



POSITION STATEMENT

Administrative Management for People Living With HIV in Correctional Institutions

This position statement does not address the medical management of HIV. The National Commission on Correctional Health Care endorses the concept that medical management of HIV in correctional settings should parallel that offered in the community. Medical management guidance is available from the U.S. Department of Health and Human Services at <http://AIDSinfo.nih.gov>.

Introduction

Confirmed cases of people living with HIV (PLWH) in state and federal prisons in 2015 is reported as 1,297 per 100,000 (Bureau of Justice Statistics, 2017), far higher than in the general U.S. population, with 14.3 cases per 100,000 (Centers for Disease Control and Prevention [CDC], 2019). The prevalence of HIV in jails is similar to that in state prisons and significantly higher than in the general population (Wilper et al., 2009). One in seven PLWH in the United States is processed through the criminal justice system each year (CDC, 2014). Thus, jails and prisons can have an impact on HIV detection, treatment, transmission, and care.

Correctional administrators have an important role in HIV education, testing, and management. The quality and length of life for incarcerated PLWH is affected by administrative decisions regarding screening and detection, access to quality medical treatment, mental health support, housing, and funding. The public health of our communities also is influenced by administrative decisions regarding prevention and discharge planning. For example, poor care coordination or failure to enroll in health insurance can result in interruptions in antiretroviral therapy (ART) that foment resistant viral mutations and increase the possibility of transmission.

Rates of HIV awareness, engagement in care, retention in care, and virologic suppression are low among incarcerated people (Iroh et al., 2015). Upon entry to jails and prisons, many PLWH are not aware of their infection. Of those who are aware, many are not engaged in routine care and not taking ART, and few are virologically suppressed. These findings highlight the important public health opportunity that jails and prisons have to impact HIV.

HIV Screening and Detection

The CDC states: "HIV screening is recommended for patients in all health-care settings after the patient is notified that testing will be performed unless the patient declines (opt-out screening). Persons at high risk for HIV infection should be screened for HIV at least annually. HIV screening should be included in the routine panel of prenatal screening tests for all pregnant women" (2006). The CDC further states: "In correctional settings, CDC recommends that HIV screening be provided upon entry into prison and before release and that voluntary HIV testing be offered periodically during incarceration. Testing has both individual and public health benefits, given the importance of getting early HIV care and the increased risk of HIV transmission among persons who do not know they have HIV." The administrator should know and adhere to applicable state law with regard to informed consent (CDC, 2006). However, a correctional health care survey (Solomon et al., 2014) showed that only 19% of prison systems and 35% of jails provided opt-out HIV testing recommended by the CDC. Data from a randomized trial of opt-



in vs. opt-out testing in an urban emergency department showed much higher rates of HIV testing for opt-out, 51% vs 38% (Montoy, Dow, & Kaplan, 2016).

The CDC recommendations underscore the move toward opt-out testing for HIV, where all individuals are tested as part of a routine physical exam unless they specifically opt out. Routine testing greatly increases the likelihood of detection, which should lead to earlier patient treatment, less spread of the disease, and a longer life for any individual with HIV. Data from eight prison reception centers showed that an HIV opt-out screening program resulted in high rates of linkage to care, retention on ART, and significant reduction in viral loads during incarceration (Lucas et al., 2016). People should be informed of opt-out options and administrators should ensure that immediate counseling and linkage to HIV care, including with a provider trained in ART, is available for patients who test positive.

To ensure continuous viral suppression, it is essential that all facilities have a process for timely continuous effective provision of ART, upon intake, during incarceration, and upon any transfer or release.

Consistent with CDC guidelines, NCCHC recommends that all pregnant women be tested for HIV and, if infected, given ART to prevent transmission to the infant. Correctional administrators should make HIV education to women a priority and encourage them to be tested for HIV, especially if they are pregnant.

Department of Health and Human Services guidelines (2019) recommend immediate ART after obtaining genotypic drug resistance testing but before results have returned in order prevent transmission to others. Consultation with HIV specialists is advised regarding appropriate testing and recommended regimens.

