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HIV Education Prison Project

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HIV Education Prison Project Hepp News

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About Hepp

HEPP News, a forum for correctional problem solving, targets correctional administrators and HIV/AIDS care providers including physicians, nurses, outreach workers, and case managers. Published monthly and distributed by fax, HEPP News provides up-to-the-moment information on HIV treatment, efficient approaches to administering HIV treatment in the correctional environment, national and international news related to HIV in prisons and jails, and changes in correctional care that impact HIV treatment. Continuing Medical Education credits are provided by the Brown University Office of Continuing Medical Education to physicians who accurately respond to the questions on the last page of the newsletter.

The editorial board and contributors to HEPP News include national and regional correctional professionals, selected on the basis of their experience with HIV care in the correctional setting and their familiarity with current HIV treatment. We encourage submissions, feedback, and correspondence from our readership.

Faculty Disclosure

In accordance with the Accreditation Council for Continuing Medical Education Standards for Commercial Support, the faculty for this activity have been asked to complete financial disclosure forms. Disclosures are listed beneath the authors' names.

All of the individual medications discussed in this newsletter are approved for treatment of HIV unless otherwise indicated. For the treatment of HIV infection, many physicians opt to use combination antiretroviral therapy which is not addressed by the FDA.

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Public Health/Correctional Partnerships at the Millennium

Anne S. De Groot, MD
Director, TB/HIV Research Lab,
Brown University School of Medicine
Consultant: Agouron Pharmaceuticals,
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Speaker's Bureau: Agouron Pharmaceuticals,
Bristol-Myers Squibb, Glaxo Wellcome

At long last, politicians, public health officials and the lay public are recognizing that the correctional health unit, as Bureau of Prisons Medical Director, Dr. Newton Kendig puts it, lies "at the nexus of public health." (Full speech from the National Conference on Correctional Health Care located on page 4.) Why are our care decisions public health decisions? Simply put: corrections is the setting where our nation's most at-risk persons access organized health care.

The topic of creating links between public health and corrections was the focus of two recent meetings: the HIV/AIDS Behind Bars Pre-conference, organized by the HIV Education / Prison Project at the National Conference on Correctional Health Care on November 5, 1999, and the Integrating Public Health and Corrections Collaborations Conference in Chicago, October 5-7, 1999. Both meetings were well attended by correctional health providers, wardens, sheriffs, and public health officials - more than 100 correctional specialists attended the Ft. Lauderdale pre-conference, filling the conference room to capacity. The Chicago meeting featured an inspirational plenary offering by the Reverend Jesse Jackson, who reminded the audience that we are "all under one big tent," thus decisions about health care made inside prison and jail walls have an impact on the community at large.

This article will provide you with the ingredients successful public health and correctional collaborations related to HIV care, and suggestions on the types of programs that might be implemented in correctional settings, as described by the speakers at both conferences. In the new millennium, the solution to providing improved correctional health care while retaining control of the correctional budget may well be to create links between correctional health care and public health programs.

HIV Testing

Public health HIV testing programs exist in every state. The tests are offered at local departments of health, local clinics, health care vans, and substance abuse centers through funding by departments of health. In the past, correctional systems have been able to take advantage of partnerships with state and city departments of health to perform HIV testing in correctional settings; in some cases, public health workers may be recruited to perform HIV pre-counseling and screening at intake.

Correctional systems should contact their state departments of health to inquire whether the DOH is willing to support the cost of HIV testing at intake, at least in part, or perform the HIV test at a discounted rate (compared to commercial laboratories).

HIV Treatment

In the pre-managed care era, some state departments of health were responsible for providing HIV care to jails and prisons. In some states, this model still exists, while in others, DOH activities have shifted.

In Rhode Island for example, the existing HIV care program was initiated as a RI State Department of Health project. The department of health shifted its funding support from treatment to prevention, as the Rhode Island Department of Corrections assumed fiscal responsibilities for the treatment of the incarcerated. At present, the Rhode Island DOH supports activities associated with case management of HIV positive inmates as well as various peer education and prevention activities within the ACI. For more information on Rhode Island's case management and peer education programs, contact Lucille Minuto, Assistant

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Public Health/Correctional Partnerships at the Millennium

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Administrator or Paul Loberti, Chief Administrator, Office of HIV & AIDS at the Rhode Island Department of Health at 401.222.2320.

HIV Transitional Case Management

Transitional case management is an important component of discharge planning. It involves visits to correctional facilities by community-based case managers who assist inmates with planning for care after release and provide a support network for the patient after his or her return to the community.

The State's Health Resources and Services Administration, an agency of the Department of Health and Human Services, administers the Ryan White CARE (Comprehensive AIDS Resources Emergency) Act through its HIV/AIDS Bureau. The CARE Act was named in honor of Ryan White, a young Indiana teenager who died from AIDS in 1990. The CARE Act funds primary health care and support services for low-income, uninsured and underinsured individuals and families affected by HIV/AIDS.

These funds are distributed to states, U.S. territories and major metropolitan areas; local planning bodies then determine funding based upon priorities within the community. CARE Act funds do not support the provision of care in correctional facilities (such as that normally provided by nurses and doctors working with HIV patients). However, community based organizations who receive Ryan White funding have provided transitional case management in correctional facilities (see Table 1).

Funds are available for HIV case management and discharge planning correctional institutions through the Special Projects of National Significance (SPNS) Program, which supports innovative models of HIV/AIDS care for medically under-served and hard-to-reach populations. In 1999, seven states received funds from SPNS and the Centers for Disease Control to improve continuity of HIV care once individuals are released from correctional facilities.

For more information on CARE Act programs, contact your local health department or Barbara Aranda-Naranjo, PhD, RN, FAAN, Director of the SPNS Program, at 301.443.9976. (HRSA's website is www.hrsa.gov/hab). The most successful discharge planning programs invite community-based HIV care providers to come into the jail or prison and arrange for the patient's follow up at the clinic in the community.

