

# PROMISING PRACTICES IN HOME AND COMMUNITY-BASED SERVICES

## *Rhode Island – Case Management that Follows Offenders Out the Prison Gates*

### **Issue: Continuity of Care & Outreach for HIV-Positive Ex-Offenders**

#### Summary

The Miriam Hospital in Providence, Rhode Island, operates an intensive case management program for people with Human Immunodeficiency Virus (HIV) who are leaving prison. The 18-month program improves continuity of care following prison release by providing social services support and addressing barriers to medical care. Since February 1997, Project Bridge has served 135 men and women. The program received the Health Resources and Service Administration's Russell E. Brady Award in August 2002 "for creating an innovative program model that ensures continuum of care for HIV-positive inmates and drug detoxification clients."

#### Introduction

People with HIV who are in the prison system need medical care during their incarceration; many also benefit from a support system that encourages them to continue that care once they are released from prison. When Rhode Island legislators debated a law to require mandatory HIV testing for sentenced prisoners, physicians at the Brown School of Medicine argued it would be unethical to conduct testing without also providing care to HIV-positive inmates. The legislature agreed, and Rhode Island awarded Miriam Hospital a contract to provide care in the prisons.

The hospital made initial efforts to institute discharge planning for HIV-positive prisoners, but without follow-up case management many prisoners' good intentions prior to release gave way to missed appointments and lapses in treatment once they were on the outside. Miriam Hospital created Project Bridge to address this gap and help give HIV-positive ex-offenders an opportunity to succeed.

This report briefly describes *Project Bridge*, which provides services for HIV-positive ex-offenders ranging from rides to medical appointments to assistance addressing legal, housing, substance abuse, and other problems.

This document is based primarily on interviews with the Project Bridge staff who conceived and designed the program, Project Bridge program materials, and written evaluations of the project.

#### Intervention

Project Bridge is a voluntary program designed to give HIV-positive people coming out of prison, including probationers, support to continue their medical care. The program's participants are 75-percent male and 25-percent female, and most have few connections to the community. All have substance abuse problems (drugs and alcohol), which is common among prisoners with HIV, a majority of whom were infected through injection drug use. Only about 40 percent have any health insurance when they enroll.

**Project Bridge is a voluntary program to give former prisoners support to continue their medical care.**

A two-person team, consisting of an outreach worker and a social worker, approach potential participants approximately 60 days prior to release, and develop a treatment plan. Upon release, the social worker and outreach worker help ensure the participant makes it to his medical appointments by providing phone call reminders and transportation (via taxi in the first

few months) to medical appointments. In addition, the social worker meets the participant at medical appointments, which serves to help participants handle waiting room delays and facilitates communications between the participant and his or her doctor. Ex-offenders enrolled in *Project Bridge* see the same medical providers they saw in prison, improving their comfort level and contributing to their continuity of care.

Each participant's two-person team also helps the participant navigate the social service system, from assistance finding a suitable place to live to applying for SSI and other entitlement programs to enrolling in a substance abuse treatment facility. Outreach workers will also attend 12-step programs with their participants, encouraging them to find sponsors and to get involved in the social aspects of their treatment programs. Outreach workers are

**The two-person team also helps participants navigate the social service system.**

also responsible for tracking down participants whose whereabouts are unknown, which may literally involve searching around town for them. During focus groups, most recently in December 2002, participants routinely stressed that they like the fact that Project Bridge staff will come look for them, saying few other people in their lives care enough about them to be concerned for their welfare.

Because *Project Bridge* is an 18-month program, one year after a person starts the program, staff evaluate whether the participant will be able to function on his or her own after leaving the program. According to program staff, about forty percent of the program's participants are transitioned out of the program, although Miriam Hospital staff at the clinic are available to help them if needed. Approximately one half of the program's participants are transitioned to other, more standard, HIV/AIDS case management programs funded by the U.S. Health Resources and Services Administration through Title II or Title IV of the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. The final 10 percent consist of people who will need intensive support due to physical, psychological, or

substance abuse problems; they are transitioned to specialized case management programs at community mental health centers.

*Project Bridge* has adopted a philosophy of harm reduction, and recovery is not a condition of treatment. If participants are active substance abusers, program staff may encourage them to use in ways that are safer (such as clean needles or methadone treatment), and may ask them to look at the role substance abuse played if they get into new trouble. Program participants generally fall into one of three categories: people who want recovery and a more stable lifestyle; people who are tired of the consequences of substance abuse but have not committed to recovery; and people with chronic disabilities who likely will need specialized case management services.

### Implementation

The U.S. Health Resources and Services Administration (HRSA) provided start-up funding for Project Bridge under the Ryan White CARE Act's Special Projects of National Significance, which funds research on innovative projects serving people with HIV. HRSA awarded the grant on October 1, 1996. Five months later, the program was up and running. Today, the program receives funding from a second SPNS research grant. Ongoing funding for the program is provided under Title II of the Ryan White Care Act, which provides monies to state health agencies that are then disbursed for case management programs.

A collaborative working relationship with the Rhode Island correctional system has contributed to the program's success, according to an October 2001 evaluation by the Health & Disability Working Group at Boston University's School of Public Health. These connections have facilitated entry into the prisons, and made it easier for project staff to visit prisoners in the prison HIV clinics and in their own cellblocks. Having a good working relationship means that the prison staff, including correctional officers, see them as trustworthy, savvy, and reliable. As a result, corrections staff allow Project Bridge

staff access to meet with their HIV-positive clients.

Project staff have created a manual, "Building a Program for Jack," that offers step-by-step guidance for those who may wish to create

**Project staff created a manual that offers guidance for creating similar programs.**

similar outreach and case management programs for ex-offenders in their communities. They have also written a

pamphlet, "This is the Man that Jack Built," which takes the reader through the case management process from a participant perspective.

### Impact

According to the Boston University evaluation, over 83 percent of participants visited a health care provider at least once every six months while enrolled in the program. Project staff said this figure is probably an underestimate because information is not available for some participants. The evaluators wrote that Project Bridge has "demonstrated many strengths with their approach to the provision of both social services and medical care. They have been successful in engaging a very challenging

population into care through a number of different activities." Project Bridge's supports cost \$175,000 each year. The average cost per person for the entire 18-month program is \$5,000 for participants without serious mental illness and \$8,000 for people with serious mental illness.

The Boston University evaluation also found that the program contributed to participants' "overall quality of life," providing stability to people by tackling both their medical and social service needs. This is consistent with what current and former participants tell project staff. During a December 2002 focus group, for example, participants stressed that project staff were trustworthy and reliable, and that they had come to rely on and appreciate their services. More specifically, participants expressed gratitude that their social workers accompanied them to medical appointments.

### Contact Information

For more information about Project Bridge, please contact Leah Holmes, Director, at (401) 455-6879 or [lholmes@lifespan.org](mailto:lholmes@lifespan.org).

### Discussion Question:

**How can this model be adapted to people with other chronic conditions leaving prisons?**

This report was written by Daria Steigman of Steigman Communications. It is one of a series of reports by The MEDSTAT Group for the U.S. Centers for Medicare & Medicaid Services (CMS) highlighting promising practices in home and community-based services. The entire series is available online at CMS' web site, <http://www.cms.hhs.gov>. This report is intended to share information about different approaches to offering home and community-based services. This report is not an endorsement of any practice.