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Health Equity for the Incarcerated Individuals: Brain Injury Population

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NOVEMBER 20, 2024

Incarceration and Brain Injury



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POPULATION DISPARITIES

Adult Population

- 65-90% in need of SUD treatment upon release
- Roughly 40% have a mental illnesses
- 9-10x the rate of Hepatitis C,
- 8-9x the rate of HIV

Juvenile Population

- Roughly 2/3 report at least one substance-related problem
- Up to 90% have experienced trauma (ACES)
- Experience suicidal ideation, and also attempt and die by suicide at rates 2-3x greater than youth in the general population
- Up to 50% are also involved with the foster care system

Racial and Ethnic Disparities

- Black adults are incarcerated in state prisons at nearly 5x the rate of white adults,
- Latino adults are incarcerated in state prisons at 1.3x the rate of non-Latino white adults
- Minority youth account for 67% of youth in juvenile correctional facilities
- The national detention rate for black youth is over 6x the rate for white youth



What statistics are missing?



**Less than 5%
of the general
population live
with a TBI-
related
disability**

Up to 70% of individuals incarcerated in prison have a brain injury.

Some studies show that roughly 65% of individuals incarcerated in prison have significant cognitive deficits.

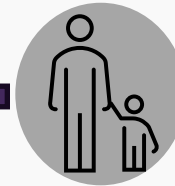
BRAIN INJURY PREVALENCE

65%-90% of individuals incarcerated in prison have a need for SUD treatment.



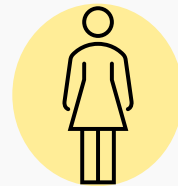
The number of individuals who have a SUD and a brain injury is anywhere from 66% - 96%

Roughly 33% of children in foster care have a brain injury



25% of former foster youth will be incarcerated within 2 years of emancipation

80%-97% of women in prison have experienced domestic/intimate partner violence.



Strangulation is a major cause of brain injury in women incarcerated in prisons



INCARCERATED ADULTS AND CHILDREN

Reentry Demonstration Opportunity Waiver

- State Medicaid waiver opportunity that allows limited in-reach services for eligible **adults in prisons and jails up to 90-days** pre-release.
- At a minimum must provide Care Management, MAT, 30 prescription filled upon release
- States have the opportunity to decide populations, length of time, and additional services
- Waiver application will be submitted in 2026 for a 2027 implementation

Consolidated Appropriations Act of 2023

- Federal statute outlined in the CAA of 2023 includes a mandate for ALL states to cover limited services for **incarcerated juveniles up to 30-days** pre-release through Medicaid and CHIP
- Targeted Case Management (TCM), behavioral and physical health screenings
- **Operational plan due January 1, 2025**



CAA MANDATORY SERVICES

Targeted Case Management

- 30 days pre- and post release
- Including referrals to appropriate care and services available in the geographic region of the home or residence of the eligible juvenile.

Physical Assessments

- 30 days prior to release from carceral settings.
- Screening and diagnostics that meet EPSDT* or state's reasonable standards of medical care

Behavioral Health Assessments






- 30 days prior to being released from carceral settings.
- Screening and diagnostics that meet EPSDT* or state's reasonable standards of medical care

**The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health and specialty services.*



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REENTRY WAIVER SMDL #23-003

In-reach timeframe	Up to 90 days California chose to go with a 90-day timeframe; NY had previously proposed 30 days.	
Populations	Expanded populations CMS encourages states to think broadly and innovatively about populations and includes examples of juveniles, LGBTQ+	
Core Services	CMS outlines 3 core services 1) Case Management; 2) MAT for all types of SUD and SUD counseling; 3) 30-day supply of medication upon release	
Data and IT	Enhanced FFP for Data/IT Infrastructure 90/10 match: inc. data sharing between Medicaid and correctional agencies or facilities; IT for better coordination between settings and providers; 75/25 match for ongoing operations of systems	
Services & Reinvestment	Expanded services States may provide services currently provided by carceral settings if they agree to reinvest the federal share in initiatives to increase access to care pre- and post-release as well as diversion.	

Innovation:

- CMS emphasizes that the provisions outlined in the SMDL are minimum considerations and urges states to innovate.
- CMS anticipates that states will “propose a range of benefit designs” and “expects that state proposals for benefit designs will be sufficiently robust.”
- CMS may provide FFP for capacity building as well as stakeholder engagement

REENTRY WAIVER PROPOSAL

Populations Under Consideration-

People with:

- 2 or more qualifying chronic conditions, or
- Hepatitis C
- Brain Injury
- Pregnant/post-partum
- Physical Disabilities
- HIV/AIDS
- Serious Mental Illness (SMI)
- Intellectual and Developmental Disabilities (IDD)
- Sickle Cell disease
- Substance Use Disorder (SUD)
- Individuals released for compassionate Leave

BRAIN INJURY CARE INNOVATIONS

Incarcerated individuals living with serious mental health conditions, substance use disorders often went without brain injury informed care.

In February 2024- DOH began outreach to Brain Injury Experts to understand the landscape of Brain Injury (BI) Care in the state.

We connected with providers from Plattsburgh, to Buffalo to NYC- these conversations helped us develop a comprehensive understanding about the gaps in care that providers and survivors experience.

These gaps disproportionately affect individuals with complex health considerations

Specific focus on care along the continuum: The NYS TBI Waiver supports the highest-acuity individuals with BI but there are many who have significant needs despite not meeting waiver eligibility criteria.



