Tarrant County Discharge Planning Project for the HIV Positive Incarcerated Inmate

Submitted May 2, 2005 to the Ryan White Care Act
By
The Tarrant County Public Health Department

Funds Requested: $44,000

Total Project Cost:
Funding Period: March 1, 2006—February 28, 2007

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Condition

HIV is a virus that causes AIDS, a disease that destroys a body’s ability to fight off infection (CDC, 2005). HIV/AIDS is a significant public health threat that is especially prominent within the correctional system, ranging from the prison system to the local county jails. It is estimated, on any given day, there are 70 incarcerated individuals infected with HIV in county jails in the Fort Worth HSDA. Of this, it is estimated that 53 individuals infected with HIV are in the Tarrant County Correctional Facilities. These results indicate that the Tarrant County Correctional Facilities house approximately 75% of these HIV positive inmates (Fort Worth HSDA Epidemiological Report, 2002). Due to a lack of systematic planning, formal linkage, and coordination between departments of corrections, social service agencies, public health, and communities at the time of release, many HIV positive inmates do not obtain the needed healthcare and support services when discharged into the community. It is critical that HIV positive inmates successfully transition back into society and maintain the stable health status they had attained during incarceration. The first few months following discharge are the most crucial in determining whether an individual will remain in the community or be re-incarcerated. This decision is largely dependent on what services and support systems are available to the inmate (Closing the Gap: Continuity of HIV Care in the Correctional Setting, 2003).

Estimated Daily Average of County Inmates in the Fort Worth HSDA Infected with HIV

<table>
<thead>
<tr>
<th>County</th>
<th>Number of Individuals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tarrant</td>
<td>53 individuals</td>
</tr>
<tr>
<td>Parker</td>
<td>3 individuals</td>
</tr>
<tr>
<td>Johnson</td>
<td>6 individuals</td>
</tr>
<tr>
<td>Hood</td>
<td>6 individuals</td>
</tr>
<tr>
<td>Erath</td>
<td>1 individual</td>
</tr>
<tr>
<td>Palo Pinto</td>
<td>2 individuals</td>
</tr>
<tr>
<td>Wise</td>
<td>2 individuals</td>
</tr>
<tr>
<td>Fort Worth HSDA</td>
<td>70 individuals (on any given day)</td>
</tr>
</tbody>
</table>

(Fort Worth HSDA Epidemiological Report, 2002). Great data.

Former inmates who are HIV positive return to the community with a number of complex health and social issues. When inmates are released from the Tarrant County jail, they are not released with any antiretroviral medications. The inmate finds that he or she must schedule a doctor's appointment and this may take several weeks before they are seen for intake, not including the doctor’s visit. Without HIV medications, an individual’s health is seriously impacted. Lack of medication adherence can result in the development of resistant strains of HIV. In addition to the lack of medical care an inmate is faced with upon release, they are often times discharged back into the community unemployed, uninsured, homeless, lacking transportation, and needing services for both substance abuse and mental illness. Good info.

Many of these needs can be avoided by effective collaboration between the correctional facility, public health, and the community. A successful intervention for continuity of care is discharge planning. Discharge planning is the process of preparing an inmate for the transition from a correctional facility to the community. Providing information about medical and social services available and how to access them once released, better prepares the newly released inmate. Since it takes time to get an appointment with an HIV doctor and get approved for medication programs, planning before release is crucial. Discharge planning is one of the single most effective interventions for facilitating positive client outcomes for the newly released HIV positive inmate (Corrections Medical Care Provider’s Discharge Planning Resource Manual, no date). Within the past few years, discharge planning programs throughout the United States have increased. One Model program that incorporated a discharge planning...
program was the CDC/HRSA Corrections Demonstration Project. This study was conducted in 1999 and was targeted toward areas with high HIV prevalence rates. The project invited applications from state and local health departments that have a working relationship with correctional facilities to be demonstration sites. This correction and community based organization (CBO) linkage allowed case managers access to inmates for the needs assessment and discharge planning development. **What was the outcome of this study? It seems like a key piece of information for your proposal, e.g., the link between services and need reduction.**

The case manager provides the linkage into the community for the inmates. Case managers can help them keep appointments and assist them with emerging needs. Once these inmates return to the community, the case manager can help them remain on their medications and gain access to the services needed to help reduce the impact of their illness on the community. Although discharge planning is dictated by local regulations and funding sources, there is the common goal of providing continuity of care to HIV positive inmates released back into the community.

