Journal of Urban Health: Bulletin of the New York Academy of Medicine, Vol. 92, No. 4
doi:10.1007/s11524-015-9968-x

Transitions to Care in the Community for Prison Releasees with HIV: a Qualitative Study of Facilitators and Challenges in Two States

Theodore M. Hammett, Sara Donahue, Lisa LeRoy, Brian T. Montague, David L. Rosen, Liza Solomon, Michael Costa, David Wohl, and Josiah D. Rich

ABSTRACT *One in seven people living with HIV in the USA passes through a prison or jail each year, and almost all will return to the community. Discharge planning and transitional programs are critical but challenging elements in ensuring continuity of care, maintaining treatment outcomes achieved in prison, and preventing further viral transmission. This paper describes facilitators and challenges of in-prison care, transitional interventions, and access to and continuity of care in the community in Rhode Island and North Carolina based on qualitative data gathered as part of the mixed-methods Link Into Care Study of prisoners and releasees with HIV. We conducted 65 interviews with correctional and community-based providers and administrators and analyzed the transcripts using NVivo 10 to identify major themes. Facilitators of effective transitional systems in both states included the following: health providers affiliated with academic institutions or other entities independent of the corrections department; organizational philosophy emphasizing a patient-centered, personal, and holistic approach; strong leadership with effective "champions"; a team approach with coordination, collaboration and integration throughout the system, mutual respect and learning between corrections and health providers, staff dedicated to transitional services, and effective communication and information sharing among providers; comprehensive transitional activities and services including HIV, mental health and substance use services in prisons, timely and comprehensive discharge planning with specific linkages/appointments, supplies of medications on release, access to benefits and entitlements, case management and proactive follow-up on missed appointments; and releasees' commitment to transitional plans. These elements were generally present in both study states but their absence, which also sometimes occurred, represent ongoing challenges to success. The qualitative findings on the facilitators and challenges of the transitional systems were similar in the two states despite differences in context, demographics of target population, and system organization. Recommendations for improved transitional systems follow from the analysis of the facilitators and challenges.*

KEYWORDS *Prisoners, HIV, Discharge planning, Transitional services, Linkage to community care*

Hammett, Donahue, LeRoy, and Costa are with the Abt Associates, 55 Wheeler Street, Cambridge, MA 02138, USA; Montague and Rich are with the Miriam Hospital and Brown University, Providence, RI, USA; Rosen and Wohl are with the University of North Carolina, Chapel Hill, NC, USA; Solomon is with the Abt Associates, Bethesda, MD, USA.

Correspondence: Theodore M. Hammett, Abt Associates, 55 Wheeler Street, Cambridge, MA 02138, USA. (E-mail: Ted_Hammett@abtassoc.com)

INTRODUCTION

One in seven people living with HIV in the USA in 2006 passed through a correctional facility that year.[1] Almost all incarcerated persons with HIV return to the community where they require services to manage their disease and address their other needs. Discharge planning and transitional programs are critical to ensuring continuity of care, maintaining treatment outcomes achieved in prison, and preventing further viral transmission in the community.[2–4] However, effectively linking prison releasees to community-based services faces multiple challenges. These include assisting releasees to keep appointments and adhere to treatment regimens and managing co-morbid conditions such as mental illness and substance use. Other challenges include homelessness, unemployment, and lack of basic needs. Inter-agency coordination and constrained service funding also pose problems.[2,5–7] A recent survey of US correctional systems revealed notable weaknesses in discharge planning and transitional linkage services for inmates with HIV.[8]

Springer[5] identified five essential components of transitional care for prison releasees with HIV: case management, continuity of antiretroviral therapy (ART), substance use treatment, mental health treatment, and HIV prevention services. The Centers for Disease Control and Prevention (CDC) also provided recommendations for the pre-release roles of correctional and medical staff working as a team to make specific appointments for care in the community, enroll releasees in entitlement programs, provide copies of medical records to inmates, and furnish supplies of medications upon release.[9]

We believe that it is useful to conceptualize transitional activities as occurring in a single "system," which includes correctional HIV care, community HIV care, and the vital linkages between them. Also important to this system are two cross-cutting elements: (1) inter-agency collaboration[10–13] and (2) government and private sector policies and programs regarding entitlements, employment, and housing.[14]

