



 NATIONAL CENTER FOR
INNOVATION IN HIV CARE

Models for improving linkage to care for people living with HIV released from jail or prison

Table of Contents

4 Summary

6 Introduction

8 Programs & Projects

HRSA/CDC Corrections Demonstration Project

CDP Project Spotlight: Massachusetts Department of Public Health

Enhancing Linkages to HIV Primary Care (EnhanceLink)

Project START Plus

Philadelphia Linkage Program's Care Coach Model

Change Team Model in Delaware Study

22 Troubleshooting Q&A

24 Credits

25 References

Summary

This is a resource guide for Ryan White HIV/AIDS Program (RWHAP) funded organizations to provide care to people living with HIV (PLWH) who are leaving prisons and jails and reentering society after incarceration. It describes proven models for linkage to care programs that can help PLWH access healthcare upon release in order to stay healthy, treatment adherent, HIV virally suppressed, and reduce their chances of recidivism.

With HIV prevalence among state and federal prisons more than three times higher than the general population (1.3% compared to 0.4%),¹ correctional facilities offer a unique opportunity to engage with PLWH and offer care. For many PLWH, this time during incarceration may be the only time they have access to HIV care. For others, due to intense stigma against HIV and homosexuality² in hypermasculine³ corrections settings, incarceration may interrupt HIV treatment they were previously receiving in the community. It is essential that AIDS service organizations (ASOs) and community-based organizations (CBOs) work with newly released PLWH to ensure continuity of care for incarcerated PLWH as they reenter society.

The HIV care continuum involves five sequential steps: (1) diagnosis of HIV infection, (2) linkage to care, (3) retention in care, (4) receipt of antiretroviral therapy (ART), and (5) achievement of viral suppression.⁴ Barriers to accessing care can include lack of stable housing, poverty, mental health and/or substance use disorder issues, and lack of access to culturally competent care.⁵ Formerly incarcerated individuals often struggle with various issues, including: substance use disorders, mental health, family estrangement, lack of support, lack of employment and housing after being released back into their communities.⁶ Thus, continuity of care for incarcerated PLWH is particularly important. Interventions that address barriers to engagement in care are vitally important.

This resource guide summarizes effective models and best practices of linkage to care programs for PLWH who are leaving jail or prison and reentering society. It is based on project reports, training manuals and resource guides on post-incarceration linkage to care programs, including the HRSA-CDC Corrections Demonstration Project, HRSA HIV/AIDS Bureau's (HRSA HAB's) Special Projects of National Significance Program (SPNS): Enhancing Linkages to HIV Primary Care & Services in Jail Settings Initiative (EnhanceLink), The Bridging Group's Project START Plus, ActionAIDS' Philadelphia Linkage Program's Care Coach Model, and the Change Team Model in Delaware Study.

Each of these programs is briefly summarized below. At the end of this guide a troubleshooting Q&A can be found to address common questions and concerns.

Corrections Demonstration Project (CDP)

The HRSA/CDC CDP was a five-year project (1999–2004) that addressed HIV testing and continuity of care for incarcerated individuals living with HIV. Seven state departments of health were funded to support projects that developed effective linkage to care models. It attempted to establish linkages between existing correctional and community health services while addressing other social service needs. Effective models used a combination of health services including HIV surveillance, medical and behavioral screening and assessment, prevention education and counseling, primary healthcare, and referral linkages. Information is summarized from their report, *Opening Doors*⁷, and *EnhanceLink's Consultancy Report* (see next paragraph).⁸

EnhanceLink

The HRSA, HABs, and SPNS: Enhancing Linkages to HIV Primary Care & Services in Jail Settings Initiative (EnhanceLink) built upon the CDP. From 2007–2012, ten grant recipients were funded, representing 20 separate jail sites. From this pilot project, a training manual was developed that illustrates the effectiveness of jail linkage work, information on components of effective jail linkage programs, best practices, and necessary information to replicate and implement the work of EnhanceLink. The EnhanceLink project highlighted important considerations for starting a successful linkage to care program, such as research and preparation, data collection, HIV testing, implementation of programs, and reintegration of formerly incarcerated individuals back into the community. Information is summarized from their training manual.⁹

Project START Plus

The Bridging Group's Project START Plus was an adaptation of Project START, an individual-level, multi-session linkage to care and risk reduction program for PLWH returning to the community after incarceration. The program provides tools and resources to increase awareness and reduce risk of HIV, STI, and Hepatitis. The program consists of six sessions with each client, working with them one-on-one to serve as a "bridge" for their return to the community. The program begins up to 2 months pre-release and continues for 3 months post-release, focusing on linkage to care through referrals, social healthcare services support, and transitional needs support. Information is summarized from their fact sheet.¹⁰

Philadelphia Linkage Program's Care Coach Model

This was a linkage to care program that includes two key staff positions: care coach and care outreach specialist. The care coach has smaller caseloads of typically 25 clients, and works one-on-one with clients during incarceration and post release. Care coaches assisted in the transition from jail-based medical care to community-based care. The care outreach specialist worked with a care coach, and served as an advocate, medical escort, and health educator. This model delivered multi-tiered services with the engagement of community partners. Information is summarized from their report, *Securing the Link*.¹¹

Change Team Model in Delaware Study

This was a model used in the National Institute on Drug Abuse-funded Criminal Justice Drug Abuse Treatment Studies HIV Services and Treatment Implementation in Corrections protocol in the state of Delaware. Research centers teamed with criminal justice organizations to identify where improvements needed to be made on the HIV care continuum in their local facilities. The change team consisted of a change team leader and a team of key staff and personnel, including representatives from correctional and community agencies. Identifying linkage to care as the area for improvement, the Delaware change team worked to increase communication between HIV community providers and Department of Corrections medical supervisors, decrease administrative burden, and improve HIV testing and educational material at medical intake. Information is summarized from the article, *Improvements in Correctional HIV Services: A Case Study in Delaware*.¹²

In the following pages, information from each program is summarized in-depth. For further guidance, links to the original reports and studies are provided throughout this report.