Housing Issues

Housing for PLWH should be appropriate for their age, gender, and custody class. NCCHC opposes routine segregated housing for these patients. PLWH, like any other incarcerated person, may require a higher level of care that may not be available at all institutions. This is a clinical judgment based on the acuity of care required for the patient. Patients should not be medically isolated or identified solely because of their HIV status.

Programs

PLWH who otherwise meet eligibility criteria for special correctional programs (e.g., education, work, parole, or medical reprieve) should be given the same consideration as others who are incarcerated, including work in the kitchen or with food.

Access to Quality Medical Treatment

The community standard for HIV care is to have access to HIV specialists who are knowledgeable about HIV management, including assessment of HIV resistance and selection of ART. The correctional administrator is responsible for ensuring continuity of care upon arrival and discharge. Quality improvement studies can be performed to ensure that PLWH receive quality services. These studies could include timeliness of referrals made and kept, patient adherence to ART, and the number of patients seen in the HIV chronic disease clinic. The administrator's role in ensuring continuity of care, one of the greatest challenges to HIV care in jails and prisons, cannot be overstated. Treatment



interruption can foster ART resistance. Viral resistance can preclude further treatment options for the remainder of the patient's life. Viral resistance can spread through communities through sexual contact, needle sharing, or perinatally. Thus, access to continuous, effective medical treatment is critical at intake, during incarceration, upon any transfers, and following release.

Pharmacy

Successful HIV therapy requires no interruption in antiviral medications. Continuity can be ensured by establishing mechanisms to make all ARTs continuously available to PLWH immediately upon arrival and during transport and upon release. All ART and related drugs to treat and/or prevent opportunistic infections should be on the formulary. All intake facilities should have a system to ensure continuity of HIV medications and should maintain adequate supplies of all approved antiviral medications so that newly admitted PLWH can continue their treatments without interruption. Jails and prisons should establish automatic renewal systems for these medications to prevent predictable interruptions in care.

Mental Health Support

As many as one in three PLWH suffers from depression. If not treated, depression can increase the risk for poor medication adherence, increased risk behaviors, and suicide. PLWH also have a high incidence of anxiety disorders. Correctional administrators need to ensure that sufficient mental health services are available to PLWH. In addition, mental health services can be useful in HIV prevention efforts. It is well documented that high-risk behaviors contribute to the spread of HIV, and many of these behaviors are associated with loneliness, depression, low self-esteem, sexual compulsivity, sexual abuse, marginalization, lack of power, and oppression. Consequently, mental health specialists should be involved in HIV prevention programs.

Education of People Living With HIV

Clinical outcomes are greatly improved when the patient is informed and motivated. Correctional administrators can foster successful HIV care and services by ensuring that PLWH receive effective education. Information should be designed to take into account the common characteristics or lifestyles that put people at risk for nonadherence with HIV treatment. Staffing levels should be appropriate to ensure provision of education and support of continuity of care.

Ongoing Prevention Services

Successful strategies to prevent HIV exposure include peer education, discharge planning, transitional case management, harm reduction techniques, and, as appropriate postexposure prophylaxis (PEP) and preexposure prophylaxis (PrEP). It has been shown that trained peer educators can effectively provide HIV education and orientation sessions in the correctional setting. Health staff and peer educators should use educational materials written in the diverse languages found in jails and prisons. The materials should be written at an 8th grade reading level and be culturally appropriate. Correctional administrators can support the training and maintenance of peer educators.

Administrators should ensure the provision of staff adequately trained and the development of case management programs for PLWH. Case managers may conduct medications adherence checks, follow up with patients not keeping HIV clinic appointments, and provide education/counseling and referrals as appropriate.



