

CORRECTIONAL HEALTH

**Improving Access to
Care Among Formerly
Incarcerated Populations
Living with HIV/AIDS
under the AIDS Drug
Assistance Program:
Model Policy for Ryan
White/ADAPs Serving
Former Inmates**



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This project aims to raise awareness about issues confronting ex-offenders living with HIV/AIDS who also access care and treatment (or whom could benefit from such care and treatment) under ADAP, as well as provide useful resources and tools to the communities serving them.

ACKNOWLEDGMENTS

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The ADAP Advocacy Association believes that the voice of individuals living with HIV/AIDS shall always be at the table and the center of the discussion – including ex-offenders living with HIV/AIDS. In 2017, a new project was launched by the ADAP Advocacy Association to improve access to care and treatment for formerly incarcerated individuals living with HIV/AIDS. The project – “Improving Access to Care Among Formerly Incarcerated Populations Living with HIV/AIDS under the AIDS Drug Assistance Program (ADAP)” – aims to raise awareness about issues confronting ex-offenders living with HIV/AIDS who also access care and treatment (or whom could benefit from such care and treatment) under ADAP, as well as provide useful resources and tools to the communities serving them.

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The ADAP Advocacy Association acknowledges the invaluable contributions made by its intern and the author of this white paper, Jonathan J. Pena, who is a rising senior in social work at the North Carolina State University. Additionally, immense gratitude is extended to numerous other contributors – including Marcus J. Hopkins, who serves as a policy consultant with the Community Access National Network (CANN). His research findings, as well as his insights about issues confronting people in America’s vast prison system surrounding healthcare rights and treatment (specifically as it relates to HIV/AIDS and Hepatitis C) are an important part of the project. Additional expertise and knowledge about State AIDS Drug Assistance Programs was received from Edward “Eddie” Hamilton, who serves as the executive director of the ADAP Educational Initiative based in Columbus, Ohio.

This white paper could not have been made possible without the cultural competency insights on inmates and parolees provided by the team at Ramsell Corporation. The ADAP Advocacy Association would like to extend a special thanks to Ramsell’s President & CEO, Eric Flowers, for his significant contributions and collaboration. Ramsell has been creating positive outcomes for the health and safety of underserved populations since 1964. They help organizations maximize limited resources through cost-effective coordination of care and services for complex populations managed by public health programs, education and corrections.

BACKGROUND

The data on the number of formerly incarcerated populations infected with HIV/AIDS – including co-infection with Hepatitis C (“HCV”), in many cases, simply isn’t available. In fact, most states’ epidemiology reports that **did** report HCV numbers didn’t account for incarcerated populations. What data is available is woefully out of date, using data four years or older. The data on HIV isn’t much better.

The Centers for Disease Control and Prevention (“CDC”) website, updated on March 14, 2017, cites numbers from 2010 – seven years prior to the most recent update.¹ The data cited is obtained from a 2012 report by the Bureau of Justice Statistics (“BJS”) – revised in March 2015 – that looked at HIV in prisons and jails from 2001–2010.² What used to be an annual report with yearly updates from 1993–2008 has apparently been shelved, over the past decade. Moreover, there doesn’t seem to be much in the way of a replacement from any government agency.

The BJS report indicated a few very important findings:

- In 2010, there were **20,093** inmates in state and federal prisons infected with HIV, representing **1.5%** of the total incarcerated population. **3,913** of those inmates were living with an AIDS diagnosis.
- Of the total HIV-infected population, **91%** were male. African-American (“AA”) men were 5 times as likely to be diagnosed than White men, and twice as likely as Hispanic/Latino men. AA women were more than twice as likely to be diagnosed with HIV than both White and Hispanic/Latino women.
- Rates of AIDS-related deaths among state and federal prisoners declined an average of **16%** a year from 2001 to 2010, from 24 deaths/100,000 in 2001 to 5/100,000 in 2010.

Other than those numbers, there isn’t a lot of information that is readily available to the public, which is troubling for a number of reasons.

Among them:

- 1 HIV remains a deadly disease that, when left untreated and/or undiagnosed, can lead to numerous life-threatening complications and death;
- 2 Incarceration settings are notorious for being hotbeds of transmission for a host of sexually transmitted diseases; and

¹Centers for Disease Control and Prevention (CDC). (2017, March 14). *HIV Among Incarcerated Populations*. Atlanta, GA: United States Department of Health and Human Services: Centers for Disease Control and Prevention: National Center for HIV/AIDS, Viral Hepatitis, Sexually Transmitted Diseases, and Tuberculosis Prevention: Division of HIV/AIDS Prevention. Retrieved from: <https://www.cdc.gov/hiv/group/correctional.html>

²Bureau of Justice Statistics. (2012, September 13). *HIV in Prisons, 2001–2010* (NCJ 238877). Washington, DC: United States Department of Justice: Office of Justice Programs: Bureau of Justice Statistics. Retrieved from: <https://www.bjs.gov/content/pub/pdf/hivp10.pdf>

- 3 This failure to present regular data updates may mean that prisons and jails are not complying with regulations requiring that all inmates be screened for HIV.

The CDC does, however, tout support for a number of community-based pilot projects. These programs are designed to help male and female inmates understand the risk associated with certain behaviors, as well as prevention strategies to be used both within and outside of incarceration settings.

WHY DOES IT MATTER?

“HIV is currently a disease that requires lifelong treatment that must be adhered to regularly in order to achieve and maintain Viral Suppression – when the Viral Load (the number of HIV virus cells active in the body) measures below 40 copies per milliliter (aka – Undetectable). With new data showing that Undetectable = Untransmittable, it is more important than ever for people living with HIV to have access to their medications in order to both stay healthy, and to prevent transmission of the disease to others. Former inmates deserve the same access to care and treatment as the general population, especially upon their discharge from prison.”

—MARCUS J. HOPKINS, Policy Consultant, Community Access National Network

One of the most frustrating aspects of conducting any research is the lack of information available to the public. Disease statistics are the foundation for making good policy at all levels of government, which means that, in order for citizens, legislators, and executives to craft data-driven, meaningful legislation and regulations, these data **must** be present. The data must be easily accessible, regularly updated (annually), and reliable. At this point, that data is simply unavailable, which further leads to the need for greater awareness, and clearer guidelines on linkages to care.

What makes this approach vitally important is that access to care and treatment for HIV-infection (and/or HCV) is something that is sorely lacking in the areas that are hardest hit; not just HIV education, really – healthcare literacy in general is an issue. As such, there is a need to work on ways to get people to actually care about their health; help to identify the appropriate linkages to care; and engage in successful care and treatment strategies that will lead them to be **Virally Suppressed**.

The AIDS Drug Assistance Program (“ADAP”) provides medications for the treatment of HIV-infection. Program funds may also be used to purchase health insurance for eligible clients. Amendments to the Ryan White CARE Act in October 2000 added additional language allowing ADAP funds to be used

to pay for services that enhance access, adherence, and monitoring of drug treatments. The program is funded by federal grants to States and Territories.

Available supports and services are going unused in too many ADAP jurisdictions, evidenced by data shared in the 2017 National ADAP Monitoring Project Annual Report published by the National Alliance of State & Territorial AIDS Directors (“NASTAD”). Among other things, NASTAD’s report highlights key components with valuable information about clients living with HIV/HCV co-infection, incarcerated and formerly incarcerated populations, aging populations (and related morbidity and mortality), and clients impacted by substance use.