HIV Discharge Medications

Traditionally, correctional systems provide a supply of medications to inmates upon release. The amount of medications supplied is usually linked to the expected delay between release and re-entry into the community HIV care system, a duration that may be shortened by providing links to publicly funded ADAP (AIDS drug assistance programs) at the time of release. See Table 2 for a listing of ADAP contacts in high HIV prevalence states (contact HIV/AIDS Bureau at HRSA at 301.443.6745).

One option for correctional HIV providers is to fill out the ADAP paperwork and obtain ADAP approval prior to release. The inmate is then given a contact for the ADAP program at the time of release and medications can start as soon as he or she selects a pharmacy. An additional "bridge" for the inmate who is to be released on medications is now provided by Stadtlanders, one of the major pharmaceutical contractors to correctional facilities. Stadtlanders has developed a free program for discharge medications called "StadtRelease" (contact Kimberly Betty at 800.833.2510 x31458 or visit the Corrections Health Care Network archives at www.corrections.com/health/healtharchives.html for more information).

TB and STD Treatment

Public health programs have consistently been involved in the diagnosis and treatment of STDs and TB in correctional settings. The list of correctional systems with access to DOH assistance for these diseases is too long to publish in this space, but would serve as an indicator of DOH willingness to support programs addressing the diagnosis and treatment of diseases that are considered a "public health concern." It may indeed be possible to build on existing models of STD/TB collaborations to increase public health programmatic support of HIV diagnosis and management in correctional settings.

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Table 1. Examples of some successful public health/corrections collaborations*

PROGRAM	EXAMPLE	CONTACT
HIV Prevention, Counseling, and Testing	**Great Brook Valley Health Center and the Massachusetts DOC (MCI Framingham)** Provides HIV case management, prevention education, counseling and testing. Funded by the Massachusetts DPH through federal grants and the Ryan White CARE Act.	**Kerry Grennan** 508.875.5258 x147 Health Center 19 Tacoma Street Worcester, MA 01605
HIV/STD/TB Diagnosis	**National Center for HIV, STDs, and Tuberculosis Prevention (NCHSTP)**. Limited funds are available from the CDC for screening patients for STDs, TB and HIV in correctional settings, usually as part of a research project.	**NCHSTP** 404.639.8011 1600 Clifton Road NE Mailstop E07 Atlanta, GA 30333
HIV Peer Education	**AIDS Counseling and Education (ACE)**, at Bedford Hills Correctional Facility, New York, and Counseling AIDS Resources Education (CARE) at Taconic Medium Security Prison, New York, promote HIV harm reduction among incarcerated women through peer education. The Women's Prison Association oversees both CARE and ACE. Funding is provided by the Department of Health AIDS Institute through the Criminal Justice Initiative and the Women's Prison Initiative, as well as the Ryan White CARE Act. **Centerforce,** based in San Quentin, CA, is a community-based organization that does prevention, transition, visitation, and literacy teaching for HIV infected inmates and their families. Funded by the CDC/HRSA Correctional Demonstration Grants.	**ACE** Liz Mastroenni 914.241.3100 x4360 LM 247 Harris Road Bedford Hills, NY10507 **CARE** Kim Collica 914.241.3010 x6125 **Centerforce** 415.456.9980 x116 64 Main Street San Quentin, CA 94964
HIV Correctional Officer Education	**Correctional Technical Assistance and Training Project (CTAT)**, affiliated with Southeast AIDS Training and Education Center at Emory University, Atlanta, GA, provides technical assistance to the seven state grantees of the HRSA/CDC correctional initiative grants. CTAT also provides training for corrections personnel in GA and by special contract to other states.	**Jackie Zalumas** 404.727.2927 735 Gatewood Road NE Atlanta, GA 30322
HIV Discharge Planning	**Transition Linkage to the Community (TLC)** provides transitional planning for Connecticut inmates that helps bridge the gap between correction and HIV services in the community.	**Sister Carol Duffy** 860.527.1866
HIV Physician Education	**-AIDS Education and Training Centers (AETC)** provide free onsite programs for correctional health care providers. **-HEPP News** is a free monthly fax newsletter that provides up-to-the-moment information on correctional HIV health care. **-HIV Insite** is a website that provides updated information on HIV health care. **-The Hopkins HIV Report** is a bimonthly newsletter for practitioners caring for patients with HIV/AIDS. Their website also provides updated information on HIV care.	Visit: www.hrsa.dhhs.gov Call 401.863.2180, Fax 401.863.1243 or Visit: www.HIVcorrections.org Visit: http://hivinsite.ucsf.edu/ The Hopkins HIV Report P.O. Box 5252 Baltimore, MD 21224 http://hopkins-aids.edu
HIV Medication	**The Illinois AIDS Drug Assistance Program (ADAP)** helps connect qualified jail and prison inmates with the state ADAP.	**Judy Eihansen** at **ADAP** 800.825.3518

** Many other examples of such collaborations exist. If you would like to add to this resources list, please call Betsy Stubblefield at 401.863.2180 or fax to 401.863.1243. This is a work in progress, and will be available on our website: www.HIVcorrections.org.*

Letter from the Editor

Dear Colleagues,

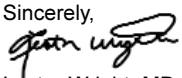
Corrections and public health agencies have not recognized the potential their partnership could have to benefit the public. They come from very different cultures; they are both busy caring for the most visible needs. Public health differs in two ways from the general health care system: it focuses on a community and emphasizes prevention. Corrections health has focused on individual inmate/patients at medical call out and emphasized urgent curative care. But corrections is a community, a group of people living in close association, and keeping that community healthy is not only more efficient than waiting to treat after illness occurs or becomes severe but also assures that those being released are healthier than when they return to the general public. It is far easier to find people and prevent and treat their health problems while incarcerated than after they return to the "free world."

Where partnerships have developed everyone benefits. In 1996 a fourth of all syphilis cases in Chicago were found in corrections; disease rates for TB and Hepatitis C may be ten times higher in those entering corrections than in the general population. If the public health goes "where the action is," will corrections health be ready to work with them? In this issue of HEPP News potential partnerships with public health are the common thread. Expect to hear more about these partnerships from many voices this year. Together we can improve the health of the public as a whole. This can be a truly positive contribution from the stand point of the corrections budget.