The transitional care systems developed for prisoners with HIV in Rhode Island[15] and North Carolina[16] have received attention in the literature and offer good examples incorporating the key elements identified by Springer[5] and the CDC.[9] This paper presents the findings from a qualitative analysis of interviews with providers and stakeholders in these two state systems to identify the facilitators of and challenges to effective in-prison care, transitional interventions, and access to and continuity of care in the community. The focus is on inmates and releasees living with HIV, but the paper also addresses, to some extent, transitional issues relevant to and programs available to all inmates and releasees.

METHODS

The data were gathered for the Link Into Care Study (LINCS), a mixed-methods project funded by the National Institute on Drug Abuse to assess transitional services for prisoners and releasees with HIV. This paper presents findings from two of the states participating in LINCS, Rhode Island and North Carolina.

The quantitative component of the project linked data from the National Corrections Reporting Program and Ryan White Services Reports to assess time from prison release to entry into Ryan White-funded community-based care.

Preliminary results of this data linkage are presented elsewhere.[17] The qualitative component elucidated the facilitators and challenges of effective transitional systems. In Rhode Island and North Carolina, we carried out 65 semi-structured, in-depth individual and group interviews carried out between March 2012 and June 2013 with correctional staff (n=27), community HIV providers (n=13), and other community providers and state agencies (n=25). Interviews were conducted with purposive samples of individuals working in the correctional systems, state departments of public health and other social services (Medicaid, mental health and substance use, vocational rehabilitation, employment), and agencies providing HIV care, mental health, and substance use services and addressing basic needs (housing, employment). We used key informants and snowball techniques to recruit the respondents. All interviews were recorded and transcribed. Qualitative interviews employed an interview guide incorporating the key question: "What makes a good linkage to care for an HIV-positive individual upon release from prison?"

We developed thematic codes guided by the five essential components of transitional care for prison releasees with HIV identified by Springer.[5] Additional codes were identified inductively based on the data collected. The research team tested and refined the codebook by applying the initial codes to a common transcript and then agreeing upon consistent code names, categories, and definitions. We also examined inter-rater reliability correlations and revised our coding definitions and retrained coders until we achieved acceptable inter-rater reliability. All transcripts were coded by four analysts using NVivo 10 software. We further sub-coded the text coded as a facilitator or barrier to six main themes: facilitators of in-prison care, facilitators of discharge planning, facilitators of post-release care, barriers to in-prison care, barriers to discharge planning, and barriers to post-release care. Text segments could be coded as both facilitators and barriers.

For this paper, we used primarily the material sub-coded as facilitators of in-prison care, discharge planning, and care in the community, but this also provided substantial information on barriers and challenges, particularly cases in which the facilitators were absent or not fully operational. The coded text from the interview transcripts selected for this analysis was examined with the source documents to contextualize the information and clarify findings.

This study was reviewed by the IRBs of Lifespan, Abt Associates, and the University of North Carolina and by the Rhode Island Department of Corrections' Medical Research Advisory Group.

RESULTS

Rhode Island and North Carolina both offer comprehensive discharge planning that starts when inmates enter prison and includes arrangement of post-release appointments and linkages to community-based services, most importantly those funded through the Ryan White program—for many years the principal funder of HIV/AIDS services for poor people. Both states also have reentry councils that address medical and other needs for all releasees, including those with HIV, and both states provide releasees on ART with supplies of medications at release.

While the basic discharge planning and reentry activities of the two state systems are similar, there are structural and organizational differences in their implementa-

tion. Rhode Island has clinicians and case managers who serve prisoners with HIV and then continue to provide care to releasees in the community, so the majority of patients receive care from the same HIV providers while incarcerated and following release. Project Bridge is the primary provider of transitional services in Rhode Island.

In North Carolina, there is no single organization designated to follow and support individuals with HIV from pre-release through post-release care. Although some of the prison HIV care providers also practice at an outside academic hospital, only a minority of releasees are seen by the same providers in the community. Also, correctional outreach nurses coordinate discharge planning in prison while separate counselors and peer navigators work with releasees in the community.