For the purposes of this white paper, two key charts further demonstrate the need for improved linkages to care during post-incarceration among former inmates living with HIV/AIDS (as seen in the following two charts).³

CHART 1
Top Ryan White Part B/ADAP Services Provided to Incarcerated Individuals, Calendar Year 2015

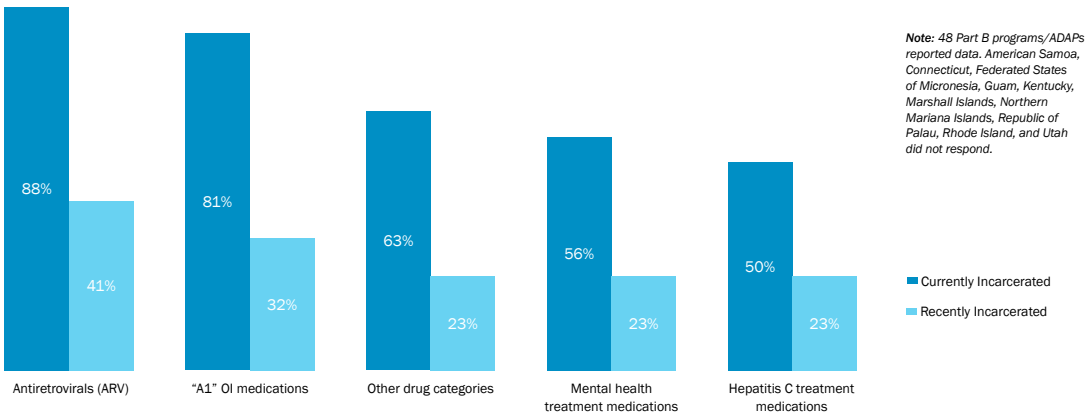
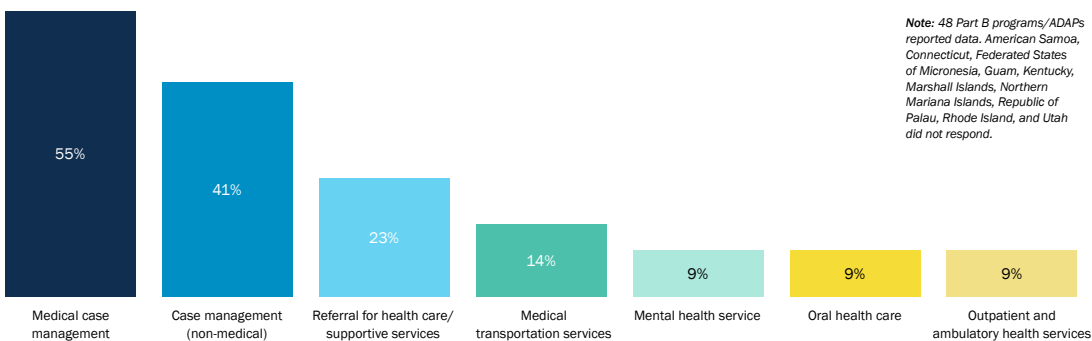


CHART 2
Top Ryan White Part B Services Provided to Recently Incarcerated Individuals, Calendar Year 2015



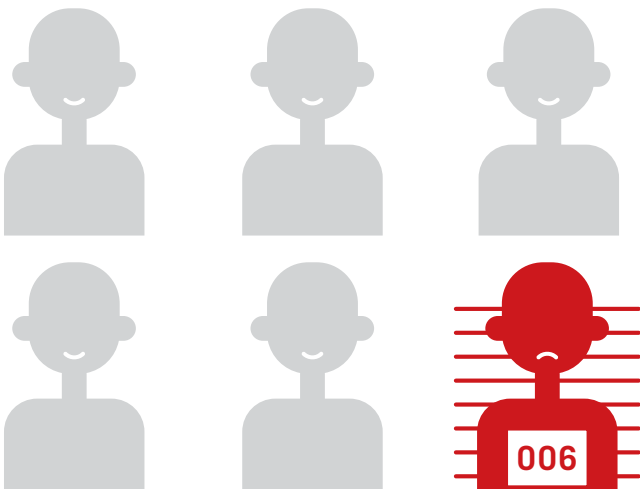
³National Alliance of State & Territorial AIDS Directors. (2017, May 18). *2017 National ADAP Monitoring Project Annual Report*; p. 24. Retrieved from <http://www.nastad.org/sites/default/files/2017-national-adap-monitoring-project-annual-report.pdf>

There exists a need to raise awareness among key stakeholders – among them, State Department of Corrections, ADAPs, community service providers, local health departments, and state/local advocacy organizations – about existing and emerging issues confronting formerly incarcerated populations. Furthermore, there is a need to model existing best practices to ADAP across the 50 states and territories in the United States.

RYAN WHITE HIV PROGRAM & STATE AIDS DRUG ASSISTANCE PROGRAMS

While this policy paper is an effort to sharpen the scope and focus on the need for improved access to care and treatment for HIV-infection (including co-infection with Hepatitis C) among formally incarcerated populations, it is equally important to widen the lens on incarceration in the United States (“U.S.”). Incarceration rates are highest in the U.S out of any country, which translates to 910 per 100,000 adults.⁴ When you factor in the 1.2 million people living with HIV in the U.S, a sixth of this population are entering prisons and jails and also transitioning back into their communities. This sets the stage for an enormous urgency to address the needs of these populations so that the public health system may begin to seal the cracks that they fall through by utilizing accurate assessments, and combining it with proactive case management to link them to care.

INCARCERATION RATES & HIV



1 in 6 of the 1.2 million people living with HIV pass through correctional settings

⁴The Lancet HIV. (2017, November 27). *Predictors of linkage to HIV care and suppression after release from jails and prison: a retrospective cohort study*. Retrieved from: [https://www.thelancet.com/journals/lanhiv/article/PIIS2352-3018\(17\)30209-6/fulltext?code=lancet-site](https://www.thelancet.com/journals/lanhiv/article/PIIS2352-3018(17)30209-6/fulltext?code=lancet-site)

Programs exist, such as the Ryan White HIV/AIDS Program (“RWHAP”) and its State AIDS Drug Assistance Program, which are designed to assist individuals with little or no insurance. The most recent National ADAP Monitoring Project’s annual report demonstrates that ADAPs are already assisting some of these individuals, but it is also clear more can be done to assist former inmates. The National AIDS Strategy also provides some guidance to help formerly incarcerated populations achieve viral suppression.

In the National ADAP Monitoring Project annual report there is useful information that can be used to promote linkages to care during post incarceration. The report includes data and tables from state-level programs with an all-inclusive eye on all 50 states, District of Columbia, Puerto Rico, U.S Virgin Islands, and the six U.S Pacific Territories.⁵ In 2017, Congress allocated \$898.8 million to ADAP, which included funding for grants like the Part B Supplemental grant, ADAP Emergency Relief grant, and the ADAP Supplemental Treatment grant.⁶ As a result of this important funding, some 273,680 clients are enrolled in the RWHAP Part B and ADAP, and 14% of ADAP clients were aided by ADAP-funded insurance and programs that provided full-pay for prescriptions.⁷ Ryan White-funded supports and services has been the cornerstone of the public health system assisting underserved populations living with HIV-infection, which would clearly include inmates transitioning back into their communities.