Also in this month's HEPP News is an algorithm for stopping prophylaxis for patients on HAART, a spotlight on a new community based discharge planning program in Massachusetts, and public health resource and contact lists. After reviewing this issue, readers should be able to identify the appropriate time to cease prophylaxis, distinguish between the various public health resources and grant opportunities for correctional health care, and select the correct antiviral treatments in accordance with the findings of recent studies. Next month's issue will focus on treatment updates.

Thank you for your continued support of HEPP News. We look forward to hearing from you!

Sincerely,



Lester Wright, MD

News Flashes

New Options for Initial HIV Treatment Efavirenz and Two NRTIs

Two studies published in the *New England Journal of Medicine* in December (Staszewski et al., and Starr et al., NEJM. Dec. 16 1999; 341(25): 1865-73, 1874-81) extolled the value of combining Efavirenz (Sustiva) with two NRTIs. Dr. Nathan Clumeck compared and commented on the studies in an editorial entitled "Choosing the best initial therapy for HIV-1 infection" (1925-26). The study by Staszewski et al. illustrated the different perspectives given by an "intent to treat analysis" (in which every discontinuation of treatment was counted as a treatment failure) and an "as treated analysis" (which provides a better assessment of antiretroviral potency). In the intent to treat analysis, efavirenz (EFZ, Sustiva), lamivudine (3TC, Epivir) and zidovudine(AZT, ZDV, Retrovir) appeared to be more effective than the alternative regimen because more patients "failed" the alternative (indinavir [IDV, Crixivan], ZDV, 3TC). When the data published in Staszeweski et al. was viewed from the "as treated" perspective, according to Dr. Clumeck, the two regimens appeared to be more or less equivalent. (However, the authors stated that the Efavirenz containing regimen had superior antiviral potency). Dr. Clumeck reminded his audience that we're still awaiting longer term comparisons of protease inhibitor containing regimens and regimens containing NNRTIs instead of PIs.

(Editor's note: Efavirenz is attractive for correctional use because it is "once a day" and requires fewer pills (three, for the standard 600 mg QHS dose) than some protease inhibitors. Abacavir is associated with rash, myalgia in fever in a significant proportion of patients, and several patients have died after developing the rash and then being re-challenged with Abacavir (Escaut-L; Liotier-JY; Albengres-E; Cheminot-N; Vittecoq-D. Abacavir rechallenge has to be avoided in case of hypersensitivity reaction [letter] AIDS.1999 Jul 30; 13(11): 1419-20.) Discriminating between Abacavir toxicity and the flu is critical for correctional HIV providers. Correctional HIV providers using Abacavir may wish to use the Abacavir rash/fever evaluation protocol developed by Dr. Rick Altice and published in April HEPP News. Efavirenz has also been noted to be associated with CNS effects such as vivid dreams and mood changes in a significant proportion of patients; effects that may either positively or negatively impact on adherence by correctional patients. Anecdotal reports of recreational Efavirenz use have arrived at HEPP News from the West Coast.)

Protease Inhibitors More Effective at Suppressing HIV-1 in Lymphoid Tissue

When compared to NRTIs alone, protease inhibitor containing regimens were more effective in the suppression of HIV-1 replication in lymphoid tissues according to a study published by L. Ruiz et al. AIDS 1999; 13(1): F1-F8. Lymphoid tissue was obtained from 12 patients, four of whom were receiving multiple NRTI therapy and one who was "sub-optimally" dosed with PIs, and seven patients who had received PI therapy for at least 6 months prior to biopsy. Protease inhibitor-containing regimens appeared to more effectively reverse HIV-induced immunopathological changes in the lymphoid tissue. Protease inhibitors have also been associated with loss of viral fitness. These potential benefits of protease inhibitor therapy are worth considering when decisions related to initial or sequential antiretroviral treatment is being considered.

BID Nelfinavir Approved by FDA

Based on information reported in a study conducted by A Peterson, F. Antunes, KN Arasteh, FD, Gobel, J Gonzalez and others and reported in Abstract number 205 at the Seventh European Conference on Clinical Aspects and Treatment of HIV infection (Lisbon, Portugal, October 23-27, 1999), the FDA recently approved a modification of Nelfinavir dosing from 750 TID to 1250 BID. Study AG 1343-542 compared the long-term antiviral efficacy of bid versus tid dosing of nelfinavir in combination with d4t and 3Tc. The study showed that 1250 mg bid and 750 TID achieved equivalent efficacy and safety beyond 48 weeks.

This is an important dose modification that will simplify protease inhibitor-containing regimens in correctional settings. By comparison, Indinavir (crixivan) is dosed three times daily at eight hour intervals. The combination of Ritonavir (Norvir) and Saquinavir (Fortovase) is an alternative BID regimen. (Abstract available at http://www.euroaids99.com.)

Preview of February HEPP News

Main article: HIV Treatment Update. Editors Joe Bick and Anne De Groot will summarize and comment on the current treatment guidelines.
HIV 101: Listing of current HAART Therapy regimens.
HEPPigram: Algorithm for restarting HAART after re-incarceration
Spotlight: 7th Retrovirus Conference (San Francisco) : Joe Bick, Anne De Groot, and Rick Altice will bring you the latest update on correctional HIV management.

SPECIAL REPORT - The State of Correctional Health Care at the End of the Millennium

From the National Conference on Correctional Health Care, Ft. Lauderdale, Florida, Nov. 1999

Captain Newton E. Kendig, MD, *Medical Director, Federal Bureau of Prisons*

HEPP News received permission to reprint Dr. Kendig's speech from the NCCHC. The text of the original has been edited to conform to HEPP News space requirements. The opinions expressed in this speech are those of the author and do not necessarily represent the opinions of the Federal Bureau of Prisons or the Department of Justice.