**Target of intervention**

The Tarrant County Public Health Department-Preventive Medicine Clinic (PMC) staff noted that it had many newly released HIV positive inmates walking into the clinic for medical care [source]. These former inmates did not receive immediate medical care that they expected because they were poorly informed and ill-prepared about the registration/intake process. For example, the verification required by the PMC includes picture ID, Social Security card, proof of income/no income, proof of residency and confirmation of HIV diagnosis. Many inmates did not have this information or were not informed that the information was needed.

These former inmates reside primarily in Tarrant County with less than 3% reside in outlining rural areas. The targets are both men and woman over 18 years of age. The newly released inmates have no income and typically live with various friends or family until more permanent housing is found. Since August of 2002, 133 inmates have received discharge planning in the Tarrant County Correctional Facility. Of those, 100 were men and 33 women. Of the men seen, 57% were African American, 37% Caucasian and 5% Hispanic. Of the 33 women seen, 42% African American, 45% were Caucasian, and 9% Hispanic.

Figure 1 presents a graph of the men and women who received discharge planning.

**Figure 1: Breakdown of Men and Women who Received Discharge Planning in 2002**
Stakeholders

The preparation for discharge planning involves many stakeholders. In regards to continuity of medical care, the only two clinics able to serve uninsured, indigent HIV positive patients in the Tarrant County area are:

- Tarrant County Public Health Department-Preventive Medicine Clinic
- John Peter Smith Hospital’s Healing Wings Clinic

Other important stakeholders consist of social service agencies as well as the community.

- AIDS Outreach Center in Fort Worth is the largest social service agency that provides services to individuals and families infected or affected by HIV. Services include housing, financial assistance, transportation, nutrition center, legal assistance, case management, counseling and support groups.
- Catholic Charities Pediatric AIDS Project is a social service agency in Fort Worth that provides case management services to women and children who are HIV positive.
- Tarrant County AIDS Interfaith provides the only dental clinic in this area for uninsured HIV positive clients.
- Tarrant Council on Alcoholism and Drug Abuse provides substance abuse case management and treatment services to HIV positive clients.
- Tarrant County Samaritan House is a residential housing program for HIV positive adults who house medical case managers, a social worker and LCDC.
- Family members of the HIV incarcerated inmate are involved with their health and well being. When an inmate is discharged, they usually stay with family members until other housing is found. However, many stay with their families, e.g., wife and kids. It seems that you assume throughout this program design that most inmates are not married with families. However, no documentation is presented about this. If most are married with families, then the family needs to be part of the treatment system in order to not become infected. I think you might be leaving out a key stakeholder here.
- Churches are important for providing ongoing spiritual, emotional and physical support to the family members and the former inmate. Many churches are used as sites for workers to educate the congregation about the devastating impacts that HIV has on families and communities.

History

In August of 2002, The Tarrant County Public Health Department-Preventive Medicine Clinic (PMC) in collaboration with AIDS Outreach Center in Fort Worth and the Tarrant County Correctional Facility implemented a discharge planning program. A social worker from the PMC and a social worker from the AIDS Outreach Center are cleared through the Tarrant County Correctional Facility to meet with inmates and conduct discharge planning each week. The PMC Social Worker is responsible for tracking the number of inmates seen to date. Since the implementation of this program, 133 inmates have received discharge planning. In the first month after release, 40% of inmates have accessed health care and social services. These results demonstrate how a discharge planning program can positively impact an inmate’s
health after being released from jail. Good. However, I am unclear how this program is different from the one you propose. Why not expand this one rather than start a new one?

