Running Head: HIV DISCHARGE PLANNING FROM CORRECTIONS

DISCHARGE PLANNING FROM THE CORRECTIONAL SETTING TO COMMUNITY HIV CARE IN MISSISSIPPI

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Introduction

Mississippi is one of the 23 states that require HIV testing of all prison inmates on entry into the state correctional setting and treatment of HIV is mandated by the Mississippi Department of Corrections [1]. While treatment of HIV-infected inmates is primarily effective in the correctional setting, as evidenced by the steadily decreasing rate of AIDS-related deaths in prisons [1], the transfer to community treatment after release from corrections has long been recognized as a problem. This paper reports a program in Mississippi to address this transition and increase the number of released offenders who enter community HIV care shortly after release.

Intervention

The transition from dependence and institutional care to autonomy and self-care can be fraught with difficulties. In Mississippi, a discharge planning program has been in place since 2001 to address this very problem. The Statewide HIV Community Service Delivery Network (Network) is a network of clinics that treat HIV disease. These clinics serve 77 of the 82 counties in Mississippi, and include seven community clinics, the state prison facilities, some county jails, and one of the state mental health hospitals. Most of these clinics are Community Health Centers and therefore provide more than HIV care and most receive federal dollars through the Ryan White Care Act.

This discharge planning program consists of a series of steps:

1) The corrections case manager offers discharge planning to inmates expected to be released within six months;

2) Inmates sign consent to release medical information;

3) A referral intake form and assessment is completed by the case manager who collects demographic information, an acuity scale that assesses need for community-based services in12 domains, and a measure of depression;

4) Medical record information is entered into a computer system (currently, CAREWare) that is shared between the corrections settings and the Network community clinics throughout the state;

5) The corrections case manager communicates with the case manager at the receiving community site by email and sets up an appointment within 2 weeks after the anticipated release date;

6) The corrections case manager updates CAREWare with all relevant clinical information (lab work and medications); and

7) The corrections case manager keeps the community case manager updated regarding actual discharge date.

At two of the state prisons, Parchman Penitentiary and Central Mississippi Correctional Facility (CMCF), an additional component of the referral and linkage process is a face-to-face planning meeting with the consenting HIV-positive inmate, the correctional case manager, and a Network representative. The meeting is scheduled within six months of anticipated release in order to assess needs and provide information about available services in the community that the inmate expects to be released to. This component has been operational at Parchman since 2003, and started at CMCF in 2009.

Results

The discharge planning program, begun by the University of Mississippi Medical Center (UMMC) and subsequently adopted by the MS Department of Corrections (MDOC) for all their HIV+ prison inmates, has resulted in a significant decrease in the number of days from release to linkage in care, defined as first contact with a provider. From 2001 to 2004, the average number of days decreased from 79 to 40 ($N = 108$; $t = 4.33$, $p < .000$).

Between 2001 and 2008, 676 HIV-positive state prisoners participated in a pre-release medical discharge planning session. The majority of these prisoners were male (78.9%) and African American (83.9%) with almost half in their 40's and most of the rest younger. Levels of need in 12 service areas as determined by the Sonoma County Acuity Scale (Table 1) were reported by the prisoner in an interview with the corrections case manager. This 12-item scale was developed by the Sonoma County Health Department for use in providing care to HIV-positive clients to describe the level of case management needed by each client (personal communication, Sonoma County Health Department, 2/2/2010). After specific needs were identified from the client, this global acuity scale was completed by the case manager using their sense of the appropriate acuity, to provide a quick picture of the level of case management needed. The items are scored on a 3-point scale: low acuity, moderate acuity, and high acuity. For the Network, this acuity was understood to relate to how soon a scheduled visit in the receiving clinic was needed, where those with high acuities required very timely appointments preferably within 2 weeks, and those with low acuities could be given an appointment in up to 3 months. While individuals being referred from one community clinic to another might have low acuity scores, those being released from prison were assigned high acuity by default, due to the need to obtain care in a very timely basis to enroll in medication programs and to prevent loss-to-followup. The ratings on the acuity scale were also utilized by the receiving case manager to identify the issues where assistance would be needed.

Some gender differences in post-release service needs were observed. Men had slightly more service needs than women, an average of 4.5 and 4.0 respectively out of the 12 service areas. Specifically, men were more likely to have legal problems, an unstable living situation, and a lack of a stable health support system. On the other hand, women had a higher need for HIV medication assistance and help with substance abuse problems.

There was no statistical difference between blacks and non-blacks in the number of service needs. There were, however, statistically significant differences in the types of service needs for each racial group. Blacks were more likely to need help with finances, legal issues, securing stable housing, and accessing anti-retroviral drugs. The non-black group was more likely to need mental health services.

Variation existed among the different age groups. There was a statistically significant difference in the number of needs for each age group, with the number of needs being directly related to age ($F=3.157$, $p=.024$). Young people had a higher need for financial assistance, legal assistance, and help in securing medication. Older individuals experienced more complications due to HIV disease progression, had more non-HIV medical conditions, lacked a stable health support system, and had problems securing consistent transportation.

Of those who participated in pre-release medical discharge planning, 578 were released into the community, an average of 67 state prisoners per year. At the conclusion of the discharge planning meeting with case managers, an appointment with a health service provider was scheduled within 30 days of release. More than 90% of the HIV-infected prisoners were assigned to a HIV health service provider that was a member of the Network.

