

Academic and Health Policy Conference on Correctional Health Care
Infectious Disease Meeting Summary
March 29, 2007

Overview: Eighteen individuals participated in the Infectious Disease Meeting (see Table on p 6). Participants represented: Industry (n = 3), Medicine (n = 6), Media (n = 1), Nursing (n = 4), and Public Health/Epidemiology/Public Policy (n = 4). Interestingly, the participants shared a focus on HIV and Hepatitis C in Corrections. Therefore, the decision was made to concentrate on these two topics. The following is a list of topics that were discussed – including important points from the discussion:

HIV TESTING

1. Informed Consent (IC)
 - Volume is an issue when processing a large number of inmates through the system
 - Different consent requirements
 - Range from verbal consent (TX) to 1 page abbreviated consent (NY) to 5 page consent (MD)
 - Barriers identified include legislative issues that influence how informed consent occurs
 - Each state with different laws regarding IC makes it difficult to develop uniform policies for incarcerated populations
 - Also different issues for jails vs. prisons (State vs. Federal)
 - CDC initiative/guidelines to make HIV testing “routine (opt out vs. opt in approaches)
 - Recommends testing of high-risk populations every 3 months
 - CDC policies include corrections – standard of care should be the same in corrections
 - Discussed what is mandatory vs. opt out approach vs. voluntary
2. Stigma
 - The persistence of stigma related to HIV testing was discussed
 - HCV less stigma – inmates more willing to be testing for HCV and discuss it openly
3. Testing Procedures
 - In most settings – inmates who test HIV positive are routinely tested for HCV
 - In most settings – inmates who test positive for HCV are encouraged to test for HIV – as part of the HCV treatment evaluation process – but not mandated
 - Different procedures for testing coming into the system vs. testing as they exit
4. “Risk Behaviors of Inmates Behind the Walls”
 - The discussion of testing and stigma prompted a discussion of “what do we really know about the sexual risk behaviors of inmates?”
 - Discussed many of the “assumptions” that health care providers believe about sexual activity among incarcerated individuals (e.g. – the common assumption that most sexual activity is non-consensual, violent, doesn’t happen etc)
 - This discussion resulted in **RESEARCH PRIORITY ONE:**

“What are the risk behaviors of inmates behind the walls?”

- Conduct a survey among prisoners that includes the following:
 - What would a program of testing look like?
 - Opt in vs. opt out approach preferences
 - Can inmates really say no to testing?
 - What would the CDC approach look like in prisons/jails?
 - May also involve “operationalizing” the CDC guidelines for us with incarcerated populations (there is a panel that recently published a guideline to do this – 4/07)
- Need to consider resistance to conducting testing within the “system” including the idea that if you find more inmates who test positive (for either HIV or HCV) this will drive the costs up because then you have to deal with treatment-related costs
- A Research question for the future might involve conducting a cost effectiveness study in correctional health (costs associated with testing and treatment for both HIV and HCV) – the problem is that outcomes are sometime difficult to obtain – because of the variable length of time of incarceration – may want to take a public health view of cost effectiveness
- Survey would explore:
 - CDC and WHO approaches to testing and counseling for both HIV and HCV
 - Semantic issues (e.g. opt in, opt out)
 - Cost/System issues
 - State Specific procedures (testing upon processing, testing upon exiting, “mandatory testing” vs. “voluntary testing” what do they really mean operationally
 - Important to pick States with different testing and counseling systems and different laws governing testing
 - Develop a Collaborative Research Group that is matched (? Or varies) by:
 - State Population (in particular to include State systems within some of the larger states – with complex systems)
 - Inmate Population
 - Jail to prison connections (or lack thereof)

NCCHC or ACA to Develop Scientific Agenda

- Essential that major correctional health organizations develop a “scientific agenda”
- Currently most researchers present their work at meetings to audiences “other than” a correctional health audience (e.g. IDSA, Liver Meetings) – this results in a chasm between research and practice
- TASK: to approach NCCHC or ACA to recommend that they formalize processes to encourage scientific presentations at annual meetings (this will be included as a recommendation in the manuscript)

- C. Bova will speak with Conference organizers about the best way to proceed with this

Data Already Being Collected for Clinical and Tracking Purposes

- A lot of data already being collected could be used for research purposes
- Can develop systems to de-identify data – this makes IRB and regulatory issues less problematic
 - IRB related issues came up intermittently throughout the discussion
 - The importance of Correctional Leadership “buy in” to any research project is essential
- Development of electronic data bases in correctional health is a priority area
- Most of these data could be used for retrospective studies – some proposed that a prospective cohort study would be especially useful – however problems with this approach would include following inmates once released (informed consent issues, tracking, refusal rate expected to be high once released...)
- Retrospective cohort findings could be used as “preliminary data” and the foundation for grant support to mechanisms such as NIH – can build from a R03 to intervention level using database data if available

