Presentation to HIV Planning Council Integration of Care Committee
Community Health Action of Staten Island
Transitional Planning and Community Re-Entry Services for HIV+ Releasees
June 19, 2013

Thanks for the opportunity to present to the Integration of Care Committee about two of Community Health Action of Staten Island (CHASI's) programs that fall within the AIDS Institute's criminal justice initiative. The first one I'll describe, Transitional Planning, is an in-prison program geared toward preparing HIV+ men to leave incarceration and successfully transition back into the community. The second is our Re-Entry program, which receives HIV+ men and women immediately after they've left incarceration. We physically pick up the released client at Port Authority or Grand Central Station and then in subsequent months, escort the client to appointments in the community to ensure that he or she is solidly connecting to medical care and any needed additional services. While the Re-Entry can look like a taxi service from the outside, in this program we're providing ongoing outreach and consistent support to HIV+ clients in a vulnerable time in their lives, and the relationship between the client and our Re-Entry counselor continues until the client has been solidly connected to community based services.

TRANSITIONAL PLANNING

Our Transitional Planning Services for HIV+ men are located at Queensboro Correctional Facility in Long Island City. Queensboro is a transitional correctional facility, a kind of "pre-release" facility, for men who've been incarcerated in Upstate prisons and are returning to the NYC area. They spend no longer than 120 days at Queensboro, usually less. While Queensboro has historically received offenders only from State prisons, offenders from Rikers Island are now additionally moving to Queensboro before their release. The goal of Transitional Planning is to help HIV+ men re-enter the NYC community with as much education and psychological preparation, and with as many services arranged in advance as possible, so that their transitions back to the community are as smooth as possible. Among other priorities, we work to ensure that medical protocols prescribed during incarceration continue without a hitch, and that supportive services are in place before the offender leaves Queensboro. Intake into Transitional Planning occurs no more than 90 days prior to release. By conducting a thorough assessment, our Transitional Planning worker helps each client identify the services he will need upon return to the community. The assessment is done with input from Queensboro's medical team, other prison staff, and as needed, the client's parole officer, so collaboration within a bureaucratic system that sets up its own unique rules is key. All of the needs are documented on a Transitional Plan, and with each offender signing off on his Transitional Plan, each offender understands the variety of services he's agreed to attend, or has been mandated by parole to attend. The Transitional Planner applies for ADAP on behalf of the client, and she works with the Queensboro medical team to ensure that each client has an adequate supply of antiviral meds so that protocols can continue without interruption. Before leaving Queensboro, each Transitional Planning client has an appointment arranged on a specific date with a specific medical provider. As

much as possible, the same specificity is arranged for community based case management (now health home), drug treatment, mental health, and vocational services.

Sometimes, offenders have a home to which they can return, but this is the rare exception. More often, attempts to secure housing are made prior to release, and this can be successful to some degree, but often the first or second day post release is spent at HASA, where emergency or transitional housing is obtained. HASA has a unit dedicated to working with releasees, and our transitional planner is in touch with Mr. Maisonette from HASA prior to each offender's release so that he knows to expect each offender on a specific date. If an offender is on parole when released, all arrangements are made in collaboration with the Department of Corrections and Community Supervision, or DOCCS. An offender may want to return to his home borough, but Parole may require him to be housed elsewhere.

One thing I want to underscore about our Transitional Planning Program is that CHASI's AIDS Institute contract for prison-based services funds exactly one full time worker. She devotes about 40% of her time to Transitional Planning, with about 60% of her time devoted to other Ryan White-funded programming, including anonymous HIV counseling and testing and HIV prevention education work geared toward skills building to lessen transmission of HIV upon release. She is also responsible for conducting outreach for our programming, and she coordinates services with other community based providers at Queensboro. I point out these details to illustrate that while it is vitally important, Transitional Planning does not by itself receive the support of one FTE.

I'm now going to provide you with program data and outcomes of our Transitional Planning work.

Our AIDS Institute contract charges us with facilitating the transition of 24 HIV+ men back to the NYC Community each year.

Since July 1, we've worked with 29 men with whom we've done an assessment of needs, and worked to create a transitional plan. 24 have been released to the community, and the other 5 have release dates scheduled from this coming Friday to August 27.

Of the 24 released, 20 identified as heterosexual, 3 as gay or bisexual, and 1 as transgender.

12 were Black
7 were Hispanic (4 from Puerto Rico)
4 were White
1 was Native American

2 of the men were in their 20's
4 in their 30's
9 in their 40's
9 in their 50's

Of the 24 men released in the past year, only one has not attended a community based medical appointment. This man, who not on parole, was released to Nassau County, and he moved to Florida soon after he was released.

Once released, 16 of the 24 men attended all of the services that we'd arranged prior to release, i.e. substance abuse treatment, case management, mental health in addition to medical care. We know this either because our own Re-Entry counselor or one of our case managers followed the client in the community, or from report from another provider.

About the 8 who didn't follow their Transitional Plans to completion—and I note that some of them attended *some* of their appointments beyond medical care:

6 were lost to follow-up after the medical appointment.
1 was re-incarcerated 2 months after his release.
1 voluntarily withdrew—this was the man who went to Florida.

