Coming Home

Presented by:

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Director

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Spencer Cox Center for Health

- NYS Designated AIDS Center
- Level 3 Certified Patient Centered Medical Home
- Inpatient & outpatient services
- “One Stop Shopping Model”
- Family-centered care
- Bilingual and multilingual staff
- Same day appointments
- 24/7 MD’s
- Three convenient locations

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Locations

Morningside Clinic
at St. Luke's Hospital
390 West 114th Street
(at Morningside Drive)

Samuels Clinic
at Roosevelt Hospital
1000 Tenth Avenue
(at 58th Street)

West 17th Street Clinic
230 West 17th Street
(between 7th and 8th Avenues)

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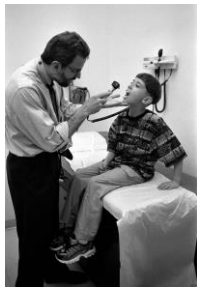
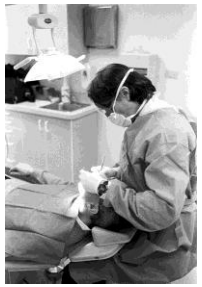
Robust Services

- Primary Care for adults and children
- Specialties: GI, Neurology, Cardiology, Endocrinology, Dermatology
- Gynecology and Family Planning
- Social Work/Case Management
- Mental Health: Psychology/Psychiatry
- Dental Care
- Rapid HIV Testing
- Pharmacy
- Integrative medicine
- Clinical Education
- Peer Support
- Treatment Adherence Support/Care Coordination
- Violence Prevention
- Health Education / Clinical Training
- Special Programs for Women, Adolescents and Formerly Incarcerated
- Non Occupational Post Exposure Prophylaxis (nPEP)
- Clinical Trials





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Spencer Cox: Three Clinical Sites

W17th Street Clinic
Command Center

Samuels Clinic
Reception Area

Morningside Clinic
Reception Area

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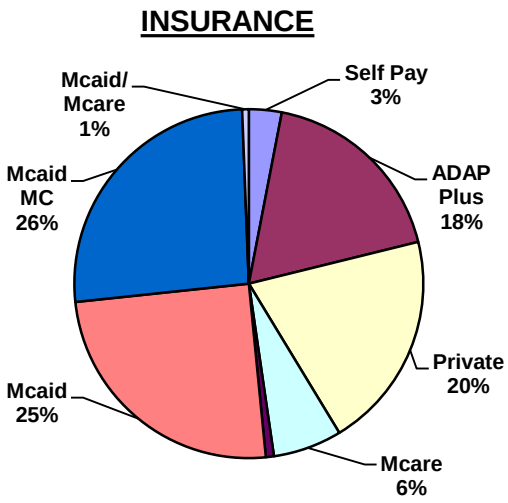
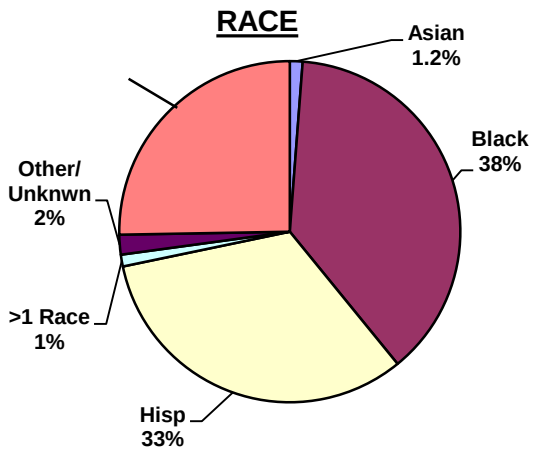
2012 Patient Demographics

