

<b>Early Intervention Services - Incarcerated</b>	<b>Pg</b>
<b>Service Category Definition – DSHS State Services</b>	<b>1</b>
<b>The ACA Opens the Door for two Vulnerable Populations - Health Affairs, March 2014</b>	<b>3</b>
<b>HIV-Infected Women Experience Worse Treatment Outcomes after Release from Jail - YaleNews, January 2014</b>	<b>4</b>

Local Service Category:	<b>Early Intervention Services – Incarcerated</b>
Amount Available:	<b>To be determined</b>
Unit Cost	
Budget Requirements or Restrictions ( <b>TRG Only</b> ):	Maximum 10% of budget for Administrative Cost. No direct medical costs may be billed to this grant.
Local Service Category Definition:	This service includes the connection of incarcerated in the Harris County Jail into medical care, the coordination of their medical care while incarcerated, and the transition of their care from Harris County Jail to the community. Services must include: assessment of the client, provision of client education regarding disease and treatment, education and skills building to increase client’s health literacy, establishment of THMP/ADAP post-release eligibility (as applicable), care coordination with medical resources within the jail, care coordination with service providers outside the jail, and discharge planning.
Target Population (age, gender, geographic, race, ethnicity, etc.):	Services are for all HIV/AIDS infected individuals incarcerated in The Harris County Jail.
Services to be Provided:	Services include but are not limited to CPCDMS registration/update, assessment, provision of client education, coordination of medical care services provided while incarcerated, medication regimen transition, multidisciplinary team review, discharge planning, and referral to community resources.
Service Unit Definition(s) ( <b>TRG Only</b> ):	One unit of service is defined as 15 minutes of direct client services or coordination of care on behalf of client.
Financial Eligibility:	Due to incarceration, no income or residency documentation is required.
Client Eligibility:	HIV-positive incarcerated resident of the Harris County Jail.
Agency Requirements ( <b>TRG Only</b> ):	Agency must execute Memoranda of Understanding with Ryan White funded Outpatient Ambulatory Medical Care providers. The Administrative Agency must be notified in writing if any OAMC providers refuse to execute an MOU.
Staff Requirements:	Not Applicable.
Special Requirements ( <b>TRG Only</b> ):	Must comply with the Houston EMA/HSDA Standards of Care.

***FY 2015 RWPC “How to Best Meet the Need” Decision Process***

<b>Step in Process: Council</b>		Date: <b>06/12/14</b>
Recommendations:	Approved: Y _____ No: _____ Approved With Changes: _____	If approved with changes list changes below:
1.		
2.		
3.		
<b>Step in Process: Steering Committee</b>		Date: <b>06/05/14</b>
Recommendations:	Approved: Y _____ No: _____ Approved With Changes: _____	If approved with changes list changes below:
1.		
2.		
3.		
<b>Step in Process: Quality Assurance Committee</b>		Date: <b>05/14/14</b>
Recommendations:	Approved: Y _____ No: _____ Approved With Changes: _____	If approved with changes list changes below:
1.		
2.		
3.		
<b>Step in Process: HTBMTN Workgroup</b>		Date: <b>04/08/14</b>
Recommendations:	Financial Eligibility:	
1.		
2.		
3.		

## FROM THE FOUNDING EDITOR

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# The ACA Opens The Door For Two Vulnerable Populations

BY JOHN K. IGLEHART

One of the least explored yet most important parts of the Affordable Care Act (ACA) are provisions that hold promise for addressing serious health care challenges facing people who make up two groups of Americans, most of whom are impoverished and uninsured. This issue of *Health Affairs* addresses the needs of these two groups: the 1.1 million Americans who are living with HIV/AIDS and the 11.6 million people who cycle through the nation's 3,300 local and county jails every year.

## HIV/AIDS

More than three decades after the first cases of HIV/AIDS were diagnosed, the benefits of early diagnosis and treatment have been well documented. Dana Goldman and his coauthors estimate that such treatments prevented about 13,500 infections per year during 1996–2009. John Romley and his colleagues calculate that early HIV treatment led to life expectancy gains valued at \$80 billion for people infected over the same time period.

In the context of the ACA, an important aspect of HIV/AIDS treatment has come to the fore: the role of the Ryan White Program in providing comprehensive health and other support services to people living with HIV/AIDS. Some have argued that the ACA renders the Ryan White Program redundant, while others, including Neeraj Sood and colleagues, urge continuation of the program because of the proven benefit of its wraparound approach to care for people living with HIV/AIDS. Reauthorization of the Ryan White Program has been stalled in Congress since the latest funding measure expired in September 2013.