### Existing service delivery system

<table>
<thead>
<tr>
<th>Program</th>
<th>Provider</th>
<th>Service Provided</th>
<th>Number of Clients Served</th>
<th>Gaps in Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV Medical Provision</td>
<td>Tarrant County Public Health</td>
<td>Primary medical care, social and medical case management</td>
<td>600 per year?</td>
<td>2 month waiting list, limited bilingual staff</td>
</tr>
<tr>
<td></td>
<td>Department-Preventive Medicine Clinic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV Medical Provision</td>
<td>John Peter Smith Hospital Healing Wings Clinic</td>
<td>Primary medical care</td>
<td>500</td>
<td>No case management, possible waiting list</td>
</tr>
<tr>
<td>Social Service</td>
<td>AIDS Outreach Center</td>
<td>Food pantry, social case management, legal, emergency financial assistance,</td>
<td>1000</td>
<td>Limited funds for financial assistance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>counseling, outreach</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transportation</td>
<td>AIDS Outreach Center</td>
<td>Daily bus passes, van transportation</td>
<td>300</td>
<td>Decrease from monthly bus pass to day pass</td>
</tr>
<tr>
<td>Housing</td>
<td>AIDS Outreach Center</td>
<td>HOPWA and Shelter Plus Care Housing</td>
<td>400</td>
<td>Waiting lists, undocumented ineligible for SPC</td>
</tr>
<tr>
<td>Housing</td>
<td>Tarrant County Samaritan House</td>
<td>Residential housing for HIV positive adults</td>
<td>45</td>
<td>Undocumented ineligible Closed to new applicants,</td>
</tr>
<tr>
<td></td>
<td>Fort Worth Housing Authority</td>
<td>Section 8 housing</td>
<td>5000</td>
<td>undocumented ineligible</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>Tarrant Council on Alcoholism and Drug Abuse</td>
<td>Case management, treatment referrals</td>
<td>45</td>
<td>No bilingual case managers</td>
</tr>
<tr>
<td>Pediatric AIDS Program</td>
<td>Catholic Charities</td>
<td>Case management to HIV positive women and children, transportation</td>
<td>250</td>
<td>No obvious gaps</td>
</tr>
<tr>
<td>Dental Program</td>
<td>Tarrant County AIDS Interfaith Network</td>
<td>Dental services</td>
<td>500</td>
<td>First come first serve basis, limited with bilingual</td>
</tr>
<tr>
<td>Mental Health</td>
<td>MHMR</td>
<td>Psychiatric medications</td>
<td>3000</td>
<td>available</td>
</tr>
</tbody>
</table>
Very good

Capacities/Needs/Barriers

Capacities
In Fort Worth, there are several AIDS Service Organizations (ASO's) that work closely together and collaborate with each other for continuity of care. These organizations typically share clients with each other. For example, a client may receive medical care with the Preventive Medicine Clinic. That same individual may live at Tarrant County Samaritan House, receive transportation and counseling through AIDS Outreach Center, and be in case management with Tarrant Council on Alcoholism and Drug Abuse. Having a strong network of ASO's working together with the client strengthens this system.

In addition, the North Central Texas Planning Council is a 36 member body of volunteer citizens appointed by the Tarrant County Judge to represent a cross-section of the community. The planning council consists of service provider representatives, government officials, civic leaders, and concerned citizens. The mission of the Planning Council is "to provide an effective planning process that involves people living with HIV/AIDS and other concerned citizens, resulting in quality HIV/AIDS services that are available for, and accessed by, those in need" (Fort Worth EMA/HSDA Needs Assessment Report, 2004, p.7). I would add this to your list of services above.

Needs

<table>
<thead>
<tr>
<th>Needs in Priority Order (first being greatest need)</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharged inmates with HIV/AIDS need to maintain the stable health they had attained during incarceration</td>
<td>From 2002-2003, the Tarrant County Public Health Department-Preventive Medicine Clinic (PMC) was not accepting any new patients. Currently the PMC has a 2 month waiting list.</td>
</tr>
<tr>
<td>Increase continuity of care to HIV positive inmates released back into the community</td>
<td>During discharge planning, many inmates report knowledge about one to two social service agencies that could provide them with services but are unfamiliar with the other resources available. Some report that they may be familiar with the services but are unsure how to access them.</td>
</tr>
<tr>
<td>Assist inmates with necessary documentation needed for intake at ASO's</td>
<td>95% of inmates (who are not in care) are not familiar with agency intake procedures and necessary documentation required.</td>
</tr>
</tbody>
</table>

Good.

