Declaration of Dr. Jaimie Meyer

Pursuant to 28 U.S.C.§ 1746, I hereby declare as follows:

I. Background and Qualifications

1. I am Dr. Jaimie Meyer, an Assistant Professor of Medicine at Yale School of Medicine and Assistant Clinical Professor of Nursing at Yale School of Nursing in New Haven, Connecticut. I am board certified in Internal Medicine, Infectious Diseases and Addiction Medicine. I completed my residency in Internal Medicine at NY Presbyterian Hospital at Columbia, New York, in 2008. I completed a fellowship in clinical Infectious Diseases at Yale School of Medicine in 2011 and a fellowship in Interdisciplinary HIV Prevention at the Center for Interdisciplinary Research on AIDS in 2012. I hold a Master of Science in Biostatistics and Epidemiology from Yale School of Public Health.

2. I have worked for over a decade on infectious diseases in the context of jails and prisons. From 2008-2016, I served as the Infectious Disease physician for York Correctional Institution in Niantic, Connecticut, which is the only state jail and prison for women in Connecticut. In that capacity, I was responsible for the management of HIV, Hepatitis C, tuberculosis, and other infectious diseases in the facility. Since then, I have maintained a dedicated HIV clinic in the community for patients returning home from prison and jail. For over a decade, I have been continuously funded by the NIH, industry, and foundations for clinical research on HIV prevention and treatment for people involved in the criminal justice system, including those incarcerated in closed settings (jails and prisons) and in the community under supervision (probation and parole). I have served as an expert consultant on infectious diseases and women’s health in jails and prisons for the UN Office on Drugs and Crimes, the Federal Bureau of Prisons, and others. I also served as an expert health witness for the US Commission on Civil Rights Special Briefing on Women in Prison.

3. I have written and published extensively on the topics of infectious diseases among people involved in the criminal justice system including book chapters and articles in leading peer-reviewed journals (including Lancet HIV, JAMA Internal Medicine, American Journal of Public Health, International Journal of Drug Policy) on issues of prevention, diagnosis, and management of HIV, Hepatitis C, and other infectious diseases among people involved in the criminal justice system. In making the following statements, I am not commenting on the particular issues posed this case. Rather, I am making general statements about the realities of persons in detention facilities, jails and prisons.

4. My C.V. includes a full list of my honors, experience, and publications, and it is attached as Exhibit A.

5. I was paid $1,000 for my time drafting an earlier version of this report filed in another case. I subsequently prepared this version of the report without receiving payment for my services.
6. I have not testified as an expert at trial or by deposition in the past four years.

II. Heightened Risk of Epidemics in Jails and Prisons

7. The risk posed by infectious diseases in jails and prisons is significantly higher than in the community, both in terms of risk of transmission, exposure, and harm to individuals who become infected. There are several reasons this is the case, as delineated further below.

8. Globally, outbreaks of contagious diseases are all too common in closed detention settings and are more common than in the community at large. Prisons and jails are not isolated from communities. Staff, visitors, contractors, and vendors pass between communities and facilities and can bring infectious diseases into facilities. Moreover, rapid turnover of jail and prison populations means that people often cycle between facilities and communities. People often need to be transported to and from facilities to attend court and move between facilities. Prison health is public health.

9. Reduced prevention opportunities: Congregate settings such as jails and prisons allow for rapid spread of infectious diseases that are transmitted person to person, especially those passed by droplets through coughing and sneezing. When people must share dining halls, bathrooms, showers, and other common areas, the opportunities for transmission are greater. When infectious diseases are transmitted from person to person by droplets, the best initial strategy is to practice social distancing. When jailed or imprisoned, people have much less of an opportunity to protect themselves by social distancing than they would in the community. Spaces within jails and prisons are often also poorly ventilated, which promotes highly efficient spread of diseases through droplets. Placing someone in such a setting therefore dramatically reduces their ability to protect themselves from being exposed to and acquiring infectious diseases.

10. Disciplinary segregation or solitary confinement is not an effective disease containment strategy. Beyond the known detrimental mental health effects of solitary confinement, isolation of people who are ill in solitary confinement results in decreased medical attention and increased risk of death. Isolation of people who are ill using solitary confinement also is an ineffective way to prevent transmission of the virus through droplets to others because, except in specialized negative pressure rooms (rarely in medical units if available at all), air continues to flow outward from rooms to the rest of the facility. Risk of exposure is thus increased to other people in prison and staff.