The importance of health care in America's jails and prisons has never been greater. Last month, the National Center for Health Statistics reported continued declines in deaths from heart disease, cancer, and stroke, and dropped AIDS as a major cause of mortality.[1] Despite these achievements, the Census Bureau recently announced that the number of persons without health insurance climbed last year to 44 million Americans.[2] The lack of health care coverage remains concentrated among the uneducated, immigrants, and the otherwise disadvantaged, who have not proportionally benefited from our advances in health care. Despite our country's affluence and medical achievements, we have yet to determine how to deliver health care equitably and cost-effectively to all Americans.

In recognition of our problems with health care delivery, the Surgeon General has issued a list of priorities for the nation:[3] (1) develop a more balanced health system by encouraging universal access to health care including mental health and healthy starts for every child, (2) maintain a global approach to disease prevention and health promotion, and (3) eliminate racial and ethnic disparities in health.

As correctional health care providers we are poised not only to help meet these priorities, but to play an essential and pivotal role. Correctional health care has become a critical nexus for public health interventions, since it is where our nation's most at-risk persons access organized health care. It has been stated that corrections is a microcosm of society, but perhaps it should be restated that society is a macrocosm of corrections, because prisons are not self-contained. The treatment of inmates directly affects and reflects on society at large. Our patients increasingly have more of the problems that most significantly affect our society: violent behavior, substance abuse, mental illness, and infectious diseases. Our challenge has never been greater.

Larger Numbers of Inmates, Longer Sentences

Prison populations continue to grow in both State and Federal systems. At year-end 1998, more than 1.8 million U.S. residents were in either jail or prison.[4] Last year, the Bureau of Prisons added approximately 10,000 inmates to its population and anticipates continued growth.

Not only do we manage more inmates than ever before, our inmates are our patients for longer periods of time and present with increasingly complex medical problems. A significant proportion of inmate morbidity is related to substance abuse. Approximately 60-80% of the nation's correctional population have used drugs at some point in their lives, twice the estimated drug use of the total U.S. population.[5] Between 1980 and 1994, the average sentence imposed on drug offenders increased from 47 to 80 months.[6,7] As persons with substance abuse histories spend more time incarcerated, the opportunities to provide drug treatment are shifting from the community to jails and prisons.

Although the press recently described jails and prisons as "incubators of infectious disease,"[8] in reality, the prevalence of infectious diseases there largely results from previously infected inmates entering the correctional systems. Jails and prisons can fuel infectious disease outbreaks, just as hospitals can, by the sheer concentration of high risk populations; but these same systems have a proven role in identifying, treating, and controlling communicable diseases.

HIV, STDs, and TB

State prisons in high prevalence areas are key sites for diagnosing new cases of HIV in persons at risk, who were previously unaware of their infection. This dramatic two-year decline has been achieved in a population at high risk of treatment failure due to ongoing substance abuse prior to incarceration. Jail-based screening for sexually transmitted diseases (STDs) is now recognized by large city health departments as a proven strategy for curbing syphilis outbreaks and identifying asymptomatic high risk populations for other STDs.[9] The decline in tuberculosis (TB) incidence in the U.S. is in part the result of TB screening programs in urban jails and the completion of directly observed therapy in long term prisons.

Despite our successes in containing communicable diseases. TB epidemics continue unabated in most parts of the world; and multi-drug resistant TB has become a global problem.[10] Effective TB control programs in jails and prisons will be essential to our national efforts to further control TB, or approach TB elimination.

Hepatitis C

Hepatitis C viral (HCV) infection presents perhaps the most daunting challenge for correctional providers, because of the marked prevalence of this chronic infection among inmates. Correctional health care providers must take an increasing role in establishing treatment standards for HCV, since the responsibility for managing infected persons will be centered in U.S. jails and prisons.

Mental Illness

A recent correctional health publication reported that jails and prisons house more mentally ill individuals than hospitals and chronic care mental institutions.[11] The institutions housing the chronically mentally ill in America are our large urban jails. The Bureau of Justice Statistics reported that nearly 300,000 mentally ill offenders were held in the nation's state and federal prisons by midyear 1998 and nearly twice as many mentally ill persons were on probation in the community.[12] Identifying and treating inmates with mental illness has important public health and public safety ramifications, since offenders with mental illness are more likely to commit a violent offense or be nonadherent to recommended behavior changes and treatments that may curb disease transmission.

The Team Model

Inmates as patients are more complicated than ever before, challenging our traditional models of health care delivery. The Bureau of Prison's Health Services Division is drafting a new mission statement: "to provide inmates access to essential quality health care in a cost effective manner." The Bureau of Prisons is reviewing various methods of primary care delivery for inmates. In one model, a team approach is used for providing care. Every inmate is assigned to a health care team. Chronically ill inmates are routinely scheduled for evaluation. A nurse triage system evaluates inmate complaints and schedules follow-up appointments. Using this model, only inmates with true emergencies or urgent health needs are seen on an unscheduled basis. This model is supported by an inmate co-pay system for certain services and by ready access to certain over-the-counter medications in the commissary.

Determining the level of care provided to inmates is as important as ensuring access to health care. Whether administrators or direct providers, correctional workers walk a fine line in deciding what level of care to provide. In reality there is no accepted community standard for health care in the U.S. because established health plans differ widely in the services they provide.

BOP Core Values

The Federal Bureau of Prisons is attempting to better define essential care for inmates and has identified several core values that should underpin the Bureau's scope of services, including: treating all inmates equally, "doing no harm," respecting inmate autonomy in treatment decisions, recognizing the importance of treatment on inmate function in activities of daily living, cost effectiveness, protecting public health, and ensuring public safety. The Bureau's goal is to provide inmates the highest quality of care, within the defined scope of services, without compromising core values.

The Bureau's mission is not only to provide inmates access to essential quality care, but also to deliver health care cost-effectively. Health care expenditures will grow dramatically in the next decade, as much as $1 trillion by some estimates. Cost containment through traditional managed care efforts has largely been realized. The escalation of health care budgets will increasingly be driven by the cost of new technologies and drug therapies.

