way of securing buy-in and opening lines of communication.

**Identify mutual interests.** This includes identifying shared goals and synergies. This helps prevent “turf wars” or reinvention of the wheel. Important things to consider include:

- **Information sharing.** Share information, including client outcomes and medical health records. This enables a more streamlined system, reduces costs, and improves transparency. For example:
  - Staff were frustrated when they did not know the outcomes of clients in the community and were painfully aware of those who are reincarcerated. When staff had client information, however, they were able to more readily intervene and reengage clients.
  - Community Health Centers, including Federally Qualified Health Centers, were repeating expensive lab tests that were performed in jails despite the ability to transfer results.

- Skilled nursing facilities, attorneys, courts, alternative to incarceration programs, and residential treatment programs needed access to medical record information in order to facilitate program placement for those who could be restored to parole or placed in alternative settings.
- **Measure outcomes.** Measuring outcomes is better for the system, provides necessary feedback to staff, and helps organizations coalesce around agreed-upon measures of success.

**Build on existing models and policies.** Familiarize yourself with the models and policies already in place and use those to inform your work. Similarly, build upon existing structures as you move forward. Examples of models and policies that were successfully leveraged include the following:

- A Consortium with existing relationships facilitated improved collaborations. The mutual goal of improved coordination and reduced duplication of effort brought the team together.
- Existing policies provided strong foundations on which to grow. These included:
  - policies on condom distribution,
  - a leadership role for a correctional representative on the HIV Planning Council, and
  - an ability to offer client incentives at the commissary.
- NYC Correctional Health Services staff have access to jail housing areas, reducing the barriers to engagement in care.
- Changes in drug policies, growth of drug treatment courts, “treatment alternatives for safer communities,” and other court programs led to the creation of a Health Liaison to the courts. With client consent, health information is provided to assist the courts in making informed judgments.

## Maintaining Partnerships: Tips to Consider

- **Don't shy away from the hard work.** Meet with the biggest skeptic in the jail—whether a community player or a Department of Correction's staffer. This person may eventually become your biggest supporter.
- **Listen. Listen. Listen.** Individuals and organizations already in the jail know how to work in this setting and how to do so without interfering with Department of Correction's operations or orders.
- **Ongoing communication is essential.** Arrange and participate in activities with both correctional and community partners; offer to provide information sessions during roll call; rotate meeting locations; and have jail-based staff visit community locations.
- **Give thanks.** Don't underestimate the power of a "thank you" in breeding good will.
- **Word of mouth goes far.** If individuals have positive or negative experiences working with you, others in the jail will find out.

*Maintain effective partnerships.* No one entity can go it alone. It's about having relationships with organizations and working together toward a shared goal. Don't take partnerships for granted, especially new ones. Recognize that they need to be nourished and reevaluated. Ongoing communication and collaboration help reduce duplication and improve outcomes and teamwork.

Whether in the jail or out in the community, it's important to remember to:

- Deliver on promises.
- Leave the premises as you found them—or better.
- Replace what you borrow.
- Send a thank-you letter with follow-up reminders.
- Research available community resources and grant funding. Establish a consortium or join with partners to submit a grant application to expand or sustain existing collaborative work.
- Think of safety first. If you are in an area where you perceive your safety is in jeopardy, you should leave that area immediately and report it to your supervisor.

See also "Key Players" section in [Chapter 7](#).



# Program Planning

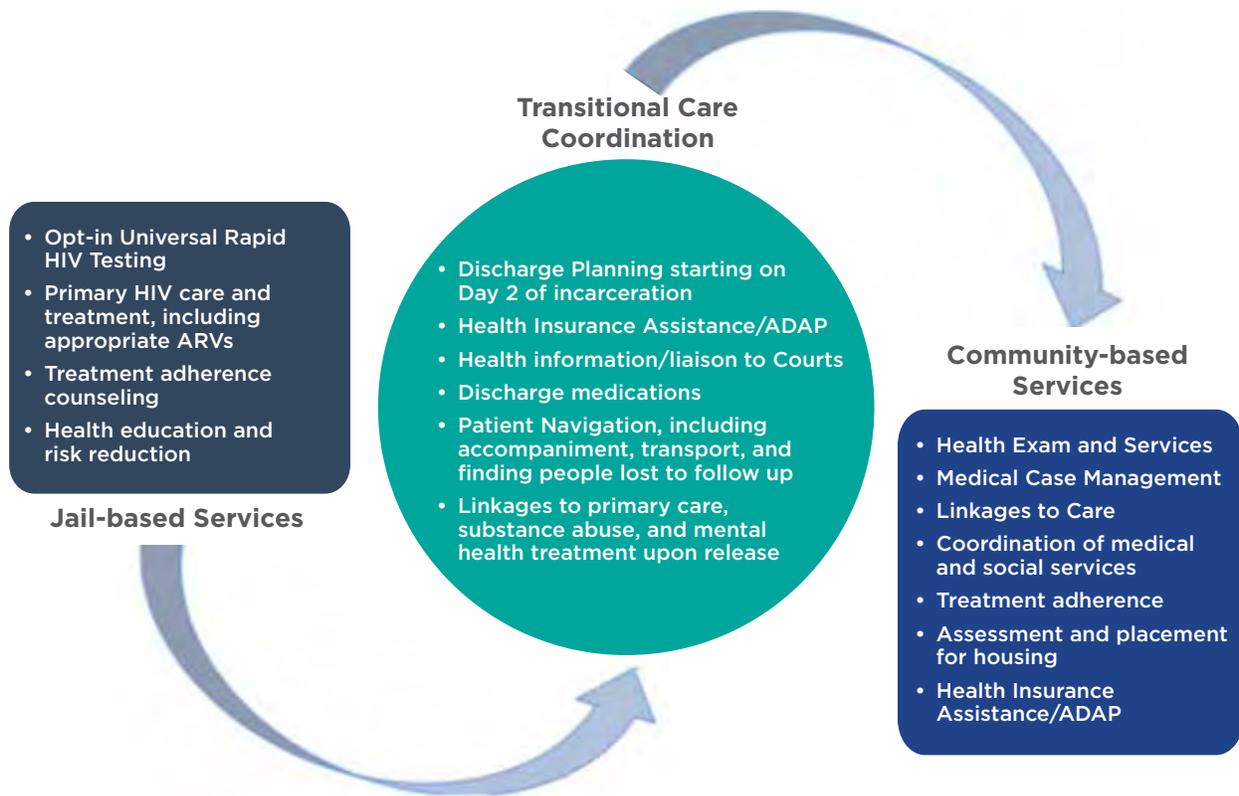
“You need to have the passion to do this work and put all the pieces together. If you have the passion, everything else will just flow—you will do the impossible to make sure that when your client leaves the jail, they know who they have to get to, where they have to go, and who to call when they need help.”

—Care Coordinator

**T**ake time to develop goals, a mission statement, and a workflow to demonstrate the system you have in mind. Focus on the outcomes and be flexible about the process. If you are the new kid on the block, take a back seat as needed. Identify where potential overlaps may occur and be open and available to all partners and clients. The following graphic, an excerpt from a THCConsortium paper, is used to help visually explain where and when processes take place:

## Distribution of Services Across Jail, Transitional Care Coordination, and the Community

Consider creating a memorandum of understanding (MOU) or linkage agreements with partners but recognize that MOUs are non-binding and need to be built on trust to succeed.



When engaging with correctional staff, tell them your plan and ask how they think you could achieve your mutual goals. Include correction staff in the planning process so that all are invested in the project and share in mutual success.

Consider the potential impact your work could have on jail operations, both positive and negative, such as interruptions to flow; staff who do not understand jail rules; and security issues with civilian staff permitting people who are incarcerated to use materials they should not (e.g., phone, computer, lotion). To address these, provide security training for all new staff and take immediate action for any infractions.

Recognize that client access to health education programs may require signing consent forms and that planning and prescreening for health insurance may

### Respect the Setting

Remember that safety and security are paramount correctional priorities. That means everything from what you bring into the jail to how you navigate jail and how you roll out your Transitional Care Coordination program must adhere to the jail's security requirements. Lockdowns and other security events may take place and require flexibility.



require different procedures depending on the jail setting, housing type, and legal charges. For correctional staff, additional security concerns may arise when holding groups. Office space may also be limited. As such, keep in mind your health mission while understanding the setting in which you're trying to work. Be watchful for *dual loyalty*—a clinical role conflict between professional duties to the client and obligations to the jail—that may arise.<sup>11</sup> It's important that you understand correctional staff concerns to the extent possible without hindering client health and safety.

## Needs Assessment

When first meeting with a client, greet them with a warm smile to make them feel more comfortable and welcomed. Be ready to address the client's immediate needs and check with correctional leadership about providing personal care items (e.g., white t-shirt or socks). Be respectful of where people are as this makes them more open to having a conversation. That may mean saying, "How about you take a shower? Here's a clean towel, and then let's talk in the morning."

Do your best to provide the client with auditory privacy, considering the jail clinic, program area, visit area, and availability of an escort officer. Sometimes access to medical records and office tools for staff—desk, chair, phone, computer, copier, or fax machine—may not be readily available. Make adjustments as necessary.

Typically, if you ask someone directly what is it they need, they'll tell you.

## The Brass Said Yes—Now What? Understanding Correction Chain of Command

Though every correction agency operates differently, the basic chain of command starts with a Commissioner or Secretary, who functions as the head of the organization and the official to whom all civilian and uniform staff report. Reporting to the Commissioner is often a Deputy, who oversees large parts of the organization (i.e., operations, administration, or program services).

They supervise Assistant Commissioners and Wardens, who oversee specific sites, such as a jail, a prison, or divisions within the organization. While this handbook is specific to NYC,

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<sup>11</sup> Glowa-Kollisch S, Graves J, Dickey N. et al. Data-driven human rights: using dual loyalty trainings to promote the care of vulnerable patients in jail. *Health Hum Rights*. 2015;17(1):E124–E35.



organizations need to know their jail's chain of command and learn who is in charge of what aspects of the agency.

In correction, decisions are generally made in a top-down, military-style approach. To be consistently effective, a Transitional Care Coordination program must know the structure and work in ways often not customary in community healthcare settings. This means you must inform officers on the front line about what you plan to do and help them to help you. Plan to address roll call. *Roll call is correctional staff attendance taken at the shift change of every tour in each jail facility.* Remember that correction officers work in a challenging environment. Introduce yourself and your team across all levels, from jail administrators and medical directors to the intake captain and the triage nurse, and try to provide something they need. Don't forget the custodial staff, transportation, and logistics team, and stop by the barbershop, law library, schools, and clothes box to introduce yourself, your boss, your team, and your mission. Ask what you can do to help and then deliver.

In NYC, correctional staff and correctional health providers have separate leadership and responsibilities. It also means that healthcare decisions are made by a healthcare institution rather than a correctional one. However, working in a jail setting comes with challenges to maintain professionalism as a health provider that raise issues of dual loyalty. Recognize these challenges and bring them to the attention of your leadership.

## Types of Staff Positions

Managing the transition from jail to the community requires staff members committed to the program care continuum outcomes of linkage to and retention in care.

Preferred skills and experience include: knowledge of public health issues affecting communities to which people return after incarceration, bilingual in English and Spanish, experience reflective of the client population, and personally impacted by criminal justice issues.

Typical staff positions included the following:

- Senior Director/executive leadership
- Director/supervisor/team leader
- Care coordinator (jail based)
- Transitional care coordinator (dually based)
- Community case manager (community based)
- Administrative support (central office)

Senior Director oversees all activities. The average supervisor-to-staff ratio is 1:8 and the average caseload is 30–50 clients.



## Introduce Program to the Community

It is equally important to establish relationships with the community providers who will be receiving your clients. This can include ambulatory care clinics, hospitals, hospice, drug treatment programs, and nursing homes. Plan to visit them to introduce yourself and your continuum of care model. Offer site visits, arranging clearances through correction leadership to allow community providers to become more familiar with your model, work flow, and staff. Give them an opportunity to present their program to your staff as well. This helps everyone get to know one another and the respective programs. This also helps you create a good resource list, which is highly valuable.

Introduce your program to treatment court programs, such as Treatment Alternatives for Safer Communities (TASC), to develop relationships that facilitate jail diversion. Meet with defense attorneys, court programs, prosecutors, and judges. Establish the foundations on which you will successfully provide health information and act as a liaison to the courts and facilitate jail diversion for your clients.

Note, it may be important to have one primary point of contact at each community organization to better streamline and track referrals after clients are discharged.

## Prepare and Train Your Staff

For new staff, provide classroom and webinar training on various topics, including confidentiality, HIV testing and counseling, HIV 101, and Hepatitis C, as well as onsite support. Train staff in motivational interviewing and Stages of Change framework to assess client readiness and promote adoption of new health behaviors.

Have new staff shadow experienced staff and supervisors. Staff schedules can be flexible and cover all seven days of the week.

Staff should be nonjudgmental and focus on what it will take for clients to remain in care after incarceration, not with the legal charges that led to incarceration. Establish trust with clients who may have valid reasons to be hesitant and distrustful. For some, the reason they are in jail may be because someone has taken advantage of them or turned on them. In particular, if you're offering services and not asking for anything in return, this can seem too good to be true.

Staff need to be adaptable and communicative, particularly given the ever-changing environment of this work. Staff should expect the unexpected and always be planning for multiple scenarios. (See critical skills graphic representation of this below.) Staff need to be able



to think outside the box and use creative thinking (“detective work”); for example, identification documentation can be hard to find. Staff need to be able to navigate and figure out how they can best obtain identification documents, such as a birth certificate.

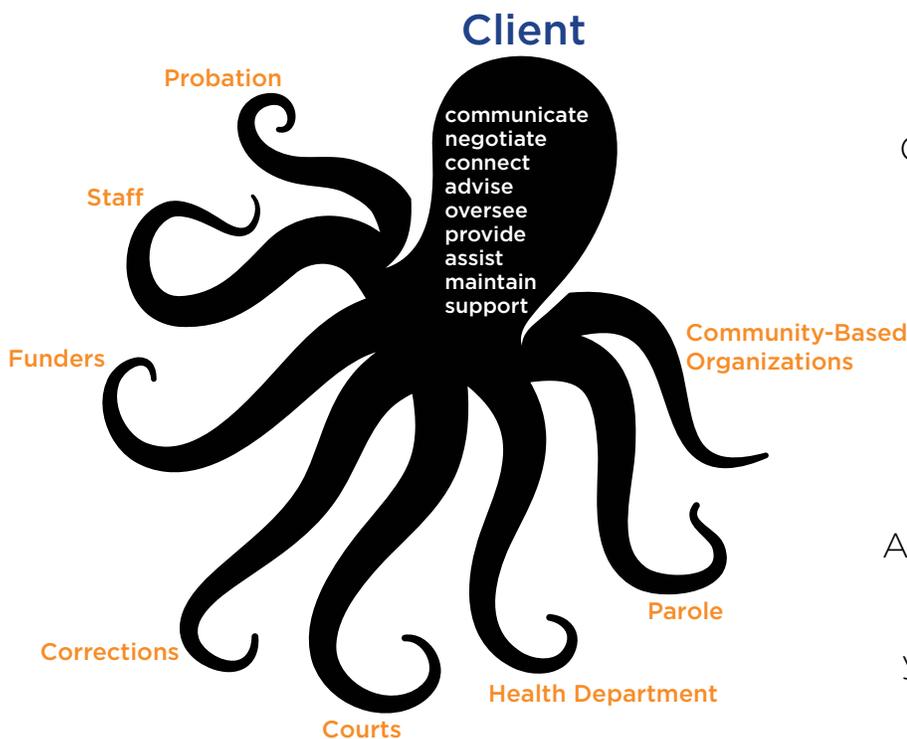
Staff need to be willing to ask for help if they need it. For those working entirely in the jail, it can feel isolating at times, and they may forget that they have an entire support structure beyond the jail. This is particularly true if they are not part of the formal culture of corrections.