11. Reduced prevention opportunities: During an infectious disease outbreak, people can protect themselves by washing hands. Jails and prisons do not provide adequate opportunities to exercise necessary hygiene measures, such as frequent handwashing or use of alcohol-based sanitizers when handwashing is unavailable. Jails and prisons are often under-resourced and ill-equipped with sufficient hand soap and alcohol-based sanitizers for people detained in and working in these settings. High-touch surfaces (doorknobs, light switches, etc.) should also be cleaned and disinfected regularly with bleach to prevent virus spread, but this is often not done in jails and prisons because of a
lack of cleaning supplies and lack of people available to perform necessary cleaning procedures.

12. **Reduced prevention opportunities:** During an infectious disease outbreak, a containment strategy requires people who are ill with symptoms to be isolated and that caregivers have access to personal protective equipment, including gloves, masks, gowns, and eye shields. Jails and prisons are often under-resourced and ill-equipped to provide sufficient personal protective equipment for people who are incarcerated and caregiving staff, increasing the risk for everyone in the facility of a widespread outbreak.

13. **Increased susceptibility:** People incarcerated in jails and prisons are more susceptible to acquiring and experiencing complications from infectious diseases than the population in the community. This is because people in jails and prisons are more likely than people in the community to have chronic underlying health conditions, including diabetes, heart disease, chronic lung disease, chronic liver disease, and lower immune systems from HIV.

14. Jails and prisons are often poorly equipped to diagnose and manage infectious disease outbreaks. Some jails and prisons lack onsite medical facilities or 24-hour medical care. The medical facilities at jails and prisons are almost never sufficiently equipped to handle large outbreaks of infectious diseases. To prevent transmission of droplet-borne infectious diseases, people who are infected and ill need to be isolated in specialized airborne negative pressure rooms. Most jails and prisons have few negative pressure rooms if any, and these may be already in use by people with other conditions (including tuberculosis or influenza). Resources will become exhausted rapidly and any beds available will soon be at capacity. This makes both containing the illness and caring for those who have become infected much more difficult.

15. Jails and prisons lack access to vital community resources to diagnose and manage infectious diseases. Jails and prisons do not have access to community health resources that can be crucial in identifying and managing widespread outbreaks of infectious diseases. This includes access to testing equipment, laboratories, and medications.

16. Jails and prisons often need to rely on outside facilities (hospitals, emergency departments) to provide intensive medical care given that the level of care they can provide in the facility itself is typically relatively limited. During an epidemic, this will not be possible, as those outside facilities will likely be at or over capacity themselves.

17. **Health safety:** As an outbreak spreads through jails, prisons, and communities, medical personnel become sick and do not show up to work. Absenteeism means that facilities can become dangerously understaffed with healthcare providers. This increases a number of risks and can dramatically reduce the level of care provided. As health systems inside facilities are taxed, people with chronic underlying physical and mental health conditions and serious medical needs may not be able to receive the care they need for these

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conditions. As supply chains become disrupted during a global pandemic, the availability of medicines and food may be limited.

18. **Safety and security**: As an outbreak spreads through jails, prisons, and communities, correctional officers and other security personnel become sick and do not show up to work. Absenteeism poses substantial safety and security risk to both the people inside the facilities and the public.

19. These risks have all been borne out during past epidemics of influenza in jails and prisons. For example, in 2012, the CDC reported an outbreak of influenza in 2 facilities in Maine, resulting in two inmate deaths. Subsequent CDC investigation of 995 inmates and 235 staff members across the 2 facilities discovered insufficient supplies of influenza vaccine and antiviral drugs for treatment of people who were ill and prophylaxis for people who were exposed. During the H1N1-strain flu outbreak in 2009 (known as the “swine flu”), jails and prisons experienced a disproportionately high number of cases. Even facilities on “quarantine” continued to accept new intakes, rendering the quarantine incomplete. These scenarios occurred in the “best case” of influenza, a viral infection for which there was an effective and available vaccine and antiviral medications, unlike COVID-19, for which there is currently neither.