So, just to reiterate the outcomes of our Transitional Planning program:

- 96% of the clients went to a first medical appointment post release;
- 67% completed all of the components of his transitional plan post release, meaning that at least one time, he attended all of the services articulated on his plan;
- 1 client, or 4%, was re-incarcerated.

Before ending my discussion of Transitional Planning, I want to say that CHASI has one of 10 AIDS Institute contracts with criminal justice providers to conduct Transitional Planning services. The rest of the providers are located in State correctional facilities, as near as Bedford Hills in Westchester and as far away from the City as Albion, which is between Rochester and Buffalo.

Any questions or comments before I move on to our second program?

COMMUNITY RE-ENTRY SERVICES

The second program we operate is our Community Re-Entry program. CHASI is the only provider in the State conducting this service in this model, and its mission is also to facilitate a smooth transition for HIV+ men and women leaving prison terms in Upstate correctional facilities. The AIDS Institute funds 9 Upstate CBOs to conduct Transitional

Planning in correctional facilities such as Albion and Bedford Hills, just like the Transitional Planning Services that CHASI conducts at Queensboro. Each offender leaving one of the Upstate facilities has a Transitional Plan forwarded to CHASI prior to release, so that we have a prescribed list of services , and usually specific providers, for each HIV+ man or woman leaving an Upstate facility.

Each Upstate Transitional Planner sends notice to CHASI about the bus or train that the offender is expected to be on. We then agree that our Re-Entry Counselor will meet the releasee at Port Authority or at Grand Central Station. This can be a very tricky hand-off, because while an offender might be scheduled to be on an eleven-hour bus-ride leaving Albion (for example) at 10 AM, releases from DOCCS facilities can be unpredictable, so that man might get on a bus hours later, usually with no way to communicate this to our Re-Entry Counselor, who will be waiting for the guy at 9 PM at Port Authority. If we're lucky, the Upstate transitional planner will be aware of the delay and will call Greg on his cell phone. Greg has been doing this work for years, so he knows about unexpected delays, and it's not uncommon for Greg to wait at Port Authority until past midnight for a man or woman released from facilities located far away from the City. If a client has worked with a Transitional Planner in an Upstate prison, that client leaves the correctional facility with Greg's contact information, including his cell phone number, and the client also has Greg's supervisor's number. We have found that if we miss a client at Port Authority, if the client wants our help, he will find Greg. We have also found that if a client wants to avoid Greg, he or she will do so.

Greg meets each man or woman getting off the bus or train, and unless housing has been pre-arranged (very rare occurrence) the immediate task is taking him or her to HASA for emergency housing. If HASA is closed for the night, Greg takes the man to the men's shelter at Bellevue and makes arrangements to pick him up first thing the next morning. Women typically leave Bedford Hills early in the morning, so we always get women to HASA before they close for the night.

In the Re-Entry program, the client is busy the first few days after release. The most immediate needs are HASA and housing. The men and women leaving Upstate facilities are usually given 30 days of antiviral medication, or 14 days, or none, depending upon what's happened for each, so sometimes, Greg advocates for getting a quick medical appointment. Following these, Greg picks up each client for every appointment in an agency car, and he personally escorts each client to his or her first medical appointment, substance abuse treatment program, mental health center, and he is with each client to help him or her navigate the HASA system so that Medicaid and SSI, SSD or income support get established as quickly as possible. Greg works with men and women returning to any of the 5 boroughs of NYC and Nassau County, and he picks them up for each appointment regardless of where they live. He is charged with working with each client until they appear to be fully engaged in medical care and their other services, up to a maximum of 6 months. No Re-Entry client's case is closed until Greg and his supervisor agree that the client appears to be sufficiently engaged in services such that Greg's help is no longer needed to maintain those connections.

One feature of our Re-Entry program is that once a month, CHASI hosts a call with every Upstate Transitional Planning program. This allows us an opportunity to get a heads up on who's scheduled for release in the coming months, to make specific plans about each client returning to NYC, and for us to provide feedback to the Upstate providers about how the clients they've sent to us are doing.

Here's some statistics and outcomes of the work we've done in the past year.

In the past year, we've received 71 referrals from Transitional Planning providers. 11 of them arrived in May and June, and unfortunately, due to the haste with which this presentation was put together, I don't have any information about the status of these most recent 11 referrals.

Of the 60 men and women about whom I have information, 52 identified as heterosexual, 8 as gay or bisexual, and 0 as transgender. Of these 60 clients 8 also identified as IDUs.

10 were female
50 were male

37 were Black
14 were Hispanic
8 were White
1 was Asian

3 were in their 20s
10 in their 30s
24 in their 40s
17 were in their 50s
6 were in their 60s

Of the 60, 34 have been confirmed as receiving community based HIV medical treatment, and 32 clients have attended all of the services that were arranged prior to release. An additional 10 clients are still active and are expected to complete services. 3 were transferred to another provider for specialized work with the mentally ill.

Of the remaining clients:

13 of the 60 never connected with Greg.
3 were transferred to a case management program working with the mentally ill
2 were re-incarcerated

To reiterate the outcomes:

57% of our Re-Entry clients were connected to medical care;
53% of these men and women completed all of the components articulated on their Transitional Plans;

17% are still active clients;
22% never connected with our Re-Entry Counselor
5% were transferred to another provider for special needs;
3% were re-incarcerated within 6 months

Questions/comments?