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SAVE THE DATES

The 2000 National Conference on African-Americans and AIDS
February 24-25, 2000
Renaissance Hotel, Washington DC
Contact the Office of CME at
Johns Hopkins. University
Call: 410.955.2959
Fax: 410.955.0807
E-mail: cmenet@jhmi.edu
Visit: www.med.jhu.edu/cme

HIV Pathogenesis, Antiretrovirals, and Other Selected Issues in HIV Disease Management
February 11, Atlanta, GA
February 26, Los Angeles, CA
March 8, Boston, MA
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The Science and Treatment of HIV: An Advanced CME Course for Clinicians
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Fax: 415.561.6740
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National HIV/AIDS Update Conference
HIV/AIDS at the Crossroads:
Confronting Critical issues
March 14-17, 2000
San Francisco, CA
Call: 514.874.1998
Fax: 514.874.1580
E-mail nauc@total.net
Visit: www.nauc.org.

National Conference on Pharmaceutical Care to Underserved Populations
April 3 -4, 2000
Chapel Hill, NC
Call: 919.966.8138
Email: steve_moore@unc.edu

10th Annual Clinical Care Options for HIV Symposium
May 4-5, 2000
Scottsdale, AZ
Phone: 888.391.3996
Fax: 508.528.7880
E-mail: registration@mail.
medscape.com
Visit: http://hiv.medscape.com
/symposium2000

Drug Use, HIV and Hepatitis: Bringing it All Together
May 7-10, 2000
Baltimore, MD
Call 877.565.3693
Fax: 301.565.3710
Visit: www.chhatt.net/
conference.htm

RESOURCES

FUNDING AND PUBLIC HEALTH COLLABORATIONS INFORMATION WEBSITES

National Center for HIV, STD and TB Prevention, Divisions of HIV/AIDS Prevention
http//www.CDC.gov/nchstp/

CDC National Prevention Information Network
http//www.cdcnpin.org

Ryan White CARE Act Information
http://158.72.83.3/hab/care.html

Substance Abuse and Mental Health Services Administration
http//www.samhsa.gov

Health Resources and Services Administration
http//www.hrsa.dhhs.gov/hab/

AIDS Education Training Centers
http//www.hrsa.dhhs.gov/hab/C/4web/aetcroster.htm

National Alliance of State and Territorial AIDS Directors
http//www.nastad.org

The HIV/AIDS Treatment Information Service
http://www.hivatis.org

The Daily HIV Briefing
http://www.aegis.com

The Corrections Connection
http://www.corrections.com

The State of Correctional Health Care at the End of the Millennium

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The Health Services Division supports models that utilize professional staff the most efficiently, with the intended result that staff spend the majority of their work day using their specific skills and training. Health care delivery has gotten too expensive for us not to maximize the use of the staff's specific skills. Doctors and mid-level practitioners need to see patients, nurses need to do nursing care, triage patients and manage clinics, and they need the support staff.

Evidence Based Disease Management
Evidence-based disease management will be increasingly necessary as more health resources are dedicated toward preventive health care and the treatment of chronic illnesses. Structuring therapies through drug formularies alone is no longer sufficient. Pharmaceuticals have become too expensive and treatment options too varied. Specific strategies based on evidence-based data must drive how we treat patients and deliver this care. This treatment approach not only better utilizes existing resources, but is also the practice of good medicine.

The use of telemedicine and the Internet will lessen the isolation of correctional medicine while furthering public safety. The challenge will be to use these technologies strategically to maximize cost efficiency. Interventions must improve operations at the frontlines, making it easier, not more difficult for doctors to treat inmates. New data systems must ensure that collected information provides outcome measures that improve correctional medicine at the most fundamental level, patient care. (For recent BOP survey see box).

Discharge Planning
Gains in health care delivery are pyrrhic victories if correctional systems do not improve linkages with community-based providers. Working with corrections is a strategic necessity for public health and is tangibly demonstrated by funding opportunities from the Centers for Disease Control and Prevention and other government and private organizations. Supporting community linkages for soon-to-be-released inmates is not sufficient in itself; studies must determine what models are effective. Broader implementation of effective models will create safer communities and forge support for funding these programs.

Role of Correctional Health Care Providers
As we near the next millennium, what doctors and nurses in U.S. jails and prisons do day in and day out has never been more important to both public safety and public health. As prison systems manage larger inmate populations, with increasingly complex histories of violence, emotional, and medical problems, maintaining institutional and public safety is paramount. The role of correctional health care providers in this effort is no less than essential, yet is frequently under appreciated. The provision of consistent, quality health care to inmates means not just healthier inmates, but creates safer prisons.

BOP Review of State Correctional Facility Health Care Budgets

as reported by Dr. Newton Kendig at the Nov. 99 NCCHC.

Dr. Kendig reported the following findings at the November 1999 NCCHC conference from an independent survey of State Correctional Systems[1] that was funded by the BOP:

- Correctional system health budgets increased 9.1%, on average, between FY† 1997 and FY 1998,
- This growth rate was comparable to rates of increases of overall correctional budgets.
- Health care represented, on average, 10.6% of correctional budgets, ranging from 5% to nearly 17%.
- Per capita costs ranged from $2.74 per inmate per day to $11.96 per inmate per day with a mean per capita of $7.15 per inmate per day.
- As compared to the Corrections Yearbook 1998, systems in this survey ranged $3.13 below to $5.70 greater than published rates.

Factors that accounted for 60% of the difference between high and low per capita cost states:

- Type of health care staff (lower cost used fewer mid level practitioners, but physician/inmate ratios did not differ between high and low cost states).
- Contracted employees vs. Correctional employees (lower cost states used more contracted).
- Use of capitated contracts (lower cost states used more capitated contracts, or payment in advance for specific services or service types).
- HIV testing at intake¥ (lower costs states were less likely to HIV test at intake).