III. **Profile of COVID-19 as an Infectious Disease**

20. The novel coronavirus, officially known as SARS-CoV-2, causes a disease known as COVID-19. The virus is thought to pass from person to person primarily through respiratory droplets (by coughing or sneezing) but may also survive on inanimate surfaces. People seem to be most able to transmit the virus to others when they are sickest but it is possible that people can transmit the virus before they start to show symptoms or for weeks after their symptoms resolve. In China, where COVID-19 originated, the average infected person passed the virus on to 2-3 other people; transmission occurred at a distance of 3-6 feet. Not only is the virus very efficient at being transmitted through droplets, everyone is at risk of infection because our immune systems have never been exposed to or developed protective responses against this virus. A vaccine is currently in development but will likely not be able for another year to the

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2 Influenza Outbreaks at Two Correctional Facilities — Maine, March 2011, Centers for Disease Control and Prevention (2012), [https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6113a3.htm](https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6113a3.htm).


general public. Antiviral medications are currently in testing but not yet FDA-approved, so only available for compassionate use from the manufacturer. People in prison and jail will likely have even less access to these novel health strategies as they become available.

21. Most people (80%) who become infected with COVID-19 will develop a mild upper respiratory infection but emerging data from China suggests serious illness occurs in up to 16% of cases, including death. Serious illness and death is most common among people with underlying chronic health conditions, like heart disease, lung disease, liver disease, and diabetes, and older age. Death in COVID-19 infection is usually due to pneumonia and sepsis. The emergence of COVID-19 during influenza season means that people are also at risk from serious illness and death due to influenza, especially when they have not received the influenza vaccine or the pneumonia vaccine.

22. The care of people who are infected with COVID-19 depends on how seriously they are ill. People with mild symptoms may not require hospitalization but may continue to be closely monitored at home. People with moderate symptoms may require hospitalization for supportive care, including intravenous fluids and supplemental oxygen. People with severe symptoms may require ventilation and intravenous antibiotics. Public health officials anticipate that hospital settings will likely be overwhelmed and beyond capacity to provide this type of intensive care as COVID-19 becomes more widespread in communities.

23. COVID-19 prevention strategies include containment and mitigation. Containment requires intensive hand washing practices, decontamination and aggressive cleaning of surfaces, and identifying and isolating people who are ill or who have had contact with people who are ill, including the use of personal protective equipment. Jails and prisons are totally under-resourced to meet the demand for any of these strategies. As infectious diseases spread in the community, public health demands mitigation strategies, which involves social distancing and closing other communal spaces (schools, workplaces, etc.) to protect those most vulnerable to disease. Jails and prisons are unable to adequately provide social distancing or meet mitigation recommendations as described above.

24. The time to act is now. Data from other settings demonstrate what happens when jails and prisons are unprepared for COVID-19. News outlets reported that Iran temporarily

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released 70,000 prisoners when COVID-19 started to sweep its facilities. To date, few state or federal prison systems have adequate (or any) pandemic preparedness plans in place. Systems are challenged to respond to COVID-19 guidelines that are modified on a near-daily basis. It may be impossible to adequately respond to the COVID-19 pandemic, while also respecting the rights and dignity of people who are incarcerated.

IV. Possible Risks of COVID-19 in ICE Detention Facilities

25. Based on my experience working on public health in jails and prisons, I can make the following general statements about how the COVID-19 outbreak will interact with and exacerbate conditions that may exist in some detention centers.

26. Any delays in access to care that already exist in normal circumstances will only become worse during an outbreak, making it especially difficult for the facilities to contain any infections and to treat those who are infected.

27. Failure to provide individuals with continuation of the treatment they were receiving in the community, or even just interruption of treatment, for chronic underlying health conditions will result in increased risk of morbidity and mortality related to these chronic conditions.

28. Failure to provide individuals adequate medical care for their underlying chronic health conditions results in increased risk of COVID-19 infection and increased risk of infection-related morbidity and mortality if they do become infected.

29. People with underlying chronic mental health conditions need adequate access to treatment for these conditions throughout their period of detention. Failure to provide adequate mental health care, as may happen when health systems in jails and prisons are taxed by COVID-19 outbreaks, may result in poor health outcomes. Moreover, mental health conditions may be exacerbated by the stress of incarceration during the COVID-19 pandemic, including isolation and lack of visitation.