### Preparing for Unpredictability

Staff need to be aware of and prepared for the unpredictability of jail-based work. Perhaps nothing is more unexpected than parole releases. In some cases, care coordinators may only receive 2–3 hours’ notice that a client has made parole. In this time, they need to finalize plans, fill any medications, and get everything upstairs before the client is transported.

Some jails, however, will be more or less predictable than others. For example, detainee jails are less predictable, both in terms of client behaviors and what can happen to client cases. Sentencing jails, however, are more predictable, as clients who have already been sentenced don’t typically want to do anything to increase their sentences.

## Critical Skills



“This is critical to working with incarcerated people. Communication with each entity in this diagram is critical because each and every one touches your clients one way or another.

All of this is connected and needs to be managed for your program to meet the needs of all your clients.”

–Jacqueline Cruzado-Quinones



Transitional Care Coordination Logic Model				
Inputs	Activities	Activities	Outcomes	Outcomes
<i>If you have this:</i>	<i>We can do this:</i>	<i>And then this:</i>	<i>Which will lead to this:</i>	<i>And then this:</i>
Existing care coordination team	Voluntary routine HIV testing	Comprehensive discharge planning	All offered HIV test at jail admission and re-offered if initial test was refused	More individuals know their HIV status
HIV continuum of care service model	Care coordination for those living with HIV	Linkages to culturally competent care	Comprehensive care plans with linkages to HIV provider sensitive to the needs of population	More HIV-patients linked to primary HIV care and treatment
Transtheoretical Model of Behavior Change (Stages of Change)	Stages of change-based approach to those who don't know their status and/or engage in risky behaviors	Appropriately tailored educational messages and counseling	Ability to assess changes in stage	Better informed clients, improved readiness to change, and increased awareness on how to best support clients
Relationships with reentry, health care, treatment court, diversion, and treatment providers that are available to address needs of the population	Health liaison to courts to assist diversion programs address the needs of the population (i.e., HIV, mental health and substance use)	Provide care coordination and linkages to care tailored to the survival, social, and medical needs of the population (i.e., housing, treatment)	Linkages to care	Better adherence, engagement in care, and better health outcomes
Electronic health record system	Electronic health record system updated to include transgender women	Use of electronic health record to identify all transgender women admitted to NYC jails	Improved ability to get to those clients quickly in order to prepare care plan with linkages to culturally competent providers	Reduced loss to follow-up since clients will be placed into a program better suited to their needs



# Client Encounters

“Try to keep it simple. Say, ‘What’s the matter? I’m here to listen and here to help you.’ The tone of your voice and your body language sets up the space for them to feel comfortable and open up and accept the services you’re offering.”

—Women’s Facility Coordinator

## Intake and Assessment

Make eye contact, smile, and greet the client warmly. Offer personal care items cleared by correction leadership, such as t-shirts, socks, and underwear to engage the client and encourage acceptance of services to discuss the client’s health. Recognize that this step requires empathy and that asking open-ended questions will likely garner more information. After the client has been made comfortable, check and photocopy their ID. Copying identification provides several benefits: 1) it verifies that you are seeing the correct client and

### Ask good questions!

- Rather than “What’s your address?” try **“How may I reach you in the community?”**
- Rather than “Who is your emergency contact?” ask **“Where shall I send laboratory results?”**
- Ask clients what their plans are for after incarceration, and work with them to identify benefits and services they want and for which they are eligible.

not revealing information to the incorrect person, 2) it provides identity documentation for benefits, and 3) it may assist with community engagement after incarcerations.

Explain to the client why you asked to meet with them (e.g., they self-reported living with HIV); assure the client that they will receive proper care and treatment, that you will not share information about their HIV status, and that you will maintain their confidentiality rights. Help the client trust the correctional health staff and emphasize that it is a good place to seek help and to privately self-disclose health problems.

Next, complete an intake assessment form with the client’s psychosocial and healthcare history, including the name of their community primary care provider, date of their most recent appointment, and preference for primary care provider after incarceration. Identify and document any unmet needs and then identify a community resource to meet those needs.

Record the name and contact information of the client’s emergency contacts and attorney, and any other pertinent information.

### *Tips for Client Engagement*

When engaging with clients, the following tips are important to remember:

- If a client is not interested or able to engage with you, a reason for “decline” must be identified for effective reengagement. Should a client “decline” services, make a note of this and arrange to meet at another time in the next 48 hours. Recognize that decline of services on a given day is not necessarily reflective of a client’s lack of interest in what you have to offer; it may simply be a bad time for them to come talk to you.
- It may work best to assign care coordinators by jail and devise a system to divvy up the workload where more than one care coordinator is assigned (perhaps using the last digit of ID numbers).
- Always note completed activities in the client’s records, including conversations in passing in the hallway.
- Prioritize client encounters: newly admitted, clients with imminent or immediate release, follow-up, and reengagement efforts.



## Daily Patient Roster for Correctional Officer Escort

Every morning, check for anyone newly admitted. Follow medical guidelines for priority conditions necessitating Transitional Care Coordination.

Prior to meeting clients, check their health records for labs, presence of chronic illness(es), and psychological diagnoses. Always read the client's psychiatric evaluation and, before every meeting, read their last psychologist evaluation write-up—it's important to know what you may be walking into. Additionally, review the client file for legal conditions for discharge (i.e., bail amount) and next court date.

The care coordinator then proceeds to meet the client in a specified area of the jail facility, such as the clinic, interview room, or day room. If the client is not ready to accept services, an “outreach for patient engagement” service note is made and a follow-up encounter to re-offer services is scheduled.

Within 24 hours of transfer from police to correctional custody, correctional health conducts a medical intake with each person who is incarcerated, including a medical intake screening, a physical exam, and a voluntary universal offer of a rapid HIV test.

## Private Interviewing in Jail Setting

Private interviewing space is often hard to find in a jail. There are a number of things to consider when utilizing space for client interviews. Check with correctional staff before giving anything other than a warm smile and greeting to a person who is incarcerated. State your needs up front. Make sure it's okay to shake hands and have audio-privacy with the client at the chosen time and place. Check with the correction officer to make sure there will be uninterrupted time before you begin your interview. Each jail may have different concerns on any given day. Head count times, meal periods, visitation, religious services, law library, or alarms may delay or interrupt your interview.

Keep in mind that a few times a day, correctional staff conduct a head count, which is a verification of the jail's census. Note, if the head count is off, a “re-count” will take place. During this re-count, as well as during any lockdowns, all movement may stop and you may not be permitted to see clients. Head count times and procedures vary by facility so anyone



working within the jail needs to know when this happens. No one—including you—will be permitted to move until this is reconciled. Note, during initial negotiations with the Warden it may be possible, though certainly not guaranteed, to have a “group count” if a full group is with you (e.g., during a health education class).

If the client’s next court date is not imminent and it seems that correctional staff have competing priorities, ask the client if the meeting can be rescheduled at another time and place.

## Removing Client Barriers

Reduce stigma by hiring staff who are reflective of the population, impacted by stigmatized diseases like HIV or the criminal justice system, and demonstrate cultural competency, including an ability to speak Spanish or other languages spoken by clients. Staff can act as role models to clients by relating to their experiences and having “walked the walk” themselves. If staff have a history of incarceration, know ahead of time whether they will be permitted in the jail. In New York, this typically means the staff member has had no justice system contact, including parole, for at least three years.

Once trust is established between the care coordinator and the client, address basic needs after incarceration first: housing, food, and clothing, then health, substance use treatment, and mental healthcare needs. Addressing clients’ most pressing needs is a core component of a Transitional Care Coordination approach. Meet the clients where they are and employ a harm reduction model. Help the clients make *their* wish list, not yours, and help them to prioritize and set short-term goals that are realistic and achievable.

Address potential unintentional “outing” of illnesses, such as HIV-infection, and protect client privacy/confidentiality. Start with a larger group session promoting health awareness in housing areas and “feel out” the group to address them properly. A number of participants will have additional questions. For example, during one jail education session a participant inquired about transmission of HIV from breast milk; take the opportunity to address the question but also address what may be the true underlying question (i.e., were they really concerned about HIV in other white fluids such as semen?).

Speak privately to those with questions or issues that are personal in nature and begin the planning process for linkage to community primary care and substance abuse treatment. With this method, not everyone is assumed to be HIV-infected, and those at risk receive education about HIV with a brief motivational interviewing session.



It may help to develop programs for chronic care and use the same staff for the HIV clients so that the staff assignments don't "out" the client. Also, it may help to remove structural components like "the pink sheet" for those who test positive.

## Barriers for Pre-trial Detainees

In NYC jails, processes for intake admission to jail as well as release to the community are conducted by the same correctional personnel. The process of admitting a person to jail has strict timeframes for completion and takes priority over community releases. This includes a medical intake and physical exam for all people who are incarcerated before being housed. The incarcerated detained in jail do not know if or when they will be released to the community from jail or court, and the number of new admissions may delay the process beyond the hours of community program operation for those soon to be released.

The NYC drop-in center was designed to address this very systematic barrier. As such, the drop-in center provides accompaniment/transport as well as housing after incarceration; this is available 24 hours a day, 7 days a week. In order to facilitate and coordinate the transport process, court attorneys are advised to request a "hold for transport."

## Creating the Discharge Plan

Before completing the discharge plan, consider the following:

- Is the client awaiting resolution of their legal case?
- What is the client's gender (male, female, or transgender)?
- What is the severity of the charges ("class"—scale high to low)?
- What type of housing or facility is the client in (e.g., special unit, such as mental observation or detox; restricted movement; cells; or open dorms)?
- Are there any exceptions or modifications that may need to be taken, such as diagnosis (e.g., HIV-positive, high-risk HIV-negative, chronic illness, medical watch, substance abuse, or pregnancy in the case of female clients) or anticipated transfer to prison?
- Is there an identified need for correction officers to escort clients?

Every time a care coordinator sits down with a client, the coordinator should double-check the client's name, address, phone number, and contact information, as clients use many AKAs.

After the client's intake is complete and the requisite planning steps have taken place, the next step is to make a medical appointment in the community using the next court date or

other information to project a release date, since the discharge date for most clients is unknown. An “appointment” may be a plan to go to a walk-in clinic on the first day available after release. Because immediate release is possible, plan for two court outcomes:

- **Sentenced**—one session should take place within 7 days of projected release date; additionally, as part of a follow-up encounter protocol, continue to see the client periodically, weekly, or monthly, depending on presenting issues (e.g., past engagement in care, treatment adherence, etc.).
- **Released**—linked to care in the community.

The client could also remain a detainee or be transferred to a state facility for a prison sentence.

At each session, discuss the discharge plan if the client remains in the jail, is transferred to another facility, or returns to the community. Recognize that your meeting may be a one-shot deal. As such, treat every session as though it is your last with this client.

When a client lives with multiple chronic conditions, you must also know when, where, and to whom the client should be referred for services. Often a client’s lack of attention to their health is a result of a larger issue. The discharge plan must juggle

## Peer Educator Training

Some people are recruited to participate in health educator training classes to improve their health literacy and self efficacy and to share this information with their peers. Peer educator training has two tracks: adult and adolescent.

### Adult Education

Participants are recruited from within the jails, including graduates from a substance use treatment readiness program called “A Road Not Taken.” The train-the-trainer course runs for 6 weeks (with one class a week) and participants are given a \$5 credit in their commissary for each session they attend and can also receive white T-shirts, socks, and undergarments as needed. Educational topics range from HIV incidence, prevalence, and trends in NYC to immune system function to role-play practice for training others.

### Adolescent Education

Adolescent classes are similar to the adult classes; however, participants are adolescents, mostly young men of color, and they co-facilitate the educational sessions alongside health educators. The trainings last for 12 sessions and participants can earn community service hours and a certificate of completion. Topics include substance use, mental health, anger and violence, sex, gender and stereotypes, masculinity, families, healthy living, and more.

For both tracks, all participants record “Teachable Moments” when using the learned skills in the jail facilities—during card playing or dominos in the housing areas. Reported “Teachable Moments” are recorded and tallied with community service hours attributed and certificates awarded at graduation.



all the issues a client faces and address as needed the client's mental health, housing situation, or substance abuse problem. These other issues may play a major role in whether the client is able to maintain care in the community. Additionally, transitional care coordinators should pre-screen for health insurance and enrollment into Medicaid to make sure client health insurance can be turned back on after incarceration, thus facilitating continuity of care.

It should be determined if any other discharge planners are within the jail. For example, within NYC jails there are mental health discharge planners. Get to know these individuals and coordinate with one another if you share clients.

Assess transportation options from jail to the first community destination and then to the primary care provider. Ask the client if they have access to personal or public transportation and if they will need accompaniment to their appointment, which can be offered and arranged by partner organizations. The outreach team—individuals who go out into the community and visit out-of-care clients at their home—also provides appointment accompaniment in the community where clients are located.

The discharge plan is noted in the client's electronic records, and the client is informed of the details. Any time the plan is modified, the client should receive a follow-up encounter and new copies of their discharge plan. If the client is sentenced or otherwise transferred, care coordinators at both the sending and receiving facilities conduct a case conference to ensure continuous care.

## Periodic Follow-up Encounters

If the client remains in jail, at the end of each session, a subsequent encounter is scheduled. At each session, review and update the intake form, as needed, and re-scan it. Ask the client how s/he is doing. If not completed at a prior encounter, construct an aftercare letter for the client, and, as before, end with two plans: one anticipating the client remains incarcerated and the other plan that the client is released to the community.

Care coordinators should provide a way for clients to reach them after incarceration. Clients may also write contact information in a designated book or paperwork that correctional staff will not confiscate. A client can request to see a care coordinator through sick call process.

## Community Follow-up

Following release, designated staff request documentation from community health providers to verify the client successfully connected to care with the referred provider. High-risk clients—including all those living with HIV—who cannot be located within 30-days after incarceration are referred to the outreach team, which takes charge of the case to find the client in the community and escort them to care. The outreach team is provided with client information to facilitate their identification of the client in the community (e.g., name; case number; date of release; where they hang out; what they look like; and any identifying characteristics, such as tattoos). If the outreach team has difficulty finding a client, they'll check the client's last residence, last provider, and whether or not they've returned to jail, as well as with the NYC Department of Social Services HIV/AIDS Services Administration (HASA). "In order to receive entitlements you need to produce documents to HASA so HASA often has the most accurate information and the client's recent address after incarceration," explains an outreach team member.