Three hundred and fifty-three (61%) former prisoners attended at least one HIV provider visit after release from prison. However, only 35% accessed HIV care within 30 days of release, a critical time frame as prisoners were released with a 30 day supply of antiretroviral medication. Those individuals who did not access care had more unstable housing than those who were successfully linked to care. There was no difference between those linked to care or not related to depression, the only available measure of need for mental health services. In terms of demographics, there were no racial or gender differences between those who did and did not access care. There was a marginally statistically significant difference between the two groups based on age. The youngest (20s) and oldest (50+) were less likely to be linked to care while those in their thirties and forties were more likely to access care.

Further analyses were conducted to examine the timeliness of linkage to care among those who successfully accessed an HIV health service provider. The time to care was measured in days and grouped into five categories: 30 days or less (40%), 31 to 60 days (20.6%), 61 to 90 days (10.8%), 91 to 180 days (18.9%), and more than 6 months (9.7%). With the exception of mental health and transportation needs, differences in other service needs were statistically significant. Individuals who took longer than 90 days to see a health service provider needed more assistance with basic needs, had more language issues, were experiencing more problems related to the progression of their HIV disease, had more non-HIV related medical problems, and had more problems related to substance abuse. Those that accessed care within 61-90 days before seeing a health care provider had the highest need for a more stable health support system. Those who accessed care within 30 days of release needed more financial assistance and legal assistance and had more problems securing their anti-retroviral medication and stable housing. There were gender differences in the time it took to access care with males accessing care earlier than females ($\chi^2 = 14.45$, $p= 0.002$). Within 30 days, 60.8% of males and only 38.8% of females had accessed care. By 60 days, 84.6% of males and 74.6% of females had been linked to care. There were no significant differences in time to care in terms of race, age, network area, or mean number of service needs.

Most HIV-infected prisoners were referred to the Jackson metropolitan region (49.3%), followed by the Delta (19.1%), southeastern (17.6%), coastal (7.4%), and northeastern (6.6%) regions of the state. A chi-square test of significance indicated that the different regions had marginally different levels of success in linking individuals to care ($p=.077$). The northeastern region had the highest percentage (76.5%) while the coastal region had the lowest percentage of HIV-infected former prisoners linked to HIV care (51.3%). There were some statistically significant differences among the regions with regards to the type of service needs of referred individuals. Individuals referred to the northeast region had the highest need for services related to legal issues. In the coastal region, individuals had a higher need for establishing stable

housing, probably due to the lingering effects of Hurricane Katrina. A greater lack of a health support system characterized individuals referred to the Jackson metropolitan region.

Conclusion

Since 2001, HIV-infected offenders in Mississippi state prisons have had access to medical discharge planning and referral to community-based HIV care providers. Although over 90% of HIV-infected prisoners participated in discharge planning and had an HIV clinic appointment scheduled, only 61% attended at least one HIV provider visit after release from prison. While the time to linkage in care was dramatically reduced through this discharge program, only 35% accessed HIV care within 30 days of release, before they ran out of the supply of HIV medications they were released from prison with. The lack of stable housing was associated with difficulty in linking to care. Sicker individuals seemed to take the longest in obtaining HIV care, perhaps because of the barriers this presented getting to multiple care settings. Finding a provider who could speak the same language and active substance use were also major barriers in timely linkage to care. Those who needed help with housing, getting antiretroviral medications, and financial assistance got into care earlier, perhaps because these problems could be addressed through Ryan White Care Act programs once they are in active in HIV care.

Transitional services are not provided in this discharge planning program. Newly released HIV-infected prisoners must go to the community clinic first before they can receive medication assistance, case management and other needed ancillary services. While the current discharge planning program has shown improvement in rates of timely linkage to care, approximately 30% of MS ex-offenders do not obtain HIV care after release from prison, and more than half of those who do enter care do so after their HIV medications have run out. While the linkage rate is higher than many states without an effective discharge planning program [2, 3], it is not sufficient to result in positive health outcomes for the individual and to prevent transmission of resistant virus into the community [4]. Further work is needed to assist with the

transition from incarceration to the community and to reduce the number of individuals who are lost to care after release from prison.

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Table 1: Sonoma County Acuity Scale

Basic Needs: physical ability to meet activities of daily living	Low Acuity 1	Moderate Acuity 2	High Acuity 3
Culture/Language: cultural/language/family issues	Low Acuity 1	Moderate Acuity 2	High Acuity 3
Financial/Benefits: stability of income	Low Acuity 1	Moderate Acuity 2	High Acuity 3
Medication Source: need to enroll in programs to obtain medicines	Low Acuity 1	Moderate Acuity 2	High Acuity 3
HIV Disease Progression: symptoms or medication side-effects or compliance	Low Acuity 1	Moderate Acuity 2	High Acuity 3
Legal: existence of legal problems that require resolution	Low Acuity 1	Moderate Acuity 2	High Acuity 3
Living situation: presence of stable housing	Low Acuity 1	Moderate Acuity 2	High Acuity 3
Other Medical needs: non-HIV health problems	Low Acuity 1	Moderate Acuity 2	High Acuity 3
Mental health: mental health problems	Low Acuity 1	Moderate Acuity 2	High Acuity 3
Substance abuse: current problems with drug/alcohol abuse	Low Acuity 1	Moderate Acuity 2	High Acuity 3
Support system: existence of a stable support system	Low Acuity 1	Moderate Acuity 2	High Acuity 3
Transportation: presence of consistent transportation to clinic appointments	Low Acuity 1	Moderate Acuity 2	High Acuity 3
A total score of 12 is considered low acuity, 13-24 is moderate acuity, and 25-36 is considered high acuity.			