30. Failure to keep accurate and sufficient medical records will make it more difficult for facilities to identify vulnerable individuals in order to both monitor their health and protect them from infection. Inadequate screening and testing procedures in facilities increase the widespread COVID-19 transmission.

31. Language barriers will similarly prevent the effective identification of individuals who are particularly vulnerable or may have symptoms of COVID-19. Similarly, the failure to

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provide necessary aids to individuals who have auditory or visual disabilities could also limit the ability to identify and monitor symptoms of COVID-19.

32. Facilities with a track record of neglecting individuals with acute pain and serious health needs under ordinary circumstances are more likely to be ill-equipped to identify, monitor, and treat a COVID-19 epidemic.

33. Similarly, facilities with a track record of failing to adequately manage single individuals in need of emergency care are more likely to be seriously ill-equipped and under-prepared when a number of people will need urgent care simultaneously, as would occur during a COVID-19 epidemic.

34. For individuals in facilities that have experienced these problems in the past, the experience of an epidemic and the lack of care while effectively trapped can itself be traumatizing, compounding the trauma of incarceration.

V. Conclusion and Recommendations

35. Reducing the size of the population in jails and prisons can be crucially important to reducing the level of risk both for those within those facilities and for the community at large. As such, from a public health perspective, it is my recommendation that individuals who can safely and appropriately remain in the community not be placed in ICE detention facilities at this time. I also recommend that individuals who are already in these facilities should be evaluated for release.

36. This is more important still for individuals with preexisting conditions (e.g., heart disease, chronic lung disease, chronic liver disease, suppressed immune system, diabetes) or who are over the age of 65.

37. Health in jails and prisons is community health. Protecting the health of individuals who are detained in and work in these facilities is vital to protecting the health of the wider community.

I declare under penalty of perjury that the foregoing is true and correct.

March 23, 2020
New Haven, Connecticut

Dr. Jaimie Meyer
CURRICULUM VITAE

Name: Jaimie P. Meyer, M.D., M.S.

Education:

B.A. Dartmouth College (Anthropology) 2000
M.D. University of Connecticut 2005
M.S. Yale School of Public Health (Biostatistics and Epidemiology) 2014

Career/Academic Appointments:

2005-08 Intern and Resident, Internal Medicine, NY Columbia Presbyterian Hospital, New York, NY
2008-11 Clinical and Research Fellow, Infectious Diseases, Yale University, New Haven, CT
2010-12 Postdoctoral Fellow, Center for Interdisciplinary Research on AIDS, Yale School of Public Health, New Haven, CT
2012-14 Instructor, Infectious Diseases (AIDS Program), Yale School of Medicine, New Haven, CT
2014-present Assistant Professor, Infectious Diseases (AIDS Program), Yale School of Medicine, New Haven, CT
2015-present Clinical Assistant Professor, Division of Primary Care/Health Systems in Nursing, Yale School of Nursing, New Haven, CT

Clinical Positions Held & Other Employment:

1999 Spanish Medical Interpreter, Boston Children’s Hospital, Boston, MA
2000-01 Research Assistant, UCSF Immunogenetics and Transplantation Laboratory, San Francisco, CA
2010-12 Infectious Diseases Attending (per diem), Hospital of Saint Raphael, New Haven, CT
2009-15 Infectious Diseases Clinician, York Women’s Correctional Institution, Niantic, CT
2015- HIV Clinician, Nathan Smith Clinic, New Haven, CT
2018- Faculty, Contemporary Management of HIV, Clinical Care Options

Board and other Certifications:

American Board of Internal Medicine, Internal Medicine, 2008, 2018
American Board of Internal Medicine, Infectious Diseases, 2010
American Board of Preventive Medicine, Addiction Medicine, 2018
DATA 2000 DEA X waiver to prescribe Buprenorphine, 2010
REMS Certified implanter and prescriber for Probuphine, 2016