Barriers

- Many service providers are limited with their bilingual staff
- Most of the HIV positive inmates are uninsured
- Inadequate public transportation prevents HIV positive inmates from obtaining needed health and social services.
- Many HIV positive inmates who are released do not have stable housing. They live with various friends or family and some stay at the local night shelters.
The former inmates who are homeless and unemployed find it difficult to provide necessary documentation (proof of income/no income and proof of residency) for intakes at ASO’s.

**You provide a good base on which to build a program.**

**Vision**

The Tarrant County Public Health Department’s vision is safer, healthier communities. We envision that HIV positive inmates will be able to successfully transition back into society upon release while protecting themselves, their loved ones, and society from the negative impact of HIV/AIDS. We envision a human service delivery system that promotes availability and accessibility of a full range of medical and social services to HIV positive inmates when released back into the community. **Good. I think the vision needs the additional statement above.**

**Mission**

The mission statement for the Tarrant County Public Health Department-Preventive Medicine Clinic is to improve the quality of life for HIV infected individuals and to protect the infected individual’s family and community. This is done by providing education, counseling, wellness information, early medical intervention and primary care to maintain a high degree of physical, mental, and social well being to the patients, family, and community. Success depends on providing quality public health services to the HIV+ community, coordination with other health care and community social service agencies, and effective use of resources. The mission statement for the discharge planning program is to increase continuity of care to HIV positive inmates released back into the community. This is done by developing strong collaborative partnerships with corrections, public health and ASO’s. **Good.**

**Program Description**

Within the past few years, discharge planning programs for the HIV+ incarcerated client have increased. The Tarrant County Discharge Planning Project is based on a model program that was implemented in 1999 and funded by CDC and HRSA, known as the CDC/HRSA Corrections Demonstration Project. Six states and one county were funded to be demonstration sites, all of which included a jail-based program (Potter, 2003). **What were the results of the demonstration projects in terms of the needs you cite?**

The timeline below illustrates CDC/HRSA’s Demonstration Project of a discharge planning program. Tarrant County’s Discharge Planning Project that will be implemented mimics the model program closely.

<table>
<thead>
<tr>
<th>4 month</th>
<th>3 month</th>
<th>2 month</th>
<th>1 month</th>
<th>Release</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Review inmate’s current medical regimen and start on KOP (meds Keep on Person)</td>
<td>• Perform comprehensive needs assessment</td>
<td>• Discuss the inmate’s needs and what steps will be</td>
<td>• Reviews steps taken and situation post-release</td>
<td>• Inmate provided with a community resource directory and</td>
</tr>
<tr>
<td>Tasks</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------------------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Meet with inmate to discuss circumstances of release</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Assess KOP adherence</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>taken</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Assess inmate’s educational level and ability to work</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Complete all forms for medication and financial aid</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>medical info</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Inmates are accompanied to appointments</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Follow-up for next 4-6 months</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Stakeholders involved in this project are not only the clients, but the Tarrant County Public Health Department, The Tarrant County Correctional Facility, ASO's, as well as the client’s family, churches and the community. The development of a discharge planning program is aimed to demonstrate that corrections and public health departments can collaborate with each other and effectively reduce the adverse health impacts on the inmates but also on communities disproportionately affected by disease and crime (Potter, 2003). The public has a large investment in the health care services provided to individuals who pass through the correctional system. With strong collaboration between the corrections and public health, communities can be made healthier and safer to live in.

The partners involved with the implementation of the program are the Tarrant County Public Health Department – Preventive Medicine, Tarrant County Correctional Facilities and AIDS Outreach Center. Each of these partners has developed a clear understanding of their roles and responsibilities. This was accomplished through memorandum of understandings and interpersonal communications with the partners. If the Tarrant County Discharge Planning Project grant is funded, trainings with each agency’s staff will be conducted to meet requirements of working in the custodial setting. Both the AIDS Outreach Center and the Tarrant County Public Health Department will provide a social worker to go into the Tarrant County Correctional facility and meet with HIV+ inmates who plan to be released from jail within 6 months. Due to limited space in the correctional facility, the social workers will provide discharge planning every Wednesday afternoon from 1:00 - 5:00 on the medical floor. The social workers will alternate each Wednesday and the TCPHD-PMC social worker will be responsible for tracking the total number of inmates seen to date. If for any reason one of the social workers is unable to go on their assigned day, it is their responsibility to contact the other person prior to their designated time for back up. This will ensure coverage each week.