It isn’t to say that incarcerated and formerly incarcerated HIV-positive populations aren’t being served by the ADAPs. According to the National Monitoring Project’s annual report, services provided to recently incarcerated individuals in 2016 shows that 42% were receiving federal funds for ADAP-related services; however, 64% of those who were currently incarcerated in county or city jails were not being provided any services because the reach of ADAP doesn’t include jail divisions.⁸

In looking at the top ADAP-related services, 79% of currently incarcerated individuals received antiretroviral medication as opposed to 42% of recently incarcerated individuals receiving antiretroviral medication.⁹ Additionally, in 2016, some of the top RWHAP Part B services that were provided to recently incarcerated individuals include case management at 58%, referral for health care at 30%, and with early prevention and outreach services at 12%.¹⁰ Individuals from this population are being targeted and serviced but there is room for improvement. What is crucial is providing the necessary

⁵AIDS Drug Assistance Program Blog. (2018, June 28). *2018 National Ryan White HIV/AIDS Program Part B & ADAP Monitoring Project Annual Report*. ADAP Advocacy Association. Retrieved from: <http://adapadvocacyassociation.blogspot.com/2018/06/2018-national-ryan-white-hiv-aids.html>

⁶AIDS Drug Assistance Program Blog. (2018, June 28). *2018 National Ryan White HIV/AIDS Program Part B & ADAP Monitoring Project Annual Report*. ADAP Advocacy Association. Retrieved from: <http://adapadvocacyassociation.blogspot.com/2018/06/2018-national-ryan-white-hiv-aids.html>

⁷AIDS Drug Assistance Program Blog. (2018, June 28). *2018 National Ryan White HIV/AIDS Program Part B & ADAP Monitoring Project Annual Report*. ADAP Advocacy Association. Retrieved from: <http://adapadvocacyassociation.blogspot.com/2018/06/2018-national-ryan-white-hiv-aids.html>

⁸National Alliance of State & Territorial AIDS Directors (2018). *National Ryan White HIV/AIDS Program Part B & ADAP Monitoring Project Annual Report*. Retrieved from: <https://www.nastad.org/sites/default/files/Uploads/2018/2018-national-rwhap-partb-adap-monitoring-project-annual-report.pdf>

⁹National Alliance of State & Territorial AIDS Directors (2018). *National Ryan White HIV/AIDS Program Part B & ADAP Monitoring Project Annual Report*. Retrieved from: <https://www.nastad.org/sites/default/files/Uploads/2018/2018-national-rwhap-partb-adap-monitoring-project-annual-report.pdf>

¹⁰National Alliance of State & Territorial AIDS Directors (2018). *National Ryan White HIV/AIDS Program Part B & ADAP Monitoring Project Annual Report*. Retrieved from: <https://www.nastad.org/sites/default/files/Uploads/2018/2018-national-rwhap-partb-adap-monitoring-project-annual-report.pdf>

interventions prior to being released so that these individuals are educated, informed and armed with the necessary resources and tools to continue (or start) their antiretroviral therapy. More intensive interventions can certainly minimize some health disparities because linkages to care and treatment will result in achieving viral suppression.

CORRECTIONAL HEALTHCARE AS A SYSTEM

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The National HIV/AIDS Strategy provides a useful blueprint to improving the care continuum for formerly incarcerated inmates living with HIV-infection. It has four main primary goals, which are reducing HIV infections, increasing access to care, optimizing health outcomes, reducing HIV-related health discrepancies, and achieve a greater call to action on a national level in tackling the HIV epidemic.¹¹ The National HIV/AIDS Strategy envisions fewer new infections but for those who receive a positive diagnosis, high quality access to care will be accessible regardless of the barriers like age, gender and socio-economic status.¹² In the case of formerly incarcerated populations, a place free from shame and stigma and in its place an open door and a helping hand that will aid and guide towards beginning anti-retroviral therapy (ART), continuity of treatment, and ultimately achieving viral suppression.

Viral suppression is crucial for HIV-positive ex-offenders during post-incarceration. Achieving and maintaining viral suppression is key because it is accompanied by enormous benefits, including better health, improved quality of life, and greater life expectancy. As viral suppression allows the body to stay healthier, it greatly diminishes the ability of opportunistic infections to occur.¹³ Additionally, those who achieve and maintain viral suppression are less likely to transmit the virus to sexual partners, which is the ultimate driver behind treatment as prevention.¹⁴ The CDC recently supported this statement when they said that undetectable equals un-transmittable.¹⁵ However, it is important to note that viral suppression is only effective when it is done with routine check-ups, medication adherence, and living a healthy lifestyle. It has also been found that inmates who are virally suppressed at the time of release are more likely to continue care with the guidance of effective counseling interventions prior to release.¹⁶

¹¹HIV.Gov. (2017, January 31). *National HIV/AIDS Strategy*. Retrieved from: <https://www.hiv.gov/federal-response/national-hiv-aids-strategy/overview>

¹²HIV.Gov. (2017, January 31). *National HIV/AIDS Strategy*. Retrieved from: <https://www.hiv.gov/federal-response/national-hiv-aids-strategy/overview>

¹³American Academy of Family Physicians. (2016, November 1). *Initial Management of Patients with HIV Infection*. Retrieved from: <https://www.aafp.org/afp/2016/1101/p708.html>

¹⁴Very Well Health (2017, October 29). *Viral Suppression*. Retrieved from: <https://www.verywellhealth.com/viral-suppression-3132658>

¹⁵HIVPlusMagazine. (2017, October 22). *CDC Officially Admits People With HIV Who Are Undetectable Can't Transmit HIV*. Retrieved from: <https://www.hivplusmag.com/undetectable/2017/9/27/breaking-cdc-officially-recognizes-undetectable-untransmittable-hiv-prevention>

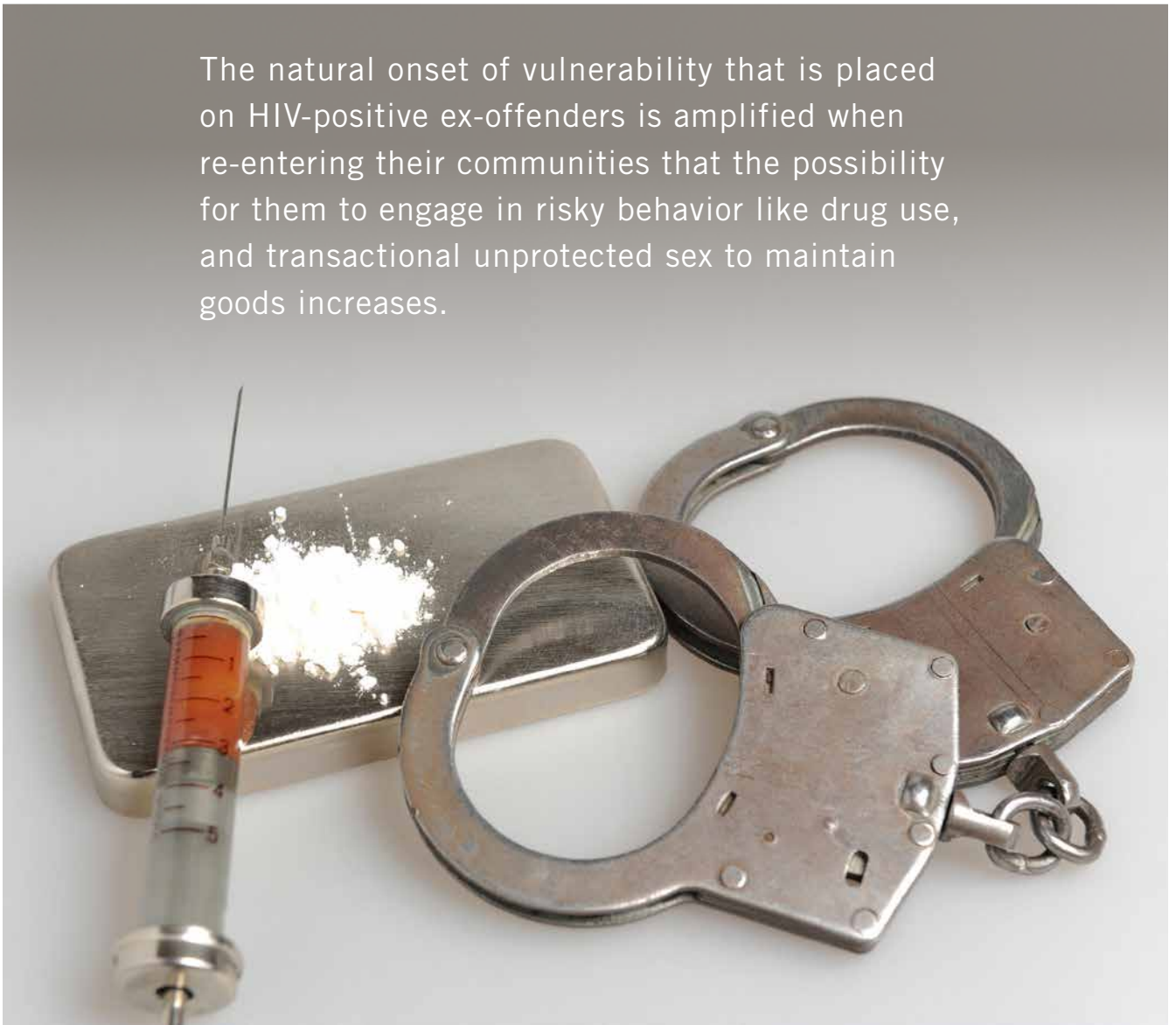
¹⁶HIVPlusMagazine. (2016, April 20). *Locked up and lost: HIV Behind Bars*. Is society throwing away the key on prisoners with HIV? Retrieved from: <https://www.hivplusmag.com/stigma/2016/4/20/locked-lost-hiv-behind-bars>