Professional Honors & Recognition

A) International/National/Regional
2018 Selected as Early Career Reviewer, NIH Center for Scientific Review
2017 Doris Duke Charitable Foundation Scholar
2016  Fellow, American College of Physicians
2016  NIH Health Disparities Loan Repayment Award Competitive Renewal
2016  Selected for AAMC Early Career Women Faculty Professional Development Seminar
2014  NIH Health Disparities Loan Repayment Program Award
2014  NIDA Women & Sex/Gender Differences Junior Investigator Travel Award
2014  International Women's/Children's Health & Gender Working Group Travel Award
2014  Patterson Trust Awards Program in Clinical Research
2013  Thornton Award for Clinical Research
2011  Bristol Myers-Squibb Virology Fellows Award
2006  John N. Loeb Intern Award
2005  Connecticut State Medical Society Award
2005  American Medical Women's Association Citation
2000  Hannah Croasdale Senior Award, Dartmouth College
1998  Palaeopitus Senior Leadership Society Inductee, Dartmouth College

B) University
2014  Fellow, Women’s Faculty Forum Public Voices Thought Leadership Program

PROFESSIONAL SERVICE

Journal Service:
Reviewer

2019-present  Section Editor: Sex and Gender Issues, Journal of the International Association of Providers of AIDS Care (JIAPAC)

Grant Service:
Reviewer:
2020  Doris Duke Charitable Foundation Physician Scientist Fellowship Award

Professional Service for Professional Organizations

2016-present  Fellow, American College of Physicians
2016-present  Member, AAMC Group on Women in Medicine and Science (GWIMS)
2013-2016  Member, American College of Physicians
2013-present  Member, InWomen’s Network, NIDA International Program
2011-present  Member, American Medical Women’s Association
2011-present  Member, Connecticut Infectious Disease Society
2009-present  Member, American Society of Addiction Medicine
2008-present  Member, Infectious Disease Society of America
2005-present  Member, American Medical Association
2005-2008  Member, New York State Medical Society

**Yale University Service**

2019-present  Core Faculty, Program in Addiction Medicine
2017-present  Affiliated Faculty, Arthur Liman Center for Public Interest Law, Yale Law School
2016-present  Leadership Council, Women’s Faculty Forum, Yale University
2015-2016  Steering Committee, US Health and Justice Course, Yale School of Medicine
2014-present  Yale Internal Medicine Traditional Residency Intern Selection Committee
2013-present  Women in Medicine at Yale Mentoring Program
2013-present  Women in Science at Yale Mentoring Program
2012-present  Affiliated Scientist, Center for Interdisciplinary Research on AIDS
2009-2011  Preclinical Clerkship Tutor, Yale School of Medicine

**Individual Mentorship**

2020  Zoe Sernyak, Yale University: Summer internship
2020  Caroline Wortman, Cornell University: Summer internship
2020  Chevaughn Wellington, Quinnipiac School of Medicine: Capstone Project Advisor
2019  Callie Ginapp, Yale School of Medicine: Research Mentor
2019  Alissa Haas, Yale School of Public Health (EMD): Research mentor
2019  Emily Bail, Yale School of Nursing: APRN Clinical mentor
2018  Camila Odio, Yale Internal Medicine Residency Program: Research mentor
2018  Zoe Adams, Yale School of Medicine: Research mentor
2018  Yilu Qin, Yale Primary Care Residency Program, HIV Training Track: Research mentor
2018  Kaitlin Erickson, Yale School of Nursing: APRN Clinical mentor
2017-2019  Emily Hoff, Yale School of Medicine: Research mentor, Thesis mentor
2017  Lindsay Eysenbach, Yale School of Medicine: Research mentor, Summer project on Syringe Service Program
2017  Megan Carroll, Yale School of Public Health: M.S. Thesis advisor (Biostatistics)
2016-2020  Britton Gibson, Yale School of Public Health and Quinnipiac School of Medicine: Research mentor
2016  Ronnye Rutledge, Yale School of Medicine: MHS Thesis advisor; awarded IDSA Education and Research Foundation 2015 Medical Scholarship and Yale School of Medicine Medical Student Research Fellowship; earned School and Departmental Honors for Thesis
2015  Kelsey Loeliger, Yale Schools of Medicine and Public Health: M.D./Ph.D. Dissertation committee
2014 Javier Cepeda, Yale School of Public Health: Ph.D. Research advisor/mentor
2014 Audrey Fritzinger, Yale PA Program: Thesis advisor; Received Honors for thesis
2014 Cecilia Dumouchel, Yale College: Summer internship
2014 Joan Chi-How, Yale School of Medicine: Internship
2014 Michelle Fikrig, Oberlin College: Summer internship
2014 Madison Breuer, Southern Connecticut State University: Internship