Key:
†FY signifies fiscal year.
?The survey did not assess or compare the quality of health care delivered by different systems. No determination was made as to whether high cost states provided better, equivalent, or lesser standards of care to their inmates when compared to low cost states.
¥HIV testing at prison entry was probably a proxy for other cost drivers, since the number of inmates with HIV infection was not different between high and low cost states.

[1] *Lamb-Mechanick, D. & Nelson, J. (1999), Prison health care survey: an analysis of factors influencing per capita costs. National Institute of Corrections Report, December.*

Public Health/Correctional Partnerships at the Millennium

Continued from page 2

HIV Education Programs
Free educational material and on-site programs for care providers, patients, and correctional staff are available through a wide variety of publicly funded resources:

(1) HIV Education for Providers

AETC: Federally supported AIDS Education and Training Centers (funded through the Department of HHS) have recently shifted their focus to address the needs of correctional HIV providers (http://www.hrsd.dhhs.gov).

HHS: Additional free HIV treatment resources include the HHS guidelines for the management of HIV, opportunistic infection, which are published on the web (http://hivatis.org/trtgdlns.html) and updated yearly by a national panel of experts. (see page 7, HIV 101).

Publications: The Johns Hopkins HIV report, HIV Insite (from the University of California at San Francisco) and the JAMA HIV website (http://www.hopkins-aids.edu/, http://hivinsite.ucsf.edu, http://www.ama-assn.org/special/hiv/hivhome.htm) are additional free resources that can be accessed by correctional HIV providers.

HEPP News: This monthly newsletter is available at no cost to correctional HIV providers (fax-back form on page 7; website http://www.corrections.org). HIV Inside, another quarterly publication, is available by request from World Health Communications (see page 8). Both publications provide Continuing Medical Education credit (CME) for providers. CEU for pharmacists and nurses will be available later this year.

(2) HIV Education for Patients

Ryan White: Fortunately, patient education-and specifically education by peers-is a primary focus for public health funding. Both federal and local programs are accessible to correctional HIV providers. The best contact for information would be the Ryan White Committee (through your local health department). They will provide a list of community based organizations that are willing to come to your facility to facilitate educational programs for inmates.

Other HIV Education Programs: A number of model programs such as ACE (Bedford Hills, NY), Span (Massachusetts), and Centerforce (San Quentin, California) successfully met inmate HIV educational needs. Some of these programs have recently demonstrated the positive effects of HIV education on subsequent HIV risk behavior after release.[2]

(3) HIV Education for Staff

Correctional security staff are the "third partner" in correctional HIV care, since they control the flow of inmates to medlines and clinics. In a number of states, AETC-funded programs that have provided education to correctional security staff have been well-received (see Table 1.) Several pharmaceutical companies are also developing free programs in recognition of the important role that correctional officers play in patient care.

Summary

Correctional interventions in the area of HIV care have had a dramatic impact in the last decade, mainly due to the identification and treatment of HIV infected individuals who were unaware of their infection prior to incarceration.[3,4,5] Correctional settings can be where persons at risk learn about HIV, about how to avoid HIV infection and become informed consumers, learning how to manage their disease. However, advances in HIV treatment in correctional settings have been uneven at best. Poor correctional HIV management can have an adverse impact on public health. Spotty medication delivery, inattentive prescribing of HIV medications, and failure to provide adequate prophylaxis can result in the delivery of inmates who are sicker and more likely to be infected with drug resistant strains of HIV back to their communities. For an even more inspirational view of our role as providers at the nexus of public health, read Dr. Newton Kendig's plenary speech, in this issue of HEPP News on page 4.

Table 2. Ryan White/ADAP contact information

State	Central Ryan White Contact (for information on local RW Committees)	ADAP Contact
California	California DOH Office of AIDS CARE Section 916.323.8949	**Michael Montgomery** *Office of AIDS ADAP* 916.327.6784
Connecticut	CT DPH Bureau of Community Health 860.509.7800	**Bette Smith** *CT Dept Social Services* 860.424.5152
Washington DC	Department of Health 202-939-7822	**Paul Brown** *Agency for HIV/AIDS* 202-727-2500
Florida	Florida DOH Bureau of HIV/AIDS 850.245.4335	**Cyndena Hall** *DOH HIV/AIDS Program* 850.245.4444 x2547
Georgia	Georgia DOH- Prevention Services Branch STD/HIV Section David Johnson 404.657.3100	**Libby Brown** *Dept of Human Services* 404.657.3129
Illinois	Judy Eihausen at ADAP 800.825.3518	**Nancy Abraham** *DOH AIDS Activities Section* 217.524.5983
Massachusetts	DOH HIV/AIDS Bureau 617.624.5300	**Mass HIV Drug Assistance Program** 800.228.2714
New Jersey	NJ DOH AIDS Prevention/Control 609.984.5874	**Ron Weinstein** *DOH Division of AIDS* 609.984.6328
New York	NY State DOH AIDS Institute 518.473.7542	**AIDS Drug Assistance Program** 800.542.2437
Pennsylvania	PA DOH HIV/AIDS Programs 717.783.0479	**AIDS Drug Assistance Program** 800.922.9384 State AIDS Fact Line: 800.662.6080
Texas	Texas DOH HIV/STD Services 512.490.2515	**Rhonda Lane** *Texas DOH* 800.255.1090

References:

[1] Pharmaceutical companies have also recognized the importance of public health- corrections linkages and were instrumental in providing support for these two conferences: HIV/AIDS Behind Bars at the Florida NCCHC was supported by an unrestricted grant from Glaxo-Wellcome. Public/Health Corrections collaborations was supported by an unrestricted grant from Briston-Myers Squibb. Integrating Public Health and Corrections Collaborations was supported by an unrestricted grant from Bristol Meyers Squibb, with additional support from the CDC, the City of Chicago Public Health, the Health Resources and Services Administration, the National Institute of Justice, Substance Abuse and Mental Health Services Administration, and in kind contribution from the National Commission on Correctional Health Care.

