HEPP NEWS

HIV EDUCATION PRISON PROJECT

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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.

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Corrections on the National Conference Agenda: Update from the 24th NCCHC

Anne De Groot, M.D.*, *Brown Univ. School of Medicine*

HIV in correctional settings is beginning to infiltrate our nation's political theater. In response to this new development, the National Commission on Correctional Health chose prominent political leader Reverend Jesse Jackson Sr. to open this year's National Conference on Correctional Healthcare (NCCHC), held September 9-13 in St Louis, Missouri.

NCCHC is the largest nationwide educational gathering of physicians, nurses, dentists, psychiatrists, psychologists, other health care professionals, administrators, attorneys, and others working in prisons, jails, juvenile confinement, and detention facilities. Participants had an opportunity to meet and network with experts as they discussed current correctional health issues. Recent developments in the management and treatment of HIV were featured in a special track of programs throughout the conference.

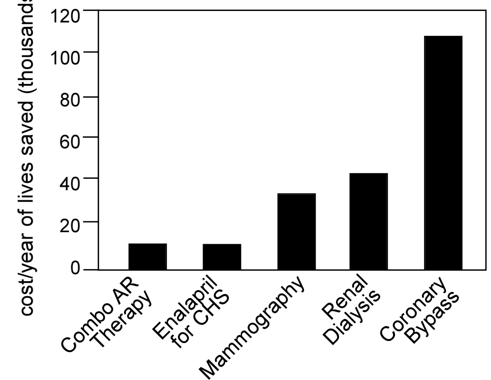
Illustrating correctional health care's most popular issues, the pre-conference seminars featured NCCHC's standards and mental health care guidelines, an introduction and an advanced look at quality assessment, practical preparations for NCCHC accreditation, and measuring outcomes of HIV interventions.

HEPP Symposium on Outcomes

One way of measuring the potential success, or outcome, of an intervention is to count the number of individuals who volunteer to participate. Based on that measure, the HIV Behind Bars 2000 was a success: attendance at the annual symposium increased this year to more than 140 individuals, most of whom stayed for the entire 4 1/2 hour session.

The focus of the symposium was on "measuring outcomes." Previous "HIV/AIDS Behind Bars" sessions have described components of HIV management (from intake to discharge planning) and models of care. This year, following up on a challenge issued by organizer Anne De

Figure 1. Cost Effectiveness of Medical Interventions



Cost effectiveness of HAART, compared to other medical interventions for other chronic diseases.

Groot at the 4th annual symposium (Ft Lauderdale, 1999), correctional providers who had performed an HIV management intervention in a correctional setting and had measured the impact of that intervention were invited to present their results.

Outcomes Research Studies

What are outcomes studies? In the HIV/AIDS arena, outcomes research attempts to measure the impact of HIV management interventions on clinical and economic outcomes. Clinical outcomes are the clinical events and progression of HIV disease that occur in clinical practice, and economic outcomes are the economic events and progression of resource use in HIV disease that occur in clinical practice.[1]

Outside corrections, researchers have asked some hard questions about HIV treatment and

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outcomes. For example, given that the lifetime cost of HIV treatment averages $149,000 (starting at a count of 500 CD4 T cells[2]) or from $10,000 to $20,000 per year of life gained, researchers have compared this investment to other healthcare investments. As it turns out, HAART is less expensive, per year of life gained, than mammography ($40,0000) and much less expensive than coronary artery bypass (see Fig 1.) In fact, one notable (but less widely disseminated) outcome of HAART appears to be that the predicted lifespan of an individual on HAART with CD4 T cells > 100 is on par with the lifespan of an age-matched peer who is HIV-seronegative![3] Thus HAART lengthens lifespan more than most other medical interventions.

Budgetary Outcomes of HIV Care

Other outcomes research has evaluated the impact of HAART and/or skilled HIV care on hospitalizations and the incidence of opportunistic infections, which is more in line with correctional budgetary concerns. HAART has clearly been shown in a number of studies to reduce the development of opportunistic infections[4] and reduce costs associated with treating these infections. Therefore, most economic outcomes evaluations of HAART have reported that the increased cost of treatment was balanced by a reduction in expenses associated with hospitalizations and specialty consultations for opportunistic infections. Furthermore, care by experienced HIV/AIDS physicians has been shown to result in two thirds fewer hospital bed days and fewer specialty consultations than care by control (non-experienced) providers. This is most likely due to the specialists' ability to prevent illnesses and toxicities in their patients. Outcomes studies have also reported on the cost-effectiveness of interventions for opportunistic infections in HIV/AIDS patients. For example, treatment of PPD positive, HIV-infected individuals is an extremely cost-effective intervention. By providing $36 of medication per patient (INH, 300 mg PO QD for one year) TB cases can be reduced to neglible proportions (36% reduction).[5]