Public Service

2019 Consultant on Medication Assisted Treatment in Prisons, Vermont Department of Corrections, Addiction Health Services
2019 Expert Witness for Women in Prison Briefing, U.S. Commission on Civil Rights
2018 Consultant for SAMHSA State Targeted Response-Technical Assistance Consortium to address the opioid crisis, American Academy of Addiction Psychiatry
2017 Consultant on HIV Care in Prisons, United Nations Office on Drugs and Crime
2017 Scientific Advisory Board, HIV Prevention and Treatment in Cis-Gendered Women, Gilead Sciences, Inc.
2016 Consultant on Women’s Health, Female Offenders Unit, Federal Bureau of Prisons
2002 “Medicine as a Profession” Fellow, Soros Open Society Institute
1999 Volunteer Spanish Medical Interpreter, Boston Children’s Hospital
1998 Honorary Service Fellow, Costa Rican Humanitarian Foundation

Research Support

Ongoing Research Support
ACTIVE
Investigator Sponsored Award (M161462) PI: Meyer 7/1/2017-6/30/2020 1.8 calendar
Gilead Sciences, Inc. $81,151 (FY1 Directs)
Delivering HIV Pre-Exposure Prophylaxis to Networks of Justice-Involved Women
Description: To leverage risk networks of CJ-involved women as a means of delivering PrEP and to evaluate the acceptability and feasibility of strategically delivering PrEP to network members.

Clinical Scientist Development Award PI: Meyer 7/1/17-6/30/20 3.0 calendar
Doris Duke Clinical Foundation $149,959 (FY1 Directs)
Developing and Testing the Effect of a Patient-Centered HIV Prevention Decision Aid on PrEP uptake for Women with Substance Use in Treatment Settings

Description: 1) To adapt a patient-centered HIV prevention decision aid to women with substance use entering treatment for substance use disorders. 2) Building on findings from Aim 1, to pilot test the effect of the adapted decision-aid intervention on PrEP uptake among women with substance use entering treatment for substance use disorders.

1 R21 DA042702-01A1 PI: Meyer 8/1/2017–7/31/2020 (NCE) 1.20 calendar NIH/NIDA $129,673 (FY1 Directs)

Prisons, Drug Injection and the HIV Risk Environment in Kyrgyzstan

Description: We propose to generate qualitative data from interviews with prisoners and prison staff and triangulate it with quantitative data from MATLINK within an analytical HIV risk environment framework which aims to: 1. Describe the individual-environment interactions that shape within-prison drug-related HIV risk practices and health expectations post-release; and 2. Measure how within-prison risk and other factors within the prison environment mediate engagement with OAT both within prison and after release.

H79 T1080561 PI: Meyer 11/30/2018–11/29/2023 1.20 calendar SAMHSA $389,054 (FY1 Directs)

CHANGE: Comprehensive Housing and Addiction Management Network for Greater New Haven

We will expand and enhance the local implementation of a community infrastructure that integrates housing, behavioral health, and addiction treatment services for highly vulnerable populations at-risk for or living with HIV (PARLWH), by virtue of their involvement in criminal justice (CJ) systems and/or engagement in sex work. The target population for CHANGE is CJ-involved PARLWH in New Haven, Connecticut who experience co-occurring homelessness, psychiatric, and substance use disorders.

Pilot Project Award mPI: Willie, Meyer 10/01/19-09/30/20 0.24 calendar Center for Interdisciplinary Research on AIDS (CIRA) $29,993


This Type II hybrid effectiveness-implementation study seeks to adapt an existing PrEP decision aid to intimate partner violence (IPV)-exposed women seeking domestic violence services at two major Connecticut service agencies. This study will: provide support for a PrEP decision aid that addresses the HIV prevention needs of IPV-exposed women; use implementation science to increase PrEP uptake; include DV agencies in intervention development and implementation; and improve understanding of PrEP scale-up by addressing implementation factors in the community settings that serve IPV-exposed women.