Introduction



Each year, approximately 17% of all people living with HIV in the U.S. will spend some time in prison or jail.

The United States incarcerates over 20% of the world's prisoners despite having less than five percent of the world's population.¹³ The U.S. incarceration rate is over four times the world average, with a rate of 693 incarcerated individuals per 100,000 residents in 2014, and a total prison population of over 2.2 million.¹⁴

According to a 2015 Bureau of Justice Statistics report, the prevalence of HIV among state and federal prisoners is 1.3%, which is more than three times higher than the prevalence in the general population (0.4%).¹⁵ In 2010, the rate of diagnosed HIV infections among prisoners was more than five times greater than the rate among those not incarcerated.¹⁶ Each year, approximately 17% of all PLWH in the U.S. will spend some time in prison or jail.¹⁷ Most incarcerated individuals acquire HIV in their communities, prior to incarceration.¹⁸ For many with PLWH, their time in prison or jail is the only time they have access to care, treatment, and support. For this reason the corrections system is a key site of engagement with some PLWH and an important place to find PLWH who have never been diagnosed or who have been diagnosed but lost to care. This provides a unique opportunity for public health professionals to access this population to provide not only acute care, but a continuity of care that extends back to the community, where 90% of people in correctional facilities will return.¹⁹

The fact that nearly one in five PLWH cycles through the jail or prison system in any given year, and that the vast majority of incarcerated individuals will return to society and their partners, spouses and families demonstrate the linkage between prisons, communities, and the overall HIV epidemic. The public health sector is increasingly recognizing the opportunity within corrections to contribute to a more successful reentry process for former incarcerated citizens into the community. It has been shown that promoting health during incarceration promotes health in communities post-release. For example, in a study examining the effects of jail sexually transmitted infection (STI) testing on neighborhood chlamydia rates, neighborhood clinics in areas with higher jail testing density found a seven times greater reduction in chlamydia rates (from 16.1% to 7.8%) compared to neighborhood clinics in areas with lower jail testing density.²⁰ A comprehensive approach that includes not only standard HIV treatment and education but also enhances continuity of care is essential to reducing HIV in correctional facilities and our communities.²¹ The following are successful programs and models that use this comprehensive approach.

ⁱ According to the Bureau of Justice Statistics: "Jails are locally-operated, short term facilities that hold inmates awaiting trial or sentencing or both, and inmates sentenced to a term of less than 1 year, typically misdemeanants. Prisons are long term facilities run by the state or the federal government and typically hold felons and inmates with sentences of more than 1 year." <https://www.bjs.gov/index.cfm?ty=qa&iid=322>



Programs & Projects

HRSA/CDC Corrections Demonstration Project

From 1999 to 2004, the Corrections Demonstration Project (CDP) addressed HIV testing and continuity of care for incarcerated individuals living with HIV by funding projects that developed effective linkage to care models. It attempted to establish linkages between existing correctional facilities and community health services while addressing other social service needs. The CDP published a 2007 report that describes the development, implementation, barriers, and recommendations from the different models used in the projects. EnhanceLink, a later project that built upon the CDP, created a consultancy report that provides an overview of the CDP. This report discusses general related issues and challenges, data elements, ethical considerations, and an overall summary of lessons learned and best practices. Information from both reports, *Opening Doors: the HRSA-CDC Corrections Demonstration Project for People living with HIV/AIDS*²² and *EnhanceLink's Consultancy Report*²³ as it relates to the CDP, is summarized below.

The major objectives of the CDP included:

- Increasing access to HIV primary healthcare and prevention services;
- Improving HIV transitional services between corrections and the community; and
- Developing organizational supports and linked networks of comprehensive HIV health and social services.

The goal of the CDP was to develop and evaluate models for linking networks of health services and correctional facilities for replication by other programs, institutions, and organizations. Effective models included activities such as clinical evaluation and treatment, prevention education, peer education, disease screening, counseling and testing, staff development and training, discharge planning, continuity-of-care case management, and prevention case management.²⁴ Through these various activities, CDP attempted to develop effective collaborations between three systems: corrections, the community, and public health.

Collaboration in Project Management

HIV services in correctional facilities must include collaboration and partnership building between corrections, community providers, public health, and most importantly, incarcerated in-

dividuals. Getting participation from incarcerated individuals in program design may be difficult, but it provides valuable insight into the services that are truly needed within and outside of corrections. Strategies for building partnerships with the community include leveraging pre-existing relationships between the state's department of health and community health providers and identifying CBOs that are able to consistently engage in the project. All in all, a review of the CDP programs showed a recurring theme: the most successful project management structures were those where one of the collaborating partners led program implementation, and a single individual within the lead organization was in charge of coordinating all project activities. The success of the collaboration heavily relied upon the commitment of those in leadership positions, such as the warden or medical director, at the partnering correctional facility.

Program Design

Within the CDP, all seven participating states implemented successful continuity of care programs in a variety of settings, in-



cluding state prisons, local jails, and youth service centers. One important finding from the successful continuity of care programs was that HIV was often not the most pressing issue for the incarcerated individuals. Other issues like housing, family reunification, employment, substance use disorders, and mental health treatment had to be addressed before participants were willing to consider HIV treatment and management. Programs must be holistic and address and prioritize the social issues participants face. Additionally program design must consider the myriad of policies that affect transition into the community, such as housing and employment prohibitions for ex-offenders who are felons. Public Housing Agencies are permitted to prohibit admission into the program for history of drug-related criminal activity, violent criminal activity, or other criminal activity that may threaten health, safety or right to peaceful enjoyment of the premises.²⁵ There is significant stigma related to hiring someone with a criminal record. Many employers ask if potential employees have been arrested or have a criminal record, and may decide not to hire someone based on that response. This common practice and stigma makes it difficult for previously incarcerated people with histories of nonviolent crimes to find employment.