Other researchers have queried whether HAART prevents other budgetary outlays, such as hospitalization costs and treatment of opportunistic infection costs. Indeed, HAART results in a net savings, especially in terms of hospitalization costs, in studies conducted outside corrections.[6]

Table 1. Correctional Outcomes Studies

	CLINICAL OUTCOMES	ECONOMIC OUTCOMES	BEHAVIORAL OUTCOMES	CORRECTIONAL OUTCOMES
Intervention	Directly Observed Therapy (DOT) vs Self-administered Therapy (SAT)	Telemedicine	Pre-release Peer Education	Discharge planning with careful linkage to community health centers
Measures	% with Viral Loads below 400	Cost per encounter	Adherence to medication	Recidivism
Additional Measure	# of patients developing medication side effects	Patient Satisfaction	Medication acceptance	Viral load on return to prison
Ex.	Florida	Texas	California	North Carolina
Results	Directly observed therapy resulted in better reductions (DOT 85% below 5 copies; SAT only 50% below 50 copies) in viral loads and fewer toxicities (15% vs 35%).	95% of telemedicine encounters pre-empted an onsite visit, reducing costs; 69% of inmates prefer telemedicine to travel.	California peer educated patients were more likely to "report" condom use (38% vs 20%, p = 0.05).	Patients returning to prison after a period of release have poorly controlled HIV.
References	Fischl, M., Rodriguez, A, Serpella, E. Monroig, R, Thompson, D, Rechtine, D., Impact of DOT on outcomes in HIV clinical trials. 7th Conference on Retroviruses and Opportunistic Infection, Chicago, IL, February 2000, Abstract 71.	D. Paar, Telemedicine in Practice; HEPP News Vol 3 (5). May 2000. RM Brecht, CL Gray, C Peterson, B Youngblood, UTMB-Texas DOC Telemedicine Project, findings from the first year of operation, Telemedicine Journal Vol 2. no 1. 1996.	Grinstead O, Zack B. Collaborative research to prevent HIV among male prison inmates and their female partners. Health Education and Behavior, 1999; 26: 225-257.	Stevenson B, Wohl D. et al. Release from prison is associated with increased HIV RNA at a time of reincarceration. XIII International AIDS Conference 2000, Durban, South Africa.Abstract TuOrD323

Outcomes in Corrections

However, as we're well aware, studies conducted in community settings are only an approximation of conditions for HIV-infected patients behind bars. What information is available for correctional settings, where the distribution of costs may be significantly different from the outlay that communities experience in providing HIV care?

The good news is that outcomes studies are being funded and performed in correctional settings and there is a new recognition of the importance of measuring the impact of an intervention (See Spotlight, Page 7). The bad news is that few outcomes studies have been performed and results are, as yet, unavailable for the largest of these studies. The HIV Behind Bars 2000 symposium featured presentations by a few "interventionists" who reported their results.

A number of the HIV "stars" of correctional medicine spoke at the HEPP symposium. Dr. David Thomas, Medical Director of the Florida Department of Corrections, Dr. Joe Bick, Medical Director of the HIV/AIDS facility at Vacaville, California, Dr. David Paar of Texas Department of Criminal Justice, and Dr. Lou Tripoli, Medical Director for Correctional Medical Services, all presented information on HIV-related interventions in their systems. Dr. Joseph Paris, Medical Director of the Georgia Department of Corrections moderated the symposium with characteristic tact and diplomacy, provided expert audiovisual support, and reported on outcomes measures for his state.

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Letter from the Editor

Dear Colleagues,

The 24th NCCHC in St. Louis had so much for everyone in the field it is difficult to pinpoint any one salient feature. Yet...a special moment is indelibly etched in my mind. At the opening ceremony, a number of correctional physicians grilled Reverend Jessie Jackson with pointed medico-social questions. The Reverend did not miss a beat, but some of his answers did not convey the flavor of staff research. It seemed that he had not previously heard some of the novel questions posed by a few well meaning, corrections-savvy NCCHC attendees.