Our analysis of the qualitative data revealed a number of facilitators of (and related challenges to) in-prison care, discharge planning and transitional interventions, and care in the community post-release. These are categorized and listed in Table 1 and elaborated on in the following subsections.

Providers

Both the Rhode Island and North Carolina transitional systems rely on HIV specialists and other providers affiliated with academic medical centers. While providers employed by the correctional system may be capable of providing high-quality services, *arrangements with academic or other qualified outside institutions* tend to bring increased independence of judgment, clinical expertise, and strength of advocacy for the needs of inmates and releasees. Some of these advantages are cited by a former correctional provider in North Carolina:

> It was good to be affiliated with a university… Providers were well trained. Education and continuing education in prisons is not top priority because it's custody-driven, so some systems are probably not as … up to date without university partnerships.—NC former correctional provider

Philosophy

The philosophies of the Rhode Island and North Carolina transitional systems are based on a *holistic approach* and personal connection between providers and clients. The holistic approach to care is reflected in the statements of staff members of an AIDS Service Organization (ASO):

> [We]…look… at 10 dimensions of the individual's life and if any of these areas are lacking, we'll try to assist (services range from medical care, mental health, substance abuse treatment, court dates, housing)… Not just about clinical care and medication because these individuals have so many other stressors in their lives. We look at the holistic picture.—RI ASO staff

A correctional social worker in North Carolina described their approach as

> a comprehensive plan from a holistic model, so it looks at housing, medical, mental health follow-up, financial plan, agency referrals, medications, transportation, any other benefits that the inmate might be eligible for—food stamps, social security.—NC correctional social worker

TABLE 1 Facilitators of transitional systems for inmates and releasees with HIV, North Carolina and Rhode Island

Category	Facilitators
Providers	• Health services providers affiliated with an academic institution independent of the state correctional department
Philosophy	• Holistic approach;
	• Patient-centered, personal connection and commitment
Leadership	• Correctional department leadership;
	• Champion of transitional system
Team approach	• Coordination, collaboration, and integration;
	• Mutual respect and learning among corrections staff and prison and community health providers;
	• Staff dedicated to transitions;
	• Information sharing and communication
Services/activities	• High quality HIV, mental health, and substance use services in prisons;
	• Timely initiation of discharge planning;
	• Comprehensive discharge planning;
	• Specific linkages/post-release appointments;
	• Supplies of medications on release;
	• Access to entitlements;
	• Case management and care coordination;
	• Proactive follow-up on missed appointments post-release
Inmates/releasees	• Releasees' commitment to transition plans

In both states, the holistic approach gives importance to rehabilitative services. One correctional administrator in Rhode Island described features of the substance use services for prisoners in that state:

> [T]his department cares about substance abuse services… This is a very forward thinking department in terms of rehab services. We've had recovery rallies inside the prison.—RI correctional administrator

A *patient-centered personal connection* between providers and clients is also essential. A Rhode Island ASO administrator noted:

> [Project Bridge staff] … work inside [the prison] which is good because we find that inmates are more likely to follow through with you if they know you and

> they feel comfortable… They're [inmates] a much different population [from] other people. They're typically not very trusting, paranoid, pretty closed. So if you've met with them inside, there's more of a connection where they're much more likely to follow through with you.—RI ASO administrator

The importance of a personal and caring approach was echoed by a provider in the Rhode Island corrections department:

> The most innovative part is the personal approach. They know there is a provider there that wants to see them… [The] case manager has taken a personal interest in them. Incarceration is a process of being rejected. [It's] part of the punishment. If you can demonstrate that you are not rejecting the individual, you can go a long ways in retaining them in care.—RI correctional provider

The *personal commitment* to the work was captured by a Rhode Island Project Bridge staff member: "You just…immerse yourself in their world." A North Carolina community agency staff member exemplified this dedication:

> we're not in it for the money, and anybody that's in it for the money is never going to be effective. It's about your outcomes…. And it's about that person. And we love our job.—NC community social service agency staff member

Leadership

Both states' corrections departments have taken *strong leadership roles* in the transitional systems. According to a correctional administrator in Rhode Island:

> I'm blessed because the leadership here …are determined to make this a good place from the medical point of view.—RI correctional administrator