For implementing the continuity of care programs, the seven grant recipients used a basic model that included the following elements:

1. One or more community-based organizations (CBOs) worked in the jail and in the community to link HIV-infected incarcerated individuals to services.
2. Case managers split their time between the jail and the community, or one set of case managers worked in the jail and another set worked in the community.
3. The case manager met with incarcerated individuals living with HIV at the jail at least one time before release to assess post-release readiness, and whether or not there were existing relationships with community providers, or if new connections were necessary.
4. The case manager developed a discharge plan that prioritized the particular services that the incarcerated individual needed and made appointments (ideally) or referrals (minimally) with providers in the community. If there was no time to make pre-release appointments for services, appointments for post-release case management were made.
5. In programs where there were two case managers, one in the jail and one in the community, the community case manager came to the jail to meet the incarcerated individual.

6. When possible, the case manager met the incarcerated individual at the jail gate at the time of release and escorted him or her to the first appointments or housing.
7. The community case manager worked with the previously incarcerated individual in the community to follow up on the discharge plan or make additional linkages to community services.

Each grantee designed its program to reflect their own individual local conditions and existing relationships. Some grant recipients used innovative strategies, including developing of a transitional housing program for three months of post-release housing, forming a partnership with shelters and transitional housing programs to ensure access to beds, collaborating with a major health center to establish a weekly clinic, and establishing diverse teams of social workers, case managers and peers to provide services.

It is important to consider the scope of the new project, including what services are already being offered and what services are available in the community. It is crucial to not over-promise what services can be delivered, as this can create or worsen a general distrust of service providers. Provided below is a checklist from the *Opening Doors* report for project development that takes these issues into consideration:

- What is the big picture?
- Who is already advocating for incarcerated individuals living with HIV?
- What is already being done for incarcerated individuals living with HIV?
- How is the jail organized?
- What existing community and criminal justice resources and structures can you tap into to strengthen your program?



CDP Project Spotlight: Massachusetts Department of Public Health

The CDP provided funding to the Massachusetts Department of Public Health HIV/AIDS Bureau (Massachusetts HAB), which implemented the Transitional Intervention Project (TIP). TIP built on the Massachusetts HAB-supported, pre-existing HIV-related services such as prevention, education, counseling, testing, and case management. TIP focused on the following activities:

- Intensive, community-based transitional case management for all previously incarcerated people living with HIV.
- Creation of a bridge between HIV services within correctional facilities and existing HIV services in community.
- Evaluation of the utility and feasibility of the TIP reintegration model.
- Provision of and improvement to chlamydia surveillance and treatment.
- A comprehensive, peer-led prevention and education program focusing on HIV, STIs, TB and hepatitis.
- HIV counseling and testing in juvenile corrections facilities, and referrals to appropriate community HIV services.

TIP services also included assistance with obtaining safe housing, establishing post-release medical treatment, obtaining health insurance, counseling on HIV treatment adherence, and locating mental health and substance use disorder services. Massachusetts HAB contracted with CBOs in six different service regions, and provided management, oversight, training, technical assistance and evaluation support. Massachusetts HAB worked with the CBOs to create eight TIP teams comprised of jail coordinators, infectious disease nurses, case managers and other correctional facility staff. TIP teams referred clients to the program during incarceration and then focused on establishing rapport with clients to develop relationships, assess their release needs, and implement client-specific service plans. Barriers to the utilization of TIP included the lack of privacy in utilizing the services during incarceration, fear of being “outed” and resulting repercussions of stigma and rejection by others, the complexities associated with medication adherence, underutilization of services and retention difficulties within TIP due to substance use disorder relapse, and territorial issues between community programs.

Recommendations for success from the TIP program include:

- Transitional case management is effective in meeting multiple needs, such as housing, substance use disorder treatment, etc., for successful transition to the community.
- Accessibility of case managers is important: ensure open access.

- Client retention and continuity is reinforced through program flexibility.
- Avoid gaps in services, which act as a barrier to care and can result in loss of clients.
- Due to high prison staff turnover, ongoing education of staff is necessary.
- Participation and support from parole officers is needed to explain the role of TIP case managers among incarcerated individuals.
- Attention must be paid to the emotional and support needs of case managers.
- According to clients, having a nonjudgmental, respectful, and accessible case manager is important to the success of the program.

Barriers to utilization of TIP:

- Lack of privacy in utilizing services during incarceration;
- The complexities of medication adherence;
- Fear of being “outed” and the repercussion of stigma;
- Substance use disorder relapse;
- Territorial issues between community programs.

To learn more about the CDP, see:

http://www.enhancelink.org/EnhanceLink/documents/ConsultancyReport_update012907.pdf

<https://www.careacttarget.org/sites/default/files/file-upload/resources/openingdoors.pdf>

Enhancing Linkages to HIV Primary Care (EnhanceLink)

Building upon the HRSA/CDC Demonstration Project, The Enhancing Linkages to HIV Primary Care & Services in Jail Settings Initiative (EnhanceLink) was a project launched by the HRSA, HAB, SPNS Program. It sought to fill the research void of evidence-based interventions for identifying high-need clients and best practices for linkage to care. It was funded to design, implement, and evaluate innovative methods for linking incarcerated PLWH into primary care. From 2007–2012, 10 grantees were funded, representing 20 separate jail sites. EnhanceLink tested 210,267 incarcerated individuals for HIV and 1,312 individuals tested positive. Of those 1,312 that tested positive, EnhanceLink enrolled 1,270 participants. From this pilot project, a training manual was produced that illustrates the effectiveness of jail linkage work, best practices, and necessary information to replicate and implement the work of demonstration models funded under the EnhanceLink initiative. That information is summarized below.²⁶

Tips for Preparation: Laying the Groundwork

It is essential to lay the groundwork for a successful jail linkage program. Those interested in starting a new jail linkage program should first:

- Explore existing programs and other organizations working within the jail/prison to avoid duplication or starting an intervention without the capacity to complete it.
- Understand the culture of corrections: what is and is not permissible in those environments, cultural competency with incarcerated individuals, building trust, challenges to adhering to the Health Insurance Portability and Accountability Act (HIPAA), and implications to the proposed program.
- Secure buy-in and create partnerships:
 - Engage entire staff, first targeting high-level decision makers.
 - Host education sessions with corrections administrators about HIV.
 - Find and collaborate with key supporters like opinion leaders in the community (e.g., RWHAP Planning Council, consortia, consumer advisory board members, etc.).
 - Share information and goals up front to allow all parties a voice.
 - Use memorandums of understanding (MOUs) to document services, relationships and reportorial structures, paired with ongoing conversation and collaboration.

