Warm Transitions: Facilitating Linkages to Care for People Returning Home from Rikers Island

Alison O. Jordan
Tanya Shah Homer Venters
New York City Department of Health and Mental Hygiene,
Correctional Health Services

RIKERS ISLAND, NY

NYC Department of Correction (DOC) operates Rikers Island (9 jails) and 3 borough facilities

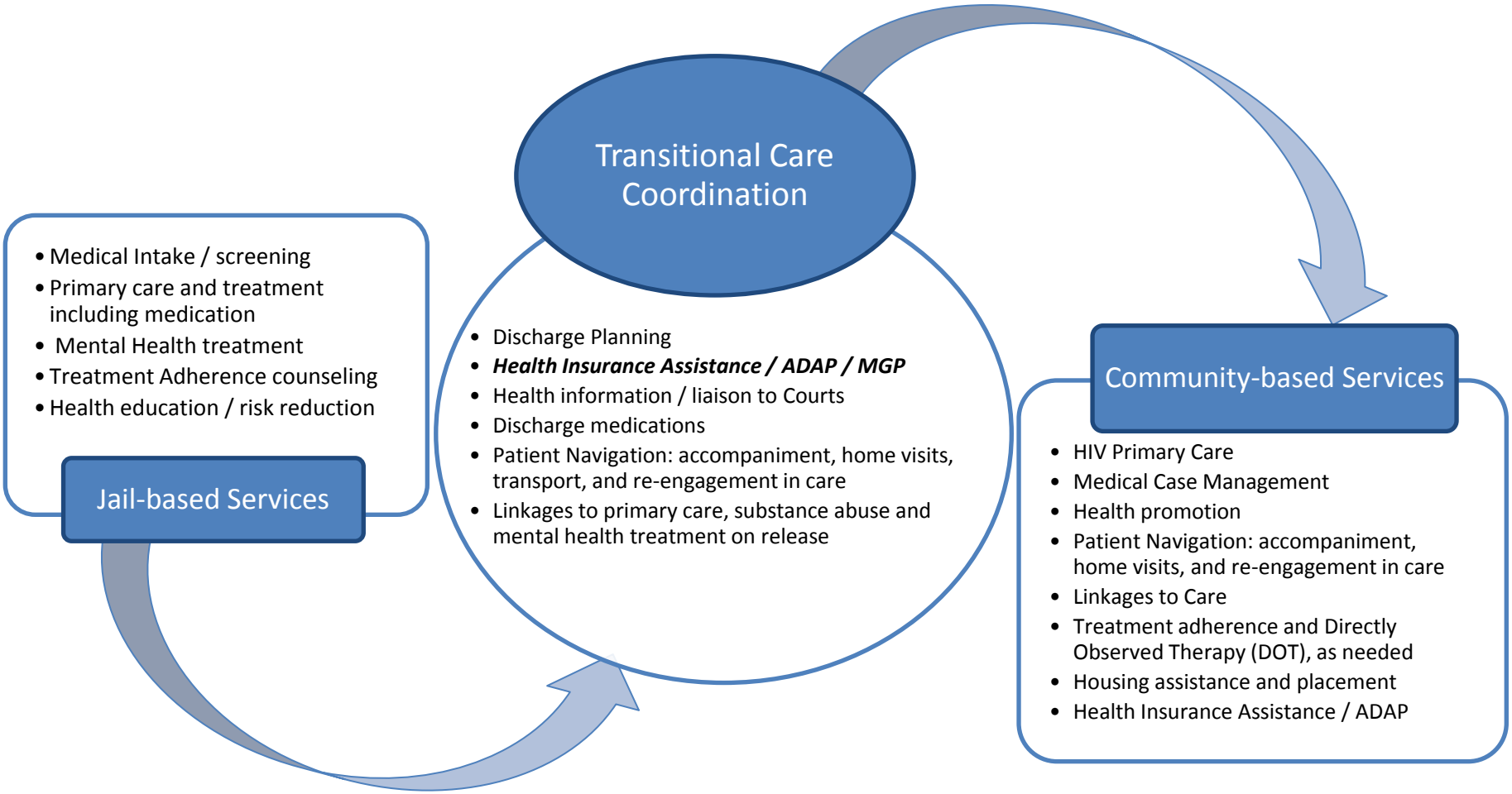
NYC DOHMH provides health and mental health care for all in DOC custody.

Background

NYC Department of Health and Mental Hygiene oversees health care of inmates in all 12 NYC jails

- Goals: Improve the health of incarcerated individuals and community health.
- Correctional Health Services oversees medical care in the jails with over 78,000 medical visits monthly
- Medicaid prescreening: 6k; Medicaid applications: 1,400
- Discharge Planning – Population-based for mentally ill (13k); HIV-infected (2.5k); others at high risk (1.5k)
- All jails use electronic health records

Continuum of Care Model



Linkages Evaluation Outcomes

Averages for 249 with 6 month post-release Jail Linkages follow up/clinical review:

Client Level Outcomes

- Improvements shown by increased CD4 count (372 to 419)
- More taking medication (from 62% to 98%)
- Fewer report hunger (from 20.5% to 1.75%)
- Overall health and mental health improved (SF-12 PCS from 47.9 to 50.4; SF-12 MCS from 44.8 to 47.5)

Program Impact

Saving lives
Saving money

- Treatment adherence improved (from 86% to 95%)
- Improved viral Load (from 52,313 to 14,044)
- Increased proportion with undetectable vL (<48) from 11% to 22%

Systems Implications

- Fewer homeless in month prior: from 23% to 4.5%
- Fewer Emergency Department visits: from .61 to .19

Bronx Lebanon HH Pilot

- Pilot: DOHMH and Bronx Lebanon to address overlapping population to facilitate continuity of care and entry / return to Health Homes for those released from jails.

- Purpose: To facilitate linkages for high risk, high need, high cost HH-eligible people leaving jails. Potential evaluation matrices based on SDOH guidance may include:
  - reducing utilization associated with avoidable inpatient stays
  - reducing utilization associated with avoidable emergency room visits
  - Improving outcomes for persons with mental illness/substance use disorders
  - determining recidivism rates.

- Proposal: DOHMH will
  - employ one Project Analyst to identify and track BLHCN HH eligible patients
  - engage patients and obtain consent to participate in the BLHCN HH
  - provide a discharge plan and medical summary on release.

- Funding:
  - one dedicated Project Analyst and
  - reimbursement for patient outreach / engagement, consent, discharge plan, medical summary and ancillary services provided on request.