Public Health/Correctional Partnerships at the Millennium

Anne S. De Groot, MD
Director, TB/HIV Research Lab,
Brown University School of Medicine

Jesse Jackson, who reminded the audience that we are "all under one big tent," thus decisions about health care made inside prison 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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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.

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

<table>
<thead>
<tr>
<th>PROGRAM</th>
<th>EXAMPLE</th>
<th>CONTACT</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV/STD/TB Diagnosis</td>
<td>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.</td>
<td>NCHSTP 404.639.8011 1600 Clifton Road NE Mailstop E07 Atlanta, GA 30333</td>
</tr>
<tr>
<td>HIV Peer Education</td>
<td>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.</td>
<td>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.</td>
</tr>
<tr>
<td>HIV Correctional Officer Education</td>
<td>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.</td>
<td>Centerforce 415.455.8980 x116 64 Main Street San Quentin, CA 94964</td>
</tr>
<tr>
<td>HIV Discharge Planning</td>
<td>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.</td>
<td>Sister Carol Duffy 860.527.1866</td>
</tr>
<tr>
<td>HIV Physician Education</td>
<td>- 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-minute 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.</td>
<td>Visit: <a href="http://www.hrsa.dhhs.gov">www.hrsa.dhhs.gov</a> Call 401.863.2180, Fax 401.863.1243 or Visit: <a href="http://www.HIVcorrections.org">www.HIVcorrections.org</a> Visit: <a href="http://hivinsite.ucsf.edu/">http://hivinsite.ucsf.edu/</a> The Hopkins HIV Report P.O. Box 5252 Baltimore, MD 21224 <a href="http://hopskins-aids.edu">http://hopskins-aids.edu</a></td>
</tr>
<tr>
<td>HIV Medication</td>
<td>The Illinois AIDS Drug Assistance Program (ADAP) helps connect qualified jail and prison inmates with the state ADAP</td>
<td>Judy Ehansen at ADAP 800.825.3518</td>
</tr>
</tbody>
</table>

* 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.
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 Clumeeck compared and commented on the value of antiretroviral therapy "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 Staszewski et al. was viewed from the "as treated" perspective, according to Dr. Clumeeck, the two regimens appeared to be more or less equivalent. (However, the authors stated that the Efavirenz containing regimen had superior antiviral potency.) Dr. Clumeeck 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, Albenorges-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 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 1344-524 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.euro-aids99.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 style 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. Despite these achievements, the Census Bureau recently announced that the number of persons without health insurance climbed among American's. The lack of health care coverage remains concentrated among the unemployed, 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: (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 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 society: violent behavior, substance abuse, mental illness, and infectious diseases. Our challenge has never been greater.

The importance of health care in America's jails and prisons has been growing in both State and Federal systems. At the end of 1998, more than 1.8 million U.S. residents were in either jail or prison. 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. Between 1980 and 1994, the average sentence imposed on drug offenders increased from 47 to 80 months. 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," the prevalence of infectious diseases there largely reflects 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. 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. 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 active 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. 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.

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 health care providers walk a fine line in deciding what level of care to provide. In reality there is no acceptable 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 core 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, and 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.

References:

Continued on page 5
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: cmene@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
Sponsored by the International AIDS Society
E-mail: cme@iasusa.org
Visit: www.iasusa.org

The Science and Treatment of HIV: An Advanced CME Course for Clinicians
March 25-29, 2000
Snowmass Village, CO
Call: 415.561.6725
Fax: 415.561.6740
Sponsored by the International AIDS Society

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

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

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.chnatt.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 formulas 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.

Dr. Kendig reported the following findings at the November 1999 NCCHC conference from an independent survey of State Correctional Systems 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.

Facts 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.

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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.hrsa.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/trtglns.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.

(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.

Table 2. Ryan White/ADAP contact information

<table>
<thead>
<tr>
<th>State</th>
<th>Central Ryan White Contact (for information on local RW Committees)</th>
<th>ADAP Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>California</td>
<td>Michael Montgomery Office of AIDS ADAP 916.327.6784</td>
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<tr>
<td>Connecticut</td>
<td>Bette Smith CT Dept Social Services 860.424.5152</td>
<td></td>
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<tr>
<td>Florida</td>
<td>Cyndena Hall DOH HIV/AIDS Program 850.245.4444 x2547</td>
<td></td>
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<tr>
<td>Georgia</td>
<td>Libby Brown Dept of Human Services 404.657.3129</td>
<td></td>
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<tr>
<td>Illinois</td>
<td>Nancy Abraham DOH AIDS Activities Section 217.524.5983</td>
<td></td>
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<tr>
<td>Massachusetts</td>
<td>Mass HIV Drug Assistance Program 800.226.2714</td>
<td></td>
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<tr>
<td>New Jersey</td>
<td>Ron Weinsein DOH Division of AIDS 609.984.6329</td>
<td></td>
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<tr>
<td>New York</td>
<td>AIDS Drug Assistance Program 800.542.2437</td>
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<tr>
<td>Pennsylvania</td>
<td>AIDS Drug Assistance Program 800.922.9384 State AIDS Fact Line: 800.662.6080</td>
<td></td>
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<tr>
<td>Texas</td>
<td>Rhonda Lane Texas DOH 800.255.1090</td>
<td></td>
</tr>
</tbody>
</table>

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 NCCCH was supported by an unrestricted grant from Glaxo-Wellcome. Public/Health Corrections collaborations was supported by an unrestricted grant from Bristol-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., Fageles, B. Health Education & Benefits, April 1, 1998; 26(2) 225-238.


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 month's 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.

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<thead>
<tr>
<th>Pathogen</th>
<th>Criteria*</th>
<th>Comment**</th>
</tr>
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<tbody>
<tr>
<td>Pneumocystis (PCP)</td>
<td>CD4&gt;200 for more than 3-6 months (CIII) and sustained VL reduction for 3-6 months (CIII)</td>
<td>Only for primary Prophylaxis</td>
</tr>
<tr>
<td>Mycobacterium Avium Complex (MAI, MAC)</td>
<td>see comments</td>
<td>Only for primary prophylaxis, Recommendation now supported by placebo controlled trial.</td>
</tr>
<tr>
<td>Toxoplasma Gondii</td>
<td>no criteria given</td>
<td>Not recommended, but implicit in Pneumocystis guideline.</td>
</tr>
<tr>
<td>Cryptococcosis</td>
<td>no criteria given</td>
<td>Not recommended, but probably safe for patients with CD4&gt;100 for 3-6 months.</td>
</tr>
<tr>
<td>Histoplasmosis</td>
<td>no criteria given</td>
<td>Not recommended, but probably safe for patients with CD4&gt;100 for 3-6 months.</td>
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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 Copyright © 1997, 1998, 1999 The Johns Hopkins University on behalf of its Division of Infectious Diseases and AIDS Service. All rights reserved

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Sppotlight: 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 who are incarcerated. Roughly half are in the county system and half are in the state system. The big difference between the state system and the county system, because of the length of stay, 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 you have a little under 20,000 people in jail system and half are in the county system. The big difference between the state system and the county system, because of the length of stay, 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.

We did some analysis on exit patterns where we collect client-level data on a discharge plan that’s contingent on a guy getting a sober bed at a drug treatment center on May 26, 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. We’re not 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 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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**HEPP News Evaluation**

5 Excellent    4 Very Good    3 Fair    2 Poor    1 Very Poor

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2. Do you feel that HEPP News helps you in your work? Why or why not?

3. What future topics should HEPP News address?

4. How can HEPP News be made more useful to you?