R01 MH121991 mPI: Meyer, Sullivan 01/01/2020-11/30/2024 1.8 calendar NIMH $374,816 (FY1 Directs)

Identifying Modifiable Risk and Protective Processes at the Day-Level that Predict HIV Care Outcomes among Women Exposed to Partner Violence

The main purpose of this study is to understand how exposure to intimate partner violence (IPV) affects women’s abilities to self-manage their HIV on a daily basis (i.e., adhere to antiretroviral medication), engage in longitudinal HIV care, and achieve and
sustain viral suppression. The project aims to build awareness of the IPV-health association and inform strategies/resources to promote resilience.

UNDER REVIEW:
R01 MH124533  PI: Meyer  07/01/2020-06/30/2025  3.6 calendar
NIMH  $577,894 (FY1 Directs)

TelePrEP+ for Women in Criminal Justice Systems
This study is designed to test an active facilitation strategy (ePrEP) for scaling up PrEP, an evidence-based practice, in two distinct settings (Connecticut and Alabama) for a key population of women involved in criminal justice systems. We will randomize justice-involved, PrEP-eligible women across two sites (CT and AL) to receive ePrEP or standard of care. Using a Type I Hybrid Efficacy-Implementation framework, we will evaluate individual-level (PrEP initiation and 6-month retention) and organizational-level outcomes important for ePrEP scalability and sustainability across diverse contexts.

Inmate Health Services 2019 (Clinical Services Contract)  PI: Meyer
10/01/2019-09/30/2022  0.96
Connecticut Department of Corrections  $436,899

Yale Center of Excellence in Prison Health
We will create a Yale Center of Excellence in Prison Health that will provide specialty e-consultation, staff development, and quality assurance programs for the CT Department of Correction (DOC) in the areas of Behavioral Health, Transitional care, and Infectious Diseases, which are the largest cost centers for DOC healthcare. We will additionally provide outpatient specialty telehealth services in key areas, including: Cardiology, Endocrinology, and Rheumatology. We focus on regional healthcare delivery (RFPs 2 and 4), acknowledging that the majority of people in these facilities will return home to the greater New Haven area, enabling continuity of care and serving as a regional hub.

Inmate Health Services 2019 (Clinical Services Contract)  PI: Meyer
10/01/2019-09/30/2022  0.96
Connecticut Department of Corrections  $250,805

Yale HIV in Jails Program
The current proposal seeks to reinvigorate and improve upon the HIV in Prisons Program to deliver high quality, cost-effective HIV care and Infectious Disease consultations to PWH in each of Connecticut’s jails (Hartford CC in RFP Region 1; New Haven CC in RFP Region 2; Bridgeport CC in RFP Region 3; Corrigan Radgowski CC and York CI in RFP Region 4).

Completed Research Support
K23 DA033858  PI: Meyer  7/1/2012 – 11/30/2017  9.0 calendar
NIH/NIDA  $153,529 (FY1 Directs)

Evaluating and Improving HIV Outcomes in Community-based Women who Interface with the Criminal Justice System
The major goal of this project is to inform, adapt and test an intervention that will improve HIV treatment outcomes for community-based women who interface with the criminal justice system, either after release from jail or during community supervision.

Patterson Trust Awards Program in Clinical Research  PI: Meyer  1/31/14-10/30/15
Disentangling the Effect of Gender on HIV Treatment and Criminal Justice Outcomes

Bristol Myers-Squibb HIV Virology Fellowship Award
PI: Meyer
9/1/11-6/30/13

NIMH T32 MH020031
PI: Ickovics
7/2/10-6/30/12
Interdisciplinary HIV Prevention Training Program, Yale University School of Epidemiology and Public Health, Center for Interdisciplinary Research on AIDS
Role: Research Scientist

NIAID T32 AI007517
PI: Quagliaello
6/30/09-7/1/10
Training in Investigative Infectious Disease, Yale University School of Medicine, Section of Infectious Disease
Role: Research Scientist

Publications
Peer-Reviewed Journals


Meyer J, Qiu J, Chen N, Larkin G, Altice F. Frequent Emergency Department Use among Released Prisoners with HIV: Characterization Including a Novel Multimorbidity


Manuscripts in Submission


Manuscripts in Preparation
Meyer J, Flash C, Gonzalez N, Pan A, Yuan Y, Rajabiun S. The Intersecting Effect of Gender and Race on Housing and HIV Outcomes in a Multisite Medical Home Project. To submit to AJPH.