While the importance of achieving and maintaining viral suppression for HIV-positive ex-offenders can't be overstated, the challenges that they face can seem monstrous. When faced with so many immediate competing needs – like access to affordable housing, food and transportation – continuity of their viral suppression may fall by the waste side. Very often the linkage to care is lost for them due to poor discharge planning and thus limited access to quality community-based programs. As a result, the natural onset of vulnerability that is placed on HIV-positive ex-offenders is amplified when reentering their communities that the possibility for them to engage in risky behavior like drug use, and transactional unprotected sex to maintain goods increases. These negative affects of poor discharge planning not only hurts the ex-offender but also hurts those within their community with other possible new cases of infection if they are not adherent to their medication.

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Jails and prison systems are such dynamic institutions that they face additional compounding challenges to providing health services other than HIV. With such a revolving door, these institutions have to tackle issues like addiction and mental illness. However, what seems to be alarming is the rate

The natural onset of vulnerability that is placed on HIV-positive ex-offenders is amplified when re-entering their communities that the possibility for them to engage in risky behavior like drug use, and transactional unprotected sex to maintain goods increases.



of HCV infections. A team of researchers at the National Drug and Alcohol Research Centre at the University of New South Wales in Sydney pooled together a series of data from 196 countries spanning from 2005 through 2015 that aimed at determining the number of inmates with HIV, hepatitis B virus (“HBV”), HCV, and Tuberculosis (“TB”). This data indicated that out of 10 million inmates HCV ranked at the top with 15.1% of infections and with HIV estimated at 3.8% of infections.¹⁷

This snapshot demonstrates this underserved population is in need of the services that would allow them to better transition from their incarceration without being lost in a helpless void. Transitional primary care services provide a bridge to receive temporary health care until a more permanent health care provider can be obtained. While these services are temporary, they can include medical case management, HIV counseling along with referrals to health care services.¹⁸ Under the RWHAP, ADAP services can be accessed and utilized for this purpose. However, it is important to note that while transitional services are available, Ryan White funded programs like ADAP are generally not extended to currently incarcerated individuals in State or Federal facilities.¹⁹ Care during this time would be the responsibility of the correctional facilities²⁰. Additionally, transitional care services have a general timeframe of utilization that typically doesn't exceed 180 days²¹.

In conjunction with transitional primary care services, certain best practices within this time frame are essential in maximizing the impact of the services that are being provided in order to achieve viral suppression. Organizations, like ActionAIDS, focus on providing client and consumer based services that help to address the challenges that this population faces in acquiring care in the Philadelphia correctional system. Funded by AIDS United and the Corporation for National and Community Services, ActionAIDS developed the Philadelphia Linkage Program's Care Coach Model, a program that provides correctional linkage to care while incarcerated in jails in order to minimize the gap of retention to care that can be lost once released.²² This model leverages care coaches who help with transitioning inmates from jail-based to community-based medical care without interruptions of treatment and care outreach specialists that help clients initiate public benefits such as Medicaid, Medicare and the Ryan White HIV/AIDS program (including ADAP). The coaches serve as escorts to appointments, as well as advocating for them.²³ Success stories have resulted from this program like a 49-year

¹⁷HIVandHepatitis. (2016, September 07). *AIDS 2016: Neglect of Infectious Disease in Prisons Highlighted at Conference*. Retrieved from: <http://www.hivandhepatitis.com/hiv-epidemiology/5845-aids-2016-neglect-of-infectious-disease-in-prisons-highlighted-at-conference>

¹⁸HIV/AIDS Bureau, Health Resources & Services Administration. (2007, September 28). *Policy Notice- 07-04*. Department of Health & Human Services. Retrieved from: <https://hab.hrsa.gov/sites/default/files/hab/Global/0704fundsfortransitionalsupportprimarycare.pdf>

¹⁹HIV/AIDS Bureau, Health Resources & Services Administration. (2007, September 28). *Policy Notice- 07-04*. Department of Health & Human Services. Retrieved from: <https://hab.hrsa.gov/sites/default/files/hab/Global/0704fundsfortransitionalsupportprimarycare.pdf>

²⁰HIV/AIDS Bureau, Health Resources & Services Administration. (2007, September 28). *Policy Notice- 07-04*. Department of Health & Human Services. Retrieved from: <https://hab.hrsa.gov/sites/default/files/hab/Global/0704fundsfortransitionalsupportprimarycare.pdf>

²¹HIV/AIDS Bureau, Health Resources & Services Administration. (2007, September 28). *Policy Notice- 07-04*. Department of Health & Human Services. Retrieved from: <https://hab.hrsa.gov/sites/default/files/hab/Global/0704fundsfortransitionalsupportprimarycare.pdf>

²²AIDS United. *Securing the Link*. A Guide to Support Individuals Transitioning Back Into the Community from Jail.