- Tailor programs to your community and jail settings.
- Determine how data will be collected, stored, and analyzed.
- Significant challenges to data collection include staff attitudes, chaotic jail environment during intake, criteria for testing, and timing of testing.

There are also important issues that need to be considered specifically when dealing with HIV testing and linkage programs in jail settings. Five central questions regarding privacy and cultural competency that need to be considered include:

1. How will testing be performed in a voluntary manner, in light of the new CDC recommendations that suggest incorporating testing into routine medical services?
2. How will testing be performed in a manner that is sensitive to the psychological impact of an incarcerated individual's learning for the first time his or her HIV status?
3. How will confirmatory testing be delivered within a brief time period, given the slightly higher false positive testing rate of rapid testing?
4. How will adverse events be monitored?
5. How will protected health information be shared in a manner that facilitates linkages but does not violate the Health Insurance Portability and Accountability Act (HIPAA)?

Tips for Getting Started

The EnhanceLink evaluation center identified strategies for building a strong and successful program. Appropriate and effective information sharing is critical to successful programs, and this includes having appropriate space for the program in the jail, coordinating the new programs with existing services, authorizing CBOs and health departments to work in the facility, and meeting security requirements. Major components of EnhanceLink activities included:

Appropriate Staffing

It is very important to have a non-judgmental and culturally competent staff because of the sensitive nature and stigma surrounding HIV status. EnhanceLink recommends that the staff include any pre-existing mental health staff and housing counselors in the jail, a health liaison or court advocate if possible, and someone to begin the process of coordinating care upon release and accompany clients to appointments. EnhanceLink also recommends that an effective referral system between medical staff and staff at partnering CBOs be established.

HIV Testing

Most EnhanceLink grant recipients were already engaged in HIV testing within jails using rapid HIV testing. However, organizations not already involved in HIV testing but looking to initiate a program should consider some important questions, included in a guide by an EnhanceLink grant recipient, Yale University School of Medicine:

- Is there a medical exam at intake or shortly after?
- Is there an opportunity to discuss HIV testing at orientation?
- Are there policies that would impede your ability to implement a new way of doing testing?
- Is there space to do the testing and to store supplies?
- Who will feel threatened by what are you doing? What can you do to minimize the sense of threat?
- How and where will they get their results?

Timing of Services and Interventions

With the short average length of stay, HIV testing should ideally be done within 24 hours of intake, or at least within 48 hours. As such, it is important to understand barriers and facilitators to HIV testing in correctional settings. The staff should be familiar with state laws surrounding HIV testing and informed consent. Policies where incarcerated individuals have to opt-out of testing rather than opt-in yield greater rates of testing. Privacy and confidentiality should be prioritized in order to make incarcerated individuals feel comfortable getting tested. Staff should determine private locations within the jail where HIV test results can be disclosed. If permitted, providing basic items like toothbrushes or socks can go a long way in increasing client willingness to participate, but testing must be voluntary and no one should ever feel coerced into it. If one incarcerated individual receives items, all incarcerated individuals should receive the same items. Before offering testing, EnhanceLink recommends that incarcerated individuals be asked about their HIV status in a private and sensitive manner to allow for self-disclosure. Those who do self-disclose should be engaged in a follow-up discussion about treatment.



HIV testing should ideally be done within 24 hours of intake, or at least within 48 hours.



Treatment and Adherence

Due to the short nature of jail stays, patients may not be placed on antiretroviral therapy (ART) until after release. However, even with the short-stay nature of jails, ART should be started as soon as possible, as immediate initiation is the standard of care.²⁷ If incarcerated individuals will not be able to start ART prior to release, they should receive education about ART before being released. If a patient is placed on ART, complex regimens with large pill burdens should be avoided. To avoid drug-drug interactions, the patient's other prescriptions should be examined and discussed with patients and medical providers. EnhanceLink recommends that the following topics be discussed when initiating treatment with incarcerated individuals:

- Benefits of HIV medication.
- Misconceptions about treatment.
- How medications work.
- Integrating regimens into daily life.
- Importance of adherence and consequences of nonadherence.
- Common side effects and how to manage them.
- Dosing and names of medications.
- Any food requirements and the effect of nutrition in medication absorption.

Risk-reduction Education

Risk-reduction education is important for those at high risk of infection but who may not be aware they are at risk, or for those who have little knowledge of HIV. Providing this education pre-release is important since the time following release has a higher likelihood for engaging in high-risk behaviors.²⁸ This education can be a formal curriculum or incorporated into support groups that are open to all incarcerated individuals to protect patient confidentiality. Considering that jail stays can be short, it may be best to condense topics into fewer sessions. Basic topics to cover include:

- HIV, STI, hepatitis and TB overviews.
- Strategies for prevention and safe-sex negotiation.
- Coping techniques.
- Communication strategies for talking with care providers and family.
- Conflict resolution.
- Nutrition information.
- Symptoms evaluation.
- Relapse prevention.
- Advance directives.
- Job training.
- Wellbeing, including exercise, journaling and spiritual needs.

Discharge Planning

For a successful connection to care post-release, it is important that action is taken from the beginning of the release process. Pre-release case management, retention strategies, and interaction with transitional services need to be prioritized. EnhanceLink recommends the following tips for effective discharge planning:

- Treat each session like it is the last; discharge within jails can be unpredictable.
- Listen closely to person's concerns and address them, especially triggers associated with poor decision-making. Use motivational interviewing techniques to prepare incarcerated individuals for release.
- Draft a discharge plan that documents needs and a plan to address each one. Once the release date is known, help the person complete an application for health insurance if needed.
- Some EnhanceLink participants found it useful to have a "to do" list included in their discharge plan that includes

resources, partner organizations, important tasks, and relevant contacts.