After the HEPP Seminar, SCP Meeting and full-length NCCHC proceedings, I had the impression that the near 2,000 attendees had satisfied (and then some) their thirst for correctional health care knowledge. With so much on everyone's plate, we were fast approaching the point of correctional health care information overload. However, one cannot have too much of a good thing. I just hope the next joint meeting duplicates or enhances the St. Louis performance.

This issue of HEPP News features a report on the HEPP-run "Outcomes" symposium at the NCCHC conference. Information on research studies preformed in correctional settings is provided in the main article, and an update on the CDC/HRSA research initiative is featured in our spotlight. We've also provide you with a few websites that may assist you with obtaining and planning your own outcome studies. In addition, our HEPPigram this month addresses differential diagnosis of skin rashes, and our HIV 101 reminds you of effective prophylactic interventions for Opportunistic Infections.

After reviewing this issue, readers should be able to diagnose different presentations of rashes, identify which preventative treatment is appropriate for opportunistic infections in HIV infected patients, and identify the benefits of HIV interventions outcomes research.

In the next issue of HEPP, Mary Sylla will review legal issues in corrections and we'll provide an update on what has happened with clinical trials in corrections since our conference one year ago. As usual, we welcome any feedback or written contributions!

Sincerely,

Joseph Paris, M.D., Ph.D., C.C.H.P.
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NAME: ____________________

FACILITY: ____________________ (Optional) # of HIV Infected Inmates: ______

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FAX: ____________ PHONE: ____________ E-MAIL: ____________

SIGNATURE: ____________________ DATE: ____________

Update from the 24th NCCHC...

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Highlighting the Need for Research

In keeping with the theme of the HEPP symposium, many other speakers at NCCHC addressed research in correctional settings. Steven Spencer, Jaye Anno, and Joseph Paris presented on "Emerging Research Topics/Issues in Correctional Health Care." Anno noted that correctional healthcare providers are 20 years behind other medical groups in terms of knowledge of our patients. Paris noted that there are unique medical issues in corrections with which community clinicians do not have to contend. Spencer sees an overall change in the trends of correctional research from measuring prevalence of certain conditions to actually measuring outcomes of corrections-based interventions.

Anno, Spencer, and Paris urged corrections physicians to conduct research concerning: inmate co-pay systems, obesity, dietary management (heart-healthy diet versus normal diet), conditions of confinement (such as the impact of having athletic facilities), the health needs of women, the impact of mental health problems on healthcare, dental needs, women's use of health services, parenting issues, and lastly, data management. Anno closed by addressing the fact that many correctional physicians claim that obstacles to care include insufficient staff, time, money, and commitment. She asked the probing question, are these barriers or excuses?

Summary

There is much to do in the field of outcomes measures in correctional settings. As Jaye Anno noted, we as correctional healthcare providers know very little about our patients as a whole. We have seen, however, many promising HIV care interventions, and are learning which ones work best. Furthermore, judging by the number of participants at our NCCHC meeting, outcomes research is of increasing interest to our colleagues. For more information on grants for outcomes research, see our resources on page 8.

For a complete listing of the sessions or more information, contact the NCCHC at ncchc@ncchc.org.

Table 2. Other NCCHC Highlights Joseph E. Paris, M.D., *Medical Director, Georgia Department of Corrections*

Meeting of SCP

The annual meeting of the Society of Correctional Physicians (SCP) was its most successful ever and it preceded and enhanced the NCCHC Meeting. Many correctional physicians joined the SCP in St. Louis. SCP President Dr. Joseph Paris from the Georgia DOC introduced Dr. Jennifer Clarke from the RI DOC, who presented an Overview of Women's Wellness, Dr. Norman Johnson of Health Professionals, who reviewed Geriatric Issues of Incarcerated Females, Dr. Rosemary Jackson, Ms. Jennie Lancaster, and Ms. Betty Rider, of the North Carolina DOC, who addressed the Difficulties of Health Services and Custody Working Together, and Dr. Kathryn Anastos, of the Albert Einstein College of Medicine, who discussed Gender and Ethnic Differences in HIV Patients. The meeting closed with an open forum on Women's Health Issues.