CARE INNOVATIONS CONVERSATIONS SERIES

Care Innovations #1- Overview of TBI Waiver, connections with providers, advocates, and policy makers from across the state.

Care Innovations #2- *Living with TBI: A Toolkit for Individuals Living with Traumatic Brain Injury*

Care Innovations #3- Lived Experience Panel

Key Objectives:

- Increase visibility of BI survivor needs, experiences, and barriers
- Highlight gaps in treatment, health disparities; and population flags
- Promote Long Term Partnerships: Foster meaningful connections among stakeholders, state agency partners, providers and experts.

OTHER SUCCESSES

State Agency Partnerships: Through the Care Innovations Series, state agencies have begun to collaborate across state government, breaking siloes and laying the framework for innovation.

Outreach from Providers: Various providers have been reaching out to different agencies within New York State, having been introduced to policy makers through the innovation series. Providers are also making meaningful connections with each other/

Training from the ACL: Staff from multiple State Agencies including NYSDOH, OASAS, OMH, OCFS, OPWDD, and DOCCS received the Toolkit for Youth with TBI training which brought awareness to this important issue

A WORKING DEFINITION

OHIP's data governance bureau (BEDG) is developing a data definition to identify members suspected to have a brain injury, either traumatic or anoxic, but are not formally diagnosed.

They are investigating members who have:

Experienced repeated opioid overdoses, or

A history of repeated injury/concussion to the neck or head followed by a CT scan, or

A history of repeated asphyxiation, including drowning.



NYHER: ROLES OF SCN LEAD ENTITIES

To achieve the objectives of screening, navigation, and delivery of HRSN services, SCN Lead Entities will...



Form partnerships within the regional ecosystem to screen Medicaid Members for HRSN, navigate to services, and close the loop on referrals



Organize and coordinate a network of diverse and culturally competent HRSN service providers, including community-based organizations (CBOs) and other partners



Pay HRSN service providers for services delivered



Facilitate data-sharing to support HRSN service navigation and delivery



Establish a leadership team that reflects the unique needs of the region



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REGIONAL SCN LEAD ENTITIES

Coverage area	Lead Entity
North Country	<u>Healthy Alliance Foundation Inc.</u>
Central NY	<u>Healthy Alliance Foundation Inc.</u>
Capital Region	<u>Healthy Alliance Foundation Inc.</u>
Western NY	<u>Western New York Integrated Care Collaborative Inc.</u>
Finger Lakes	<u>Forward Leading IPA, Inc</u>
Southern Tier	<u>Care Compass Collaborative</u>
Hudson Valley	<u>Hudson Valley Care Coalition, Inc.</u>
New York City ¹	<u>Public Health Solutions</u>
Bronx	<u>Somos Healthcare Providers, Inc.</u>
Staten Island	<u>Staten Island Performing Provider System</u>
Long Island	<u>Health and Welfare Council of Long Island</u>



1. Includes Brooklyn, Manhattan, and Queens

Source: Governor Hochul Announces \$500 Million for New Social Care Networks Program to Deliver Social Services and Improve Health Outcomes for Millions of Low-Income New Yorkers. August 7, 2024. Press Release

OVERVIEW OF HEALTH-RELATED SOCIAL NEEDS SERVICES



Screening

- Medicaid Members can choose to be screened for HRSNs using the [Accountable Health Communities HRSN screening tool](#)



Navigation

- Medicaid Managed Care Members are eligible for navigation to existing or enhanced HRSN services
- Medicaid Fee-For-Service (FFS) Members are eligible for navigation to existing local, state, or federal services (e.g., SNAP)



Nutrition

- Nutritional counseling and classes
- Medically tailored home-delivered meals
- Food prescriptions
- Pantry stocking
- Cooking supplies (pots, pans, etc.)



Housing

- Medically necessary home modifications and remediation, incl. asthma remediation
- Medical respite
- Rent / temporary housing
- Utility set-up / assistance
- Housing Navigation
- Pre-tenancy services
- Community transitional services
- Tenancy sustaining services

Enhanced HRSN services



Social care management

- Navigation to social care services (including other enhanced HRSN services and existing services such as education, childcare, interpersonal violence resources, etc.)



Transportation

- Reimbursement for public and private transportation to connect to HRSN services and HRSN care management activities (e.g., get to an appointment with housing navigator)

Duration of each service varies depending on service type and Member need



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EXAMPLES OF ENHANCED HOUSING SERVICES

Medically necessary home accessibility / safety modifications

- Ramps
- Handrails
- Electric door openers
- Widening of doorways
- Non-skid surfaces

Medically necessary home remediation

- Mold / pest
- Ventilation, AC, heater, etc. repair
- Refrigeration for medical treatment
- Home environment assessment

Asthma remediation

- Home remediation / equipment provisioning tailored to individuals with asthma
- Home environment assessment

Medical respite

- Recuperative care: pre-procedure and post-hospitalization
- Care coordination and connection to supportive housing

Rent / temporary housing

- Rent / temporary housing support (up to six months)
- Utility assistance

Utility set-up / assistance

- Activation expenses and back payments to secure / keep utilities (e.g., electric)

Pre-tenancy services

- Tenant rights education
- Housing interviews
- Application assistance

Community transitional services

- Security deposits
- First month's rent
- Utility activation fees

Tenancy sustaining services

- Eviction prevention
- Fiscal planning
- Emergency planning
- Independent community living skills

Housing transition and navigation

- Assistance with housing search



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