TRANSITIONAL CARE COORDINATION (TCC): NEW YORK CITY

Evidence-Informed Structural Intervention

INTERVENTION DESCRIPTION

Goals of Intervention
- Improve access to HIV care services after incarceration

Intended Population
- Incarcerated persons with HIV (PWH)

Brief Description

Transitional Care Coordination (TCC) is a structural-level intervention focused on improving HIV-related outcomes for incarcerated persons with HIV (PWH) prior to their release into their communities in New York City, New York. In TCC, a Patient Care Coordinator provides a discharge plan during the second day of incarceration. The discharge plan addresses basic needs (i.e., housing security, food security, and clothing) and addresses barriers to access care (e.g., health insurance, AIDS Drug Assistance Program) and additional community support services. TCC also provides health education, liaisons to the court, assistance with discharge medication, and linkages to primary HIV care, substance abuse and mental health treatment. Additionally, TCC provides patient navigation services that include home visits, providing transportation to care visits, and accompanying the person on the care visit upon release.

Theoretical Basis
- None reported

Intervention Duration
- Ongoing

Intervention Settings
- Correctional facilities
- Community-based organization
- Residential homes

Deliverer
- Team leader supervises: Facility coordinator, Patient care coordinators (PCC) (jail- and community-based), and Transition coordinator
- Health Liaison

Delivery Methods
- Case management
- Discharge care plan development
- Linkage to care
- Patient navigation
- Transitional care services

Structural Components

- Access – HIV health care
  - Provided a 7-day supply of ART medication and 21-day prescriptions to participants at the time of release
  - Provided a medical summary and discharge kit that included condoms, a health passport, a listing of community STD clinics and syringe exchanges, a pocket guide to criminal justice-related services, and key words to use (e.g., "Jail Release Services") when calling the New York City service telephone line
  - Linked participants to HIV medical care, substance abuse treatment, and mental health services at the time of release
- Capacity Building – Hiring; Provider/supervisor training
  - Hired and trained staff to serve as Coordinators (i.e., Facility Coordinators, Patient Care Coordinators, and Transitional Coordinators) to implement care coordination and serve as patient navigators, if needed, to facilitate linkage to HIV medical care
  - Hired and trained Health Liaisons to collaborate with Patient Care Coordinators to assist placing non-violent detainees in behavioral health treatment programs (e.g., residential substance abuse treatment) or specialized medical care (e.g., skilled nursing and hospice programs) as medical alternatives to incarceration
- Social Determinants of Health – Survival
  - Created discharge care plans to address housing, employment/income, food security, transportation, health insurance, and social support
  - Provided transportation to initial HIV medical appointments on release, as needed

INTERVENTION PACKAGE INFORMATION

The intervention package is not available at this time. Please contact **Alison O. Jordan**, ACOH Consulting LLC, or **Janet J. Wiersema**, NYC Health + Hospitals Correctional Health Services, 55 Water Street, 18th Floor, New York, NY 10041.

Email: Alison O. Jordan (ali@acojaconsulting.com) or **Janet J. Wiersema** (jwiersema1@nychhc.org) for details on intervention materials.

EVALUATION STUDY AND RESULTS

Study Location Information

The original evaluation study was conducted in New York City, New York between April 2008 and May 2011.

Key Intervention Effects

- Improved ART adherence
- Improved ART uptake
- Reduced viral load

Recruitment Setting

- New York City jails

Eligibility Criteria

Persons with HIV were eligible if they were incarcerated in a New York city jail, likely to be released to the community within 6 months, aged 18 years or older, and willing to receive medical care for their HIV infection.

Study Sample

The baseline study sample of incarcerated persons with HIV (n = 434) is characterized by the following:

- *57% Black or African American persons, 7% White persons, 1% persons identifying as another race*
- *35% Hispanic, Latino, or Latina persons*
- *78% male persons, 20% female persons, 2% transgender persons*
- *Age: 3% persons <30 years old, 13% persons 30-39 years old, 49% persons 40-49 years old, 30% persons 50-59 years old, 4% persons ≥60 years old*
- *47% < high school or GED, 38% high school diploma or GED, 15% ≥ some college*
- *55% currently on ART*
- *Mean percentage of time taking ART as prescribed: 80.3 %*
- *26% experienced housing instability*
- *25% experienced food insecurity*
- *84% had a usual provider*
- *Mean viral load of 47,515 ± 159 276 (SD)*
- *Mean CD4 count of 383 ± 262 (SD)*

Note: Percentages may not add up to 100% due to rounding.