"*Champions*" of transitional services and continuity of care emerged in both Rhode Island and North Carolina. Rhode Island has had two long-time and strong rehabilitative/transitional services administrators who have advocated for a comprehensive transitional system. A state colleague approvingly described one of these administrators:

> …aggressive…in getting people at the table…a real leader in terms of making those connections by being a pain sometimes…Sometimes that's what it takes. [A person who is] really devoted to rehabilitation and assisting people and making a difference in people's lives…You need somebody that's going to be a little pushy, a little aggressive—RI state behavioral health administrator

In North Carolina, among the chief administrators of rehabilitative programs and services in the corrections department are individuals with similarly long tenures who assumed important leadership roles in the transitional system.

Team approach

Coordination, *collaboration*, *and integration* are fundamental elements in effective transitional systems. In both states, community-based reentry councils coordinate services for clients. Council members include elected officials, representatives from community and faith-based organizations and law enforcement, service providers,

and business leaders. Monthly meetings review the post-release plans for high-risk individuals. The North Carolina reentry council is coordinated at the state level by the corrections department with five local councils run by intermediary organizations. Activities include development and maintenance of relationships with service providers, probation and parole agencies, and other stakeholders.

A staff member of a North Carolina community-based organization (CBO) stated that a key transitional success factor is "integrated processes, so… processes on the inside… are…designed to work in collaboration with pieces on the outside." A Rhode Island CBO staff member echoed this: "It's a plan that doesn't just arrange an array of health and behavioral health and psychosocial supports, but … that really integrates and coordinates those services."

Another important aspect of the team approach is the development of *mutual respect and learning among prison and community providers and correctional departments*. A Rhode Island correctional staff member reported the development of mutual understanding: "the security side of the house gets to know the community providers and vice versa." A correctional administrator in North Carolina emphasized that health providers must always be respectful of security considerations and other correctional priorities and noted that providers generally take such an approach:

> When…visiting the warden or one of the superintendents… the first thing [a provider lets them know is that] 'I understand this is your house. You are in charge here. But if you would give me an opportunity, I would like to present A, B, C, D, or I'd like to have a chance to talk with you.'—NC correctional administrator

Understanding of the importance of continuity of HIV care and related services must also be built in the community, as noted by a public health administrator in Rhode Island:

> [Project Bridge] has done wonders to educate clinical providers as well as the community [regarding] the benefits of providing care for releasees with HIV, substance abuse histories, Hep C.—RI state Department of Public Health administrator

A common feature of the North Carolina and Rhode Island transitional systems is having *staff dedicated to linkage and continuity of care from prison to the community*. These dedicated staff address the multiple issues facing releasees and work directly with service providers. In Rhode Island and North Carolina, discharge planning for all inmates provides linkages to mental health, substance use, and other services. Both states also have linkage programs and staff specifically for inmates and releasees living with HIV. At the time of our interviews, North Carolina had bridge counselor positions but did not have any staff who were assigned exclusively to work with the prison population. Beginning in the fall of 2013, the state hired more counselors to work specifically with newly released HIV-positive inmates on transition activities. A state public health administrator in North Carolina reported what bridge counselors tell releasees:

> [O]kay, we're here to help. Now that you're out, let's look at all of this, including and most importantly getting you into care and let's talk about your partners. Let's talk about who you are going to go home and have sex with now that you're out after 5 years in prison and does he or she know that you're [HIV-]

> positive and how can we help you with this?—NC Department of Public Health administrator

In Rhode Island, programs such as the state's AIDS Drug Assistance Program (ADAP) work directly with Project Bridge staff to develop and implement transitional services. An ADAP staff member noted that Project Bridge staff are on the inside allowing for better engagement and communication with the corrections discharge planning teams and with outside agencies.