There are 6 different jails in the Tarrant County Correctional Facility. At this time, clearance has only been given to the New Jail facility located at 110 N. Lamar in Fort Worth, Texas. The target population will be HIV+ inmates both men and women 18 years of age and older who plan to be released from jail within 6 months. For Fiscal Year 2005, discharge planning will be provided to 75 temporarily incarcerated HIV+ persons.

Discharge planning with the HIV+ inmate includes conducting an in-depth psychosocial assessment that identifies needs, sets, and prioritizes goals. The psychosocial assessment is broken down into components such as medical care, housing, transportation, finances, support system, etc. Based upon identified needs, goals are then set. The social worker also educates the inmate about services available in the community and more importantly how to access them. The social worker meets with the inmate several times prior to release to discuss steps taken and to
coordinate appointments for the inmate when released. A discharge planning packet is also put together for the inmate that is tailored to the identified needs and goals. This usually includes a resource guide, telephone numbers, contact names to both social and medical services, and step by step instructions on how to get established with agencies. The discharge planning packet is left in the inmate's personal property so that it is readily available upon release.

The Tarrant County Discharge Planning Project resembles the model program in that the social worker conducts a comprehensive needs assessment with the inmate. Identified needs and steps taken to address needs are then discussed. The social worker also meets with the inmate several times prior to release to discuss action steps. The social worker also coordinates appointments for the inmate to access services upon release. These steps mimic the model program.

Very good.

Preventive Medicine Clinic Organizational Chart
The Preventive Medicine Clinic Organizational Chart

The Tarrant County Public Health Department has many divisions. The physician and nurse practitioner work inside the Preventive Medicine clinic but are supervised by the Medical Director. This may help explain the unconnected ness to the rest of the Preventive Medicine Clinic staff. The Tarrant County Discharge Planning Program will be supervised by the PMC supervisor. However, this program is not part of the clinic and will be separate. Nice charts, but
I am very confused by the 3 charts. It would be nice to use color coding or something and to better describe the existing system.

Goals and Objectives

Grant Program Area: Continuity of Care

Goal 1: To ensure that HIV + inmates have continuity of care when released back into the community.
Outcome Objective 1:1: To increase the knowledge of community resources in 65 HIV + inmates receiving discharge planning at the Tarrant County jail by 40% by 12-1-2006, as measured by social worker reports.
Process Objective 1:1: Provide education on community resources with 100% of HIV+ inmates who are receiving discharge planning in the Tarrant County jail by 12-1-2006, as measured by social worker reports.

<table>
<thead>
<tr>
<th>Tasks for Process Objective 1:1</th>
<th>Responsibility</th>
<th>Measure</th>
<th>Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Based upon needs identified in needs assessment, inmates will be educated on services</td>
<td>Both PMC and AOC Social worker</td>
<td>Pre and Post tests</td>
<td>12-1-2006</td>
</tr>
</tbody>
</table>

Outcome Objective 1:2: Corrections and public health departments will collaborate with each other to reduce the adverse health impacts on inmates and on communities disproportionately affected by HIV by 30%, as measured by social worker reports and ARIES Database.
Process Objective 1:2: 40% of HIV+ inmates released from Tarrant County jail that received discharge planning will access medical care and social services within the first 3 months of release, as measured by ARIES Database.

<table>
<thead>
<tr>
<th>Tasks for Process Objective 1:2</th>
<th>Responsibility</th>
<th>Measure</th>
<th>Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coordination of medical and social service appts. prior to discharge</td>
<td>PMC and AOC Social Worker</td>
<td>Chart audits, Follow up, ARIES Database</td>
<td>12-1-2006</td>
</tr>
</tbody>
</table>

Evaluation and Impact

Process Evaluation
Process Objective 1: To provide education on community resources with 100% of HIV+ inmates who are receiving discharge planning in the Tarrant County jail by 12-1-2006, as measured by pre and posttest. The research design used is the one-group pretest-posttest design. During the initial assessment, the social worker will give the inmate a pretest that measures their knowledge of community resources. After taking the pretest, the inmate will be educated on community resources available to them once released from jail. This will be followed by a posttest to see if the inmate's knowledge of services increased this is outcome. For process, all you do is measure if the training was provided as prescribed after the education was given. The PMC social worker is responsible for compiling results of pre and posttest scores. Scores are tabulated and given to PMC supervisor for monitoring purposes.