²³ActionAIDS and AIDS United. *Securing the Link: A Guide to Support Individuals Transitioning Back Into the Community from Jail*. Washington, DC. 2016. Retrieved from https://www.aidsunited.org/data/files/Site_18/Resources/Securing%20Link/SIF16_SecuringtheLink_final.pdf

old man named Robert who's had a history of incarceration and struggled with HIV medication adherence.²⁴

Another program that is helping to bridge connections and utilizes best practices is Project Start+. It is a reentry program designed to address the barriers and challenges that are faced post release in a unique way. Staff works with clients two months prior to release and three months post release engaging in intensive planning to link them to long-term care. With Project Start+ linkage to care isn't just about HIV but rather the totality of immediate needs like housing, food, and employment that are packaged in this program.²⁵

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Additionally, telemedicine is leaving its mark in the realm of health care. Prisons can often be located in rural areas away from medical centers and specialists so medical visits are a great challenge for correctional facilities. Telemedicine allows inmates to see specialists without ever leaving the facility. Further more telemedicine can help improve continuity of care and help address any other chronic issues.²⁶ A study at the Illinois Department of Corrections facilities found that 91% of telemedicine patients achieved viral suppression in the first six visits. This was compared to 59% of patients who were receiving on-site standard care.²⁷



²⁴ActionAIDS and AIDS United. *Securing the Link: A Guide to Support Individuals Transitioning Back Into the Community from Jail*. Washington, DC. 2016. Retrieved from https://www.aidsunited.org/data/files/Site_18/Resources/Securing%20Link/SIF16_SecuringtheLink_final.pdf

²⁵The Body. (2017, November 1). *Don't Leave People in Prisons or Jail Behind*. Retrieved from: <http://www.thebody.com/content/80557/dont-leave-people-in-prisons-or-jail-behind.html>

²⁶Kaiser Health News. (2018, May 1). *Telemedicine Opening Doors To Specialty Care for Inmates*. Retrieved from: <https://khn.org/news/telemedicine-opening-doors-to-specialty-care-for-inmates>

²⁷Kaiser Health News. (2018, May 1). *Telemedicine Opening Doors To Specialty Care for Inmates*. Retrieved from: <https://khn.org/news/telemedicine-opening-doors-to-specialty-care-for-inmates>

Telemedicine procedures are set up in two model categories: synchronous or asynchronous.²⁸ Synchronous is the confidential exchange between the patient and the specialist where interactive physical exams can take place via two-way video and audio connectivity.²⁹ Real-time interaction allows for reliable information to be shared and other acute or chronic conditions managed besides HIV like diabetes and pulmonary medicine.³⁰ Asynchronous models are known as “store and forward”.³¹ This is the avenue that is used when lab results or even images from an MRI or x-rays are sent to the provider in order for it to be reviewed and make the necessary recommendations based on the information being provided.³² This transmission of information can also include a series of medical data and an inmate’s full medical history, which can be stored.³³

11

When piecing together the structure of any post-incarceration linkage to care program, planning is paramount to achieving greater success in HIV care continuum. In many cases, inmates first day of release falls outside the window of normal business hours and contacting health services may be difficult to do. To help offset it, some important to-do list should be considered in being checked off as part of a correctional facilities release plan for post incarceration HIV care continuum. Correctional facilities should provide a full medical discharge summary and a written medication prescription.³⁴ This would allow for both short and long term health care providers to receive much needed history of lab and test results. While linkage to care is being accessed and prescriptions filled, facilities should provide a medication supply during this transitional phase. This will help to minimize the gap from post release until a doctor’s visit is obtained. In Illinois, the Department of Public Health provides planning and resources for discharge which includes a 30 day supply of prescription medication, case management, and an application for ADAP enrollment.³⁵ This is yet another example of how engaging with inmates prior to release can help with continuity of care and community reintegration.

In a study conducted by the University of North Carolina (UNC) and Texas Christian University, it was found that 40% of individuals that were interviewed were unable to successfully maintain viral suppression six months after release.³⁶ When looking at the gamut of the HIV care continuum, this underserved population easily becomes significant when assessing linkage to care. So what else can be done?

²⁸National Center for Biotechnology Information. (2017, Feb 6). *Telehealth:Increasing Access to High Quality Care by Expanding the Role of Technology in Correctional Medicine*. Retrieved from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5332924>

²⁹National Center for Biotechnology Information. (2017, Feb 6). *Telehealth:Increasing Access to High Quality Care by Expanding the Role of Technology in Correctional Medicine*. Retrieved from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5332924>

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³²National Center for Biotechnology Information. (2017, Feb 6). *Telehealth:Increasing Access to High Quality Care by Expanding the Role of Technology in Correctional Medicine*. Retrieved from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5332924>

³³National Center for Biotechnology Information. (2017, Feb 6). *Telehealth:Increasing Access to High Quality Care by Expanding the Role of Technology in Correctional Medicine*. Retrieved from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5332924/>

³⁴ActionAIDS and AIDS United. *Securing the Link: A Guide to Support Individuals Transitioning Back Into the Community from Jail*. Washington, DC. 2016. Retrieved from https://www.aidsunited.org/data/files/Site_18/Resources/Securing%20Link/SIF16_SecuringtheLink_final.pdf

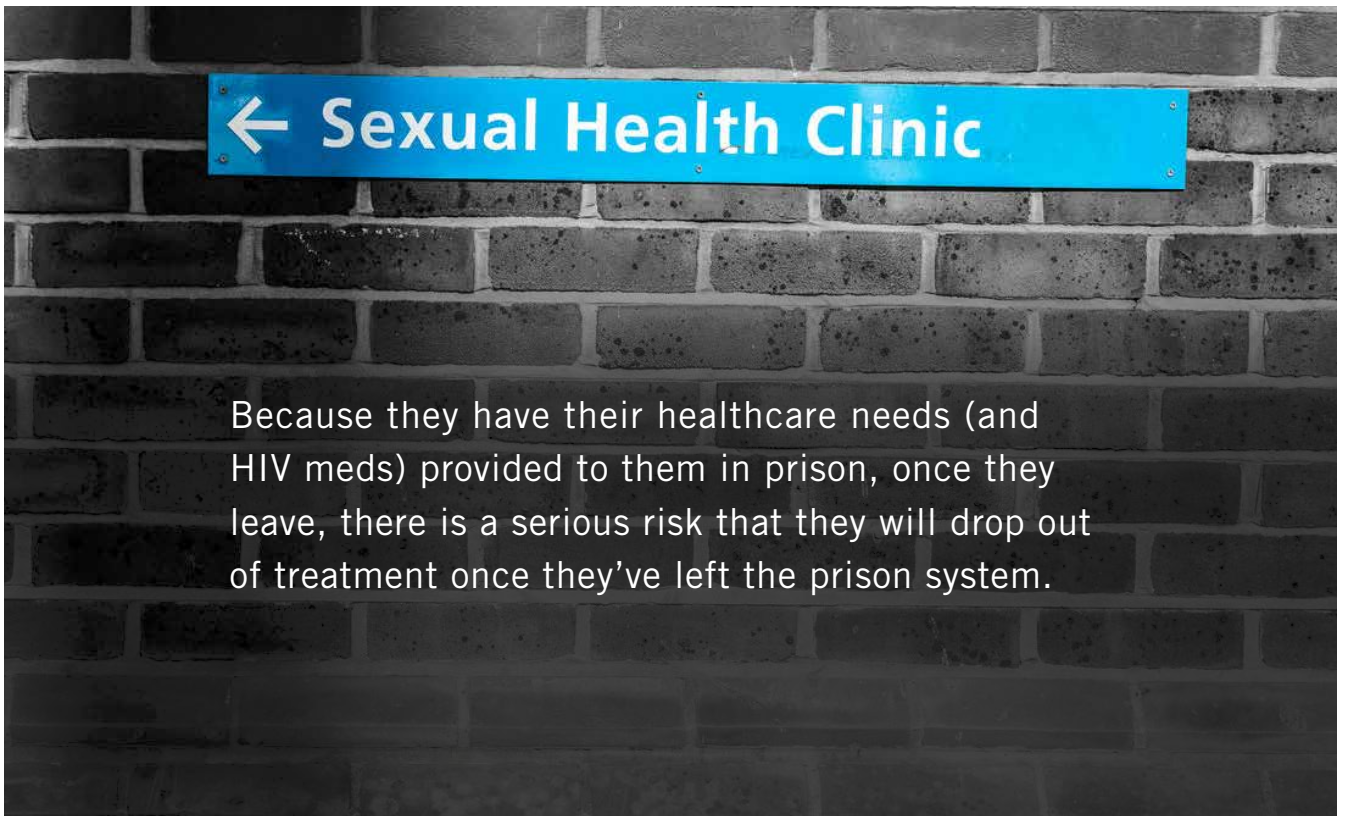
³⁵Illinois Department of Corrections. (2014). *2014 Illinois HIV/AIDS Epidemiology Profile*. Retrieved from <http://www.dph.illinois.gov/sites/default/files/publications/1-25-16-OHP-HIV-factsheet-Incarcerated.pdf>