Smooth and complete *information sharing and communication* among team members are also important to successful transitions. Automated and linked information systems can facilitate the transfer of information between staff and organizations but strong inter-agency collaborations and quality data are pre-requisites for effective information sharing. Ideally, community providers are notified of clients' release dates, receive patients' prison medical records, and reach out to releasees to make appointments or ensure that pre-arranged appointments are kept. A North Carolina community HIV provider summarized this process:

> Communication…. Here is the contact name of the person you are going to go see and we are going to send your records to that doc so you can hit the ground running, letting the clinic know so and so is coming…—NC community HIV provider

An administrator of a North Carolina program that provides services to people with substance use or mental health problems who are involved in the criminal justice system elaborated:

> getting information communicated well in advance of the release, not 48 hours [before]. Getting releases of information signed, having everything set up when a person gets out because we know that [those] first few days and weeks are critical.—NC TASC administrator

The Rhode Island system tries to ensure that necessary residential information is made available to entitlement programs such as ADAP, even when releasees are living in shelters or other unstable housing.

Unfortunately, information sharing procedures, no matter how well-designed, do not always work as they should. According to interviewees, a common problem in both states is lack of accurate advance information on release dates and times. A correctional provider in North Carolina reported that

> …a lot of times, information is supposed to be faxed to the [community] providers [but] that doesn't always happen… [Community] providers [sometimes say] 'Hey, I know this guy was released 2 or 3 weeks ago. I didn't get anything.'—NC correctional provider

Services/Activities

Both states offer *high quality HIV care* for prisoners. In North Carolina, inmates with HIV receive "directly observed care" that includes motivational interviewing, case planning, and support for attendance at appointments and medication

adherence. A provider in the North Carolina corrections department asserted that the care in prison is:

> better than they would get outside. … [T]here are a couple of things that happen very well at the prison. Number one, you write an order for HIV anti-retrovirals and they get them…faster …—sometimes the same day. And all of them are available. No insurance hassles…—NC correctional provider

In addition to medical care, inmates in both states are able to access *mental health and substance use treatment services*. Inmates in Rhode Island with opioid-related disorders are maintained on methadone treatment in the correctional facility if they have less than 30 days until release.

Interviewees noted that effectiveness of transitional systems depends on *timely initiation of discharge planning*. In North Carolina, correctional administrators reported that

> Linkage to care starts when they come in the door. Basically, you do the interview, you talk to them about their plans upon release, and it starts there and it continues on. You put things into place to make them successful, no matter how long they're going to be in our system.—NC correctional administrator

North Carolina and Rhode Island have both developed *comprehensive discharge planning* processes. A North Carolina correctional administrator described the process:

> A lot of basic information is gathered at intake, but then that record follows the inmate all the way through the incarceration, so it's a great source of information, or it gives you a place to know if something is missing.—NC correctional administrator

A community agency staff member described discharge planning in Rhode Island:

> Everybody… gets a [discharge] plan and it's very comprehensive because it goes through …every single piece from housing to bus passes… and every single thing in-between. Clothing vouchers, medical appointments, medication, counseling, everything is covered.—RI community mental health/substance abuse agency staff member

To make this process work effectively, interviewees emphasized, case managers and linkage counselors need to have accurate and complete knowledge of the services and resources that are available in communities.

Rhode Island stakeholders (correctional staff, community service providers, and policymakers) believe that making *specific post-release appointments and other linkages to services* while individuals are incarcerated is critical to the effectiveness of the transitional system. Community-based substance use and mental health treatment agencies meet prisoners pre-release and set up appointments for them in the community. According to a Rhode Island community agency staff member,

> [I]f someone is being released from prison and the discharge planner thinks they… need outpatient substance abuse counseling, they'll contact me within 90 days of the inmate's release and I will go in, see them, set up an appointment

> so that when they leave, they've already got the appointment. They don't have to go on a waiting list…and it's a smooth transition.—RI community mental health/ substance abuse agency staff member

These comments were echoed by a correctional administrator:

> We know that… from the minute they walk out the door … all of the challenges begin and it's a pretty complex world out there and sometimes it's hard to know where to go, what to do. So I think the more that they can be set up with while they're here with very clear instructions on this is where you go, this is who you talk to, and actually have an appointment made for them would be the most helpful.—RI correctional administrator

However, referrals or even specific appointments may not be sufficient to ensure continuity of care. The unpredictability of release dates and the numerous patient-based and institutional challenges to linkage of releasees to community-based services require comprehensive, targeted action to maximize the likelihood that linkage is successful. A state agency behavioral health administrator noted:

> [E]xperience for us has shown that you can't just give somebody an appointment card and say goodbye because that's not going to happen. You really need to establish a connection from the inside that's going to follow through on the outside.—RI state behavioral health administrator.