Process Objective 2: 40% of HIV+ inmates released from Tarrant County jail that received discharge planning will access medical care and social services within the first 3 months of release, as measured by chart audits and ARIES Database. Chart audits will be done monthly by the PMC supervisor on the social worker’s documentation to ensure that follow-up is being done. ARIES Database can be accessed to track client’s involvement with ASO’s.

Outcome Evaluation

Outcome Objective 1: To increase the knowledge of community resources in 65 HIV+ inmates receiving discharge planning in the Tarrant County jail by 40% by 12-1-2006, as measured by pretest and posttest scores. Tracking the inmate's knowledge of services will be done by compiling the scores of the pre and post tests given to them during discharge planning. The PMC social worker is responsible for compiling scores from the pre and posttest. Scores are tabulated and given to the PMC supervisor for monitoring purposes.

Outcome Objective 2: Corrections and public health departments will collaborate with each other to reduce the adverse health impacts on inmates and on communities disproportionately affected by HIV by 30%, as measured by social worker reports and ARIES Database. ARIES is a statewide HIV social service database that is able to track client’s involvement with ASO’s. It is a computer network and information system to collect client data. Service delivery reports will be generated from ARIES to see who has accessed services after release from Tarrant County jail. ARIES has the ability to provide immediate data about clients, services, and outcomes. The PMC supervisor is responsible for generating necessary reports. If measures in outcome and process objectives are not being met, the PMC supervisor will hold a meeting and address issues with the PMC social worker, AOC supervisor and AOC social worker to remedy situation. Weekly evaluations will be done by PMC supervisor until objectives are met. Evaluations will consist of communication and feedback with the social workers and/or chart audits.

Impact Evaluation
The development of the discharge planning program is aimed not only to reduce the adverse health impacts on the HIV+ inmate but also on communities disproportionately affected by disease and crime. This discharge planning’s goal is to:

1) Standardizing health and social services for the HIV+ inmate
2) Reducing recidivism
3) Reducing crime
4) Reducing public health risk of infection
5) Involving the community
6) Benefiting the economy (fewer hospitalizations saving $300,000 a year)

Great information, what is the source. This should have been presented earlier since it is powerful information. These 6 impacts seem to go way beyond the goals and objectives. It seems that since they are the goals of discharge planning (process) they should have been in the outcomes objectives somewhere.

Data collection, management and analysis

The PMC social worker is responsible for compiling results of pre and posttest scores. Scores are tabulated and given to PMC supervisor for monitoring purposes. To monitor all process objectives, case conferences and chart audits will be performed to ensure program is implemented as designed. Service delivery and quality of care are assessed through case conferences. Case conferences are held monthly to present cases and include PMC supervisor, PMC social worker, AOC supervisor and AOC social worker. Chart audits are done monthly by the PMC supervisor on the social worker's documentation and area for improvement noted and change implemented. The PMC supervisor is responsible for generating data through the ARIES database. Data collection through the ARIES Database can track clients who are accessing services. Service delivery reports will be generated from ARIES to see who has accessed services after release from Tarrant County jail. ARIES has the ability to provide immediate data about clients, services, and outcomes. The PMC supervisor is responsible for monitoring to ensure that the goals and objectives are being met.

Some of this should have been in the evaluation section above. It seems like you will need an internal information system to record who is seen, when, progress, etc. Having manual records...