- Collect multiple ways of reaching clients post-release. This can include the client's support system, information about where they hang out, their "street name" or nickname, and any identifying tattoos/markers.



Treat each session like it is the last; discharge within jails can be unpredictable.

Linkage Services

An important aspect of continuity to care is linkage services, which include post-release referrals to care, intensive case management, and follow-up. Formerly incarcerated individuals have many competing needs, to which HIV care may be a low priority. Successful interventions recognize that basic needs such as food, clothing, safe housing, and drug treatment and mental health support are priorities, and as such, they promote access and linkage in programs that address those needs. EnhanceLink makes the following recommendations:

- Formulate and strengthen relationships with community resources, creating supportive relationships between jail and community staff, and know what resources are available. These resources can include healthcare, housing, mental health and substance use disorder treatment, transportation assistance, food services, legal services, employment services and support groups.
- Case managers should offer more intensive and individualized services based on client need. This could mean focusing on housing, legal support, or securing identification.
- Case managers should meet releasees at the gate and provide transportation to appointments or transitional housing, as well as following up with them post-release.
- For those with substance use disorder, consider discussing risks of sharing needles and overdose prevention. Connect them with appropriate therapy such as inpatient or outpatient care or sober homes.
- If a client is lost-to-follow up, check re-incarceration first, and then shelters, drug and alcohol facilities, mental health facilities, hospitals, coroner's office, or where they live/hang out (depending on what they consented to).





Case managers should meet releasees at the gate and provide transportation to appointments or transitional housing.

10 recommendations from the EnhanceLink evaluation center to address re-integration into the community

1. All released individuals should be assessed for individualized treatment plans and linked to providers.
2. Program model should be designed to minimize or eliminate foreseeable barriers. For example:
 - a. Transportation on day of release to transitional housing should be provided.
 - b. There is utilization of a nonjudgmental staff that is trained in cultural sensitivity.
3. Primary medical care should be combined with dentistry and ophthalmology – two essential, unmet needs.
4. Case managers should collaborate with service providers to ensure continuing access to care.
5. Care settings should be chosen based on level of service, commitment and sensitivity to the community.
6. There should be coordination of care by case managers to ensure availability of services.

7. Treatment plans should be designed to improve patient's HIV medical status and address social service needs.
8. Intense relapse prevention efforts should be utilized through use of psychiatry and substance use disorder counseling.
9. Case managers and outreach workers should meet clients on their turf to “sell the service.”
10. Project administrators and educators should market their program to other providers and collaborating agencies to disseminate information about available services.

For more information, see:

HIV/AIDS Bureau, Special Projects of National Significance Program. Training manual: creating a jail linkage program. Rockville, MD: U.S. Department of Health and Human Services, Health Resources and Services Administration; 2013. <https://careacttarget.org/sites/default/files/file-upload/resources/Jail%20Linkage%20Program%20IHIP%20Training%20Manual.pdf>



Project START Plus

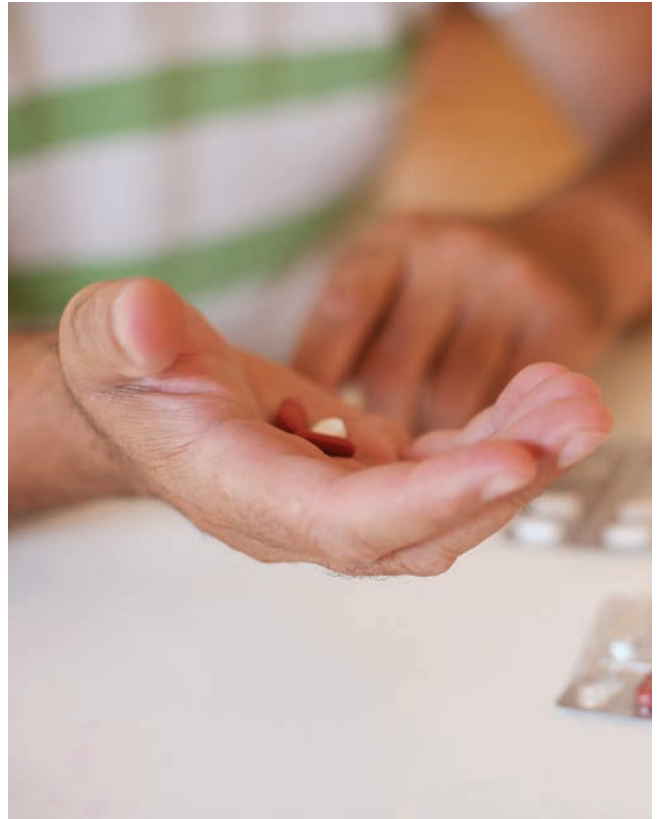
Project START Plus is an adaptation of Project START, an individual-level, multi-session linkage to care and risk reduction program for PLWH returning to the community after incarceration. It is based on the conceptual framework of incremental risk reduction and provides tools and resources to increase awareness and reduce risk of HIV, STI, and Hepatitis.ⁱⁱ Pilot studies demonstrated that 100% of participants received their supply of medication, 75% received a prescription for their medication, 93% filled their prescriptions, and 96% were linked to HIV care in community. A fact sheet was produced, and key points are summarized below:²⁹



Project START Plus began two months before release and continued for three months post-release.

Key Points

The Project START Plus program consisted of six one-on-one sessions with each client to help them smoothly reintegrate into the community and maintain HIV treatment. The program began two months before release and continued for three months post-release. The pre-release sessions focused on linkage to care, transitional needs, individualized risk behaviors and criminogenic factors (situations or factors that are likely to cause criminal behavior). Sessions included information and assistance with enrolling for health insurance, obtaining medical documentation for medications and prescriptions, referrals to social services, individual goal sheets, needs assessments, and post-release follow-up scheduling. The post-release sessions included meeting with participants within 48 hours of release at their community medical provider's location, assuring medication was obtained, assisting in making ongoing referrals and linkages to CBOs, reviewing and updating goal sheets, providing risk reduction educational materials, and transitioning the participants to longer-term care.