³⁶The Body. (2017, August 10). *We're Failing Our HIV-Positive Prisoners—and, With Them, All African Americans*. Retrieved from: <http://www.thebody.com/content/80298/were-failing-our-hiv-positive-prisoners--and-with-.html>

In order to help inmates navigate and mitigate these concerns, each state provides their own version of a reentry program – a set series of meetings with each inmate that can start anywhere between nine to six months prior to their release date. While each state’s DOC has its own take on this process, most every state brings in case workers to address the various concerns and issues that may arise once inmates are reintegrated into the general population. They may help inmates fill out applications for employment, work their way through the process of applying for and enrolling in any state or Federal services (e.g. – Medicaid, Medicare, Ryan White) for which they might be eligible, and/or make appointments with local healthcare providers in order to ensure continuity of care.

For many inmates reentering society, reentry and reintegration is complicated by not having a source of income, reliable transportation, housing, and/or savings in place. Because they have their healthcare needs (and HIV meds) provided to them in prison, once they leave, there is a serious risk that they will drop out of treatment once they’ve left the prison system.

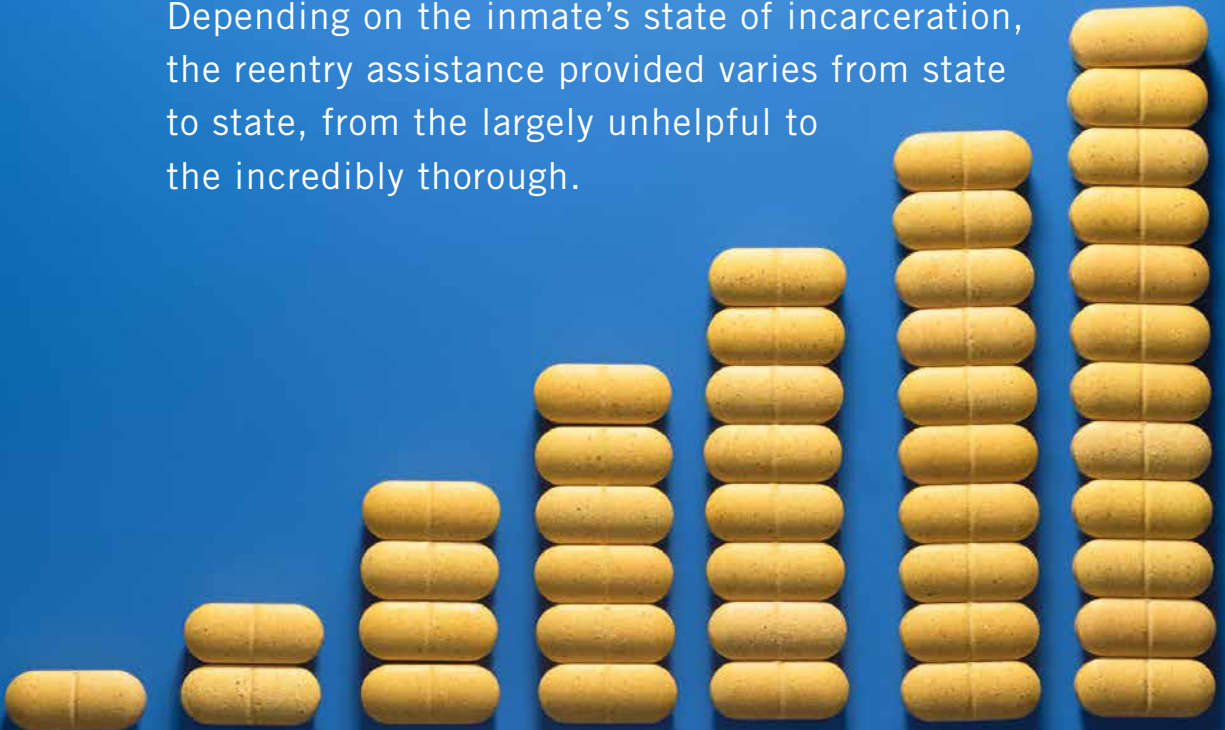
It should be noted that the policies put in place by state DOCs might not be representative of any individual employee’s views or opinions on the issue of HIV care. It must remember that the vast majority of employees have little to no input in crafting these policies, and most, if not all, of the decisions reached by those who craft policy are well above their pay-grades.



To that end, all state DOCs were surveyed and as of August 8th, 2018, twenty-five (25) states replied to information requests with another eight (8) states that did not respond, but whose reentry processes/policies were publicly available on their respective state DOC websites. The research findings yielded:

- Depending on the inmate’s state of incarceration, the reentry assistance provided varies from state to state, from the largely unhelpful (Arizona, Colorado, Hawaii, and Iowa), to the incredibly thorough (Rhode Island). Here is why these specific states are mentioned:
 - **Arizona** – while the state does provide released inmates with a 30-day supply of their HIV medications, as well as allowing them to take any leftover meds, the state does not link inmates with HIV to the state’s Ryan White program (which is quite extensive and relatively generous), nor do they make appointments with HIV care providers to ensure continuity of care. They will aid with Medicaid applications “as applicable,” which we assume means that it is based on eligibility for the program
 - **Colorado** – similar to Arizona, Colorado provides linkage only to Medicaid, and then, if the application is accepted and approved, they will work with the agency to link patients to local providers who are accepting new Medicaid patients. They do not link inmates to Ryan White – perhaps the most comprehensive and generous program in the U.S. – and provide only a 10-day supply of HIV medications to inmates upon release

Depending on the inmate’s state of incarceration, the reentry assistance provided varies from state to state, from the largely unhelpful to the incredibly thorough.



- **Hawaii** – the state provides only a 14-day supply of HIV meds and will make appointments with local providers. They do not provide linkage to either Ryan White or Medicaid
- **Iowa** – the state does provide a generous supply of medications to reentering inmates – a 30-day supply given directly to the inmate, and up to 60 days transferred to a community pharmacy. That said, they only assist with the Medicaid process if the inmate is evidently eligible, and will only make appointments for healthcare providers if the inmate already has a primary care provider
- **Rhode Island** – by contrast, Rhode Island’s DOC has perhaps the most comprehensive HIV care program in the U.S. justice system, both during and post-incarceration. The state contracts with the state university to provide care throughout inmate incarceration at state facilities and ensures that continuity of care continues by keeping inmates with their same providers after they leave (should they stay in the state). Additionally, inmates are provided with an excellent comprehensive reentry program that integrates the state’s Ryan White program and assists with the Medicaid application process. They also look into accessing HOPWA (Housing Opportunities for Persons With AIDS) to help provide housing if they are returning without a reliable home
- **New Hampshire**’s DOC was unaware of the Ryan White Program. The ADAP Advocacy Association was able to provide them information about the program and connect them with the state’s Ryan White Director. NH is currently determining whether or not to incorporate Ryan White as part of their Reentry Program for inmates living with HIV/AIDS who do not qualify for Medicaid
- In addition to the aforementioned states who do not provide linkage to Ryan White, five states who responded (ID, MN, NH, NC, OK) did not indicate in their responses whether or not they provide linkage
- 12 states do not provide information related to their reentry process on their state DOC websites. Many do not do so because they have entered into exclusive contracts with private providers and what they are contracted to provide is not allowed to be released to the public
- **The District of Columbia** provides inmates with only a 3- to 7-day supply of HIV meds, but does provide them with a prescription for an additional month’s supply
- 9 states (CA, DE, FL, MD, MS, ND, OR, SC, and WV) neither replied to our information requests, nor had any available documents on their state DOC websites related to their reentry procedures or policies

With these findings it is evident that more guidance is needed to ensuring that equitable access to care and treatment is a reality for all reentering inmates living with HIV/AIDS. That said, these data and findings are only useful insofar as they can be used to address inequities that exist.