Rowell-Cunsolo and colleagues (2015) found that 13% of formerly incarcerated persons reported having sex in New York prisons. Harm reduction techniques such as condom distribution and counseling have been used successfully in incarcerated populations (May & Williams, 2002). Following a successful prison pilot, California passed legislation in 2014 introducing condoms to its 34 state prisons, following Vermont and Mississippi. Condoms are also available in correctional facilities in Los Angeles, New York, and Philadelphia. The use of effective and proven public health strategies to reduce the risk of contagion is our primary concern. NCCHC recommends that correctional administrators implement harm reduction strategies including condom distribution and counseling. Counseling should address the risk of reinfection with other, potentially more resistant or virulent, strains of HIV, the importance of maintaining an undetectable viral load, and consideration of PrEP for HIV-negative partners.

Confidentiality

One of the most difficult tasks facing correctional staff is to maintain confidentiality of health information, such as tests, diagnoses, and treatments. Correctional administrators can promote confidentiality by creating a supportive environment that reminds staff to exercise caution and diligence in maintaining confidentiality. Administrators should ensure that custody staff receive regular training to not discuss observed or overheard health care, and to reinforce health staff training by insisting that patient information is not discussed within earshot of other patients or officers and that ART medications not be dispensed in recognizable containers. Administrators also should ensure that health records are secured at all times and avoiding identifying policies such as separate medication carts, packaging, pill lines, clinics, or days of the week when PLWH are seen.

Infection Control

Correctional administrators should provide infection control training for staff. They should ensure implementation and enforcement of standard precautions policies, such as sterilizing equipment for each patient, preventing exposure during surgical procedures, and wearing masks and gowns when appropriate. Combining standard precautions with harm reduction strategies and treatment with ART is the most effective way to address HIV infection control issues in correctional facilities. Current procedures for postexposure prophylaxis should be effectively implemented.

Discharge Planning

Testing, engagement care, and viral suppression are generally worse after incarceration than before. These findings underscore the need for stronger reentry and linkage-to-care programs during transition to the community.

Discharge planning for soon-to-be-released PLWH is critical. However, fewer than one in five prisons and jails follows CDC guidelines for helping patients transition into the community (Iroh, Mayo, & Nijhawan, 2015). This includes services such as making an appointment with a community health care provider, assisting with enrollment in an insurance program such as Medicaid, and providing a copy of the health record and an adequate supply of HIV medications. PLWH need to receive education on their condition, prevention of transmission, and availability of services in the locality where they intend to reside.

Facilities need to make arrangements to ensure no interruption in ART. All patients exiting while on ART should be scheduled for follow-up with an HIV provider the community and should receive detailed, printed contact information, including directions. They also should be given a supply of their HIV



medications sufficient to last until the appointment with the community provider. Optimally, health staff would contact the community HIV clinic to enhance linkage for the soon-to-be-released PLWH and provide condoms. Some community clinics will interview the patient prior to release and thus improve the chances of a successful transition.

There are numerous evidence-informed interventions to implement HIV continuity of care services. These include Transitional Care Coordination: From Jail Intake to Community HIV Primary Care; Project Start; Hampden County's Public Health Model for Correctional Health Care; and models developed by the Transitions Clinic Network. (See Continuity of Care Models below for links.)

Linkages With Community Resources

The Ryan White CARE Act has played a significant role in funding HIV care and ART medications for uninsured PLWH in the United States. Ryan White funding can be used to support discharge planning from intake to 90 days after release from jails and as part of reentry planning in prisons (HIV/AIDS Bureau, 2018).

In some localities, patient assistance programs (PAPs) funded by pharmaceutical companies have complemented Ryan White services. Correctional administrators should understand the availability of PAPs in the communities where patients will reside after release, with the aim to better prepare exiting patients to seek and to receive aftercare.

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Continuity of Care Models

- Hampden County Public Health Model for Correctional Health Care
<http://hcsdma.org/wp-content/uploads/2015/03/Public-Health-Model-2002-Archive.pdf>
- Project Start
<https://www.cdc.gov/hiv/research/interventionresearch/rep/packages/start.html>
- Transitional Care Coordination: From Jail Intake to Community HIV Primary Care
<https://nextlevel.targethiv.org/deii/jails>
- Transitions Clinic Network
<https://transitionsclinic.org/>

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