For more information, visit:

http://www.thebridginggroup.com/project_start.html

ⁱⁱ One quarter of HIV-infected persons in the U.S are also co-infected with Hepatitis C virus (HCV), and among HIV-infected injection drug users, HCV is common with 50-90% prevalence. HCV is one of the most important causes of chronic liver disease in the U.S, and liver damage progresses more rapidly in HIV-infected individuals. The U.S Public Health Service/Infectious Diseases Society of America guidelines recommend that all HIV-infected persons be screened for HCV infection. (<https://www.cdc.gov/hepatitis/populations/hiv.htm>)

Philadelphia Linkage Program's Care Coach Model

With a focus on building relationships with clients, health providers, the criminal justice system, and community agencies, this ActionAIDS model was a linkage to care program that included two key staff positions: care coach and care outreach specialist. The care coach had smaller caseloads of typically 25 clients, and worked one-on-one with clients during incarceration and up to 24 months post-release, with services tailored to individual needs. Care coaches assisted in the transition from jail-based medical care to community based care and communicate with parole/probation officers to ensure client understanding of the legal parameters of their release. The care outreach specialist worked with a care coach, and served as an advocate, medical escort, and health educator, ensuring consistent collaboration between clients, care coaches and medical providers. The Care Coach Model delivered multi-tiered services with the engagement of community partners. Information from their report, *Securing the Link*, is summarized below.³⁰

Considerations for Program Development

For the success of any correctional linkage-to-care program, it is crucial to establish relationships with key correctional facility staff and administrators. It is important for interested organizations to discuss how the proposed service program could be helpful, and should provide concrete research, program outcomes, and epidemiological data with these key staff and administrators. ActionAIDS, the Philadelphia ASO that created and coordinated the program, developed relationships with the following personnel:

- City commissioner of jails
- Chief of medical operations of the correctional facility
- Wardens, private contracted medical providers
- Infectious disease doctor of the correctional facility
- Jail social services
- Chaplain services
- Re-entry committee

It is also important to identify and develop relationship with community agencies and key community stakeholders:

- Community HIV medical providers
- Office of adult parole and probation
- Specialized courts within jurisdiction
- Local public health departments
- Substance use disorder treatment and recovery
- Mental health services
- Housing services

Programs should consider their existing HIV testing protocol and personnel who will be involved in the testing. It may also be helpful to consider hosting monthly collaborator meetings to create stronger ties among the partnering agencies. ActionAIDS utilized these monthly meetings, where the group spent approximately one hour discussing a client anonymously. This allowed the care coach to use this information to create a more in-depth service care plan. These meetings also led to stronger ties and expedited client appointments within the collaborating agencies. Transparency and clear program parameters are also two important components of program design and implementation, as well as understanding training and security clearance protocols and developing a standardized data collection system.

Steps to Program Implementation

Step 1: Program Referral Protocol

The ability to identify potential clients quickly is important for the success of a linkage to care program, due to the sometimes quick processing and release cycles. A program should develop a referral protocol that reflects the type of facility and average length of stay, and allows adequate and realistic time from referral to intake. Pre-release visits should also be coordinated to link individuals to case management services before release. In some cases, Compassionate Release referrals may be needed if hospice/palliative care would be more appropriate for an individual. Referrals to the Philadelphia Linkage Program were primarily made within jails through:

- Infectious disease doctors.
- Electronic medical records.
- Health services administrations.
- Jail social services.
- Hospice.

Referrals received from the community included:

- Community medical providers.
- Public defenders' offices.
- Medical case managers from other agencies.
- Family members and partners.
- Client self-referrals.

Step 2: Intake and Assessment

Upon referral, staff should conduct an intake session with the client at the correctional facility to introduce the program and staff, complete forms, and conduct a risk assessment. During the

intake session, the program staff should also review the service agreement and get ensure that the required client consent forms and agreements are completed. ActionAIDS developed the Acuity Vulnerability Screening (AVS) tool to refer clients to appropriate services and allocate services to those most in need. It was used to identify those with the highest need who were then subsequently placed in the longer-term Care Coach Model service. Those with less need were assigned to short-term linkage services. This assessment is conducted prior to release and repeated every six months for 24 months while the client is engaged in care services.

Step 3: Client Engagement and Pre-Release Visits

Correctional linkage-to-care programs are dependent on pre-release meetings with clients. Engagement between clients and staff builds a supportive relationship and facilitates conversations and change. It is optimal to prepare for release one to two months prior to release, but due to a lack of predictability, it is best to foster a relationship during every visit. It is important to have a clear and goal-oriented plan, and obtaining appropriate releases of information and completed applications will help expedite client's linkage-to-care upon release. In anticipation of possible high-risk activities clients may engage in upon release back into the community, case managers can facilitate discussions about harm reduction, overdose education, and secondary prevention during incarceration.

Step 4: First Day-Out Planning

The most important issue to address on the first day out is housing, and knowing what resource are available immediately is the key to ensuring linkage to care. The Care Coach Model provides the following considerations when planning for the first day of release:

- What is the correctional facility's release plan?
- Does the client have an appropriate and safe environment to go following release?
- What is the plan for follow-up with staff after release?
- Does the client need immediate food and clothing resources?
- Planning for access to medication at release, especially over the weekend, helps clients remain adherent to medications. Accessing a pharmacy that is familiar with your program and population can make this process easier.

Step 5: Immediate Post-Release Follow-up

It is essential for staff to make an immediate connection with clients post-release. They should meet with clients in their home communities or neighborhoods, or encourage walk-ins to the office. If the assigned case manager is not available, there should be a backup case manager or intake worker to see the client as soon as possible. The Care Coach Model provides 24-hour access to case management services through emergency, on-call coverage, ensuring that clients can be connected to services during evenings or weekends.

Step 6: Care Outreach Services

In the Care Coach Model, each client is also assigned a care outreach specialist. These are community health workers who serve as advocates, medical escorts, and health educators. They serve as a liaison between the client, case manager, and medical providers. Once the client is in care, the care outreach specialist completes their core appointments in 30 days. These include:

- Department of Public Welfare application.
- Social Security Insurance benefits application.
- Court cost and fines payment plan.
- Residency information obtainment.
- Identification obtainment.