Among the many NCCHC Concurrent Sessions, the following sessions stand out:

- Staff from the Hampden County Correctional Center presented a successful public health model of health care for corrections consisting of a three-year evaluation and research of the measurable benefit and favorable outcomes of their model.
- Another seminar addressed the rights of medical professionals facing the option of settling a civil lawsuit. Robert Vogt analyzed insurance policies, consent issues, impact of the settlement on regulatory and reporting agencies and confidentiality.
- Drs. Spaulding and Clarke, and staff from the RI DOC had sessions on "Developing an Algorithm for Testing Jail Entrants for Sexually Transmitted Diseases" and related topics.
- "Domestic Violence Issues for Correctional Health Care Professionals" were explored by Dr. Diane Rechtine and others from the Florida Department of Corrections.
- William Rold, JD, CCHP, noted correctional attorney, described the latest developments in the laws effecting the provision of health care to incarcerated individuals.
- A dental presentation by Thomas Shields II, DDS, CCHP, and Gregory Becker, DM, of the Florida Department of Corrections, dealt with periodontal disease and associated bacteria and their link to numerous systemic diseases including infective endocarditis, cardiovascular disease, atherosclerosis, respiratory disease, and diabetes, as well as various bacteremias in correctional facilities.
- Richard Novack presented the latest concerning nelfinavir dosing. Although pharmacokinetics of nelfinvavir might predict that TID dosing would be superior to BID dosing, the improvement in adherence that occurs from switching to BID actually results in better treatment outcomes.
- The geriatric inmate was covered by Norman Johnson, MD, Health Professionals LTD, Karen Stocke, RN, Stephen Cullinan, MD, and Adrian Feinerman, MD.
- Dr. Joseph Paris presented the HIV + Inmate Post Release Program of the Georgia Department of Corrections, aimed to ensure continuity of HAART after release to society.

References:

* *Consultant: Agouron Pharmaceuticals, Bristol-Myers Squibb*
Speaker's Bureau: Agouron Pharmaceuticals, Bristol-Myers Squibb, Glaxo Wellcome

1. Moore R. Cost-Benefits of Antiretroviral Therapy. The Brazil/Johns Hopkins University HIV/AIDS Conference October 20, 21 and 22, 1999, Rio de Janeiro. http://www.hopkins-aids.edu.
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3. Justice A. CHORUS HIV Cohort. 39th Interscience Conference on Antimicrobial Agents and Chemotherapy (ICAAC) San Francisco September 25-29, 1999. Abstract 1158.
4. Gallant, J., and Moore, R., et al., The impact of prophylaxis on outcome and resource utilization in pneumocystis Chest 107 1995, k1018-1023.
5. Moore R. Cost-Benefits of Antiretroviral Therapy.
6. Gebo KA, Chaisson RE, Folkemer,JG, Bartlett JG, and Moore RD. Costs of HIV medical care in the era of highly active antiretroviral therapy. AIDS 1999; 963-969.

Prevention of Opportunistic Infections. *The following are recommended as standard of care.*