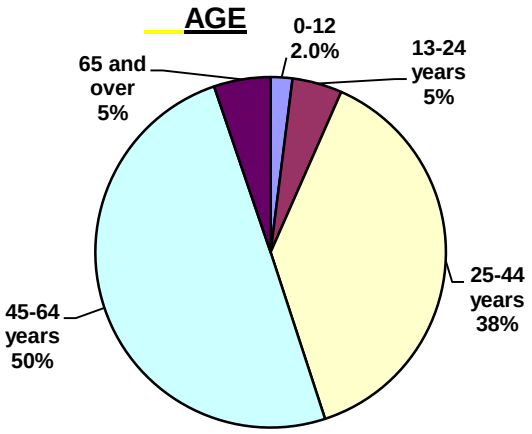
Patients: 7, 785 (74% HIV+)

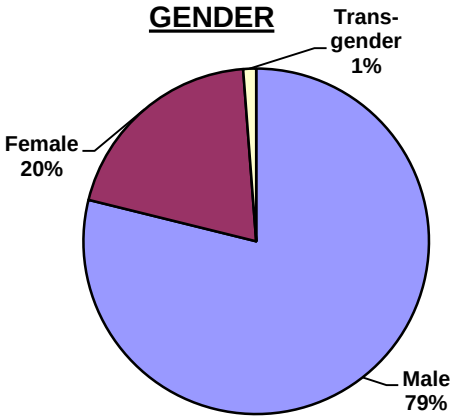
Visits: 110,451

Discharges: 1,472









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Coming Home Program

- Goal: To improve the physical, mental health, emotional and social well being of people with a history of incarceration and chronic diseases during their transition back home to their communities.
- Objectives: 1) Provide continuity of care, 2) Offer counseling and supportive services, 3) Ensure culturally sensitive, knowledgeable staff.
- Services: Individual and group counseling, social outings, patient navigation and chronic disease management education by Community Health Advocates, and substance use treatment readiness groups.
- Funding (~$1 million/year): MAC AIDS Fund, Elton John AIDS Fund, Centers for Medicare and Medicaid (via the Transitions Clinic Network, Office of Minority Health and SAMHSA.

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Coming Home Patients

- **2006-April 2013: 2,110 patients served**
  - **22% HIV+**
  - **78% HIV-**

- Demographics
  - Predominantly black (55%) and Latino (33%), male (74%).
  - HIV+ patients are older (65% are 45-64) than HIV- patients (40% are 45-64).

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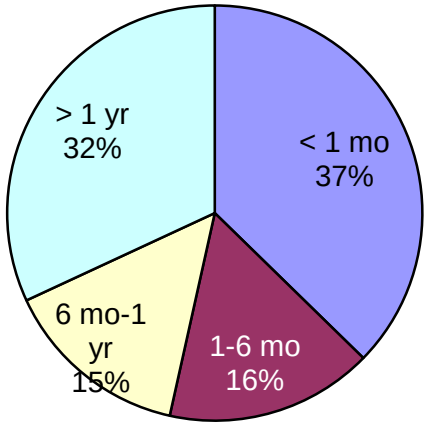
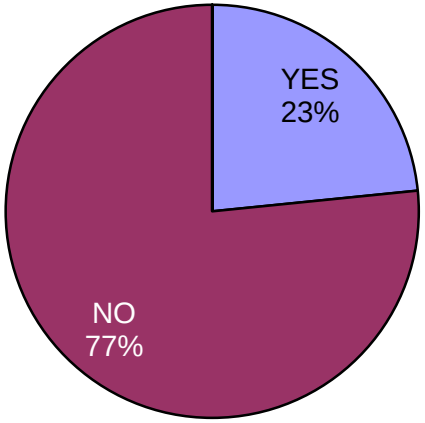
Coming Home Patients