Community outreach for reengagement in care is a critical component of the Transitional Care Coordination model. For clients, it is reassuring to know that there are people who care about them and are still invested in helping them take care of their health. "Be patient though as some folks will say 'yes' and then not be home when you're there to pick them up. Be persistent," advises an outreach team member.

Bring a good dose of street smarts. While correctional health outreach team members typically travel alone, it's okay to use the buddy system as well. Trust your intuition. If there is a lot going

### Educating and Connecting with Community Members

More than **400,000 visits** are made to people incarcerated in NYC jails each year. To take advantage of this community connection, NYC Correctional Health Services launched a Rikers Island Visitor Center Health Station focused on outreach and education. Connecting with community members helps **improve their health** and wellbeing as well as facilitate a healthier environment for clients to come home to and serves as a kind of early intervention.

Educational topics covered at the Rikers Island Visitor Center Health Station include opioid overdose prevention, **HIV and HIV testing**, lowering risk of heart disease and hypertension, condom use, breastfeeding, and intimate partner violence-associated services. Blood pressure testing, BMI assessments, **naloxone overdose reversal kits** and associated trainings, condoms, lubricants, and healthful cooking classes have been offered. **Health insurance enrollment assistance** is also provided on a rotating schedule with community partners.



on in the community or a lot going on in front of the building and an outreach team member feels uncomfortable, they should come back another time. Mornings tend to be calmer so that's often the best time for a follow-up.

Because of the outreach team, people not yet in care get to care faster, and this activity provides “back-up” support to the foundational activities and groundwork already in place.

The first few weeks after incarceration is a critical period for many people and, for high-risk clients, requires ongoing follow-up. In addition to the linkage-to-care disposition, it should also be determined whether clients are engaged in care 90 days after release. Working with clients during this critical period to provide social supports—like surrogate family—for the first 3–4 months improves the likelihood of continued engagement in care and treatment thereafter.

After linkage to care and beginning approximately 6 weeks before the 90-day follow-up status date, the client is transitioned to ongoing case management. This facilitates a transition to other services providers such as Health Homes for continued and ongoing support.

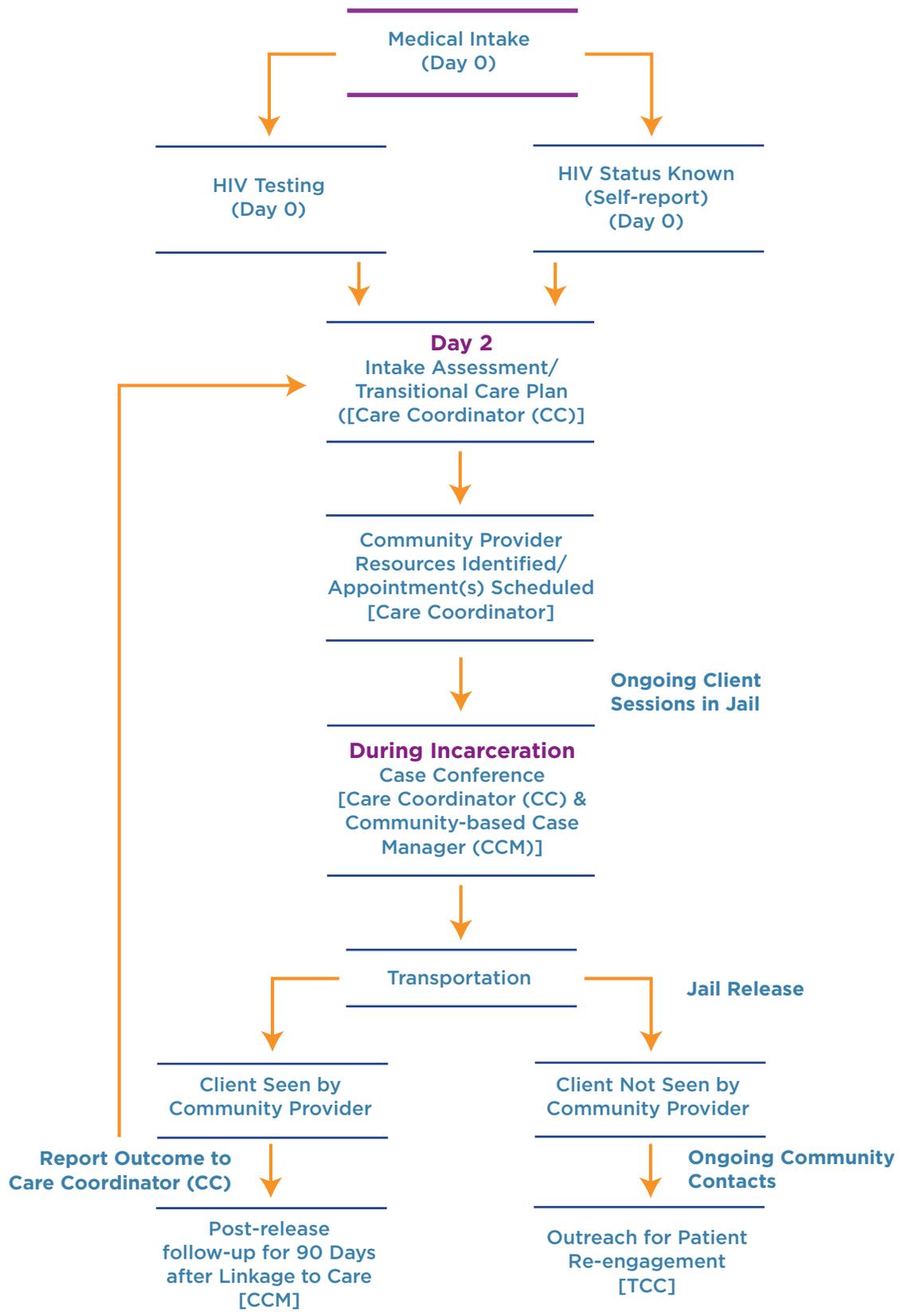
The 90-day follow-up status can fall into three categories:

- 1. in care**
- 2. re-incarcerated**
- 3. unable to determine.**

For a client to be considered in care, the 90-day follow-up is documented as contact with the client's primary care provider, case manager, care coordinator, or pharmacy. If an appointment has been missed, evidence of care can be found in a number of ways, such as the making and/or keeping of a rescheduled appointment, receiving lab work, picking up medication, or going to an alternate care provider (such as seeing a medical provider at a substance abuse treatment program). A client who has been re-incarcerated will have this status documented in their chart with the date of incarceration, jail, and housing information. These statuses are documented in the client's records. Once all data are entered (and the client is not re-incarcerated), a case can be closed.

If an HIV client has not scheduled or missed appointments at 90-days after incarceration (and research shows they were not re-incarcerated nor are they listed within death records), then it is unknown whether they are in continuous care. A progress note is then written detailing the routes taken to attempt a confirmation of care and any information showing the client's maintenance in care is undetermined.

## Connection to Care Process Flow Chart



# Medical Alternatives to Incarceration

## Court Advocacy/Health Liaison to the Courts

Some individuals are eligible for Alternatives to Incarceration, Alternatives to Sentencing, or diversion from jail in the best interests of the community. As an outgrowth of Transitional Care Coordination, correctional health acts as a health liaison to the courts and works with defenders, courts, court advocates, parole, and the District Attorney's Office with client consent. Health information is provided to assist in enrolling these clients into substance use treatment and other medical interventions in lieu of continued incarceration. Correctional health staff provide medical summaries, letters to the court, home care and nursing home assessments, and assist in identifying programs that are the right fit to address the patient's medical needs after incarceration. Court affiliates advise when a placement in lieu of incarceration is accepted by the court for each client, and then care coordinators arrange for "bridge" medication, transportation, and/or accompaniment to the program as ordered. Linkage to care as a medical alternative to incarceration is confirmed by the court affiliate who documents when the client arrives at the program.

Treatment Courts and other specialty courts may identify mentally ill individuals as well as individuals who were eligible for residential drug

### Eligibility Criteria

Screen individuals to determine program eligibility, which may include:

- Willingness to enter a skilled nursing facility, hospice, or substance use treatment program
- Safety of others in congregate setting
- Either a detainee or parole violator
- No immigration hold
- Chronic illness, including HIV.

programs by nature of their reason for coming to jail. While organizations exist that help facilitate alternatives to incarceration programs for such clients, the programs often require a health assessment as well as medical documentation for the courts in order to facilitate such placements.

A health liaison provides health information about people who are incarcerated on non-violent charges with chronic or severe health conditions to court advocates. Court advocates in turn work to arrange client transitions from jail to a medical placement community program.

With patient consent, this process can begin by calling the defense attorney or district attorney to discuss the client's eligibility for a program that will work with the courts. Then discuss the options with the client and apply for program acceptance. While the client may prefer an outpatient program with three-quarter housing, the court may not agree to placement unless the program is inpatient with clean and sober requirements. Note that acceptance into a program is not guaranteed.

The care coordinator facilitates program acceptance by providing to the court medical documentation (e.g., medical request for home care form, patient review instrument, aftercare letter, lab results including TB test results and/or CD4 count, psychosocial history) along with program suggestions and justifications on behalf of the client. The program acceptance letter should be scanned and securely transmitted to the appropriate official.

Facilitate a warm transition by arranging for a case manager to accompany and/or transport client from court to jail. A *warm transition* applies social work tenets to public health practices. This approach creates a more effective engagement opportunity and results in increased retention in care of individuals with chronic conditions.<sup>12</sup>

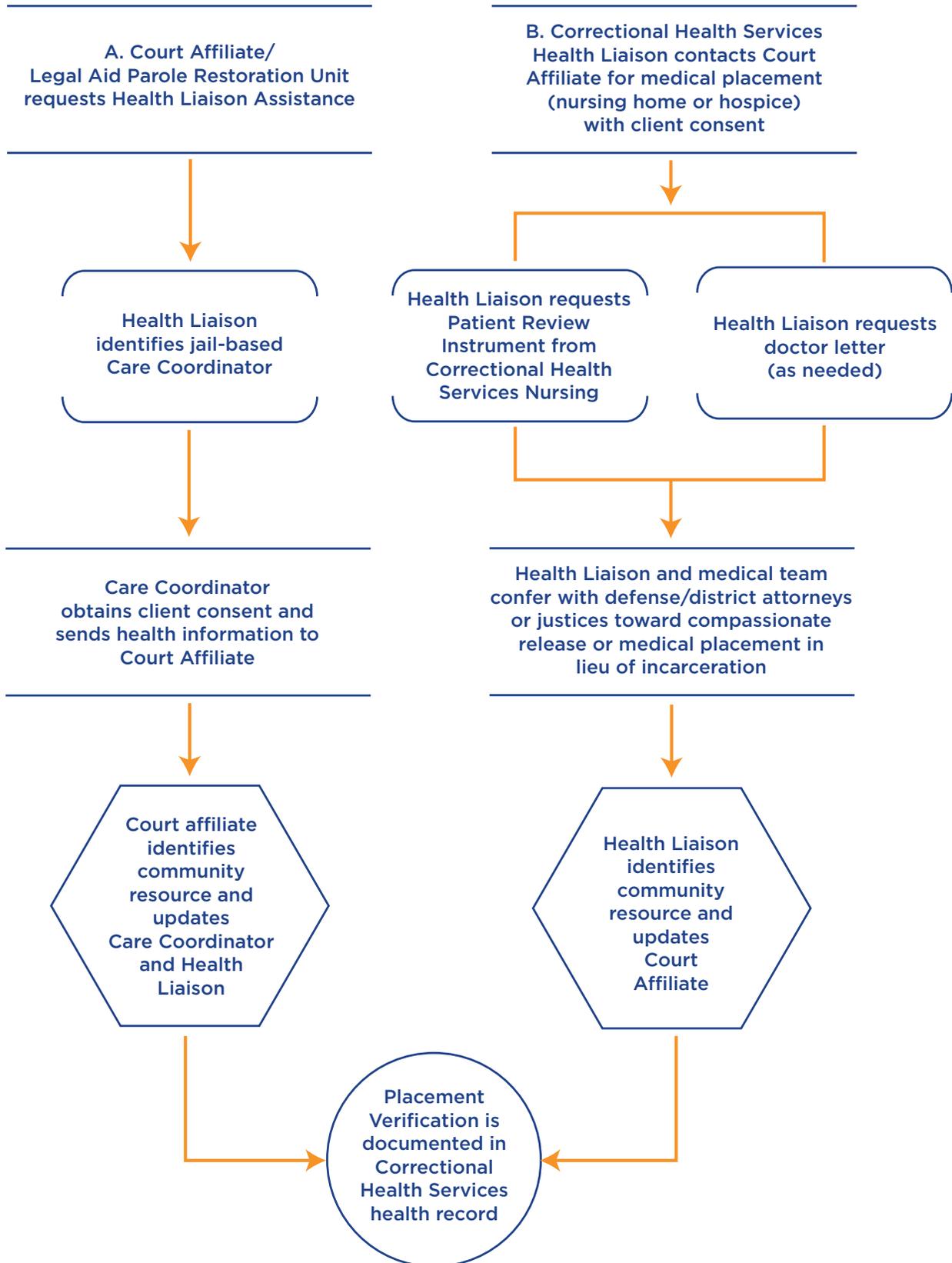
The court may request the preparation of discharge medication. If the client is currently prescribed medications, up to 7 days of "bridge" medication may be provided after incarceration and an electronic script will be sent to a pharmacy selected by the client. Arrangements may also be made for a program provider to pick up the medication on behalf of the client. Recognizing that providers are busy, try to give 72 hours' notice between the request for a filled script and a client's release; some cases, of course, require quicker turnaround.

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<sup>12</sup> Jordan AO, Cohen LR, Harriman G, et al. Transitional Care Coordination in New York City Jails: Facilitating Linkages to Care for People with HIV Returning Home from Rikers Island. *JAIDS*.(Suppl). 2013;Suppl2;S212-219.



## Medical Alternatives to Incarceration Process Flow Chart



## Health Liaison to the Courts

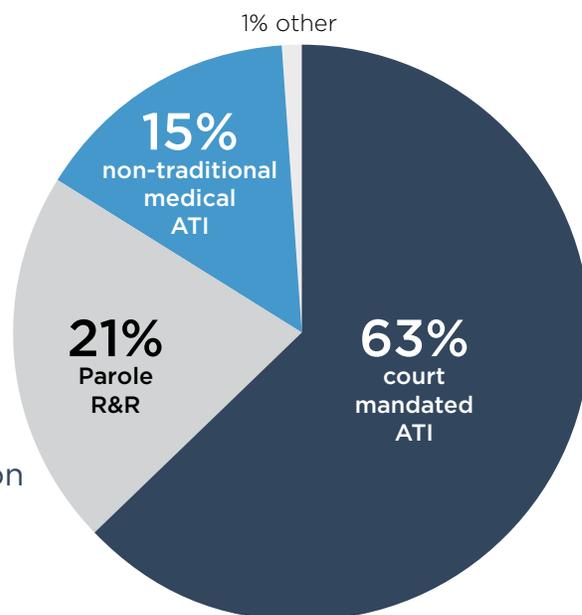


**80%**  
Released and Linked



In 2015, the health liaison collaborated on **800** court advocacy cases.