[2] Grinstead, O., Zack, B., Faigeles, B. Health Education & Benefits, April 1, 1998; 26(2) 225-238.

[3] Mostashari F, Riley E, Selwyn A, Altice F. J Acquir Immun Def Syndr and Human Retro. Aug 1, 1998; 18(4) 341-8.

[4] Hammett, T. M. Prevention and Treatment of HIV/AIDS: An opportunity not yet seized. HEPP News, December 1999; 2(11).

[5] Maruschak, L. (1999), HIV in Prisons 1997, Bureau of Justice Statistics Bulletin, U.S. Department of Justice, Washington DC, November 1998.

HIV 101

Guidelines for stopping Prophylaxis or Maintenance Therapy in patients with HIV Infection who have responded to a HAART Regimen.

Health and Human Services (HHS) guidelines on treating opportunistic infections now suggest that patients taking expensive and usually poorly tolerated prophylactic therapy to prevent first episode of disease (e.g., azithromycin or clarithromycin for the prevention of MAC) may stop when CD4 levels have stayed above the threshold for starting prophylaxis for three to six months and there has been sustained suppression of viral load. This months HIV 101 summarizes the new guidelines. It is critically important for correctional healthcare providers to counsel patients that the new guidelines are only applicable in the presence of a sustained response to HAART. Should the patient discontinue HAART therapy or exhibit progression on HAART, the need for treatment and prevention of opportunistic infections should be reassessed.

Pathogen	Criteria* If, as a result of HAART, the following changes occur	Comment**
Pneumocystis (PCP)	CD4>200 for more than 3-6 months (CIII) and sustained VL reduction for 3-6 months (CIII)	Only for primary Prophylaxis
Mycobacterium Avium Complex (MAI, MAC)	see comments	Only for primary prophylaxis. Recommendation now supported by placebo controlled trial.
Toxoplasma Gondii	no criteria given	Not recommended, but implicit in Pneumocystis guideline.
Cytomegalocirus (maintenance therapy)	CD4>100-150 for more than 3-6 months(CIII)	Primary prophylaxis is not generally recommended. Other factors should also be considered (CII)
Cryptococcosis	no criteria given	Not recommended, but probably safe for patients with CD4>100 for 3-6 months.
Histoplasmosis	no criteria given	Not recommended, but probably safe for patients with CD4>100 for 3-6 months.

Rating system:
C= Optional. Evidence for efficacy insufficient to support recommendation for or against, or efficacy may not outweigh adverse consequences.
II = Evidence from at least one well designed, non-randomized trial or other observational studies.
III = Expert opinion.
*If primary prophylaxis, the patient has never had the condition and this treatment prevents primary occurrence. If maintenance, the patient had the condition and this treatment prevented secondary recurrence.
**The correctional provider will need to carefully consider whether the patient is expected to retain HAART benefit over the long term before discontinuing treatment. For example, one might be wise not to discontinue prophylaxis in patients who are soon to be released.

Adapted from the MMWR report on August 20, 1999 / 48(RR10);1-59, available at http://www.cdc.gov/epo/mmwr/preview/mmwrhtml/rr4810a1.htm#tab13 and the Johns Hopkins University website: www.hopkins-aids.edu/publications/report/jan00_5.html

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FACILITY: _____ (Optional) # of HIV Infected Inmates: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

FAX: _____ PHONE: _____ E-MAIL: _____

SIGNATURE: _____ DATE: _____

Spotlight: New Initiatives in the Massachusetts DOC & DOH

Tim Gagnon is HIV Program Coordinator of the Massachusetts County Jails Program and, with his colleagues at the MA DOH, a recent recipient of one of the $1 million dollar "Correctional Demonstration Project" grants from HRSA/CDC. We elected to interview Mr. Gagnon about his new grant for this Public Health/Correctional Linkages issue of HEPP News.

HEPPNews: *What has been your involvement with HIV in corrections?*
Tim Gagnon: I helped to design a system to deal with HIV throughout the correctional system, which continues to this day. With some financial help from the sheriffs and the DPH we were able to get the outside communities involved. We subcontract a lot of the services in the HIV programs to the community in order to get HIV a little bit more on everybody's radar.

The effect has been really astounding. When we started going in there in '92 I don't think there were more than 125 HIV infected inmates being treated annually in the whole county-jail system. Last year we provided services to all 1,500 men and women who are HIV infected- just in the county jail systems.

HN: *The funding you just received from HRSA and the CDC was to start new discharge planning in the county jails?*
TG: Let me back up a little. When you're talking about jails and houses of correction you're talking about a very transient, short prison stay for many more people. On any given day in Massachusetts, there's about 25,000 people that are incarcerated. Roughly half are in the state system and half are in the county system. The big difference between the state system and the county system, because of the length of stays, is that any given year, there may be close to 60,000 admissions to the county jail system, versus a state system, which usually averages about 3,000 new persons each year.

Historically, what has happened in the jail and house of corrections populations is that people aren't there long enough for their HIV to become problematic in a clinical sense. Correctional care providers obviously dealt with the people that they knew about, but most of the work pre-dating the programs we have now was not sustained nor was it comprehensive. It didn't have to be, because people were never there long enough.

HN: *Given that history, you started your new programs?*
TG: (Yes). If inmates have some special needs, the case-workers on the inside will attempt to get those needs addressed. But we don't have a mandate or the ability to follow someone into the community after they have left. That's where the new money comes in. We've done such a tremendous job upstream - while people are incarcerated, educating, testing, treating, and case-managing. We've created a situation where in Massachusetts in any given year over the past few years, we're discharging anywhere between 1,000 and 1,500 prisoners--men and women with HIV--back to the community. Once they get back there, even if we are able to develop a fairly comprehensive discharge plan for them, you just don't know what's going to happen to people.