Comparison

The study was a one-group, pre-post intervention cohort study. The cohort study pre-intervention (baseline) data was compared to 6-month follow-up data.

Relevant Outcomes Measured

- ART uptake was measured at baseline and at 6-month follow-up, defined as being currently on ART within 7 days prior to incarceration.
- ART adherence was self-reported using a visual analog scale measured at baseline and at 6-month follow-up, ranging from 0% to 100%, and defined as percentage of time taking ART as prescribed.
- Viral load was measured as mean viral load at baseline and at 6-month follow-up.

Participant Retention

- 56% of study participants were retained at the 6-month follow-up.
  Because participant retention is not a criterion for the Structural Interventions chapter, the Prevention Research Synthesis project does not evaluate that information.

Significant Findings on Relevant Outcomes

- A significantly greater percentage of participants reported taking ART at the 6-month follow-up than at baseline (n = 243; 92.6% vs 55.6%; $p < 0.05$).
- A significantly greater percentage of participants reported taking ART as prescribed at the 6-month follow-up than at baseline (n = 243; 93.2% vs. 80.7%; $p < 0.05$).
- There was a significant decrease in the mean viral load (+ SD) from baseline to 6-month follow-up (n = 243; baseline = 54,031±183 404; 6-month follow up = 13,738± 23,310; $p < 0.05$).

Strengths

- None identified

Considerations

Engagement in HIV care was not evaluated because it was self-reported.

Additional significant positive findings on non-relevant outcomes

- There was a significantly higher mean CD4 count (+SD) at the 6-month follow-up compared to the baseline (6-month follow-up = 412± 271; baseline = 374± 263; $p < 0.05$).
- A significantly lower percentage of participants reported housing instability at the 6-month follow-up compared to the baseline (6-month follow-up 4.15% vs baseline 22.4%; $p < 0.05$).
- A significantly lower percentage of participants reported food insecurity at the 6-month follow-up compared to the baseline (6-month follow-up 1.7% vs baseline 20.7%; $p < 0.05$).
- There was a significantly higher mean current health self-rating (+SD), in which 1 = excellent, 5 = poor, at the 6-month-follow up compared to the baseline (6-month follow-up 3.22±1.05 vs baseline 2.81±0.79; $p < 0.05$).
- There was a significantly higher mean SF-12 physical composite score (+SD) and mean SF-12 mental composite score, respectively, at the 6-month follow up compared to the baseline.
    - Mean SF-12 physical composite score: 50.4±8.1 vs 47.9±10.6; $p < 0.05$
    - Mean SF-12 mental composite score: 47.5±6.9 vs 44.8±9.5; $p < 0.05$
- There was a significantly lower mean emergency department visits (+SD) at the 6-month follow up compared to the baseline (6-month follow-up 0.20± 0.61 baseline 0.60±1.19; $p < 0.05$).

Non-significant findings on relevant outcomes

- None reported

Negative findings

- None reported

Other related findings

- None reported

Implementation research-related findings

- None reported

Process/study execution findings

- All study participants received transitional care coordination services while incarcerated. Addressing all of a client's most pressing needs, such as housing, substance abuse treatment, and mental health care needs as well as referrals to primary medical care are core components of this approach.

Adverse events

- None reported

Findings from Subsequent Studies

- An adaptation of TCC in Puerto Rico was conducted by Wiersema et al., 2020 and is determined to be evidence-informed for the Structural Interventions Chapter.

Funding

Not reported

REFERENCES AND CONTACT INFORMATION

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Researcher: **Alison O. Jordan, LCSW**
ACOJ Consulting, LLC
Queens, New York

Email: ali@acojaconsulting.com