Budget and Budget Justification

Anticipated Revenues

<table>
<thead>
<tr>
<th>Source of Revenue</th>
<th>Amount Targeted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amount Requested</td>
<td>44000</td>
</tr>
<tr>
<td>Total Revenue towards project</td>
<td>44000</td>
</tr>
</tbody>
</table>

Expenditures
Beginning Date: 3/1/2006
Ending Date: 2/28/2007

<table>
<thead>
<tr>
<th>Items</th>
<th>Units</th>
<th>Donated</th>
<th>Requested</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personnel &amp; number of months (including donated time e.g., volunteers)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paula McNeely, LSW</td>
<td>12</td>
<td>0</td>
<td>37720</td>
</tr>
<tr>
<td>Benefits (Fringe as a % of salary &amp; other)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paula McNeely, LSW</td>
<td>17%</td>
<td>0</td>
<td>3580</td>
</tr>
</tbody>
</table>

Travel (local, in-state-out of state and how calculated)

0 Do you not reimburse travel? 0 0

Equipment

Computer @ 1

1 0 2000

Supplies

Office supplies

1 0 200

Others

Education for HIV updates, conferences

1 0 500

Totals

0 44000

Total project cost

44000

Budget Justification

The requested amount is $44,000 for FY 2006-2007 for the implementation of the Tarrant County Discharge Planning Project with HIV+ inmates who are soon to be released from the Tarrant County Correctional facilities. A need for this type of service was indicated when the Preventive Medicine Clinic staff noted an influx of ex-offenders walking into the clinic in an attempt to receive services this should be in the needs section. Often these HIV+ persons were frustrated in their efforts to obtain services because they often lacked the knowledge and were poorly informed about how to access medical and social services. An additional case manager to the PMC clinic is needed in order to offer this service.

Personnel: An additional social worker to the PMC clinic is needed in order to provide this type of service. The additional social worker is needed because the current social worker at the PMC clinic cannot take on this extra caseload. The salary requested is comparable to entry level social workers hired by Tarrant County.

Employee fringe benefits reflect the benefits currently received by employees of the contract agencies.
Travel: There are no expected travel expenses. How do you travel to the jails?

Equipment: The computer will be a one-time expense. The use of a computer is needed to effectively provide services and is also needed in order to access the new ARIES database.

Office Supplies: Office supplies will consist of copy and computer paper, printer cartridges, etc. Tarrant County has made contractual arrangements as a governmental entity to receive lower rates on supplies. As a result, these costs are minimal.

Other: Personnel will use existing office and work space. Other costs include educational expenses for attending HIV Conferences.

Future Funding

Many Texas agencies and funders have recognized that discharge planning is one of the single most effective interventions for facilitating positive client outcomes for the newly released HIV positive inmate source*. Potential future funders include the Ryan White Care Act, Department of State Health Services, and Tarrant County funding. These funders will be asked to help support the discharge planning program in the future. The Preventive Medicine Clinic supervisor will be responsible for developing and implementing the contractual agreements with future funders. As stated earlier, a discharge planning model can have important effects on a community. The Tarrant County Discharge Planning Program aims to standardize health and social services for the HIV+ inmate, reduce recidivism, reduce crime, reduce public health risk of infection, and benefit the economy. I like this list, but the link between your services and this list needs additional work.

Good section.

Applicant qualifications

The Tarrant County Discharge Planning Project represents the culmination of public health officials, agencies, and correctional officials united to address the needs and help develop solutions for the newly released HIV+ inmate. The Tarrant County Public Health Department – Preventive Medicine Clinic envisioned a discharge planning program that would provide continuity of care to HIV+ inmates who were released into the community. The Tarrant County Public Health Department has proven to be a valuable local resource by providing services to all Tarrant County residents aimed at promoting, achieving, and maintaining a healthy standard of living. With effective collaboration from all stakeholders, the Preventive Medicine Clinic is well qualified to carry out and succeed with the Tarrant County Discharge Planning Project.

The primary person responsible for this project will be the Preventive Medicine Clinic Supervisor, see Appendix A, Job description. If the grant application is funded, Paula McNeely, LSW has agreed to provide the discharge planning in the Tarrant County jail. As her resume (Appendix B) indicates, Paula has extensive experience working with the HIV+ population. Paula is currently a social worker with the Tarrant County Public Health Department -
Preventive Medicine Clinic. She provides medical case management to HIV+ patients in the clinic. Paula has worked with HIV+ clients for the past seven years and has a strong knowledge of resources available to clients in the community. In addition to her experience as a medical case manager, she has also worked as a social case manager at AIDS Outreach Center, which is the largest social service agency in Fort Worth that provides services to HIV+ clients and their family members. Paula has the expertise in linking inmates with the medical and social services needed upon their release back into the community. Paula has been instrumental in pulling the stakeholders together for this grant and her current employer welcomes her taking on this new position if the grant is funded. Excellent section.