Providing health information to the courts **improves health outcomes** and **reduces impact** of incarceration on communities with the greatest health disparities.



A client discharged to a program should be considered linked to care and documentation should be obtained from the program. For HIV clients, verify documentation is acceptable and meets Ryan White Program requirements.

### Compassionate Release

Compassionate release can be initiated by the courts or by the treatment team. Compassionate release is warranted for those at the end of life and who are not seen as a danger to society. Correctional health may initiate a compassionate release medical placement for individuals who are terminally ill; have a significant, permanent disability; or have chronic conditions that cannot be optimally managed within a correctional facility.

Identification of potential candidates may be made by the jail-based treatment team, including physicians, care coordinators, health educators, and other involved correctional health staff.

With client consent, the correctional health senior leadership team reviews the client's medical information, and consults with care coordinators, supervisors, attorneys, and the courts to develop a compassionate release plan. The team then composes and submits letters, as well as medical documentation, on behalf of clients to facilitate compassionate release. Alternatively, the court may request supporting documentation for compassionate release.

As part of this process, a referral to the courts will include the client's:

- name,
- case number,
- facility location,
- charges,
- parole status,
- immigration status,
- the completed medical assessment,
- familial and/or community support, and
- attorney contact information.

If compassionate release is pursued, a transitional care plan is created, and court advocacy service encounter forms are completed.

## Health Homes

A *health home*, aka “Medicaid health home,” as defined in Section 2703 of the Affordable Care Act, offers coordinated care to individuals with multiple chronic health conditions and can provide community supports sought by justices to fulfill the release requirement for community ties. Eligibility includes at least one of the following:

- Two or more chronic conditions (e.g., mental health condition, substance use disorder, asthma, diabetes, heart disease, BMI over 25, or other chronic conditions (including substance use disorder))
- One qualifying chronic condition (HIV/AIDS) and risk of developing another, or
- One serious mental illness.

A large percentage of the 10,000 people who are incarcerated on any given day meet health home criteria and up to 10% of each Health Home's roster of assigned patients are incarcerated at any given time. Transitioning eligible detainees to a Health Home requires several components be in place. This includes a relationship with a healthcare provider who



can bill Medicaid and has systems in place to provide care management and continuity of primary care.

Health homes include case management and a coordinated approach to care, including integration of behavioral health and primary care. Connecting high-need clients to Health Homes has several public health implications: increased client healthcare access, medical attention to significant and chronic conditions, and overall improvement to individual health, as well as positive implications for broader community health overall.

Correctional health is able to match rosters with most of the NYC-based Health Homes and, in two pilot projects, a warm transition approach is used to facilitate return of a client to his/her assigned Health Home. Through these projects, Transitional Care Coordination staff work to reengage patients enrolled with the Health Home, as well as conduct outreach and pre-screenings of clients who may be eligible for Health Home services after incarceration. Eligible clients who accept participation in the pilots are connected to a Health Home care management agency and/or primary care after incarceration.

## Health Homes vs. Medical Homes: What's the Difference?

A **patient-centered medical home** is a physician-led, coordinated care model offering comprehensive, team-based care focused on quality and coordination of client care services.

A **health home** expands on the traditional medical home model by enhancing coordination of medical with behavioral health care for individuals with multiple chronic illnesses



# Records and Documentation

**D**uring intake, information (e.g., HIV status or other chronic conditions) are entered into the electronic health record (EHR). A report is created for newly admitted HIV-positive clients and reports are sorted by facility and client lists.

The EHR enables care coordinators to access client information quickly, as well as keep track of activities completed and notes necessary for future encounters. This includes notes within the case management tracking software system. Care coordinators should be sure to document the following into the client's record:

- client's emergency contacts,
- the discharge plan complete with addresses and phone numbers (including the primary care provider, housing, and other social services), and
- any notes about the client.

Within the client's record, be sure to clearly and correctly document the client's date of birth; social security number; common aliases; and common markings, such as tattoos and birthmarks, all of which are needed for after incarceration follow-up. At each sitting, check on the client's address, phone number, emergency contacts, and name, as clients use a lot of AKAs.

An important document that must be completed and signed during the intake assessment is a permission to release client information form. While correctional health is not a Health Insurance Portability and Accountability Act (HIPAA)-covered entity, mutual consent must be obtained in order to facilitate information sharing with community partners. On this form, list your own agency and the care facilities the client is being referred to so that you can follow up

after incarceration. If the client will be receiving court advocacy, the advocating agency should also appear on the HIPAA form and supporting documentation (e.g., program acceptance letter, medication request) and should be scanned into the client's electronic health record. This information and documentation are necessary to verify the client's identity and follow the client after incarceration.

In order to confirm a client has been seen by his/her provider, care coordinators should receive a fax or email form with the provider signature, date, and stamp. This form should clearly state the name of the client, his/her date of birth, provider name and contact person, and the date the client was seen. When signed and returned by the provider, the form should be scanned into the client's EHR.

When a client is reincarcerated, the care coordinator doing the reassessment will now have all records and forms of documentation from previous encounters to reference and use in order to better serve the client.



# Problem Solving and Goal Setting

Identify the key players relevant to a Transitional Care Coordination program.

These include individuals with formal and informal authority in your organization as well as in partnering organizations.

Listen first and then ask key questions, such as:

- How do things work now? Can you help me? Who plays what roles? What do the key players need?
- I have a problem/idea/goal and need help to solve it. It seems to me you are an expert in this. Can you help?

Be clear about both your short-term and long-term goals, and what you want to achieve overall. Be flexible about how to achieve a desired outcome.

Just like putting together a puzzle, sort all the pieces (components of the system), find the corners (existing resources, core components), and work with the straight edges first (find mutuality/partners that are aligned with your mission). Starting to get the picture?

## Example: Negotiating to Form a Group of Peer Leaders

**Problem Identified:** A consumer group member with a history of incarceration indicated that stigma and lack of trust are barriers to accepting the offer of an HIV test.

**Suggested Solution:** Consumers indicated that an offer from a peer rather than person in white coat would reduce this barrier.

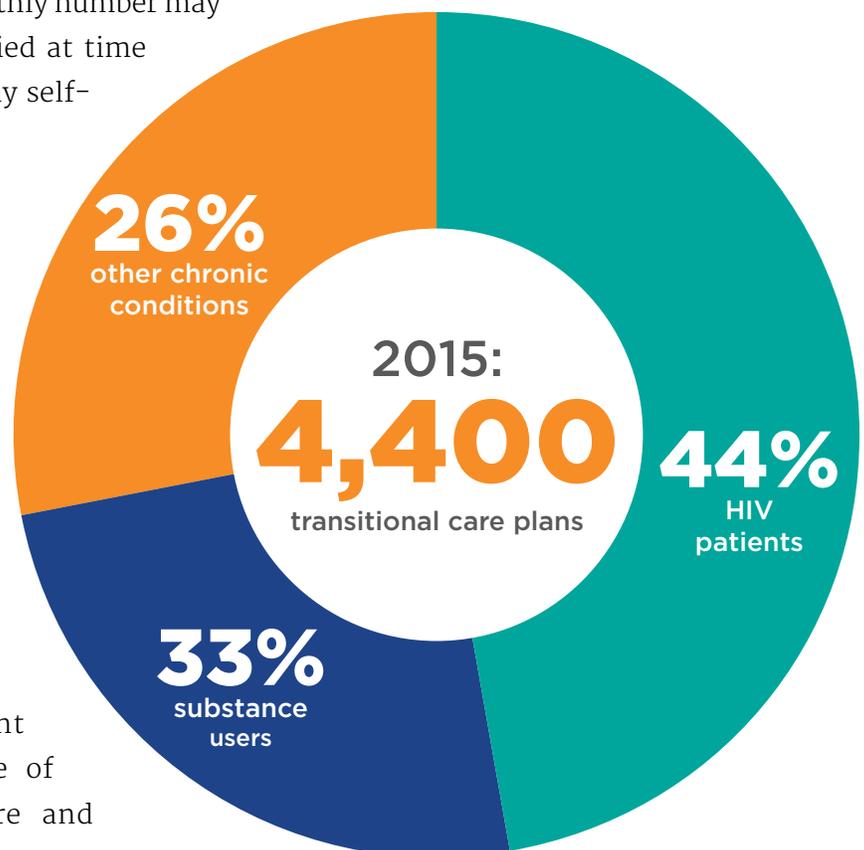
### Implementing the solution:

1. We met with the Warden to involve him in planning a program in which client peers act as educators.
2. We explained the problem and discussed the solution. We asked if we could reach out to a natural leader group (“Inmate Council”) to recruit peer leaders as health educators.
3. The Warden suggested using graduates from the treatment readiness program and we agreed.
4. The Warden offered to place graduates in different housing areas to reach a wider audience.
5. Peer Leaders as Health Educators was officially established.

# Data Quality Management

**A**dministrative staff track key data indicators in order to assess the program. In addition, they ensure staff is working to the best of its ability, all resources are covered, and clients are getting the best services possible. The total monthly number of priority conditions (e.g., chronic care conditions, including HIV) needs to be known. In some cases, the monthly number may be higher than the number identified at time of medical intake, as individuals may self-report at a later date.

Another important rate is the number of clients contacted and number of clients that receive a plan. While some clients may decline to be seen for a variety of reasons when presenting for a session, every attempt must be made to engage the client in a caring and non-judgmental manner and to provide health education and risk reduction services toward improving client understanding of the importance of accessing community health care and services after incarceration.



The rates of linkage to care and maintenance in care after 90 days must be tracked. These can be compared with previous rates and targets to identify problems, opportunities for improvement, or consistency overall and individually. While the goal is for everyone living with HIV who receives a transitional care plan to be linked to care after incarceration, NYC Correctional Health Services has consistently documented a 70% linkage-to-care rate with 80% maintained in care 90 days after their first community appointment.

These rates are directly related to the quality of work and management involved in achieving them. Falling below targets or expectations, especially the linkage-to-care rate, indicates a need for quality improvement and a possible need for training, and adjustments in protocols, procedures, or approaches. Care coordinators should document linkage to care in order to have the feedback needed to continue to self-evaluate their engagement and counseling skills as well as celebrate client followthrough on goals.

While the goal is for everyone living with HIV who receives a transitional care plan to be linked to care after incarceration, NYC Correctional Health Services has consistently documented a **70%** linkage-to-care rate with **80%** maintained in care **90 days** after their first community appointment.

## Reliability and Good Impressions

Keep in mind that success breeds more success! A good first impression on clients, correction staff, and service partners is extremely important. Word-of-mouth will be your friend if you deliver as you promise. Others with HIV or other chronic illnesses will self-report if they know that people who care will help them.

**T**he United States has the highest rates of mass incarceration—more so than any other developed country in the world. This has both economic and societal costs.

Correction's spending in the U.S has ballooned to \$68 billion. Moreover, incarceration does not occur in a vacuum; more than 90% of people who are incarcerated return to the community. Studies show poor health outcomes following release and that incarceration may increase community risk of infectious diseases, depression, anxiety, and violence. And despite health risks, many people only have access to health care when incarcerated.<sup>13</sup>



**Source:** Zack B, Hane LM. University of California, San Francisco, NYC Health and Hospitals Correctional Health Services. *Making the Case: Community Impact of the Criminal Justice System and How Planning and Policy Promote Health*. 2015.

<sup>13</sup> Zack B, Hane LM. University of California, San Francisco, NYC Health and Hospitals Correctional Health Services. *Making the Case: Community Impact of the Criminal Justice System and How Planning and Policy Promote Health*. 2015.

By implementing a Transitional Care Coordination model, providers have an opportunity to connect with hard-to-reach clients who often struggle with a host of social, mental, and healthcare challenges. Although discharge planning periods may be brief and this work requires coordination with correction staff, care coordinators, and community organizations, it can be done and has been successfully demonstrated by the *THCConsortium*. To make longer-lasting change, however, the structural and systemic issues that led to mass incarceration and health disparities in the first place must be addressed.

SPECIAL THANKS TO OUR TRANSITIONAL  
HEALTHCARE CONSORTIUM



... AND OUR TRANSITIONAL CARE COORDINATION TEAM!



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# Guidelines for Working in NYC Jails

## The Client Population

The population of the New York City correctional system consists of approximately 85,000 incarcerations of 65,000 individuals per year, with approximately 10,000 individuals in the custody of the Department of Correction on any given day. The median length of stay is 7 days; approximately 50% are released within a week of jail admission. Approximately 10–12% of people who are incarcerated in NYC jails are women, including 250 transwomen.

## I. Understanding the Correctional Environment

Implementing Transitional Care Coordination activities in the correctional setting depends in part on acquiring a thorough understanding of the formal and informal regulations in the jail, and building collegial relations with correction personnel. In order for Transitional Care Coordination staff members to familiarize themselves with the workings of the jail environment, new staff training will include an orientation to the following:

### A. The Correctional Setting

1. All staff will receive security training from correction. You are considered “civilians” by correction staff.
  - a. This training will help staff members understand the importance of security within the correctional facility for their own safety and for the safety of their co-workers.
2. All staff will be given a tour of all Rikers Island facilities and Borough Houses of Detention.
  - a. This will help staff members understand the setting of each individual jail.
3. All new staff will observe (“shadow”) experienced staff members working within all the correctional facilities.
  - a. This will allow new staff the opportunity to become acquainted with other correctional staff from the different jails.
  - b. This will expose new staff to the different styles of presenting HIV education material.

### B. Correction Personnel

1. CORRECTION CHAIN OF COMMAND IN RIKERS ISLAND FACILITIES  
Warden: Responsible for the entire operation of the facility

*The following personnel report to the Warden:*

Deputy Warden of Programs: Responsible for the operations of the following: medical services, recreational services, educational services, social services, suicide prevention, religious services, law library, counsel, facility information system (F.I.S.), and the barber shop.

Deputy Warden of Security: Responsible for fire and safety, custody, facility arsenal (firearms and security equipment), security, risk group (gang) tracking, facility statistics, searches, and overall facility safety.

Deputy Warden of Administration: Responsible for the General Office, Personnel Office, facility budget, maintenance, staff discipline, food services, environmental health, and laundry.

Assistant Deputy Warden (A.D.W.) Tour Commander: Responsible for the operation of the facility for their assigned tour.

Captain: Responsible for correctional staff in their assigned area.

2. All staff should be properly introduced by their Supervisor or other staff members to the facility Warden, Deputy Warden of Programs, Deputy Warden of Security, Programs Captain, Security Captain, front gate officer and programs officer (officer who is in charge of the area and is responsible for “calling down” the people who are incarcerated for programs and meetings).
  - a. This will allow all staff members to familiarize themselves with the facility administration.
  - b. This will also facilitate preliminary steps that will enable staff members to accomplish their work tasks. (i.e., receive facility unrestricted I.D., secure office space, classroom space for group presentations, etc.)
3. Staff may participate in correction’s activities held in the facility.
  - a. Such activities include Black History Month, Latino Month, and breast cancer awareness events.
  - b. This will allow the staff members to familiarize themselves with the officers from different areas within their facility and facilitate correction’s cooperation when calling clients to an activity.
  - c. This will allow for the full integration of Transitional Care Coordination activities within correction’s and other program activities.