Other services that may be necessary include phone services, mental health assessment and insurance navigation.

Step 7: Transitioning to Longer-Term Systems of Care

Successful and comprehensive linkage to care programs help PLWH transitions into long-term systems of care. The Care Coach Model works with clients for up to 24 months to be able to link them to more services and support their retention in care and medication adherence, until they are eventually transferred to general case management. Closure can be difficult, but it should be woven in to all sessions. It is helpful to have closure guidelines to best serve the client's needs.

For more information on considerations for program development and the steps of program implementation, see the ActionAIDS and AIDS United report *Securing the Link*:

https://www.aidsunited.org/data/files/Site_18/Resources/Securing%20Link/SIF16_SecuringtheLink_final.pdf

Change Team Model In Delaware Study

In 2008, the Criminal Justice Drug Abuse Treatment Studies (CJ-DATS) was launched by the National Institute on Drug Abuse (NIDA) to better understand the organizational issues that affect implementation of evidence-based services in correctional settings.³¹ In response to NIDA's priority of HIV care improvements in correctional facilities, the HIV Services and Treatment Implementation in Corrections (HIV-STIC) protocol was developed.³² This multisite research program conducted randomized trials to test the effectiveness of a change team process improvement model for improving HIV services in correctional settings, compared to a control that solely received a directive from correctional administrators to improve HIV services.³³ Both experimental and control groups received baseline training about the HIV service continuum, HIV prevalence and issues among offenders, and evidence-based HIV services in corrections for HIV prevention, testing, and linkage to care.

The project was composed of nine research centers each linked with a criminal justice partner organization. The criminal justice partner (typically an administrator from the criminal justice organization) decided on which aspect of the HIV services continuum needed the most improvement in their local system, such as prevention, education, and testing while incarcerated, and linkage to HIV care upon returning home. Guided by a mod-

ified NIATx (Network for Improvement of Addiction Treatment) process improvement strategy, a local change team consisting of frontline staff who work directly with the HIV services needing improvement was developed. The change process was facilitated by an "external coach" who was trained in the NIATx treatment model.³⁴ Among the participating organizations were the Center for Drug and Health Studies (CDHS) at the University of Delaware and the Delaware Department of Correction (DE DOC). These organizations decided to focus on improving linkage to HIV care for individuals returning home after release. The findings and lessons learned from their study, as found in *Improvements in Correctional HIV Services: A Case Study in Delaware*, are summarized below.³⁵

The Change Team Model, Process, and Procedure

After the baseline training, the research staff, criminal justice partner, corrections facility sponsor (typically a DOC administrator), the head nurse for the contracted DOC medical provider and the NIATx coach came together to select the change team leader (CTL) and other members. According to the HIV-STIC protocol, the suggested qualities and credentials of the CTL include the ability to interact with all levels of management, lead-



ership, communication, delegation skills, experience making changes, energy, enthusiasm, ability to instill optimism, and a goal-oriented and systematic approach. For this site, the head nurse was chosen as the CTL, and other members of the change team included staff from a contracted substance use disorder treatment facility, other nurses, and representatives from a community-based HIV treatment organization.

The change team was then presented the NIATx model by the external coach. An important element to the NIATx approach is a “walk-through” of the service that the change team is seeking to improve.³⁶ This provides the opportunity to improve their understanding of what the client experiences when trying to access and participate in services. Experiences and findings from the walk-through were presented to the change team and information was then used to inform goals and develop strategies for improving service delivery.

Another important element of the NIATx approach and the change team model was the rapid cycle testing approach, which included monthly meetings to discuss changes being made to address barriers using the “Plan-Do-Study-Act” concept:

- Plan: Team brainstorms ideas for a strategy to improve a process or service.
- Do: Team takes those ideas to action and works on implementing change.
- Study: Team tracks barriers, facilitators, and progress
- Act: Teams adopts, adapts or abandons changes depending on studied results.

The goal of these meetings was to engage in discrete and obtainable short-term process goals, which could be achieved in less time and burden. Once goals are met and progress is being made, meetings were reduced to once every other month.

Outcomes and Implications for the Future

During the study period, only five PLWH were released, making it difficult to measure improvement at the client level. However, the change team and walk-through led to improvements of the process for linking PLWH care upon release. Two success-

ful outcomes included: (1) increased communication between the Department of Corrections (DOC) medical provider and the community HIV provider through a communication form containing information on individuals being discharged with HIV, their appointments in the community, and re-incarceration, and (2) significantly reduced discharge paperwork through the creation of a standardized form. The original six-page linkage to care discharge form mimicked exactly the forms the community HIV provider used. The change team was able to condense it into a one-page, specific form, usable by both the DOC and the HIV provider. Simple and efficient, this form was ultimately written into DOC policy.

Additionally, the change team introduced an opt-out question for HIV testing to the medical intake packet, which substantially increased the number of HIV tests conducted. These improved HIV testing procedures were not put into DOC policy, and thus staff training and buy-in of the new procedure is important for those facilities that do not have it as protocol.

Finally, the change team found that the HIV educational packet given to individuals at medical intake was outdated and written at a reading level that was too technical and advanced. The change team was able to update the material, format it to be appropriate for a fifth-grade reading level, and translated it to Spanish. These changes greatly increased access to the HIV educational materials. The updated packet was added to the required medical intake packets at each facility.

In conclusion, the NIATx model for implementing change provided participants with a process to implement changes, and evaluate changes from the start. The walk-through and change team process led to putting the community HIV provider and DOC medical provider in direct contact, which ultimately led to a more efficient and standardized process of linking incarcerated individuals with HIV to care in the community upon release. The walk-through and collaborative meetings opened the opportunity to identify barriers and improve them, such as expanding access to HIV testing and education.



The change team introduced an opt-out question for HIV testing to the medical intake packet, which substantially increased the number of HIV tests conducted.