Developing and Testing HIV and HCV Educational Materials

- There is a need to develop culturally-specific (the culture of prisons) educational brochures and materials (including discharge planning manual)
- Some have already done this and used “art to teach” and pictures but would like a mechanism to evaluate the effectiveness of these materials
- Under this topic – the issue of “cultural competence” came up – the idea that the prison is a unique culture which needs materials, practices, and evaluation mechanisms that are unique within this context
- **This discussion linked to the idea of discussing issues related to discharge or release from prison:**
 - The example of county systems that have the same MD provide care while incarcerated and then provides care once released into the community
 - Transitional Systems (that organize health care providers care, housing and case management)
 - Re-entry programs – that help with housing and medical coverage upon release

Drug Delivery Research

- DOT vs. KOP
- How does one transition from DOT to KOP and then again once released?
- Once again the issue of stigma associated with DOT came up – although it was suggested that with current ARV agents (once or twice daily dosing) has made it less likely that others will know that these are ARV agents
- A possible research question was posed: What is the difference in ARV adherence after release among inmates using DOT versus KOP during incarceration? (the idea here is to sort out what is the best method of delivering medications while incarcerated to assist with re-entry adherence)

POSITION STATEMENT ON RESEARCH IN CORRECTIONAL HEALTH

Standardize Quality of Care within Correctional Settings before embarking on Ambitious Research Agenda

TRAINING

- Current training programs included 3-day fellowship in HIV/HCV (AETC) – these programs provide continuing education, build capacity and are used to establish relationships between providers and organizations
- Hospitalist training
- Commonwealth Medicine (MA) trainings
- Nursing – correctional health sub-specialty for APRN students at UMass Worcester Graduate School of Nursing
- Graduate Student Stipends (TX) for thesis work and post doc studies in correctional health
- Tufts – ID Fellowship has an elective – spend several sessions in correctional health setting
- UMMS – medical students and residents spend time doing testing and counseling in correctional health setting
- **KEY COMPETENCIES in Correctional Health**
- Understanding the unique setting and cultural issues inside the walls (issues of trust, ability to say no when needed, understanding prison regulations and reason for these regulations, understanding the unit providers, understanding personality disorder and substance abuse issues
- Understand the “correctionalization of medicine”
- Concerns about confidentiality of health information
- Remember that the mission of providing health care may be secondary to the mission of custody
- Importance of doing your own assessment of the inmates’ situation (rather than taking the word of others)
- Need to be aware that even reasonable requests (e.g. bunk change, extra soap etc) has ramifications for the entire system
- Need to understand the culture of “how inmates learn to work the system” for getting what they want
- As a specialist (e.g. ID) – relying on the primary care provider for support – knowing when to refer back and developing systems to prevent “splitting” of providers
- Need the resources and time to do adequate training (do direct care providers have the time to do training?)
- One advocated bringing in outside specialists to conduct training in medical specialty areas
- Suggest that health care within the prison system is “nurse-driven” - need to include nurses and every level of provider (associates, clerks) in training

- After the discussion on training – the group decided that they want to make a clear statement that the Health Care Providers have “Every Right to Be in There”
- the system often sets them up as invited guests

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CENTER OF EXCELLENCE SYSTEMS

- Discussed systems where inmates with like diagnosis are “segregated” (e.g. HIV) to provide specialized care
- According to participants some of these “Centers” have associated with positive outcomes (e.g. less stigma, improved health outcomes)
- The issue of segregating any population has many caveats as well that need to be explored

Summary Areas:

1. All Treatment Should be done according to DHHS/IAS Guidelines
2. Streamline Informed Consent Procedures of HIV Testing using CDC guidelines with an opt out approach
3. Prisons are Health Care Facilities and Routine Testing is appropriate
4. Research: Survey on Informed Consent; Position Statement on Research in Correctional Health (DHHS panel statement, July 2006) (INSERT WEB SITE); Data Base Development

NEXT STEPS:

1. e-mail group with summary to comment
2. e-mail group summary with integrated comments
3. e-mail group the names and contact information of the entire group
4. Find a way to disseminate policies and procedures used in other settings to be shared with other members of the group (e.g. develop a WEB SITE for this purpose – maybe NCCHC would be willing to take this on)
5. Check with NCCHC about recommendation to increase scientific agenda
6. Contact those who will work on report of this meeting (J. Baillargeon, L. Boly, C. Bova, D. Paar & W. Mazur) to decide on how to organize and prepare final manuscript (draft due 6/30/07 to J of Correctional Health)

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