## II. How Are People Who Are Incarcerated Classified by Correction?

### A. Housing Classifications

#### 1. HEALTH STATUS

Medical staff or Mental Health staff are responsible for making the determination to place people who are incarcerated with others who are similarly ill (e.g., have infectious diseases) or in mental observation wards based on their examination of the individual. Special program housing areas are available for people with similar medical or mental health needs, including infirmary care.

## 2. SUBSTANCE ABUSE

Medical staff will determine if an individual is chemically dependent. These individuals may be housed in the Detoxification Unit at a specific facility or hospital prison ward. Specialized program housing areas are also available, including those for substance use treatment readiness.

## 3. SECURITY CLASSIFICATION

People who are incarcerated are housed by correctional staff according to their security classification which is determined by a number of factors such as

- a. Prior criminal history,
- b. Current charges,
- c. Age,
- d. History of violence in jail.

## 4. CENTRALLY MONITORED CASES (CMC)

Those who are considered “notorious.”

- a. Publicity in media,
- b. Violent in jail (assault on a staff or another person who is incarcerated),
- c. Escape risk,
- d. Any other history that correction department determines.

## 5. PUNITIVE SEGREGATION / SOLITARY CONFINEMENT (“Bing”)

Adults who are incarcerated and found guilty of violating the rules of the correction department and given an infraction may be sent to punitive segregation for a certain number of days. Refer to the NYC Board of Corrections Standards for current rules.

# *B. Criminal Justice System Classifications*

## 1. DETAINEES

- a. Individuals who are awaiting trial,
- b. Individuals who are remanded by court,
- c. Individuals who cannot make bail,
- d. Individuals who have a warrant.

## 2. CITY-SENTENCED

Individuals who are sentenced to a misdemeanor for one year or less. Individuals can be serving two consecutive sentences that combined are not more than a year.

## 3. STATE-SENTENCED

- a. Individuals serving a longer sentence for a felony conviction.
- b. Individuals who violated the terms of parole (parole violator).

### III. Frequent Occurrences Within Jails

There are security-related activities that may interfere with your planned tasks when you work in a correctional facility. Some occur daily and others are periodic and will interrupt the planned activities during your workday.

#### A. Common jail occurrences

##### 1. WHAT IS A SEARCH?

A search is a procedure that the Department of Correction mandates for the safety and security of the institution to locate any possible contraband (items not permitted in jails), such as excess clothing, razor blades, drugs, needles, pencils with erasers, etc. Searches are conducted at least once per tour (an 8-hour work shift) or when the need arises. There is no movement of people who are incarcerated during a search.

##### 2. WHAT IS A COUNT?

A count is a verification of the institutional census (checking that the number of people who are incarcerated physically within the institution matches the jail census). A count is conducted several times throughout a 24-hour period. There is no movement of people who are incarcerated during count time.

##### *WHAT SHOULD STAFF DO DURING SEARCHES AND COUNT TIME?*

Be mindful of count times in your work location. As searches and count times are regular procedures that occur at various times throughout the day, they should be planned for during your working schedule. Staff should continue their regularly scheduled work activities unless otherwise instructed. People who are incarcerated may be counted in place, rather than in their assigned housing area, depending on the security needs of each facility (i.e., people who are incarcerated may be counted while they attend regularly scheduled health education groups, or are in the jail health clinic).

##### 3. WHAT IS A LOCK DOWN?

A “lock down” is when movement of all people who are incarcerated stops due to an alert or an unusual occurrence within a facility. Civilian movement may also be restricted.

##### 4. WHAT IS A RE-COUNT?

The original count of the facility is off and needs to be verified. All people who are incarcerated are physically counted and all movement of people who are incarcerated stops.

##### 5. WHAT IS AN ALARM?

Correctional staff calls for assistance due to a fight, staff being assaulted, escape, or other emergency. All movement except correctional staff stops—people who are incarcerated as well as civilians.

##### 6. WHAT IS A TACTICAL SEARCH OPERATION (TSO)?

Each facility will send staff (Officers and Captains) to a specific facility when necessary for a major search. This search could take hours. There are different levels of TSO.

**Level 1:** One Captain and 10 Officers from each facility.

**Level 2:** Two Captains and 20 Officers from each facility.

**Level 3:** Three Captains and 30 Officers from each facility.

The levels of TSO can escalate. Officers and captains may be sent to another facility to conduct a search whenever necessary. Sometimes all movement stops depending on the level of the TSO and the size of the facility.

WHAT TRANSITIONAL CARE COORDINATION STAFF SHOULD DO WHEN THERE IS A TSO, LOCK DOWN, RE-COUNT, OR ALARM:

1. Staff should notify their supervisor. If the supervisor is not available, contact the main office and speak with covering manager or other assigned staff.
2. In case of emergency, staff may also reach out to Operations 24/7/365.

ALTERNATIVE TRANSITIONAL CARE COORDINATION ACTIVITIES WHEN CORRECTIONAL ACTIVITIES IMPACT REGULAR PLANNED WORK:

1. If there is no movement for clients or civilian staff, Transitional Care Coordination staff must:
  - a. Immediately inform their supervisor. If the supervisor is not available, contact the covering manager staff or main office until you speak with a person (leaving a message is insufficient).
  - b. Make use of this time for other activities such as:
    - i. Prepare for Transitional Care Coordination program activities such as creating a list of clients for the escort officer to call down.
    - ii. Follow up with providers and community-based organizations to document linkages to care.
    - iii. Update progress notes and other documentation in eCW and eSHARE.
    - iv. Review literature and materials to better inform your work.

## 7. WHAT IS AN ALERT?

There are three different types of alerts that are defined by degrees of severity. The lowest being yellow and the highest being red; these alerts could last hours.

- a. **YELLOW ALERT:** Facility count is off, a re-count is ordered, and the facility is on a "lock down."
- b. **ORANGE ALERT:** A breach of security and possible escape.
- c. **RED ALERT:** A verified escape. There is a lock down and a re-count is ordered of all the jails, no movement for staff and no one leaves Rikers Island while a red alert is activated.

WHAT TRANSITIONAL CARE COORDINATION STAFF MEMBERS SHOULD DO WHEN THERE IS AN ALERT:

1. If staff is barred from entering Rikers Island or any facility because of an alert, call your supervisor or director. If unavailable, call the main office, state the emergency, and speak with one of the other directors for further instructions. Staff may also reach out to Operations 24/7/365.
2. If you are already at your facility, notify your supervisor or director as soon as possible. If unavailable, call the main office, state the emergency, and speak with one of the other directors for further instructions.
3. For your safety, follow instructions from correctional personnel during security actions, including alerts.

#### 8. GENERAL SAFETY AND SECURITY:

Your safety is paramount. Keep in mind that you are in a secure facility where correctional priorities are care, custody, and control of people who are incarcerated. Your personal safety must be your first concern. Be aware of your surroundings and activities outside your work space. If you provide a patient/client with a pen to sign an official document, make sure you receive it back. If you make a call to a family member while your patient/client is present and s/he speaks with them from your office telephone, make sure the conversation is brief and stays on topic. Be aware of fire safety rules and in the event of a fire, evacuate. In case of an emergency, take needed action, then notify supervisor or covering manager. Be watchful and mindful, along with caring, supportive, and engaging.

# Correctional Health Services Intake Assessment (MCM, MCM-W, CMN, TCC)

Client Name: \_\_\_\_\_

Client Record # \_\_\_\_\_

ALL Intake Date:

\_\_\_\_/\_\_\_\_/\_\_\_\_  
mm dd yyyy

Program Staff: Complete this form through a combination of client interview and chart review at intake. Please note that this form is used for multiple service categories. Not all data elements contained in this form are expected for each service category. To identify which questions are required for your service category, please find the data element requirement codes in the grey section header bar or to the left of individual questions.

Data Element Requirement Codes:

1 = Required; 1 = Optional

Service Category Codes:

ALL = All Categories; 1 = MCM; 2 = TCC; 3 = MCM-W/CMN

## I. Clinical Information

Chart Review or Client Interview

ALL Date of first known visit to this agency for any service: \_\_\_\_/\_\_\_\_/\_\_\_\_ (mm/dd/yyyy)

1  3 Date of first known outpatient/ambulatory care visit at this agency:

Same as above OR \_\_\_\_/\_\_\_\_/\_\_\_\_ (mm/dd/yyyy)

ALL HIV Status:  (Check only one)  HIV+, Not AIDS  HIV+, AIDS status unknown  CDC-Defined AIDS

ALL HIV Diagnosis Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ (mm/dd/yyyy)

ALL If AIDS, AIDS Diagnosis Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ (mm/dd/yyyy)

ALL HIV Risk Factor:  (Check all that apply)

MSM  IDU  Heterosexual  Blood transfusion/components

Hemophilia/coagulation disorder  Perinatal  Risk factor not reported or not identified

2  3 Do you currently have a Primary Care Physician (PCP)/HIV primary care provider?  Yes  No

ALL Last PCP visit prior to enrollment: \_\_\_\_/\_\_\_\_/\_\_\_\_ (mm/dd/yyyy) OR  Unknown  N/A

1 Initial/referral visit with PCP within this program: \_\_\_\_/\_\_\_\_/\_\_\_\_ (mm/dd/yyyy)

Most recent CD4 counts and Viral Load measures from on or before the program enrollment date:  (Start with the most recent)

ALL CD4 Records  If none are available, check box at right:  No CD4 count on record

CD4 count	CD4 % (optional)	Date (mm/dd/yyyy)

ALL Viral Load Records  If none are available, check box at right:  No viral load count on record

Viral Load count	Viral Load Undetectable	Date (mm/dd/yyyy)
	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

Legend:  1 = Required; 1 = Optional

Service Category Codes: ALL = All Categories; 1 = MCM; 2 = TCC; 3 = MCM-W/CMN

# Correctional Health Services Intake Assessment (MCM, MCM-W, CMN, TCC)

Client Name: \_\_\_\_\_

**ALL** Hospitalizations & ED Visits: *(If client had any ED or inpatient care in year before enrollment, fill in table.)*

# of Events	Start Date (mm/dd/yyyy)	End Date (mm/dd/yyyy)	Reason/Discharge Dx	Facility
# of Hospitalizations:				
(If none, enter "0")				
# of ED Visits:				
(If none, enter "0")				

**ALL** Does client have any other medical conditions requiring treatment?  Yes  No  Unknown

**ALL** If Yes, What condition(s)? *(Check all that apply)*

- Cancer
- Diabetes
- Heart disease/hypertension
- Liver disease
- Other (Specify: \_\_\_\_\_)
- Kidney disease
- Hepatitis C
- Tuberculosis (TB)
- Asthma

**ALL** Has client ever received a mental health diagnosis?  Yes  No  Unknown

**ALL** If Yes, What diagnosis or diagnoses? *(Check all that apply)*

- Depression
- Anxiety Disorder (Panic, GAD, etc.)
- PTSD
- Bipolar Disorder
- Psychosis (Schizophrenia, etc.)
- HIV-associated Dementia
- Other (Specify: \_\_\_\_\_)

**ALL** Pregnant:  Yes  No  Unknown  N/A (male) *If No, Unknown or N/A, go to Section 11.*

**ALL** If Yes, Date of report of client's pregnancy to program: \_\_\_\_/\_\_\_\_/\_\_\_\_ (mm/dd/yyyy)

**ALL** Is client enrolled in prenatal care?  Yes  No  Unknown

*For the following questions, check "N/A" if client plans to terminate (and thus is not preparing for a live birth)*

**ALL** If Yes, When was client enrolled in prenatal care:

- First trimester
- At time of delivery
- Second trimester
- N/A
- Third trimester
- Unknown

**ALL** Estimated Due Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

OR select one of the following:  N/A  Unknown

**ALL** Is client prescribed ART to prevent maternal-to-child (vertical) transmission of HIV?

- Yes
- No
- Unknown
- N/A

Legend: **1** = Required; 1 = Optional

Service Category Codes: ALL = All Categories; 1 = MCM; 2 = TCC; 3 = MCM-W/CMN

# Correctional Health Services Intake Assessment (MCM, MCM-W, CMN, TCC)

Client Name: \_\_\_\_\_

## II. Antiretroviral Treatment (ART) Review

*Chart Review or Client Interview*

**ALL** Is client currently prescribed ART?  
 Yes *If Yes, Complete regimen detail below.*     No *Skip this table.*

1 2 3 HIV medication names	1 2 3 Dosage		1 2 3 # Dosage	1 2 3 Frequency	1 2 3 Date Started (mm/yyyy)
	# per Dose	Dose Unit (pills, ccs, mls)			
1.				<input type="checkbox"/> Daily <input type="checkbox"/> Weekly	___ / ___
2.				<input type="checkbox"/> Daily <input type="checkbox"/> Weekly	___ / ___
3.				<input type="checkbox"/> Daily <input type="checkbox"/> Weekly	___ / ___
4.				<input type="checkbox"/> Daily <input type="checkbox"/> Weekly	___ / ___

**ALL** If client is not on ART, Why is the client not currently prescribed ART? *(Check only one)*  
 Not medically indicated     Not ready—by PCP determination     Intolerance/side effects/toxicity  
 Payment/insurance/cost issue     Client refused     Other reason     Unknown

## III. Client Information

*Client Interview*

**ALL** Total number in household *(including the client)*: \_\_\_\_\_

**ALL** Current employment status: *(Check only one)*  
 Full-time     Part-time     Unemployed     Unpaid volunteer/peer worker  
 Out of workforce     Other (Specify: \_\_\_\_\_)     Declined

**ALL** Highest level of education achieved: *(Check only one)*  
 No schooling     8th grade or less     Some high school  
 High School/GED or equivalent     Some college     Bachelors/technical degree  
 Postgraduate     Declined

**ALL** Primary Language Spoken (i.e., at home): *(Check only one)*  
 English     Spanish     Other (Specify: \_\_\_\_\_)     Declined

**ALL** If Primary Language is not English: Secondary Language Spoken: *(Check only one)*  
 English     Spanish     Other (Specify: \_\_\_\_\_)     Declined

**ALL** Country of Birth: *(Check only one)*  
 USA     US territory/dependency (○ Puerto Rico    ○ Other (Specify: \_\_\_\_\_))  
 Other country (Specify: \_\_\_\_\_)     Declined

**ALL** *If not USA, ask:* In what month and year did you first come to the US? \_\_\_ / \_\_\_ (mm/yyyy)     Declined

Legend: **1** = Required; 1 = Optional  
 Service Category Codes: ALL = All Categories; 1 = MCM; 2 = TCC; 3 = MCM-W/CMN

# Correctional Health Services Intake Assessment (MCM, MCM-W, CMN, TCC)

Client Name: \_\_\_\_\_

## IV. Insurance Information ALL

*Chart Review or Client Interview*

**Insurance Status:**  Uninsured  Insured (If Insured, complete insurance details on next page. Otherwise, skip to Section V.)