SEAMLESS CORRECTIONAL DISCHARGE

Linkages to care for all formerly incarcerated populations – but especially people living with chronic conditions, such as HIV/AIDS – would be well-served by seamless connections to supports and services designed to foster greater community reintegration. For the purposes of this white paper, an intuitive web-based, secure platform that is available on-demand would appear more appropriate than traditional bricks and mortar settings. Applications already exist whereby software solutions that are fully customizable to meet the complex work flows of organizations focused on community corrections (prisoner reentry) and correctional healthcare and continuity of care.³⁷ In today’s technological-savvy environment, such solutions manage data and facilitate client tracking, reporting and case management for the most at-risk in our communities. A technology-based approach also leverages mobile technology capability that enables its use in the field on tablets and smart phones.

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Additionally, such an approach would better link Correctional Healthcare Providers (i.e. privately held companies such as Corizon, Wexford, Armor, GeoCare, as well as County or State Agencies) with Government Correctional Agencies (i.e. state Departments of Correction, County Sheriffs and Probation Departments, Parole Agencies). The fewer obstacles that exist between private and public resources – as well as those provided by community nonprofits – foster post-incarceration healthcare as a system.³⁸

Implementation of this model wouldn’t come without possible challenges and pain points for providers. Among them:³⁹

- For clinical care providers, easy access to the most recent client/patient medical history and data is an important value-added component (i.e., facilitates pre-encounter treatment planning).
- Establishing communication with other providers (avoiding “phone tag”, trading emails).
- Certifying eligibility (getting clients equipped with the necessary documents to qualify them for service).

³⁷Flowers, Eric. (2018). *Breaking the Cycle of Recidivism*. Ramsell Corporation. Retrieved from <http://www.ramsellcorp.com/whowehelp/corrections.aspx>

³⁸Flowers, Eric. (2018). *Breaking the Cycle of Recidivism*. Ramsell Corporation. Retrieved from <http://www.ramsellcorp.com/whowehelp/corrections.aspx>

³⁹Flowers, Eric. (2018). *Breaking the Cycle of Recidivism*. Ramsell Corporation. Retrieved from <http://www.ramsellcorp.com/whowehelp/corrections.aspx>

- Ensuring follow through (client transportation to other providers, monitoring adherence).
- Challenge to efficiently aggregate/disaggregate data (tracking per individual client and also program wide).
- Gathering and maintaining documentation certifying eligibility.
- Dual entry of data into different systems.
- Attributing results to specific staff or certain activities.



These challenges and pain points aside, a web-based system that solves the problem of coordination of care and benefits for ex-offenders who are in need of any of a number of different paths of assistance to successful reentry into society from state and city/county correctional facilities is ideal. Pre-screening for eligibility and matching returning citizens with the available programs and resources within their community is more likely. A cloud-based system is configurable to meet the specific workflow demands of the case managers, data control and privacy/confidentiality needs, and outcomes reporting needs of the individual correctional and correctional healthcare agencies.⁴⁰

Common barriers confront many ex-offenders transitioning back into their communities. Though some remain systemic – such as lack transportation and employment – linkages to improved access to care is achievable. A web-based system can be used by front line staff for individual needs assessment, identifying resources and providing the appropriate linkage to care of all available programs, by administrative staff for creating lifetime electronic records of treatment/services, monitoring client adherence and outcomes, and creating customized reports for grant and contract compliance. Finally, for a funding entity such as state or federal agency or national foundation, the system allows for single visibility for purposes of monitoring accountability and measuring success in meeting program and initiative objectives.⁴¹

One of the first barriers that ex-offenders face when they are released is transportation. With 3.6 million people not having access to medical care due to transportation barriers, this immediate need is certainly amplified for this population and may seem like an enormous task to tackle.⁴² Distance is a common issue with transportation due to many prison facilities being located in rural areas but when you factor in the cost of traveling or even deficient infrastructure, staying focused on adherence can be difficult to do

⁴⁰Flowers, Eric. (2018). *Breaking the Cycle of Recidivism*. Ramsell Corporation. Retrieved from <http://www.ramsellcorp.com/whowehelp/corrections.aspx>

⁴¹Flowers, Eric. (2018). *Breaking the Cycle of Recidivism*. Ramsell Corporation. Retrieved from <http://www.ramsellcorp.com/whowehelp/corrections.aspx>

⁴²Patient Engagement HIT. (2017, November 20). *Overcoming Transportation Barriers to Drive Patient Care Access*. Retrieved from: <https://patientengagementhit.com/news/overcoming-transportation-barriers-to-drive-patient-care-access>

when you can't get any traction out the gate. Without addressing this barrier, ex-offenders will find it difficult if not nearly impossible to attend or maintain any health care appointments and decrease their ability in achieving or maintaining viral suppression.

In one of the largest prisons in the U.S, the Huntsville, Texas correctional facility seems to have a system in play that buffers the issue of transportation. When released, each ex-offender walks down to a greyhound bus station where they first cash a release check. The checks are issued by the Texas Department of Criminal Justice in the amount of \$50 if they were paroled and \$100 if discharged for time served.⁴³ This money can serve as a great benefit when the need to travel is paramount but those released from this facility won't be spending their money on travel just yet. Along with their release checks, they are given a prison transportation voucher that they can use to get back to their perspective county of residence.⁴⁴ While not all correctional facilities will have the necessary budget or the collaborations to implement such avenues, it still serves as a guide when tackling the issue of transportation for this population when released.

Gaining access to reliable transportation not only allows this population to connect to much needed resources like health care but it also allows them the opportunity to seek employment. Having a steady job is an important piece to the overall success of the HIV care continuum. Not only does employment allow this population to support themselves but it also enables them to support their loved ones, engage in their community and the flexibility to pursue any life goals. The greater the positive outlook on life is, the greater the chance they have in saying engaged in care. However, the barriers in obtaining employment due to their record are ones that are difficult to overcome.