Having *supplies of medications* that will enable releasees to avoid interruptions in treatment before their first appointments in the community is another extremely important element in the transitional system. Rhode Island's policy is to provide a 7-day supply of antiretroviral (ARV) medication on release while North Carolina generally provides a 30-day supply. According to a correctional medical provider, nurses in Rhode Island are usually able to get longer supplies than 7 days if needed. On the other hand, according to Rhode Island providers, there are sometimes difficulties in getting the medication supplies to individuals before they are released, necessitating a return to the facility to pick up their medications, which often does not occur.

Timely *access to entitlements* represents an important facilitator for continuity of care and successful transition. In many states, there are legal and policy barriers to applying for benefits while still in prison. North Carolina and Rhode Island have both worked to overcome these barriers. The advent of the Affordable Care Act has eased the process, as related by an administrator of a Rhode Island community agency:

> One of the issues that healthcare reform is creating is [the] opportunity for more uninsured ex-offenders to rapidly access healthcare, be eligible, presumptively, for Medicaid or some managed Medicaid product. So you're finally getting the criminal justice system seeing that you need to start early with the Medicaid application, because it takes so long to process it, or with an SSI application, and that you do have pretty impaired offenders that, if they come out without a source of health insurance or a source of income, they're going to be really high risk for relapse. So… apply[ing] for SSI or Medicaid… has to be started [during] that 30 days prior to discharge.—RI social services agency administrator

In Rhode Island, Project Bridge works with clients to complete all their applications for entitlements. A counselor in North Carolina described a similar approach:

> [I]f someone needs ADAP, I do their ADAP application. If someone needs to apply for Medicaid or get their Medicaid transferred from another state… I would help them go through those processes. That way they have access to medications and to a doctor….If they have to change their address for Social Security … I help them do … that… as well.—NC community provider

According to a North Carolina correctional administrator, ensuring Social Security coverage begins at least 6 months before release.

Case management and care coordination are critical ingredients for positive transitional outcomes. According to a North Carolina case manager,

> …the most important thing is early and complete communication between the [prison] discharge staff and the [community] social worker …that is going to be taking the case after release.—NC counselor

Rhode Island community agencies hold multi-disciplinary conferences to facilitate care coordination for all patients. An ASO administrator described these conferences:

> If there's a case that's fired-up and there's all kinds of problems with it and we know two or three agencies are involved, then we'll have a case conference… So you have the doctors and the psychologists and social workers and case managers and people will just throw out ideas, come up with a case plan, decide who is the leader on the case.—RI ASO administrator

Reentry councils serve as high-level forums for inter-agency leadership and collaboration to improve the overall transitional system but they also work to coordinate care and services for individual releasees. In Rhode Island, a community agency staff member described the re-entry council meetings:

> [i]nmates being released within the next 30 days [and] all the providers sit around the table and we decide what services this person needs and who is going to provide them…—RI community mental health/substance use agency staff member

A North Carolina correctional social work administrator described coordination from the perspective of the needs of individual clients:

> It has to be a cooperative plan in that all of the agencies that you are accessing are on board and invested. It's not enough to be on board. They have to be invested in success. It has to be a cooperative plan in that everybody understands their role in the whole plan. For instance, it does me no good to get a medical appointment for an inmate if Medicaid is not on board to pay the bill, and none of that's any good if I don't see that there's transportation to get them to the places that they need to be.—NC correctional administrator

In Rhode Island, ADAP works with case managers to make sure releasees get their medications and that the transitional agencies work with public housing

authorities to improve access for people with criminal histories. A community mental health administrator described the collaboration:

> we've developed a really good relationship with the [city] housing authority, where they have been more flexible around some of their rules in terms of people's prison history … and that's really worked fairly well ….—RI community mental health agency administrator

Coordination with substance use treatment providers is a domain of special relevance for this population. A Rhode Island corrections administrator described the arrangement with a substance use agency:

> All substance abuse folks are seen by the [agency] staff here [in prison], and it's the same staff that sees them when they get out… So we have a direct pipeline.—RI correctional administrator

Finally, coordination with probation and parole is essential, as officers in these departments work with releasees on a regular basis. According to a Rhode Island correctional administrator,

> [W]e're trying to have discharge planners…work with probation and parole and be able to follow up with people for 60 days while they're out… I think we know those initial months if they're successful give them a better chance. And we're… making those … initial appointments for them here as part of their discharge plan and not putting that burden on the probation-parole officer.—RI correctional administrator

Rhode Island also holds bi-monthly probation forums that help to coordinate services for individual clients:

> The probation supervisor gets up first [and] discusses what probation is, what the seven terms or nine terms of probation are and…what's expected of them…The police are there [and] let them know that…we're not just here to arrest you. We're here to help you, too…Then all the service providers… get up one at a time and… let everybody know what services we provide, where we are located… at the end, they're encouraged to come…and talk to us.—RI community mental health/substance use agency staff member

The obverse of these system strengths is that they do not always work as intended. Coordination and linkage are sometimes limited by fragmented referral processes. A North Carolina community counselor noted challenges to coordinating care:

> I wish it were…a set routine…I wish that I could expect to work with the same person and to get the same information and to have it just be very set, because … I feel like so many people must be falling through the cracks just because it's so divided up and I get referrals from so many people—NC counselor

Transitional systems need procedures *for pro-active follow up with patients who miss appointments* in the community. One North Carolina community HIV provider described the approach:

> [W]hen you have a patient who doesn't show up, the first thing [in] our protocol is [that] we call the patient and if we can't reach them that way we send a letter

> and we try to get them rescheduled. Then a small period of time may go by and they will get referred to our peer navigator who then actually goes out and knocks on a door, last known address, tries phone numbers, tries to find the patient. If they can't do it we also have a state counselor [who] cover [all] region[s] and they are supposed to get referrals. At some point it will definitely be coming via CAREWare [the Ryan White automated system]; they will get…the information back via CAREWare from clinics who have lost patients…—NC community HIV provider

Releasees' commitment

A final but no less indispensable factor in successful transitions is that the client must own and commit to carrying out the plan. No amount of advance arrangements can substitute for this commitment. According to a North Carolina correctional administrator,

> The person that you're writing the plan for has to be invested in it. They have to take ownership. It's their plan. I routinely tell inmates, "I'm not going home with you. I'm not driving you to an appointment. I'm going to do the best I can do give you the best plan that I can when you leave, but it's your plan.—NC correctional administrator

DISCUSSION

The transitional systems of Rhode Island and North Carolina have many similar elements, strengths, and challenges as well as some major differences. Both systems incorporate the key features defined by Springer[5] and the CDC.[9] A fuller understanding of the quality and effectiveness of the transitional systems, as well as identification of possible improvements, emerges from these qualitative data, but these findings must be viewed in light of contextual differences and variations in the organization of the transitional systems in the two states.

Rhode Island is a much smaller state than North Carolina, so distances from the single correctional facility to communities of return are shorter and there are fewer providers with which to coordinate. By contrast, North Carolina has many more facilities and service providers and generally longer distances to travel from prisons. Rhode Island has a unified correctional system that includes jail, prison, probation, and parole, whereas in North Carolina, the corrections department is responsible only for state prisons.

There are also differences between the Rhode Island and North Carolina transitional systems. Rhode Island employs a dually based (prison and community) discharge planning and case management approach, while in North Carolina prison, case management is administered separately from post-release case management. This structure allows for more of the specific linkages, referrals, and appointments to be completed pre-release in Rhode Island, whereas in North Carolina this more likely occurs in the community post-release. In North Carolina, the transitional system includes community-level leadership with corrections as a partner and discrete activities that are initiated in the prison system. In Rhode Island, the transitional system is characterized by stronger and more formal leadership roles played by the correctional department and a single provider of transitional services within and outside the correctional facilities.

Our study has several limitations. Rhode Island and North Carolina are not necessarily representative of all states. Rather, they are atypical in the attention they have devoted over many years to linkage and continuity of care for inmates and releasees with HIV. However, their strategies and achievements may help to inform improvements in transitional systems elsewhere.