	RISK	PREFERRED PREVENTION	ALTERNATIVES
Pneumocystis carinii	CD4 count <200/ mm^3, prior PCP or HIV-associated thrush or FUO x 2wks (A II)*	TMP-SMX 1 DS/day or 1 SS/day (A I)*	▪ TMP-SMX 1 DS 3x/wk (B I) ▪ Dapsone 100mg qd or 50mg po bid (B I) ▪ Dapsone 50mg qd plus pyrimethamine 50mg/wk plus leukovorin 25mg/wk (B I) ▪ Dapsone 200mg/wk plus pyrimethamine 75 mg/wk plus leukovorin 25mg/wk (BI) ▪ Aerosolized pentamidine 300mg q mo ▪ Atovaquone 750mg po bid with meals (NEJM 1998;2\339:1889) (B I)
M. Tuberculosis	Positive PPD (≥5 mm induration) with prior treatment (A I), recent TB contact (A II) or history of inadequately treated TB that healed (A II)	▪ INH 300 mg/day + pyridoxine 50mg/day ≥ 270 doses, 9 mos. or up to 12 mos. with interruptions. (A II) ▪ INH 900mg + pyridoxine 100mg 2x/wk with directly observed therapy, ≥ 76 doses, 9 mos. or up to 12 mos. with interruptions (B I) ▪ Patient not receiving PI or NNRTI: Rifampin 600mg/day + pyrazinamide 20mg/kg/day with ≥ 60 doses x 2 mos. or up to 3 mos. with interruptions (A I)	Patients receiving a PI or NNRTI need rifabutin in place of rifampin/pyrazinamide 20mg/kg and dose adjustment of the antiretroviral agent (B III). ▪ Amprenavir-standard; rifabutin-150 mg/d ▪ Efavirenz-standard; rifabutin-450mg/d ▪ Indinavir -- 1200mg q8h; rifabutin -- 150mg/d ▪ Nelfinavir -- 1000mg tid; rifabutin -- 150mg/d ▪ Ritonavir -- standard dose; rifabutin -- 150mg qod Note: Rifabutin should not be combined with delavirdine and dose schedules are not available for Fortovase. Rifabutin should be combined with pyrazinamide 20mg/kg/day with ≥ 60 doses x 2 mos. or up to 3 mos. with interruptions (B III) Rifampin 600mg qd x 4mos. (B III) **Contact with INH resistant strain:** Rifampin plus pyrazinamide x 2 mos. (Above doses) (A I) Alternative: Rifabutin/pyrazinamide (above doses x 2 mo.) (B III); Rifabutin 300mg po qd x 4 mo. (C III) **Contact with strain resistant to INH and rifamycin:** use 2 agent with anticipated activity-ethambutol/pyrazinamide or levofloxacin/pyrazinamide Pregnancy: INH regimens
Toxoplasma gondii	CD4 count <100/ mm^3 plus positive IgG serology for *T. gondii*	TMP-SMX 1 DS/day (A II)*	TMP-SMX 1 SS/day (B III) ▪ Dapsone 50 mg po qd plus pyrimethamine 50mg/wk plus leukovorin 25 mg po/wk (B I) ▪ Dapsone 200mg po/wk plus pyrimethamine 75 mg po/wk plus leukovorin 25 mg po/wk ▪ Atovaquone 1500mg qd ± pyrimethamine 25mg qd + leukovorin 10mg qd (C III).
M. avium complex	CD4 count <50 mm^3	Clarithromycin 500mg or bid (A I) or azithromycin 1200mg po weekly (A1)	Rifabutin 300 mg po qd (B I) or azithromycin 1200 mg/wk plus rifabutin 300mg qd (C I) (check rifabutin dose adjustment for use with PIs or NNRTIs)
Varicella	Significant exposure to chickenpox or shingles who are either seronegative for VAV or have no history of primary or secondary VZV	VZIG 5 vials (6.25mL) IM within 96 hours of exposure, preferably within 48 hours (A III)	Prophylactic acyclovir was included in the 1995 USPHS/IDSA Guidelines, but was deleted from the 1999 version due to lack of supporting clinical evidence of efficacy.

Adapted from Bartlett JG and Gallant JE. 2000-2001 Medical Management of HIV Infection. Johns Hopkins University, Baltimore, MD. 2000.

*Bactrim is preferable because it prevents two illnesses: Pneumocystis carinii and Toxoplasma gondi.

Rating systems for strength of recommendation

A: Both strong evidence for efficacy and substantial clinical benefit support recommendation for use. Should always be offered.

B: Moderate evidence for efficacy-or strong evidence for efficacy, but only limited clinical benefit-supports recommendation for use. Should generally be offered.

C: Evidence for efficacy is insufficient to support a recommendation for or against use, or evidence for efficacy may not outweigh adverse consequences (e.g. toxicity, drug interactions, or cost of the chemoprophylaxis or alternative approaches). Optional.