It is estimated that in the U.S there are 5 million formerly incarcerated people.⁴⁵ Information from a national dataset also stipulates that unemployment is at a rate of over 27% for this population.⁴⁶ Additionally, this rate is higher than the U.S employment rate during any given period in our history including the Great Depression.⁴⁷ However, despite this information there is evidence that formerly incarcerated people want to work. Analysis from the same national dataset suggest that 93.3% of 25-44 year old formerly incarcerated people are actively looking for work or employed in comparison to 83.8% of their peers in the general public.⁴⁸ In areas like Boston measures are being taken to help guide this population. The city has launched

⁴³National Public Radio. (2015, April 12). *Newly Released Texas Inmates Prepare For A Long Ride to Freedom*. Retrieved from: <https://www.npr.org/2015/04/12/398763933/newly-released-texas-inmates-prepare-for-a-long-ride-to-freedom>

⁴⁴National Public Radio. (2015, April 12). *Newly Released Texas Inmates Prepare For A Long Ride to Freedom*. Retrieved from: <https://www.npr.org/2015/04/12/398763933/newly-released-texas-inmates-prepare-for-a-long-ride-to-freedom>

⁴⁵Prison Policy Initiative. (2018, July). *Out of Prison & Out of Work: Unemployment among formerly incarcerated people*. Retrieved from: <https://www.prisonpolicy.org/reports/outofwork.html>

⁴⁶Prison Policy Initiative. (2018, July). *Out of Prison & Out of Work: Unemployment among formerly incarcerated people*. Retrieved from: <https://www.prisonpolicy.org/reports/outofwork.html>

⁴⁷Prison Policy Initiative. (2018, July). *Out of Prison & Out of Work: Unemployment among formerly incarcerated people*. Retrieved from: <https://www.prisonpolicy.org/reports/outofwork.html>

⁴⁸Prison Policy Initiative. (2018, July). *Out of Prison & Out of Work: Unemployment among formerly incarcerated people*. Retrieved from: <https://www.prisonpolicy.org/reports/outofwork.html>

the office of returning citizens that will help connect nearly 3,000 individuals that return home from incarceration each year to areas like employment.⁴⁹ Other successful programs include operation exit that places ex-offenders into an apprenticeship program.⁵⁰ Opportunities like this allow this population the chance to sharpen their abilities with occupational skills training for workforce and community reentry.

When you are in a large urban environment you have array of resources that can be easily accessed like an infectious disease specialist or a social worker. However, when you step out side of that environment and are a part of rural Americans that make up 15 to 20% of the population in the U.S, remote locations become a barrier to accessing care.⁵¹ Additionally, while up to 20% of Americans are in rural areas, the physicians that are on hand fail to meet the demand. With only 10% of the nations physicians working in these rural locations, access to quality care for ex-offenders becomes an elusive goal.⁵² Despite this, action can and is being taken to close the gap on out of reach health care.

One avenue that is being utilized to address the need for physicians in rural areas is schools. School medical programs are increasingly recognizing the need to place residents in rural communities.⁵³ With these placements a better understanding of rural medicine can be gained and tailored to specific needs. Recruitment from rural areas is also peaking the interest of medical schools. The idea and hope is that these individuals will return to their communities to share what they have experienced and decide to stay and practice.⁵⁴ Another tool that medical school institutions are utilizing is The Rural Training Track Collaborative.⁵⁵ It provides the opportunity for medical schools in rural areas, and their residences, to learn and train on a rural campus.⁵⁶ This is a great way to cultivate the need for physicians by diversifying their experience and placing them in rural hospitals.

This approach to remedy clinician shortages is already being implemented in some rural communities. Legacy Health Endowment (“LHE”), based in Turlock, California, worked with Livingston Community Health and CSU Stanislaus to create a new Master’s in Family Medicine, which will graduate 23 nurse practitioners in December 2019.⁵⁷

⁴⁹Boston.gov. (2017, October 27). *City Launches Office Of Returning Citizens*. Retrieved from: <https://www.boston.gov/news/city-launches-office-returning-citizens>

⁵⁰Boston.gov. (2017, October 27). *City Launches Office Of Returning Citizens*. Retrieved from: <https://www.boston.gov/news/city-launches-office-returning-citizens>

⁵¹Association of American Medical Colleges. (2017, October 31). *Health Disparities Affect Millions in Rural U.S Communities*. Retrieved from: <https://news.aamc.org/patient-care/article/health-disparities-affect-millions-rural-us-commun/>

⁵²Healio. (2017, June 2). *Trying to Understand and Close the Rural Health Gap*. Retrieved from: <https://www.healio.com/family-medicine/practice-management/news/online/%7B9adbc230-e87b-4a49-8516-fd9811b7b780%7D/trying-to-understand-and-close-the-rural-health-care-gap?page=2>

⁵³Becker’s Hospital Review. (2018, June 20). *Fixing the medical staff shortage problem in rural areas*. Retrieved from: <https://www.beckershospitalreview.com/population-health/fixing-the-medical-staff-shortage-problem-in-rural-areas.html>

⁵⁴Becker’s Hospital Review. (2018, June 20). *Fixing the medical staff shortage problem in rural areas*. Retrieved from: <https://www.beckershospitalreview.com/population-health/fixing-the-medical-staff-shortage-problem-in-rural-areas.html>

⁵⁵Becker’s Hospital Review. (2018, June 20). *Fixing the medical staff shortage problem in rural areas*. Retrieved from: <https://www.beckershospitalreview.com/population-health/fixing-the-medical-staff-shortage-problem-in-rural-areas.html>

⁵⁶Becker’s Hospital Review. (2018, June 20). *Fixing the medical staff shortage problem in rural areas*. Retrieved from: <https://www.beckershospitalreview.com/population-health/fixing-the-medical-staff-shortage-problem-in-rural-areas.html>

⁵⁷Legacy Health Endowment. (2018, September 27). *Valley Deserves Better Health Care and More Doctors. Here’s How We’ll Get Them*. Retrieved from: <https://legacyhealthendowment.org/newsmedia/>

RESOURCES & TOOLS

Various organizations have created resources to aid in the process of developing and implementing competency trainings and policies. The ADAP Advocacy Association recommends the following organizations for medical competency training resources:

- **AIDS United**
https://www.aidsunited.org/data/files/Site_18/Resources/Securing%20Link/SIF16_SecuringtheLink_final.pdf
- **American Civil Liberties Union (ACLU)**
<https://www.aclu.org/other/aclu-national-prison-project>
- **Bureau of Justice Statistics, Office of Justice Programs, U.S. Department of Justice**
<https://www.bjs.gov>
- **Centers for Disease Control and Prevention (CDC)**
<https://www.cdc.gov>
- **Community Education Group**
<http://www.communityeducationgroup.org>
- **HIV/AIDS Bureau (HAB), Health Resources & Services Administration, U.S. Department of Health & Human Services**
<https://hab.hrsa.gov/sites/default/files/hab/Global/0704fundsfortransitionalsupportprimarycare.pdf>
- **National Alliance of State & Territorial AIDS Directors – *Understanding State Departments of Health and Corrections Collaboration Part I***
https://www.nastad.org/sites/default/files/resources/docs/NASTAD_Corrections_Report_November_11-Part1.pdf
- **National Alliance of State & Territorial AIDS Directors – *Understanding State Departments of Health and Corrections Collaboration Part II***
https://www.nastad.org/sites/default/files/resources/docs/NASTAD_Corrections_Report_December_11-Part2.pdf
- **Prison Policy Initiative**
<https://www.prisonpolicy.org/reports/outofwork.html>
- **Ramsell Corporation**
<http://www.ramsellcorp.com/howehelp/corrections.aspx>

CONCLUSIONS

It has been nearly 40 years since the HIV/AIDS epidemic began showing up across the United States. After all this time, with the amazing level of resources and support available for those living with the disease, it became clear that there was little information publicly available concerning incarcerated populations. What was also clear was the lack of focus by state Departments of Corrections on HIV care for current and former inmates. Evidence suggests that, despite numerous lawsuits related to HIV care, this underserved population receives insufficient care while incarcerated in jail and prison, which often continues upon being released from jail and prison. These systemic failures further complicate matters for reentering former inmates who will also face the present health disparities, ongoing societal challenges faced by former inmates upon release, and the knowledge that most new infections are caused by people not currently receiving care and treatment. These institutions also fail to disclose the amount of medications inmates are provided upon release, making it difficult to track or accurately report the circumstances inmates face upon reentering the general population. These failures are often compounded by states providing NO policy information whatsoever on their reentry programs. This policy white paper aims to change the care continuum paradigm for current and former inmates by promoting more comprehensive HIV care programs in the criminal justice system, both during and post-incarceration.