Our qualitative data collection did not include interviews with inmates or releasees primarily because other studies have already done this. A qualitative sub-study involving interviews with prisoners[18] was done as part of a North Carolina randomized trial of transitional programs. In addition, a qualitative study of jail releasees in Rhode Island elaborated on the strengths of that system of transitional care, identifying some of the same factors that we identified in our study.[19]

Recommendations for improved transitional systems based largely on our analysis of the facilitators and challenges in Rhode Island and North Carolina include the following:

- Leadership
  - Strong leadership in state health and corrections departments;
  - "Champions" for transitional systems.
- Services/activities
  - Comprehensive (HIV, rehabilitative, and other support) services in prison and in the community;
  - Patient-centered, holistic approaches with caring and committed staff who make personal connection with clients;
  - Timely and comprehensive discharge planning and linkage with appointments that occur early in the post-release period;
  - Encouragement and provision of incentives to community-based providers to welcome and serve releasees in a responsive and culturally appropriate manner;
  - Timely, proactive follow-up on missed post-release appointments to reduce the likelihood of treatment interruption;
  - Coordination of care through case management and case conferences;
  - Coordination mechanisms for involved agencies—e.g., reentry councils, probation/parole forums, case conferences;
  - Intensive preparation and counseling of inmates/releasees to "own" their transitional plans and help them develop the commitment and wherewithal to follow their plans.
- Transitional policies and procedures
  - Additional procedures (and structural supports) to assure that all information (on appointments and other arrangements for community-based services) and medications are provided to releasees in a consistent manner (e.g., at the same time of day or from the same location in the prison facility) and that releasees are aware of what is provided;
  - If possible, limiting prison release to certain time windows (e.g., only during daytime hours when community services such as medical care and entitlement programs are accessible);
  - Systems to improve information flow within the correctional department and to furnish community providers with releasees' information and enable them to contact releasees in the community;

- Revision of public and private sector policies and administrative procedures that inhibit timely linkage and access to care and/or undermine facilitators of continuity of care—e.g., policies and procedures related to Medicaid and other entitlements, housing, employment, substance use, and mental health treatment;
- "Continuous quality improvement" strategies and tools to ensure alignment of transitional systems with the key elements identified in the literature[5], published guidelines[9], and other research.

Useful future study could involve more in-depth examination of local programs and providers that have achieved success in linking prison releasees with HIV to community-based care and interviews with releasees participating in such programs to further identify specific supportive procedures and policies that can be replicated elsewhere. Ongoing review of the operation of the transitional systems in the two states would also inform further improvements in procedures and services. The effects of the Affordable Care Act on all of these processes and outcomes would also be a fruitful domain for future study. Finally, development of data systems and improved data availability to measure more accurately and systematically transitional outcomes would enable more rigorous and thorough evaluation of such systems for people living with HIV and, indeed, all correctional inmates and releasees.

The Rhode Island and North Carolina transitional systems for prisoners and releasees with HIV serve some of the most challenging patients at perhaps the most critical and difficult times of their lives. Both systems have shown positive results. Learning the lessons suggested by the facilitators and challenges of successful transitions from prison to community-based HIV care detailed in this paper should help to further improve these two state systems and inform the development of successful transitional systems elsewhere. Successful transitions contribute to controlling and ultimately ending the HIV epidemic by improving not only the health of individual releasees but also the health of their families and communities. Thus, the sooner transitional systems are perfected, the better.

ACKNOWLEDGMENTS

The authors are grateful to the Rhode Island Department of Corrections and Department of Health, the North Carolina Department of Public Safety and Department of Health and Human Services for their collaboration and support on this study, as well as to all of the service providers and other stakeholders who participated in the interviews on which this paper is largely based. We also gratefully acknowledge the funding support of the National Institute on Drug Abuse, National Institutes of Health through grant # 1R01DA030778 Improving Linkage to HIV Care Following Release from Incarceration, awarded to Miriam Hospital with subgrants to Abt Associates and University of North Carolina. This work was also supported by NIH grants K24DA022112 and P30AI042853. Last but not least, we are indebted to Alice Lee for her research assistance on this project.

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