Categories Reflecting Quality of Evidence Supporting the Recommendation

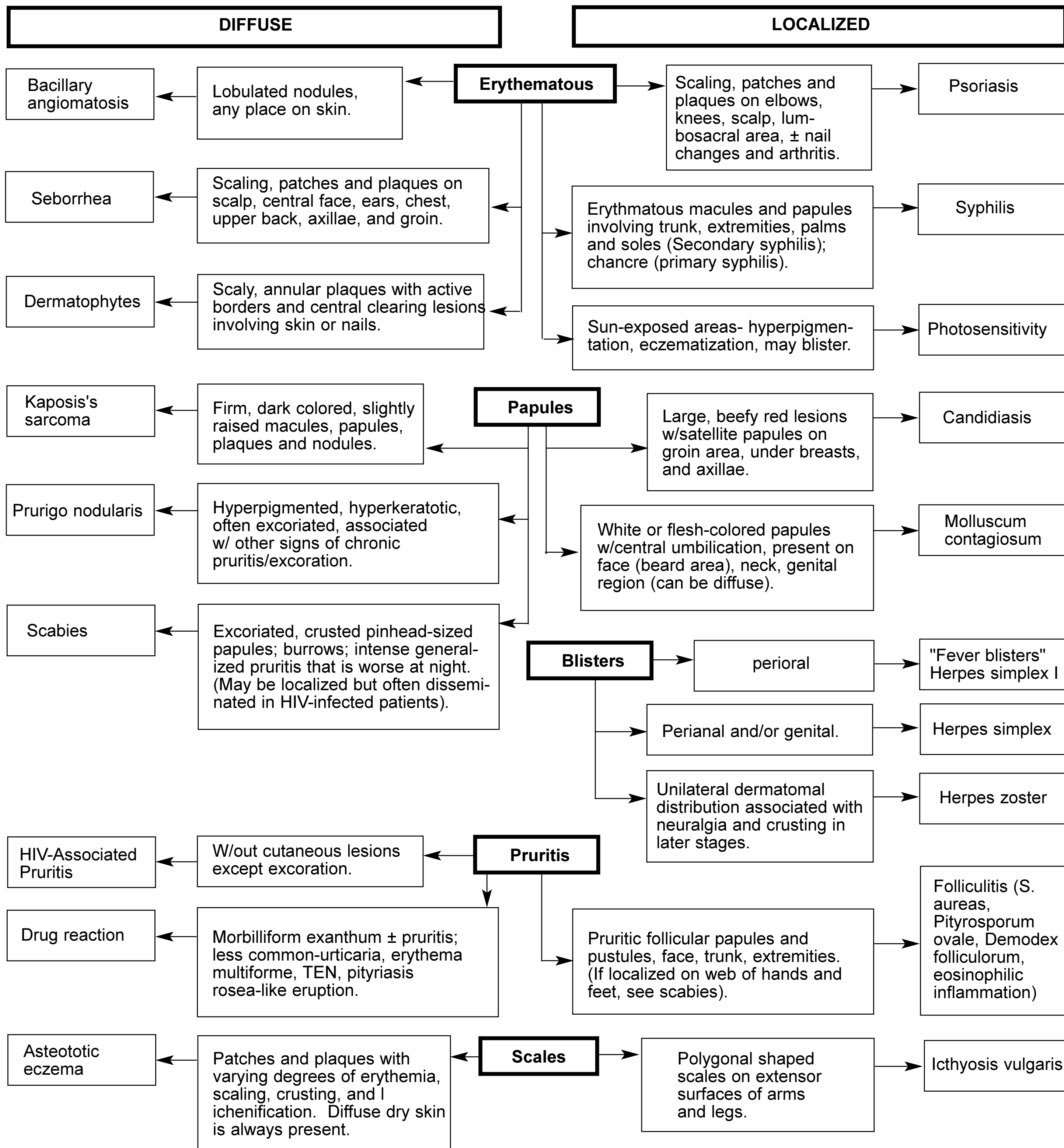
I: Evidence from at least one properly randomized, controlled trial.

II: Evidence from at least one well-designed clinical trials without randomization, from cohort or case-controlled analytic studies (preferably from more than one center), or from multiple time series studies or dramatic results from uncontrolled experiments.

III: Evidence from opinions of respected authorities based on clinical experience, descriptive studies, or reports of expert committees.

HEPPIGRAM

Differential Diagnosis of Rashes in HIV-Infected Patients



For treatment of rashes, see the reference for this flowchart, Table 7-10: Dermatologic Complications in Patients with AIDS in Bartlett JG and Gallant JE. 2000-2001 Medical Management of HIV Infection. Johns Hopkins University, Baltimore, MD. 2000.

SPOTLIGHT: Federal Funding For HIV in Corrections: One Year Later

by HEPP Staff

A year ago, departments of corrections in seven states received a million dollars each in CDC/HRSA grant money. California, Florida, Illinois, Georgia, Massachusetts, New Jersey, and New York are using the funding to create stronger ties and linkages between HIV-infected inmates and community health care providers with an eye toward improving continuity of medical care after release. One year later, CDC officials are beginning to evaluate the progress of these grantees and their programs with the hope of eventually identifying a model for community linkages for other corrections jurisdictions.

The goal of the CDC/HRSA initiative was to target African Americans and other racial minorities, increase access to HIV/AIDS primary health care and prevention, improve transition between correctional facilities and the community for HIV positive offenders and develop support in the community for HIV health and social services. "The emphasis is to focus on folks who are HIV positive and those who have been disproportionately impacted as well as those with any other behavioral risks, TB, hepatitis-and we can't ignore substance abuse. They all roll into one," said John Miles, of the Centers for Disease.