Dissemination & Marketing Strategies

Discharge planning with the HIV+ inmate will only be successful if utilized. To promote use, the Tarrant County Discharge Planning Project will do the following: 1) Involve pharmaceutical reps. Drug reps can provide literature, host presentations and lunches to educate health care providers. This is also a means to network. The use of drug reps is very useful in the jail setting to bring all medical staff together to inform of the new discharge planning program. It allows staff to meet the social workers and get contact information if they have questions regarding an inmate. 2) Involve case managers at ASO’s to spread information about the discharge planning program for their clients. 3) Function as a clearinghouse for general information regarding correctional facilities and the processes that an inmate goes through. 4) Provide public awareness at designated sites for health department outreach, ex churches, drug treatment centers, homeless shelters, etc. Former inmates would be requested to attend any luncheons, educational meetings, and outreach efforts to obtain information on the benefits of the program from an inmate’s perspective. The budget contains in-state travel expenses. Portions of the travel will be used to present project results at the HIV/STD Convention held every other year in Austin, Texas. You must sleep in your car as you only budgeted $500 for these trips. I think you are way under budgeted.

Conclusion

HIV/AIDS is a significant public health threat that is especially prominent within the correctional system. Due to a lack of systematic planning and coordination between departments of corrections, social service agencies, public health, and communities at the time of release, many HIV positive inmates do not obtain the needed healthcare and support services when discharged into the community. It is critical that HIV positive inmates successfully transition back into society and maintain the stable health status that they had attained during incarceration. The development of Tarrant County’s Discharge Planning Project is aimed to demonstrate that corrections and public health departments can collaborate with each other and effectively reduce the adverse health impacts on the inmates but also on communities disproportionately affected by disease and crime. The public has a large investment in the health care services provided to individuals who pass through the correctional system. With strong collaboration between the corrections and public health, communities can be made healthier and safer to live in. Very good.
Appendices

Appendix A:

Job Title: Preventive Medicine Clinic Supervisor. Job Purpose: Oversee the operations of the Health Department's HIV Preventive Medicine Clinic (PMC). Supervise technically skilled public health employees and the required available resources in achieving short/long-term goals and objectives of the departmental work group.

Essential Duties and Responsibilities:

1. Coordinate all PMC operations to ensure quality care of HIV+ individuals

2. Perform professional/managerial level administrative tasks to plan and achieve departmental short-term goals and objectives; troubleshoots routine and special situations and follows through to resolution.

3. Select, hire, and train or ensure training of PMC work group for staff development

4. Evaluate job/personal performance of staff; make decisions or recommendations regarding hiring, promotion, compensation actions, disciplinary actions, demotions and terminations.

5. Reviews ongoing tasks/projects of staff at appropriate frequency level of review; provides guidance and support to employees in the performance of their duties.

6. May review, recommend and/or implement policy and procedure changes to department/work group to improve efficiency. Allocate resources to most effectively and efficiently meet client needs. Establish and maintain clinical and support service referral networks.

7. Documents and maintains required records and statistics as it pertains to departmental/work group operations.

8. Ensures compliance with any or all applicable laws, civil service rules, statutes, and regulations.

9. Prepare grant applications, periodic management, federal and state reports and budgets.

10. Monitor, track and/or control budgeted departmental expenditures.

11. Perform direct client assessments and clinical support activities as necessary.

12. Coordinate participation in research studies.

13. May assume duties of departmental manager as directed and perform other related duties as assigned.
Appendix A continued
Qualifications: BSN degree in Nursing. Minimum of 3 years supervisory experience with one year HIV/AIDS or communicable disease experience. Clinic management experience preferred. 1-4 years of related experience depending upon educational attainment. Master's Degree in nursing science, health care administration, public administration, business administration, or related area may substitute for two years of experience and is preferred. Knowledge of fundamental concepts, practices and procedures of field of public health specialty.

Benefits?:

Appendix B (deleted resume)
References


Corrections Medical Care Provider’s Discharge Planning Resource Manual. (No date).