Check all that apply, and complete the related details/dates on each checked insurance type:

Insurance Type	Insurance details	Effective Date (mm/dd/yyyy)	End/Expiration Date (mm/dd/yyyy)
<input type="checkbox"/> Private	<div style="border: 1px solid black; padding: 2px; margin-bottom: 5px;">(Check only one)</div> <input type="checkbox"/> Employer plan <input type="checkbox"/> Individual plan	___/___/___	___/___/___ <input type="checkbox"/> Unknown <input type="checkbox"/> N/A
<input type="checkbox"/> ADAP/ADAP+	<div style="border: 1px solid black; padding: 2px; margin-bottom: 5px;">(Check all that apply)</div> <input type="checkbox"/> ADAP (Rx Coverage) <input type="checkbox"/> ADAP Plus	___/___/___	___/___/___ <input type="checkbox"/> Unknown <input type="checkbox"/> N/A
<input type="checkbox"/> Medicaid or CHIP	<div style="border: 1px solid black; padding: 2px; margin-bottom: 5px;">(Check only one plan type)</div> <input type="checkbox"/> SNP (special needs plan) <input type="checkbox"/> MCO (managed care organization) <input type="checkbox"/> FFS (fee-for-service) <input type="checkbox"/> Not sure which type	___/___/___	___/___/___ <input type="checkbox"/> Unknown <input type="checkbox"/> N/A
<input type="checkbox"/> Medicare		___/___/___	___/___/___ <input type="checkbox"/> Unknown <input type="checkbox"/> N/A
<input type="checkbox"/> Military, VA, Tricare		___/___/___	___/___/___ <input type="checkbox"/> Unknown <input type="checkbox"/> N/A
<input type="checkbox"/> IHS (Indian Health Service)		___/___/___	___/___/___ <input type="checkbox"/> Unknown <input type="checkbox"/> N/A
<input type="checkbox"/> Other Public Insurance		___/___/___	___/___/___ <input type="checkbox"/> Unknown <input type="checkbox"/> N/A

## V. Financial Information ALL

*Client Interview*

**What is your annual household income?** \$ \_\_\_\_\_ per year

**We will be asking you questions in the next two sections about substance use and sexual behaviors. Some of these questions may seem personal in nature, but we ask them of everyone in this program.**

- Please answer honestly. You may refuse to answer a question; refusing will not affect your care.
- Please feel free to ask if you need any of the questions explained to you.
- If you do not want to answer a question now, please tell me and we will return to it another time.

Legend: 1 = Required; 1 = Optional

Service Category Codes: ALL = All Categories; 1 = MCM; 2 = TCC; 3 = MCM-W/CMN

# Correctional Health Services Intake Assessment (MCM, MCM-W, CMN, TCC)

Client Name: \_\_\_\_\_

## VI. Use of Prescriptions, Injectables and Other Substances ALL

*Client Interview*

Have you used any of the following substances? Read the list starting with tobacco.

Substance	... have you ever used this?	If ever used it, ask:		For use in past 3 months, ask:	
		In the past 3 months?	How often do you use?	How have you taken this? <span style="border: 1px solid black; padding: 2px;">(Check all that apply)</span>	
Haven't used any	<input type="checkbox"/> *	<span style="border: 1px solid black; padding: 2px;">*If haven't used any substance <b>EVER</b>, skip to Section VII.</span>			
Tobacco	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined	_____ cigarettes smoked weekly (for other forms of tobacco, # times used weekly) <i>or</i> <input type="checkbox"/> < weekly <input type="checkbox"/> Declined (reminder: 1 pack = 20 cigarettes)	<input type="checkbox"/> Orally (chewing tobacco) <input type="checkbox"/> Smoked <input type="checkbox"/> Inhaled/snorted (snuff) <input type="checkbox"/> Declined (no answer)	
Alcohol	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined	_____ drinks weekly <i>or</i> <input type="checkbox"/> < weekly <input type="checkbox"/> Declined		
Marijuana	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined	_____ times weekly <i>or</i> <input type="checkbox"/> < weekly <input type="checkbox"/> Declined	<input type="checkbox"/> Orally (Eaten/swallowed) <input type="checkbox"/> Smoked <input type="checkbox"/> Declined (no answer)	
PCP/ Hallucinogens	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined	_____ times weekly <i>or</i> <input type="checkbox"/> < weekly <input type="checkbox"/> Declined	<input type="checkbox"/> Orally (Eaten/swallowed) <input type="checkbox"/> Smoked <input type="checkbox"/> Inhaled/snorted <input type="checkbox"/> Injected <input type="checkbox"/> Declined (no answer)	
Crystal Meth	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined	_____ times weekly <i>or</i> <input type="checkbox"/> < weekly <input type="checkbox"/> Declined	<input type="checkbox"/> Orally (Eaten/swallowed) <input type="checkbox"/> Smoked <input type="checkbox"/> Inhaled/snorted <input type="checkbox"/> Injected <input type="checkbox"/> Declined (no answer)	
Cocaine/Crack	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined	_____ times weekly <i>or</i> <input type="checkbox"/> < weekly <input type="checkbox"/> Declined	<input type="checkbox"/> Orally (Eaten/swallowed) <input type="checkbox"/> Smoked <input type="checkbox"/> Inhaled/snorted <input type="checkbox"/> Injected <input type="checkbox"/> Declined (no answer)	
Heroin	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined	_____ times weekly <i>or</i> <input type="checkbox"/> < weekly <input type="checkbox"/> Declined	<input type="checkbox"/> Orally (Eaten/swallowed) <input type="checkbox"/> Smoked <input type="checkbox"/> Inhaled/snorted <input type="checkbox"/> Injected <input type="checkbox"/> Declined (no answer)	
Rx Pills to get high	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined	_____ times weekly <i>or</i> <input type="checkbox"/> < weekly <input type="checkbox"/> Declined	<input type="checkbox"/> Orally (Eaten/swallowed) <input type="checkbox"/> Smoked <input type="checkbox"/> Inhaled/snorted <input type="checkbox"/> Injected <input type="checkbox"/> Declined (no answer)	
Hormones/ steroids	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined	_____ times weekly <i>or</i> <input type="checkbox"/> < weekly <input type="checkbox"/> Declined	<input type="checkbox"/> Orally (Eaten/swallowed) <input type="checkbox"/> Patch <input type="checkbox"/> Injected <input type="checkbox"/> Declined (no answer)	
Anything else: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined	_____ times weekly <i>or</i> <input type="checkbox"/> < weekly <input type="checkbox"/> Declined	<input type="checkbox"/> Orally (Eaten/swallowed) <input type="checkbox"/> Smoked <input type="checkbox"/> Inhaled/snorted <input type="checkbox"/> Injected <input type="checkbox"/> Declined (no answer)	

Legend: 1 = Required; 1 = Optional

Service Category Codes: ALL = All Categories; 1 = MCM; 2 = TCC; 3 = MCM-W/CMN

# Correctional Health Services Intake Assessment (MCM, MCM-W, CMN, TCC)

Client Name: \_\_\_\_\_

*If client has, at this interview, reported injecting any substance in the table above, select "Yes" to the question below and select "in the past 3 months" beneath that. Ask the client directly about sharing injection equipment.*

**ALL** Have you ever injected any drug or substance? *If No, go to Section VII.*

- Yes  No  Declined (no answer)

**ALL** *If Yes, When was the last time you injected any substance?*

- in the past 3 months  
 between 3 and 12 months ago  
 more than 12 months ago  
 Declined

**ALL** *If the client reported any injection behavior in the past 3 months, ask:*

**Do you currently receive clean syringes from a syringe exchange program or pharmacy?**

- Yes  No  Declined

**ALL** Have you ever shared needles or injection equipment with others?

- Yes  No  Declined

**ALL** *If Yes, When was the last time you shared needles or injection equipment?*

- in the past 3 months  
 between 3 and 12 months ago  
 more than 12 months ago  
 Declined

## VII. Behavioral Risk Reduction **ALL**

*Client Interview*

**In the past 12 months, did you have sex with anyone (oral, anal, or vaginal sex)?**  Yes  No  Declined *If No, go to Section VIII.*

*If Yes to the above question, please ask the following questions:*

**How many sexual partners have you had in the last 12 months?** \_\_\_\_\_  Unknown  Declined

**In the past 12 months, have you had vaginal sex with a male?<sup>A</sup>**  Yes  No  Declined

**In the past 12 months, have you had vaginal sex with a female?<sup>B</sup>**  Yes  No  Declined

**In the past 12 months, have you had vaginal sex with a transgender person?**  Yes  No  Declined

*If Yes to any vaginal sex, then ask:*

**In the past 12 months, have you had vaginal sex without a condom?**  Yes  No  Declined

**In the past 12 months, have you had anal sex with a male?**  Yes  No  Declined

**In the past 12 months, have you had anal sex with a female?<sup>B</sup>**  Yes  No  Declined

**In the past 12 months, have you had anal sex with a transgender person?**  Yes  No  Declined

*If Yes to any anal sex, then ask:*

**In the past 12 months, have you had anal sex without a condom?**  Yes  No  Declined

**In the past 12 months, have you had oral sex with a male?**  Yes  No  Declined

**In the past 12 months, have you had oral sex with a female?**  Yes  No  Declined

**In the past 12 months, have you had oral sex with a transgender person?**  Yes  No  Declined

*If Yes to any oral sex, then ask:*

**In the past 12 months, have you had oral sex without a condom, dental dam or other barrier?**  Yes  No  Declined

<sup>A</sup>It is optional to ask this question if the client is biologically male.

<sup>B</sup>It is optional to ask this question if the client is biologically female.

Legend: **1** = Required; 1 = Optional

Service Category Codes: ALL = All Categories; 1 = MCM; 2 = TCC; 3 = MCM-W/CMN

# Correctional Health Services Intake Assessment (MCM, MCM-W, CMN, TCC)

Client Name: \_\_\_\_\_

## VIII. General Health and Well-Being ALL

*Client Interview*

### 1. In general, would you say your health is:

- Excellent     Very good     Good     Fair     Poor

### 2. The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

- |   | Yes, limited a lot       | Yes, limited a little    | No, not limited at all   |
|---|--------------------------|--------------------------|--------------------------|
| a. <u>Moderate activities</u> , such as moving a table, pushing a vacuum cleaner, sweeping a floor or walking | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Climbing <u>several</u> flights of stairs  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

### 3. During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

- |  | All of the time          | Most of the time         | Some of the time         | A little of the time     | None of the time         |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| a. <u>Accomplished less</u> than you would like                | <input type="checkbox"/> |
| b. Were limited in the <u>kind</u> of work or other activities | <input type="checkbox"/> |

### 4. During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

- |  | All of the time          | Most of the time         | Some of the time         | A little of the time     | None of the time         |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| a. <u>Accomplished less</u> than you would like                  | <input type="checkbox"/> |
| b. Did work or other activities <u>less carefully than usual</u> | <input type="checkbox"/> |

### 5. During the past 4 weeks, how much did pain interfere with your normal work (including work within and outside of your living space)?

- Not at all     A little bit     Moderately     Quite a bit     Extremely

### 6. These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks . . .

- |   | All of the time          | Most of the time         | Some of the time         | A little of the time     | None of the time         |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| a. Have you felt calm and peaceful?         | <input type="checkbox"/> |
| b. Did you have a lot of energy?            | <input type="checkbox"/> |
| c. Have you felt downhearted and depressed? | <input type="checkbox"/> |

### 7. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, family visits, etc.)?

- |  | All of the time          | Most of the time         | Some of the time         | A little of the time     | None of the time         |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
|  | <input type="checkbox"/> |

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Legend: 1 = Required; 1 = Optional

Service Category Codes: ALL = All Categories; 1 = MCM; 2 = TCC; 3 = MCM-W/CMN

# Correctional Health Services Intake Assessment (MCM, MCM-W, CMN, TCC)

Client Name: \_\_\_\_\_

## IX. Disability Status ALL

Client Interview

Are you deaf or do you have serious difficulty hearing?  Yes  No  Not Asked

Are you blind or do you have serious difficulty seeing, even when wearing glasses (or contact lenses)?

Yes  No  Not Asked

Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?  Yes  No  Not Asked

OR  Client's age is less than 5 years old (If checked, skip to Living Arrangement/Housing Information)

*If the response to EITHER question 2a or 2b in Section VIII. General Health and Well-Being was "Yes, limited a lot" then select "Yes" for the next question; if the response to BOTH of those questions (2a and 2b) was "No, not limited at all" then select "No" for the next question. Under these two scenarios, the client does not need to be asked about difficulty walking or climbing stairs.*

Do you have serious difficulty walking or climbing stairs?  Yes  No  Not Asked

Do you have difficulty dressing or bathing?  Yes  No  Not Asked

Because of a physical, mental, or emotional condition, do you have serious difficulty doing errands alone such as visiting a doctor's office or shopping?  Yes  No  Not Asked

OR  Client's age is less than 15 years old

## X. Living Arrangement/Housing Information ALL

Client Interview

ALL Are you currently enrolled in a housing assistance program?  Yes  No  Declined

ALL If Yes, Agency: \_\_\_\_\_ OR  Unknown

ALL What is your current living situation? (Check only one box at left)

- Homeless/Place not meant for human habitation (such as a vehicle, abandoned building, or outside)
  - Emergency shelter (non-SRO hotel)
  - Single Room Occupancy (SRO) hotel
  - Other hotel or motel (paid for without emergency shelter voucher or rental subsidy)
  - Supportive Housing Program If checked, complete the indented detail questions below:
    - Transitional Congregate
    - Transitional Scattered-Site
    - Permanent Congregate
    - Permanent Scattered-Site
- ALL HIV housing program?  Yes  No
- Room, apartment, or house that you rent (not affiliated with a supportive housing program)
  - Staying or living in someone else's (family's or friend's) room, apartment, or house
  - Hospital, institution, long-term care facility, or substance abuse treatment/detox center
  - Jail, prison, or juvenile detention facility
  - Foster care home or foster care group home
  - Apartment or house that you own

ALL Since what date (month and year) have you been living in your current situation? \_\_\_\_ / \_\_\_\_ (mm/yyyy)

OR select one of the following:  Unknown  Declined

Legend: 1 = Required; 1 = Optional

Service Category Codes: ALL = All Categories; 1 = MCM; 2 = TCC; 3 = MCM-W/CMN

# Correctional Health Services Intake Assessment (MCM, MCM-W, CMN, TCC)

Client Name: \_\_\_\_\_

**ALL** How long do you expect to be in your current living situation? If you do not know, what is your best guess? *(Check only one)*