## JAIL-INVOLVED POPULATIONS

Compared with the general public, people who populate jails—disproportionately male, minority, and poor—have higher rates of communicable diseases such as HIV/AIDS; tuberculosis; mental illnesses and substance abuse disorders; and chronic conditions, including asthma, diabetes, and hepatitis B and C. Regardless of where these people reside, it is important that their conditions be treated, particularly because 95 percent of them return to the community without coverage—at least before enactment of the ACA.

Appropriate treatment has been lacking because, in general, health professionals have not viewed the criminal justice system as part of community health; most care is provided through large correctional corporations that hold contracts with hundreds of jails. When fully implemented, the ACA will offer coverage to people released from jails by reducing the financial barriers through Medicaid expansion (in twenty-six states thus far) and subsidized insurance through exchanges.

The ACA does not change Medicaid's prohibition on paying for eligible services while people are incarcerated; once jailed individuals are released, benefits could accrue to those who are eligible and enroll. Marsha Regenstien and Sara Rosenbaum estimate that 25–30 percent of people released from jails could enroll in Medicaid in expansion states and that about 20 percent could enroll in an exchange, depending upon their reported income. But as Kavita Patel and colleagues note, this will occur only if correctional facilities and community providers work more closely together. Matthew Bechelli and his coauthors examine three case studies

for evidence that closer coordination helped bend the cost curve. Josiah Rich and colleagues offer recommendations for improving both correctional care and access to community-based care. Amy Boutwell and Jonathan Freedman underscore the critical role that health plans will play in enrolling former inmates, and Stephen Somers and colleagues emphasize the importance of new partnerships between Medicaid and corrections agencies.

James Marks of the Robert Wood Johnson Foundation, working through Community Oriented Correctional Health Services, and Nicholas Turner, president and director of the Vera Institute of Justice, emphasize that strong linkages among correctional health care, community providers, and inmate reentry are critical to improving treatment for a largely “hidden” population. But, at the same time, the country has a vested stake in improving this population's care because if its members' health problems remain unresolved, they could jeopardize the public health and safety of the communities to which they return.

HIV/AIDS and jail-involved populations overlap in important ways. In 2009, because of the proven benefits of early HIV diagnosis and treatment, the Centers for Disease Control and Prevention encouraged correctional facilities to adopt more effective HIV testing and treatment programs. Also, based on a survey of jail and prison medical directors, Liza Solomon and coauthors found that opportunities to link HIV-positive inmates with community care once they are released are being missed.

## FUNDING ACKNOWLEDGMENT

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## HIV-infected women experience worse treatment outcomes after release from jail

By Helen Dodson

January 21, 2014



A Yale study has uncovered significant gender differences in the treatment outcomes of HIV-infected jail detainees who are transitioning to life outside jail, with women faring much worse than men. The study appears online in the *American Journal of Public Health*.

In the United States, the HIV epidemic is highly concentrated among those in the criminal justice system. One sixth of all people living with HIV/AIDS

transition through jail or prison annually. In addition, the criminal justice population has high numbers of people who experience economic or social instability, psychiatric disorders, and substance use disorders. These conditions have an adverse impact on treatment outcomes for those infected with HIV, and also interfere with HIV prevention and treatment efforts. Unlike prisons, jails house individuals who are pre-trial or have short sentences, leading to rapid turnover that is particularly destabilizing.

The team examined gender differences in HIV treatment outcomes at the time of release from jail and six months after release. One third were women. Compared with men, the women studied were significantly less likely to attain any of the three optimal HIV treatment outcomes at six months after release from jail. Those outcomes include having a regular HIV-care provider, gaining access to life-saving antiretroviral therapy, and achieving viral suppression — a phenomenon that can reduce HIV transmission to others. Overall, women were half as likely as men to achieve viral suppression by six months post-release.

Because the women are significantly less likely than men to get the continuing care they need to control their viral load, they have significantly more negative health outcomes, including transmission to their sexual partners.

“Women living with HIV and transitioning from jail often have severe psychiatric and substance use disorders that interfere with healthcare engagement. We have identified a gender-specific resource gap for people with HIV leaving jail and returning to communities,” said first author Jaimie Meyer, M.D., of the infectious diseases section of Yale School of Medicine.

The authors write that it’s urgent that future HIV prevention interventions be tailored to the unique needs of women in the criminal justice system.

Senior author is Frederick Altice, M.D., of Yale School of Medicine. Other authors are Alexei Zelenev and Jeffrey Wickersham of Yale; Paul Teixeira of the New York City Department of Health and Mental Hygiene; and Chyvette Williams of the University of Illinois School of Public Health.

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