The grant from HRSA and the CDC will fund three initiatives. One is to start a statewide network of people who will be community based, whose job is to help transition former prisoners back into their communities. This program, called the Transition Intervention Project (TIP), is an expansion of a pilot mental health transition project that the Mass DPH funded starting a year and a half ago that has a licensed social worker helping prisoners with adjustment issues. Our staff will work with jails and prisons three months before someone gets out-regardless of whether the patients are incarcerated in the county or the state or even in the federal system. We're going to connect our staff to the inmates before they hit the streets in Massachusetts. The second initiative is to establish a Chlamydia screening program at the Nashua State Jail in Boston. The third initiative involves prevention education work in the community correctional centers.

We're really excited about this. Even though a person has made great strides to deal with their addictive behaviors, get involved in some quality HIV care and have done well while they are incarcerated, there are a lot of problems once they get out. Often they don't have transportation and there might be language barriers to accessing services. Our programs should be really helpful, and benefit inmates statewide.

Some of the easier tasks are getting them an appointment for HIV and helping them maintain access to their medications. But quite often the kinds of services that recently released inmates with HIV need to access do not traditionally have anything to do with HIV. The other problems they face are the more complicated social services needs. Studies have shown that the first 6-8 months on the street are when people are more likely to do something that will cause them to be re-incarcerated. There are programs that will do this kind of work (bridging the gap) such as the Fortune Society in New York, and Span in Boston.

HN: *Where are the programs going to take place?*
TG: We did some analysis on exit patterns where we collect client-level data on all our county-jail inmates, who represent the biggest number of prison inmates. Our research has concluded that 90% of all the HIV infected prisoners who are discharged from correctional facilities in Massachusetts go back to one of 10 communities in the state.

We then divided the state up into 6 regions. We want community-based providers from these particular regions to submit proposals to us to do this work. We'll have someone from this office that will coordinate this statewide project the way I coordinate the jail stuff statewide. On the micro-side, there are HIV coordinators in all of the prison and jails in Massachusetts. When someone is getting ready to leave, part of the discharge plan is to connect them with the representative from their region who will talk to the potential client. That's where the relationship is born. Then when the person gets out, they'll be able to contact this person. In some cases, the person may pick them up in the jail when he gets out.

A lot of times we lose people that way. You've spent three months working on a discharge plan that's contingent on a guy getting a sober bed at a drug treatment center on June 5, 1999, and for whatever reason, they decide to release him on May 26. Now this guy has nowhere to go. This happens very frequently. So we have to have people who are very mobile and very flexible on the outside who can be reached by being paged or called on the phone. Part of our budgeting on this program is to put people on the street with laptops and cell phones so that they're totally mobile.

HN: *Is there going to be a way for you to measure the success of the program?*
TG: We're working on an evaluation piece for this right now. We'll obviously be keeping track of the kinds of services people access. We'll create some unique identifiers for clients to keep track of the kinds of services they'll utilize while they're in this phase of their careers. We'd like to see that people are staying engaged; if they have mental health issues that they're able to access mental health treatment, if they're on meds that they stay adherent, and stay engaged with their medical providers. That's what we're looking for in terms of outcomes. Certainly if all these things are in place, we would expect that people are less likely to get back into a behavioral pattern that will result in re-incarceration, but that remains to be seen.

HN: *What is the future of funding for these programs?*
TG: Our feeling is that there is a well-funded universe and network of social services in this state. Certainly it exists with regard to HIV services. It is our hope that at the end of the funding period, which is three years long, that we will have better defined this universe of services in terms of which ones these people need to access more than others. At the end of the funding cycle a lot of the case management pieces that are being funded by this will most likely be absorbed by the community based agencies that are funded to provide a lot of these services in the first place. Our goal is to put ourselves out of business, in a sense.

HN: *When does everything begin?*
TG: It's happening right now. We're in the process of putting the RFP together and attempting to hire a statewide coordinator. We are negotiating with the CDC and HRSA some evaluation criteria that we'll build into this.

I think that from the public health standpoint, this is an opportunity that is not realized on a national level-not only with HIV but especially with Hepatitis C and STDs. There's a real case to make. If, as a society, we spend a little bit of money on preventive health care on this population now, we save a lot of money 5 to 20 years down the road. I would like to advocate this work for reasons other than cost effectiveness, but often that is the strongest case we can make for these interventions.

Self-Assessment Test for Continuing Medical Education Credit

Brown University School of Medicine designates this educational activity for 1 hour in category 1 credit toward the AMA Physician's Recognition Award. To be eligible for CME credit, answer the questions below by circling the letter next to the correct answer to each of the questions. A minimum of 70% of the questions must be answered correctly. This activity is eligible for CME credit through February 29, 2000. The estimated time for completion of this activity is one hour and there is no fee for participation.

True/False:

1. ____ The combination of efavirenz, lamivudine, and zidovudine has been found to be more effective than indinavir, zidovudine, and lamivudine.

2. ____ Protease inhibitor containing regimens were more effective in the suppression of HIV-1 replication in lymphoid tissue than NRTIs alone.

3. ____ Efavirenz has been noted to be associated with CNS effects that may impact on adherence by correctional patients.

4. The Ryan White CARE Act provides which of the following?

a) Funds that help support provision of care to incarcerated HIV infected patients.
b) Funds for primary health care and support services for low-income, uninsured and underinsured individuals and families affected by HIV/AIDS.
c) Support for research or models of HIV/AIDS care for medically under-served and hard-to-reach populations.
d) Assistance with access to HIV medications for under-served populations.

5. When can cytomegalovirus maintenance therapy prophylaxis be stopped?

a) When a patient has maintained a CD4 count of 100 for more than 3-6 months, during which time he had no OI's.
b) When a patient has maintained a CD4 count of 150 for 7 months, during which time he had no OI's.
c) When a patient has maintained a CD4 count of at least 200 for at least 6 months.

6. Experts suggest is it possible to stop PCP primary prophylaxis given which criteria?

a) CD4>300 for more than 3-6 months
b) CD4>150 for >6-8 months, and sustained VL reduction for 3-6 months
c) CD4>200 for >3-6 months and sustained VL reduction for 3-6 months
d) Not recommended, but probably safe with CD4>100 for 3-6 months
e) Not recommended

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