- At least 1 year     6 months-< 12 months     1 month-< 6 months     < 1 month

**ALL** Were you ever homeless?     Yes     No     Declined

**ALL** If Yes, When were you last homeless? \_\_\_\_ / \_\_\_\_ (mm/yyyy)

1 **2** 3 *Do not ask if client is homeless:*

What are your current housing issues? *(Check all that apply)*     N/A

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Cost                      | <input type="checkbox"/> Eviction or pending eviction         | <input type="checkbox"/> Conflict with others in household  |
| <input type="checkbox"/> Doubled-up in the unit    | <input type="checkbox"/> Expanding household (e.g. newborn)   | <input type="checkbox"/> Release from institutional setting |
| <input type="checkbox"/> Health or safety concerns | <input type="checkbox"/> Space/configuration (e.g. too small) | <input type="checkbox"/> Other (Specify: _____)             |

## XI. Legal and Incarceration History **ALL**

*Client Interview*

Have you ever served any time in jail, prison, or juvenile detention (JD)?     Yes     No     Declined

*If Yes, Have you served any time in the past 12 months?*     Yes     No     Declined

Are you currently on parole/probation?     Yes     No     Declined

*If client served any time in New York State, enter the NYSID [unique identifier assigned by the New York State Division of Criminal Justice Services (DCJS)]. This is an eight-digit number followed by one-character alpha (letter). Note: if the client has an old NYSID (with only 7 digits plus the letter at the end), insert a zero (0) at the start to reach 8 digits.*

NYSID: \_\_\_\_\_ *Entered via eSHARE Common Demographics screen*

## XII. Current Enrollments and Needed Referrals **ALL**

*Client Interview*

*Check current enrollments and any immediate referrals needed. Provide detail on referrals in Care Plan.*

Currently Enrolled?	Referral Needed?	Service Category:
<input type="checkbox"/>	<input type="checkbox"/>	ADHC
<input type="checkbox"/>	<input type="checkbox"/>	SNP
<input type="checkbox"/>	<input type="checkbox"/>	Medicaid Health Home
<input type="checkbox"/>	<input type="checkbox"/>	Other Medicaid Case Management
<input type="checkbox"/>	<input type="checkbox"/>	HASA
<input type="checkbox"/>	<input type="checkbox"/>	Outpatient Bridge Medical Care
<input type="checkbox"/>	<input type="checkbox"/>	No to all of the above

Legend: **1** = Required; 1 = Optional

Service Category Codes: ALL = All Categories; 1 = MCM; 2 = TCC; 3 = MCM-W/CMN





# TCC Intake Assessment/Discharge Plan

NAME: \_\_\_\_\_

B/C#: \_\_\_\_\_ NYSID#: \_\_\_\_\_

EVERY ENTRY **MUST** BE SIGNED AND DATED (Note Required Sections\*)

Date	Service Type	Observations																
	<p>4. Discharge Plan/ Care Plan/Service Plan*</p> <p>Initial here _____</p>	<p>Met with patient and developed discharge plan addressing assessed needs. Is this an Initial Plan, an Update to the Plan or a New Plan (replacing last plan) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Initial Discharge Plan <input type="checkbox"/> Update to Plan <input type="checkbox"/> Start New Plan (Replacing care plan)</p> <table border="1" data-bbox="516 552 1521 783"> <tr> <td><input type="checkbox"/> Primary Care*</td> <td>Complete Assistance with Health Care template</td> </tr> <tr> <td><input type="checkbox"/> Housing</td> <td>Complete Housing Assistance template</td> </tr> <tr> <td><input type="checkbox"/> Treatment</td> <td>Complete Assistance with Health Care template, Other Services</td> </tr> <tr> <td><input type="checkbox"/> Transportation</td> <td>Complete Arrange Transport template</td> </tr> <tr> <td><input type="checkbox"/> Entitlements</td> <td>Complete Assistance with Benefits template</td> </tr> <tr> <td><input type="checkbox"/> Court Advocacy</td> <td>Complete Court Advocacy template</td> </tr> <tr> <td><input type="checkbox"/> Other</td> <td><input type="checkbox"/> Safety Plan <input type="checkbox"/> Discharge Medication <input type="checkbox"/> After Care Letter</td> </tr> <tr> <td colspan="2">Complete Section 10 on page 3</td> </tr> </table> <p>NOTES:</p>	<input type="checkbox"/> Primary Care*	Complete Assistance with Health Care template	<input type="checkbox"/> Housing	Complete Housing Assistance template	<input type="checkbox"/> Treatment	Complete Assistance with Health Care template, Other Services	<input type="checkbox"/> Transportation	Complete Arrange Transport template	<input type="checkbox"/> Entitlements	Complete Assistance with Benefits template	<input type="checkbox"/> Court Advocacy	Complete Court Advocacy template	<input type="checkbox"/> Other	<input type="checkbox"/> Safety Plan <input type="checkbox"/> Discharge Medication <input type="checkbox"/> After Care Letter	Complete Section 10 on page 3	
<input type="checkbox"/> Primary Care*	Complete Assistance with Health Care template																	
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<input type="checkbox"/> Treatment	Complete Assistance with Health Care template, Other Services																	
<input type="checkbox"/> Transportation	Complete Arrange Transport template																	
<input type="checkbox"/> Entitlements	Complete Assistance with Benefits template																	
<input type="checkbox"/> Court Advocacy	Complete Court Advocacy template																	
<input type="checkbox"/> Other	<input type="checkbox"/> Safety Plan <input type="checkbox"/> Discharge Medication <input type="checkbox"/> After Care Letter																	
Complete Section 10 on page 3																		
	<p>5. Assistance with Health Care*</p> <p>Initial here _____</p>	<p>Conducted appointment preparation and arranged for community Primary Care Scheduling</p> <p>Provider Name: _____ Contact person: _____</p> <p>Location: _____</p> <p>Date: _____ Contact info: _____</p> <p>Time: _____</p> <p>Walk-in Hours: _____</p> <p>Conducted appointment preparation and arranged for health services other than primary care:</p> <p><input type="checkbox"/> Mental Health Counseling <input type="checkbox"/> Substance Use Treatment <input type="checkbox"/> Case Management</p> <p><input type="checkbox"/> Treatment Adherence <input type="checkbox"/> Patient Navigation</p> <p>Provider Name: _____ Contact person: _____</p> <p>Location: _____</p> <p>Date: _____ Contact info: _____</p> <p>Time: _____</p> <p>Walk-in Hours: _____</p> <p>Conducted follow up encounter to with the client to assist with health care and related services:</p> <table border="1" data-bbox="516 1524 1521 1633"> <tr> <td><input type="checkbox"/> Help with filling out forms</td> <td><input type="checkbox"/> Referral/Appointment-making</td> </tr> <tr> <td><input type="checkbox"/> Eligibility Assessment</td> <td><input type="checkbox"/> Arrangement for interpreting services</td> </tr> <tr> <td><input type="checkbox"/> Reminder call/message</td> <td><input type="checkbox"/> Appointment Preparation</td> </tr> <tr> <td><input type="checkbox"/> Arrangement for childcare</td> <td></td> </tr> </table> <p>NOTES:</p>	<input type="checkbox"/> Help with filling out forms	<input type="checkbox"/> Referral/Appointment-making	<input type="checkbox"/> Eligibility Assessment	<input type="checkbox"/> Arrangement for interpreting services	<input type="checkbox"/> Reminder call/message	<input type="checkbox"/> Appointment Preparation	<input type="checkbox"/> Arrangement for childcare									
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<input type="checkbox"/> Eligibility Assessment	<input type="checkbox"/> Arrangement for interpreting services																	
<input type="checkbox"/> Reminder call/message	<input type="checkbox"/> Appointment Preparation																	
<input type="checkbox"/> Arrangement for childcare																		
	<p>6. Referral to TCC Partner</p>	<p>To which organization was the patient referred?</p> <p><input type="checkbox"/> Exponents <input type="checkbox"/> Fortune <input type="checkbox"/> Palladia <input type="checkbox"/> WPA Initial here _____</p> <p>Date referred to TCC partner: ____/____/____</p> <p>Partner referral status? <input type="checkbox"/> Client declined <input type="checkbox"/> Not accepted by Partner</p> <p><input type="checkbox"/> Released before seen <input type="checkbox"/> Seen (Complete case conference template) <input type="checkbox"/> Not yet seen</p>																
	<p>7. TCC Case Conference</p>	<p>Confirm that session was held with client and TCC Bridge Program Staff and Community Provider Staff prior to release to community <input type="checkbox"/> Yes <input type="checkbox"/> No</p>																



# Correctional Health Services TCC Intake Assessment/Discharge Plan

NAME: \_\_\_\_\_

B/C#: \_\_\_\_\_ NYSID#: \_\_\_\_\_

EVERY ENTRY **MUST** BE SIGNED AND DATED (Note Required Sections\*)

Date	Service Type	Observations												
	12. Arrange Transport          Initial here _____	Was transportation arranged from jail to the community? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, with The Fortune Society? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, Name provider: _____ Planned transport date: ____/____/_____ Contact Person name: _____ Contact Information: _____												
	13. Court Advocacy          Initial here _____	<table border="1" style="width: 100%;"> <tr> <td style="width: 50%;"><input type="checkbox"/> Determined Eligibility for:</td> <td style="width: 50%;"> <input type="checkbox"/> DTAP TASC <input type="checkbox"/> Parole R&amp;R Hospice <input type="checkbox"/> Compassionate Release  <input type="checkbox"/> Castle/Gardens <input type="checkbox"/> Bridge Back to Life <input type="checkbox"/> Treatment Court  <input type="checkbox"/> Other _____             </td> </tr> <tr> <td colspan="2"><input type="checkbox"/> Letter to court <input type="checkbox"/> Next court date: (MUST BE SIGNED BY EXECUTIVE DIRECTOR)</td> </tr> <tr> <td colspan="2"><input type="checkbox"/> Appointment Preparation: Date: _____</td> </tr> <tr> <td colspan="2">Provider Name: _____ Time: _____</td> </tr> <tr> <td colspan="2">Location: _____ Walk-in Hours: _____</td> </tr> <tr> <td colspan="2">NOTE:</td> </tr> </table>	<input type="checkbox"/> Determined Eligibility for:	<input type="checkbox"/> DTAP TASC <input type="checkbox"/> Parole R&R Hospice <input type="checkbox"/> Compassionate Release <input type="checkbox"/> Castle/Gardens <input type="checkbox"/> Bridge Back to Life <input type="checkbox"/> Treatment Court <input type="checkbox"/> Other _____	<input type="checkbox"/> Letter to court <input type="checkbox"/> Next court date: (MUST BE SIGNED BY EXECUTIVE DIRECTOR)		<input type="checkbox"/> Appointment Preparation: Date: _____		Provider Name: _____ Time: _____		Location: _____ Walk-in Hours: _____		NOTE:	
<input type="checkbox"/> Determined Eligibility for:	<input type="checkbox"/> DTAP TASC <input type="checkbox"/> Parole R&R Hospice <input type="checkbox"/> Compassionate Release <input type="checkbox"/> Castle/Gardens <input type="checkbox"/> Bridge Back to Life <input type="checkbox"/> Treatment Court <input type="checkbox"/> Other _____													
<input type="checkbox"/> Letter to court <input type="checkbox"/> Next court date: (MUST BE SIGNED BY EXECUTIVE DIRECTOR)														
<input type="checkbox"/> Appointment Preparation: Date: _____														
Provider Name: _____ Time: _____														
Location: _____ Walk-in Hours: _____														
NOTE:														
	14. Crisis Intervention          Initial here _____	<input type="checkbox"/> Developed Safety Plan  Resources Identified: _____ Location: _____  NOTE:												
	15. Transitional Care Services/ Coordination with Service Provider          Initial here _____	Contacted Community Provider to coordinate transitional services (check one for each contact): <input type="checkbox"/> Primary Care <input type="checkbox"/> Mental Health treatment provider <input type="checkbox"/> Residential Treatment <input type="checkbox"/> Housing Services <input type="checkbox"/> HASA <input type="checkbox"/> Outpatient Treatment provider <input type="checkbox"/> Skilled Nursing/Hospice <input type="checkbox"/> Care Coordination Contractor <input type="checkbox"/> RITC partner <input type="checkbox"/> Attorney <input type="checkbox"/> Family Member: _____ <input type="checkbox"/> Other _____  Method: <input type="checkbox"/> Telephone <input type="checkbox"/> Case Conference <input type="checkbox"/> Teleconference <input type="checkbox"/> In person <input type="checkbox"/> Email <input type="checkbox"/> Other correspondence <input type="checkbox"/> Other _____  Purpose: <input type="checkbox"/> Case Conference <input type="checkbox"/> Appointment Making <input type="checkbox"/> Treatment Plan <input type="checkbox"/> Discharge Medications <input type="checkbox"/> After Care Letter <input type="checkbox"/> Other: _____  Provider Name: _____ Location: _____  NOTE:												
	16. TCC Confirmation of Primary Care          Initial here _____	Release date ____/____/____ Date Seen by Community Provider ____/____/____ Date connection confirmed ____/____/____ Date Confirmation scanned into eCW ____/____/____  NOTE:												

# TCC Intake Assessment/Discharge Plan

NAME: \_\_\_\_\_

B/C#: \_\_\_\_\_ NYSID#: \_\_\_\_\_

EVERY ENTRY **MUST** BE SIGNED AND DATED (Note Required Sections\*)

Date	Service Type	Observations	
	17. Home Visit/ Outreach       Initial here _____	Outreach conducted in: <input type="checkbox"/> Client home <input type="checkbox"/> Other field site <input type="checkbox"/> Phone <input type="checkbox"/> Other program site  NOTE:	Service Delivered (service details) <input type="checkbox"/> Other supportive activities <input type="checkbox"/> Life skills training—individual <input type="checkbox"/> Other
	18. Accompaniment       Initial here _____	<b>Client is accompanied to:</b> <input type="checkbox"/> Primary Care <input type="checkbox"/> Other Health Care Services <input type="checkbox"/> Social Services	<b>Client is accompanied from:</b> <input type="checkbox"/> Patient's home or other field location (non-service-provider) <input type="checkbox"/> One service provider to another (different street address) <input type="checkbox"/> One service provider to another (same street address)  Provider Name: _____ Contact Person: _____ Location: _____ Date: _____ Time: _____  NOTE:

# HIV Continuity of Care Model

## NYC Services to People with HIV During and After Incarceration

Goal	Type	Location	Description	Provider	Timeframe
Identification	Rapid HIV Testing	Jail Health Clinic	Opt-in universal testing	Correctional Health Services (CHS) Medical	On jail admission and on request
	Intake Exam	Jail Health Clinic	Self-report status	CHS Medical	On jail admission
	Early Intervention Services Health Education/ Risk Reduction	Jail Dorms	Group sessions, Condom Demonstrations/ Distribution HIV testing	CHS/Transitional Health Care Consortium (THCC)	First month of Incarceration Condoms on request Condoms on release
Comprehensive care	Treatment and Care	Jail Health Clinic	Primary HIV Care & Treatment including ARVs as appropriate	CHS Medical	On jail admission and on follow up as clinically indicated
Individual Session During Jail Stay	Health Education Non-Medical Case Management	Jail Health Clinic	Treatment Adherence Counseling	CHS Medical	Day 2 and on follow up as clinically indicated
	Discharge Plan	Jail Health Clinic, Program Office	Assessment, Resource identification, service plan	CHS THCC (self-report)/Medical (newly diagnosed)	Day 2 and weekly as indicated
Transitional Care Coordination	Health Insurance Assistance	Jail Program Office	Facilitate health insurance and ADAP applications	CHS THCC	Day 2 and on follow up as indicated
	Court Advocacy	Jail/Court	Provide health information and identify resources to facilitate treatment in lieu of jail time	CHS THCC/ Community courts, advocates	From day 2 to court date
	Discharge Medication	Jail, Court, Community office	Seven-day supply of medication; 21-day prescription	CHS THCC (known) Medical (newly diagnosed)	On release
	Patient Navigation	Jail, Court, Community	Accompaniment, transportation, finding people lost to follow up	CHS THCC, community partners	From release to linkage to care
Linkage to Care	Medical visit	Community	Health exam and services	Community medical provider	Within 30 days of release from jail
Maintenance in Care	Care Coordination	Community	Medical Case Management, treatment adherence, patient navigation, tracking maintenance in care	Care Coordination programs in community	From Linkage to Care to fully engaged in care
	Coordination of Medical and Social Services	Community	Assessment and placement for housing, Assistance with health insurance and ADAP	Care Coordination programs in community	From Linkage to Care to fully engaged in care



THE CITY OF NEW YORK  
DEPARTMENT OF CORRECTION  
**OPERATIONS ORDER**



<input type="checkbox"/> NEW		<input checked="" type="checkbox"/> REVISED		SUBJECT
EFFECTIVE DATE	NUMBER	PAGE 1	A.I.D.S EDUCATION AND PREVENTION PROGRAM	
08/ 09 / 91	24/91	OF 3 PAGES		
AUTHORIZED BY THE CHIEF OF OPERATIONS				
Gerald A. Mitchell, Chief of Department <i>Gerald A. Mitchell</i> SIGNATURE				

### I. INTRODUCTION

The growing AIDS epidemic in the New York City area compels this Department to address the fact that the inmate population is comprised of a large number of high risk individuals, as identified by health officials. Therefore, the New York City Department of Correction is instituting an aggressive approach relative to AIDS Education and Prevention. This program also consists of distributing condoms to the inmate population.