Time from release to clinic



Referred while incarcerated



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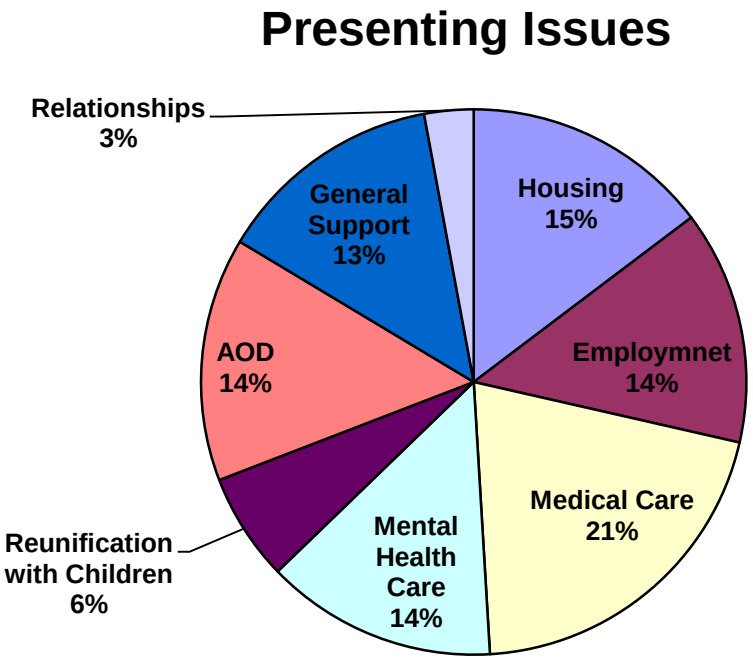
Predominant Issues

HEALTH CARE NEEDS

- High incidences of chronic diseases (69% of patients), mental health (43%) and substance use issues (64%).
- Trauma is prevalent in this population.



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Post-Release Challenges: Healthcare

- Medical records not provided.
- Medications and prescriptions often not given upon release.
- Inability to pay for prescriptions before Medicaid is active.
- Disconnect between treatment mandated during incarceration and assessment in the community.
- Challenges communicating with parole officers to provide appropriate care.

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Post-Release Challenges: Healthcare

- No guarantee that Medicaid application process was completed; no way to track progress towards determination.
- No standard, universal discharge planning practice.
  - Varies depending on state correctional facility.
  - Not all programs comprehensively address medical, MH and prescription needs.
- New York State prescription grant card only covers psych meds; results in avoidable ER visits.

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Post-Release Challenges: Housing

- Upon release many enter a homeless shelter or 3/4 housing (4-10 person rooms). Unsafe shelters and crowded congregate housing places people at risk to engage in violent behavior, risking recidivism.
- Supportive housing not available to all.
- Patients living in halfway houses or homeless shelters have no/limited access to telephones.
- With high upfront costs, securing an apartment (or room) is very challenging.

Post-Release Challenges: Navigating Systems and Institutions

- Obtaining documents requires official identification; cost can be prohibitive.
- Public transportation is hard to navigate.
- Process to apply for public assistance programs is lengthy and cumbersome.
- Taking medication as prescribed is difficult outside of structured environment.
  - Time management is a new skill after spending years in a controlled environment.
- Parole requires formerly incarcerated to get a job within two weeks of discharge.
  - Barriers: incarceration history, limited education and experience, and limited skills with technology.

Best Practices

INSIDE CORRECTIONAL FACILITY & UPON DISCHARGE:

- Apply for Medicaid before release.
- Make initial appointment with medical facility just prior to discharge.
- Provide formerly incarcerated with copies of medical records (regardless of ability to pay) and prescriptions.
- Offer guidance about questions to ask new providers and how to navigate medical care on the outside.
- Provide complete medical summary to facilitate transition to new medical provider.
- Offer tools and skills in time management (calendars etc.)

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Best Practices

IN HEALTH CENTERS:

- Establish a relationship inside and meet formerly incarcerated upon release → escort.
- Include formerly incarcerated re-entry counselors on staff.
- Address stigma of health providers and staff.
- Help formerly incarcerated develop short/long term goals.
- Establish unrestricted funds to help secure documentation.
- Provide case management and mental health support.
- Establish strong relationships with community providers for formerly incarcerated (housing, employment, legal).
- Build relationships with DOCCS staff at all levels to problem solve and address administrative challenges.

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Spencer Cox Center for Health Staff

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MORNINGSIDE | SAMUELS | WEST 17TH STREET