Book Chapters


Other Publications and Reports


Other Media Communications


Invited Conference Presentations & Published Abstracts


Effects of Intimate Partner Violence on HIV and Substance Abuse in Released Jail Detainees. 5th Academic and Health Policy Conference on Correctional Health. Atlanta, Georgia. March 2012.

Frequent Emergency Department Use among Released Prisoners with HIV: Characterization Including a Novel Multimorbidity Index. IDWeek: Infectious Diseases Society of America Annual Meeting. San Diego, California. October 2012.

Correlates of Retention in HIV Care after Release from Jail: Results from a Multi-site Study. IDWeek: Infectious Diseases Society of America Annual Meeting. San Diego, California. October 2012.


Women Released from Jail Experience Suboptimal HIV Treatment Outcomes Compared to Men: Results from a Multi-Center Study. HIV Intervention and Implementation Science Meeting. Bethesda, Maryland. September 2013.


Evidence-Based Interventions to Enhance Assessment, Treatment, and Adherence in the Chronic Hepatitis C Care Continuum. International Harm Reduction Conference. Kuala Lumpur, Malaysia. October 2015.


**Invited Lectures/Seminars**

**Yale School of Medicine Affiliated**

“HIV 101”: Yale Affiliated Hospital Program, Greenwich Hospital Internal Medicine Residency Conference. March 2011.

“Clostridium Difficile”: Yale Affiliated Hospital Program, Greenwich Hospital Internal Medicine Residency Conference. April 2013.

“Community-Acquired Infections.” Student Microbiology Workshop, Yale University School of Medicine. September 2013.

“Hospital Associated Infections.” Student Microbiology Workshop, Yale University School of Medicine. September 2014.

“Microbiology of the Central Nervous System.” Student Microbiology Seminar. Yale University School of Medicine, Physician Associate Program. October 2014.


“Implicit Bias and incarceration.” Yale School of Medicine Pre-clinical clerkship seminar. September 2015.

Incarceration and Health Disparities.” US Health and Justice course, Yale School of Medicine, Physician Assistant Program, and Yale School of Nursing. November 2015.


“Management of Substance Use Disorders.” Yale Affiliated Hospital Program, Greenwich Hospital Teaching Rounds. February 2016.

“Management of Substance Use Disorders.” Yale Affiliated Hospital Program, Bridgeport Hospital Resident Teaching Rounds. June 2016.

“Clostridium Difficile Infection.” Yale Affiliated Hospital Program, Norwalk Hospital Resident Conference. October 2016.

“Management of Substance Use Disorders.” Yale Affiliated Hospital Program, Bridgeport Hospital Resident Teaching Rounds. November 2016.
“Mass Incarceration: Film and Panel Discussion.” Yale Department of Psychiatry, Psychiatry and Film Series. December 2016.


“HIV in the Criminal Justice System.” Yale Affiliated Hospital Program, Danbury Hospital Noon Conference. June 2017.

“Management of Substance Use Disorders.” Yale Affiliated Hospital Program, Norwalk Hospital Teaching Rounds. October 2017.

“Management of Substance Use Disorders.” Yale Affiliated Hospital Program, Bridgeport Hospital Noon Conference. March 2018.


“Diagnosis and Management of Urinary Tract Infections.” Yale Affiliated Hospital Program, Norwalk Hospital Teaching Rounds. November 2018.


“Clostridium Difficile.” Yale Affiliated Hospital Program, Norwalk Hospital Teaching Rounds. October 2019.

Invited small group facilitator. “Taking a Substance Use History.” Session delivered as a required component of the Interprofessional Longitudinal Clinical Experience (ILCE) course delivered to all first-year Yale medical, nursing and PA students. Yale School of Nursing. November 1, 2019.

Non-Yale School of Medicine Affiliated

“HIV and Addiction”: Rhode Island Chapter of the Association of Nurses in AIDS Care, 7th Annual Education Day. September 2010.


“Trends and obstacles associated with healthcare for incarcerated or recently incarcerated women.” Arthur Liman Public Interest Program, Yale Law School. October 2015.


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