### II. POLICY

- A. The Department does not condone sexual contact within the correctional system. However, we realize that the potential to spread the AIDS virus exists.
- B. Upon the effective date of this order, the AIDS Education and Prevention Program, presently in place at the Anna M. Kross Center and the New York City Correctional Institution for Men, will also be expanded to all New York Correctional Facilities, to include all inmates and inmate housing areas, except those inmates housed in the mental health unit at C-71, mental observation housing and inmates confined to punitive segregation.
- C. The Commanding Officer of each facility shall ensure that written procedures are promulgated specifying the provisions noted herein.

	EFFECTIVE DATE 08 / 09 / 91	SUBJECT A.I.D.S. EDUCATION AND PREVENTION PROGRAM	
	OPERATIONS ORDER		
	NUMBER 24/91	PAGE 2 OF 3 PAGES	

### III. GUIDELINES

- A. Prior to any facility implementing the provisions of this Operations Order, the Department of Health educators must provide an AIDS education and prevention session to all inmates housed in the facility. This educational program must also be provided on an on-going basis to newly admitted inmates as part of the inmate orientation process.
1. The above shall be implemented in accordance with a schedule established between the Department of Correction and the Department of Health - Correction Aids Prevention Program (C.A.P.P.).
  2. The program shall include a comprehensive A.I.D.S. education agenda, providing written information, an audio visual presentation, and a description of the facility's condom distribution program.
- B. In order to effect the requirements of paragraph A above, all Department of Health educators shall have direct access or security escorts to all housing areas, except the mental health unit at C-71.
- C. Inmates shall not be permitted to retain possession of condoms when transferred to another departmental facility or hospital prison ward, etc. They shall surrender any condom in possession to appropriately identified staff, prior to departing the facility of transfer.
1. The distribution of condoms shall only be effected by appropriate medical staff.
  2. A maximum of three (3) sealed condoms may be in the possession of an inmate at any given time.

	EFFECTIVE DATE 08/09 / 91	SUBJECT A.I.D.S EDUCATION AND PREVENTION PROGRAM	
	OPERATIONS ORDER		
	NUMBER 24/91	PAGE 3 OF 3 PAGES	

### III. GUIDELINES (cont'd)

3. Any condom that is removed from its original container or if the container is unsealed, the condom shall be considered contraband and subsequently confiscated.

### IV. SUPERSEDES

Operations Order #27/89 - A.I.D.S. EDUCATION AND PREVENTION PROGRAM, dated 6/19/89.

# HIPAA Compliant Authorization for Release of Medical Information and Confidential HIV\* Related Information

This form authorizes release of medical information including HIV-related information. You may choose to release just your non-HIV medical information, just your HIV-related information, or both. Your information may be protected from disclosure by federal privacy law and state law. Confidential HIV-related information is any information indicating that a person has had an HIV-related test, or has HIV infection, HIV-related illness or AIDS, or any information that could indicate a person has been potentially exposed to HIV.

Under New York State Law, HIV-related information can only be given to people you allow to have it by signing a written release. This information may also be released to the following: health providers caring for you or your exposed child; health officials when required by law; insurers to permit payment; persons involved in foster care or adoption; official correctional, probation and parole staff; emergency or health care staff who are accidentally exposed to your blood, or by special court order. Under State law, anyone who illegally discloses HIV-related information may be punished by a fine of up to \$5,000 and a jail term of up to one year. However, some re-disclosures of medical and/or HIV-related information are not protected under federal law. For more information about HIV confidentiality, call the New York State Department of Health HIV Confidentiality Hotline at 1-800-962-5065; for more information regarding federal privacy protection, call the Office for Civil Rights at 1-800-368-1019.

By checking the boxes below and signing this form, medical information and/or HIV-related information can be given to the people listed on page two and three (or additional sheets if necessary) of the form, for the reason(s) listed. Upon your request, the facility or provider disclosing your medical information must provide you with a copy of this form.

I consent to disclosure of (please check all that apply):  
 My HIV-related information  
 Both (non-HIV medical and HIV-related information)  
 My non-HIV medical information\*\*

## Information in the box below must be completed. Please make sure to cross out all unused fields by marking with an "X".

Name and address of facility/provider disclosing HIV-related and/or medical information:

\_\_\_\_\_

Name of person whose information will be released: \_\_\_\_\_

Name and address of person signing this form (if other than above): \_\_\_\_\_

\_\_\_\_\_

Relationship to person whose information will be released: \_\_\_\_\_

\_\_\_\_\_

Describe information to be released: *Information on reason(s) for referral to the program, demographics, assessments, diagnoses, laboratory tests, medications, care plans, appointment-keeping, program services received, enrollment status, and reason for end of program services.*

Reason for release of information: *Coordination of Care between providers on HIV care team, when the team involves more than one agency.*

Time Period During Which Release of Information is Authorized:

From: \_\_\_\_\_ To: \_\_\_\_\_ **OR**  until case closure out of this program (check if applicable)  
(today's date: mm/dd/yyyy) (1-3 years following today's date: mm/dd/yyyy)

*Disclosures cannot be revoked once made. Additional exceptions to the right to revoke consent, if any:*

*The right to use the information already shared (for example, for program purposes such as to determine the quality of the services provided) cannot be revoked even if you are no longer participating in the program. Revoking consent requires notice in writing to the Care Coordinator (or Medical Liaison) and Primary Care Provider within this Care Coordination program.*

*Description of the consequences, if any, of failing to consent to disclosure upon treatment, payment, enrollment, or eligibility for benefits (Note: Federal privacy regulations may restrict some consequences):*

*If a Care Coordination program is carried out by two or more agencies working together under one contract, failure to consent to the sharing of HIV-related information and general medical information between the primary care and Care Coordination providers will prevent enrollment in the Care Coordination program. However, failing to consent and/or revoking your consent will not affect your access to regular medical care or treatment at this facility, and you may still receive other services at the agencies listed in this release. You may even still receive Care Coordination, through another agency or network. This form is only necessary if you want to take part in the Care Coordination program in this facility.*

Please sign below *only* if you wish to authorize all facilities/providers listed on pages 1, 2 (and 3 and 4, if used) of this form to share information among and between themselves for the purpose of providing medical care and services.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**\*Human Immunodeficiency Virus that causes AIDS**

**\*\*If releasing only non-HIV related medical information, you may use this form or another HIPAA-compliant general medical release form.**

Please Complete Information on Page 2 and/or Pages 3 and 4.

# HIPAA Compliant Authorization for Release of Medical Information and Confidential HIV\* Related Information

**Complete information for each separate facility/provider within a Care Coordination network with which general medical and/or HIV-related information will be shared. A "separate" facility or provider is one based at an organization other than the organization of the enrolling primary care physician. Attach additional sheets as necessary. It is recommended that blank lines be crossed out prior to signing.**

Name and address of all facilities/providers with which general medical and/or HIV-related information will be shared. General medical and/or HIV-related information will be shared by your primary care providers with the following Care Coordination network facilities/providers as necessary.

1) Name: \_\_\_\_\_ Agency: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/Borough: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Phone #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

2) Name: \_\_\_\_\_ Agency: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/Borough: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Phone #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

3) Name: \_\_\_\_\_ Agency: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/Borough: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Phone #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

4) Name: \_\_\_\_\_ Agency: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/Borough: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Phone #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

5) Name: \_\_\_\_\_ Agency: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/Borough: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Phone #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

6) Name: \_\_\_\_\_ Agency: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/Borough: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Phone #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

The law protects you from HIV-related discrimination in housing, employment, health care and other services. For more information, call the New York State Division of Human Rights Office of AIDS Discrimination Issues at 1-800-523-2437 or (212) 480-2522 or the New York City Commission on Human Rights at (212) 306-7500. These agencies are responsible for protecting your rights.

My questions about this form have been answered. I know that I do not have to allow release of my medical and/or HIV-related information, and that I can change my mind at any time and revoke my authorization by writing to the facility/provider obtaining this release. I authorize the facility/ provider(s) noted on page one to release medical and/or HIV-related information of the person named on page one to the facilities/provider(s) listed.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
(Subject of information or legally authorized representative)

If legal representative, indicate relationship to subject: \_\_\_\_\_

Print Name \_\_\_\_\_

Client/Patient Number \_\_\_\_\_

# HIPAA Compliant Authorization for Release of Medical Information and Confidential HIV\* Related Information

**Complete information for each non-Care Coordination facility/person to be given general medical information and/or HIV-related information. Attach additional sheets as necessary. It is recommended that blank lines be crossed out prior to signing.**

Name and address of facility/person to be given general medical and/or HIV-related information.

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Reason for release, if other than stated on page 1:

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If information to be disclosed to this facility/person is limited, please specify:

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Name and address of facility/person to be given general medical and/or HIV-related information.

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---

Reason for release, if other than stated on page 1:

---

---

If information to be disclosed to this facility/person is limited, please specify:

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The law protects you from HIV-related discrimination in housing, employment, health care and other services. For more information, call the New York State Division of Human Rights Office of AIDS Discrimination Issues at 1-800-523-2437 or (212) 480-2522 or the New York City Commission on Human Rights at (212) 306-7500. These agencies are responsible for protecting your rights.

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Signature \_\_\_\_\_ Date \_\_\_\_\_  
(Subject of information or legally authorized representative)

If legal representative, indicate relationship to subject: \_\_\_\_\_

Print Name \_\_\_\_\_

Client/Patient Number \_\_\_\_\_

# HIPAA Compliant Authorization for Release of Medical Information and Confidential HIV\* Related Information

**Complete information for each non-Care Coordination facility/person to be given general medical information and/or HIV-related information. Attach additional sheets as necessary. It is recommended that blank lines be crossed out prior to signing.**

Name and address of facility/person to be given general medical and/or HIV-related information.

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---

Reason for release, if other than stated on page 1:

---

---

If information to be disclosed to this facility/person is limited, please specify:

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---

Name and address of facility/person to be given general medical and/or HIV-related information.

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---

Reason for release, if other than stated on page 1:

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---

If information to be disclosed to this facility/person is limited, please specify:

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---

Name and address of facility/person to be given general medical and/or HIV-related information.

---

---

Reason for release, if other than stated on page 1:

---

---

If information to be disclosed to this facility/person is limited, please specify:

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---

If any/all of this page is completed, please sign below:

Signature \_\_\_\_\_ Date \_\_\_\_\_

Client/Patient Number \_\_\_\_\_

# Transitional Care Coordination (TCC)

## Priority Indicators

**Timing:** Newly admitted, soon to be released, released and unaware of recent diagnosis.

**Severity:** Eligible for residential placement / program including Skilled Nursing Facility, Infirmary resident, MedWatch status, unstably housed; consider co-morbidity and severity level (see table below).

**Diagnoses:**

- HIV-infected
- Hep C treatment administered in jail
- Prenatal care
- CHF (congestive heart failure)
- Cancer
- COPD (chronic obstructive pulmonary disease)
- PE/DVT (pulmonary embolism / deep vein thrombosis)
- Diabetes Mellitus (DM I then DM 2)
- At risk of HIV (i.e. never tested , MSM, IDU, G/C diagnosis, IPV)

Other conditions based on severity level as follows:

Condition	Basis for Referral to TCC	Priority Consideration
Asthma	Controller medication OR not well controlled OR prescribed prednisone	ALL, Y/N Severity level
Cancer	Offsite Specialty Clinic Oncology referral	ALL, name of body part
Diabetes	IFF ever Uncontrolled, ever A1c 9+	ALL, Y/N Severity level
Heart Disease	Hx of Heart Attack OR Congestive Heart Failure	ALL, Specify if History of Heart Attack AND/OR Congestive Heart Failure
Hepatitis C	ALL	ALL, Y/N Severity level
Hypertension	Uncontrolled with HTN diagnosis and Ever greater than 190 s and or 115 d	“Ever Uncontrolled with HTN Diagnosis”, Y/N Severity based on “Ever greater than 190/115”
IPV	As a co-occurring condition	ALL
Kidney Disease	Receiving Dialysis treatment OR End stage renal disease	Specify: Dialysis treatment &/OR End stage renal disease
Liver Disease	End Stage Liver Disease OR On treatment for Hepatitis C	ALL, Specify: End Stage Liver Disease OR On treatment for Hep C
Mental Health	As a co-occurring condition	“M” designation; Specify if SMI
Pregnancy	ALL	History during latest booking case
Seizure Disorder	As a co-occurring condition	ALL
Substance Use	ALL	Rx for Buprenorphine or Methadone, Ever used a Needle; Severity: ever used a needle to inject , ever hospitalized
STI	HIV (ALL known) HGIL+ during jail stay. After incarceration findings of HGIL, G/C, Syphilis (RPR+)	HIV G/C ,HPV, RPR + labs HGIL or lab finding after incarceration
Tuberculosis	ALL	Treated during latest booking case
Unknown HIV Status	MSM, other priority STI	ALL Never tested