Dr. Kimberly Arriola, a member of the Evaluation & Program Support Center (EPSC) team at Emory University in Atlanta, summarized the current status of the projects at the HIV/AIDS Behind Bars 2000 Pre-Conference Symposium, National Commission on Correctional Health Care Conference, St. Louis, MO. Other members of the EPSC team include Ronald Braithwaite, Ph.D. (project principal investigator), and Alyssa Robillard, Ph.D. Additional members include Theodore Hammett, Ph.D. (Co-Principal Investigator) and Sofia Kennedy, MPH of Abt Associates (Cambridge, MA).

Dr. Arriola emphasized that correctional settings are ideal for prevention and treatment interventions, and that HIV treatment, management, and prevention interventions to date appear to have been inadequate. Therefore, the goal was not to fund improved HIV care, but rather to model how linkages to the community can address the problem of HIV management in corrections.

Evaluation Objectives

The objectives of the evaluation are to document the process of program implementation, and to describe the challenges & strategies, and determine whether the interventions are building on existing programs or forging new collaborations. The grantees were to demonstrate the range & volume of services provided and examine client-level outcomes for selected intervention components. Furthermore, they were to show linkage with key services in the community; utilization of care; and the impact of their interventions on HIV risk reduction.

"We are looking at which [program style] is better. Giving someone a referral card is nice, but a phone call, appointment and a face-to-face hand-off is even better. Hopefully in the long run, if we do all of this well, we will see if it has an impact in recidivism and reducing [disease] transmission," said Miles.

The program features a "constellation" of interventions (HIV treatment, Case Management, Discharge Planning, Prevention Case Management) along with HIV prevention (Educational sessions, peer-based programs), disease screening, and staff training in a range of settings in prisons, jails, and juvenile facilities.

Evaluation Activities

During year one, the evaluators learned about the grantees via site visits and meetings (obtaining buy-in was important!). According to grantees, one of the major impediments to the development of programs was the lack of existing research and programmatic infrastructure, such as experience with IRB approval of projects to be carried out in correctional settings, (see main article).

Some of the information that will soon be available includes information gathered during intake (jail or prison) such as discharge planning needs, health status, health care utilization, alcohol and drug use and treatment, and client demographics. In addition, information will be gathered from the medical record such as the client's HIV status, whether the client was tested during that incarceration, and mental illness diagnoses. At release, the staff will evaluate the final discharge plan and perform a medical record abstraction. Even more importantly, during Post-Release Services, staff will report at 30-day intervals on medical & mental health care, treatment, housing, benefits, and employment (see Table 1).

In addition, the researchers will conduct offender interviews as they go through the discharge process. "We will be doing a baseline and a follow-up interview with participants either three months post the last contact with the intervention in the community or 6 months past release, whichever come first," said Ted Hammett of Abt Associates.

According to Hammett, the follow-up interview with clients will be a self report where investigators will look at whether linkages were made and if the clients were able to access them.

TABLE 1. Aggregate Data

Treatment/Case Management	■ Started on HAART ■ Are receiving Case management or discharge planning M/DP ■ Released with referrals/appointments ■ Released with HIV medications
HIV Prevention	■ Single sessions or series of sessions ■ Unduplicated number of participants ■ Demographics (series participants) ■ Percentage completing every session in series ■ Spanish-language sessions ■ Sessions conducted by peer educators ■ Length of sessions
Peer Educator Training	■ Number of peers recruited ■ Number of recruits who completed training ■ Demographic characteristics of peer educators
Disease Screening & Staff Training	■ Disease Screening (by disease entity) ■ Tests· positive tests ■ Results not received ■ Partner notification/contact tracing ■ Treated/started on treatment ■ Staff Training ■ Single session/series of sessions ■ Number eligible/attending

Expected Challenges

CDC officials are well aware that corrections and public partnerships can be challenging to develop depending on the jurisdiction.

"We're very fortunate in the states that competed [for the grants]. They are all states with major problems with the burden of disease [and the community was open to partnerships]," Miles said. "In general there's a real recognition that keeping the inmate population healthy is part of improving the safety and well being of the institution. It also bodes well with the community trying to build the collaboration; that needs to be there."

In January, CDC officials and grantees will meet to discuss any hurdles experienced along the way to creating the community linkages for HIV-positive offenders.