Troubleshooting Q&A

What is the role of ASOs and CBOs in linkage to care programs?

As seen throughout this report, ASOs and CBOs played an integral role in all linkage to care programs and projects. For some, like Philadelphia's Linkage to Care program, the ASO Action-AIDS created and coordinated the program. In the change team model program, staff of ASOs were members of the teams and assisted with transitional needs assessments and linking clients to community providers. In the EnhanceLink project, the grant recipient varied; some were ASOs and some were departments of health. In the latter case, those organizations and facilities contracted with ASOs for varying needs such as transitional services such as housing or drug use disorder treatment programs, or for staff to act as case workers for the clients. Whether heading the creation and coordination of the program, or contracting with facilities or departments of health, ASOs and CBOs play an integral role in linking released individuals to the HIV care they need.

Linkage to care programs can be costly, how can we control costs and ensure cost effectiveness?³⁷

The EnhanceLink interventions were found to be cost effective at an average cost of \$4,219 per client. Some cost-effective practices proven by EnhanceLink:

- Have a case manager work closely with jail medical staff and engage in cross-cutting. For example, obtaining medical records from community clinicians to reduce lab work duplications and diagnostic evaluations.
- If a client is pre-trial, case managers be able to negotiate to have their home HIV medications to be given in jail.
- Coordination of medical records. By examining client's past charts and determining if they had been seen in the community previously, a case conference can be established between the community doctor and jail medical director to provide specialty care in collaboration.



The EnhanceLink interventions were found to be cost effective at an average cost of \$4,219 per client.

What role should local or state departments of public health (DPH) play?³⁸

An effective linkage program should be based on clarifying the role of the local DPH. Roles will vary depending on whether or

not DPH provides primary care. If DPH is a health service provider, then it may be best to have DPH coordinate discharge planning.³⁹ In the case that DPH is not a health service provider, it may be more appropriate to have a community health center or AIDS service provider coordinate the incarcerated individual's discharge planning. However, key personnel within local DPH may be instrumental to program success by helping to provide connections to community-health service providers and providing epidemiological and surveillance data.⁴⁰

What if the prevalence of HIV in communities and jails/prisons is low in my area?⁴¹

Areas with low prevalence will not be able to identify a large number of new PLWH in jails/prisons nor link a large number to care. However, the majority of jails across the country are small with low HIV prevalence, so it would be wise to develop models that work in those settings. One strategy may be to cluster jails or develop a consortium of jails that apply for a grant together.

How can we ensure successful data collection?⁴²

There are many strategies that can minimize burden and help ensure complete, accurate data submission on the effectiveness of the implemented linkage to care programs:

- Consider and reduce burden to both incarcerated individuals and providers.
- Train providers to collect the data (develop a training curriculum, have update trainings, use train-the-trainer models).
- Make instruments similar in content and format to forms currently in use (as simple as possible).
- Compile list of frequently encountered problems with the completion of forms.
- Establish open communication directly with the providers.
- Secure buy-in and participation from all project partners.
- Establish consequences for the evaluators of incomplete data submission
- Ensure full access to medical records for program staff while simultaneously ensuring confidentiality: provide only information that necessary.
- Consider whether to provide monetary incentives for participants.
- Create a "culture of compliance" with evaluation protocols with support from funders.

What are some strategies to support individuals upon release?⁴³

The time immediately following release is when clients are most vulnerable. It's important to address their priorities, and offer support. To avoid relapse, risk-taking behaviors, and ensure a continuity of care, EnhanceLink recommends:

- listening to their stories and concerns.
- asking open-ended questions.
- being nonjudgmental and encouraging patients to be honest about behaviors.
- understanding where patients are “coming from” and their priorities.
- providing transportation services where possible.
- providing referrals to necessary services, such as health-care, food, housing, and clothing.
- scheduling a meeting with a case manager at the time of release, if possible.
- accompanying patients to their first medical appointment.
- supporting patients in meeting parole and probation requirements”

Post-release can get complicated, what are the first steps to take?

From Philadelphia's Linkage Program⁴⁴, some sample first steps that Care Coaches took after release are as follows:

- Call Correctional Health Services administrator to request client's discharge paperwork, including:
 - medication list, including current prescription of ARTs
 - discharge photo identification
- Update client locator information with current information, such as address and phone number.
- Schedule (or confirm) a medical appointment with the community medical provider.
- Submit prescriptions to client-preferred pharmacy, along with method of payment (Ryan White HIV/AIDS Program AIDS Drug Assistance Program (RWHAP ADAP), pharmaceutical patient assistance program, etc.)
- Check insurance status (through the use of your state's eligibility verification system).
- Submit applications for health insurance/RWHAP ADAP as needed.
- Complete RWHAP certifications and/or other applicable certifications for region.

- Link client with food and clothing resources.
- Link client with emergency shelter, if needed.
- Link client with substance use disorder and mental health treatment as needed.

Initial intake assessments have been made, and post-release plans have been established. What should be done during the remaining time the client is incarcerated?

Once all post-release plans are in order, during the period of incarceration case managers can facilitate educational discussions with clients as part of standard education in anticipation of possible engagement in high-risk activities upon release. Issues to focus on will be specific to each individual, but common topics include: ART medications, adherence, drug and alcohol resources, overdose prevention, mental health and trauma recovery, disclosure of HIV diagnosis, referrals for vocational services or General Educational Development (GED) programs.⁴⁵



Internal precautions need to be taken within the correctional facility to protect the confidentiality of all individuals when they are called down for medical care services.

What are some ways we can take HIV and stigma into consideration?

If an ASO is coordinating the linkage to care program within corrections facilities, consider naming the program independently of the ASO, especially if your agency is identified as a community provider for PLWH, or has the words “HIV” or “AIDS” in the name. For example, ActionAIDS is a community-based ASO in the Philadelphia area. It called its jail services program the “Philadelphia Linkage Program” and all printed materials provided do not indicate that it is a program of ActionAIDS. Additionally, internal precautions need to be taken within the correctional facility to protect the confidentiality of all individuals when they are called down for medical care services.⁴⁶

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