Conclusion

Evaluation of the outcome of this CDC/HRSA Initiative is likely to offer insight on what factors influence engagement & maintenance in post-release medical care. Although the researchers have encountered several obstacles and experienced delays in data gathering, the initiative has potential to make a major impact on public health policy and establish models for implementation elsewhere.

At the HEPP symposium, audience participants were informed that the CDC study forms would be available to other individuals interested in collecting data. Contact Dr. Arriola at Emory University or Dr. John Miles at the CDC for additional information. Although no additional states or sites will receive funding through this initiative, HEPP readers may find it useful to adapt the CDC/HRSA forms to their own projects. Information about other potential sources of funding for HIV intervention projects is available from the websites sited in the resource section of this issue.

Save the Dates

Management of HIV/ AIDS in the Correctional Setting: A Live Satellite Videoconference Series, Antiretroviral Update 2000
Available for online viewing at your convenience after October 16 at the HEPP News Website: http://www.hivcorrecttions.org
2.5 CME credits available from Albany Medical College

Corrections to Community: Continuity of Care
A one-day discharge planning training presented by SEATEC.
November 9, 2000, Gainsville, GA
December 7, 2000, Forsyth, GA
January 10, 2001, Tifton GA
All trainings are free, provide lunch, and run from 9am to 4pm.
Contact: Marjorie Dunne at seatec_training@hotmail.com
Call: 404.712.9687
Visit: http://www.seatec.emory.edu

American Public Health Association Annual Conference
November 13-16, 2000, Boston, MA
A number of correctional healthcare topics will be featured.
To register, Call: 514.847.2293
Email: APHA@laser-registration.com.
Visit: www.apha.org

Request for Proposals (RFP): Equal Access Initiative- Computer Grants Program 2000/2001.
Due Date: December 1, 2000
100 minority community-based HIV/AIDS organizations will lreceive access to the Internet through a unique in-kind computer grants program.
Contact: National Minority AIDS Council (NMAC) at 202.483.6622 or info@nmac.org
Visit: www.nmac.org/pubs/RFP2000-2001.htm

National STD Prevention Conference
December 4-7, 2000
Milwaukee, WI
Contact: Glenda Vaughn, Centers for Disease Control and Prevention
Call: 404.639.1806
E-mail: ghv1@cdc.gov

Medical Management of AIDS: A Comprehensive Review of HIV Management - Winter Symposium
December 7-9, 2000
San Francisco, CA
Contact: Cliff Brock
Department of Medicine UCSF
Call: 415.476.5208
Fax: 415.476.3542
Email: cme@medicine.ucsf.edu
Web: http://medicine.ucsf.edu/programs/cme

2001 ACA Winter Conference
January 22-24, 2001
Nashville, Tennessee
Call 1-800-222-5646, ext. 1922
Fax: 1-301-918-1900
Visit: www.corrections.com/aca

News Flashes

New Complication of HIV: Osteonecrosis of the Hip

Investigators at the National Institutes of Health (NIH) have demonstrated that a disabling bone disorder, osteonecrosis of the hip, is surprisingly common among patients with HIV infection. Concern that the disorder might be a new and unrecognized complication of HIV infection prompted the investigation, a collaboration between the NIH Clinical Center and the National Institute of Allergy and Infectious Disease (NIAID). Magnetic resonance imaging was used to evaluate 339 study volunteers, all patients with HIV. While none of the study participants had the hip pain typically associated with osteonecrosis, 15 (4.4%) were found to have the disorder. One concern is that the lesions will lead to clinical symptoms that ultimately require total hip replacements. The reason for this unexpected complication of osteonecrosis (bone death) is unclear. A longitudinal study is under way to determine how many patients will develop these lesions and how many will ultimately need hip replacement. (NIH News Release, Clinical Center Communications).

Kentucky Inmates to receive medical care for hepatitis C

A few months after a federal magistrate condemned the Kentucky Corrections Department for denying medical treatment to a prisoner with life-threatening hepatitis C, the agency adopted a new plan that could mean up to 1,000 inmates will get the care, at a cost of $25,000 per patient. The department currently is testing 800 to 1,000 inmates who have the viral infection, a leading cause of liver disease, to see who will qualify for the expensive drug therapy. The Correction Department's new plan provides treatment to inmates with liver disease who meet all of eight qualifications, including the willingness to undergo random drug tests. Prisoners are excluded for any of 17 reasons, including "high-risk behavior" after their diagnosis, such as "sexual behavior, body piercing and tattoos." Patients also are excluded if they are scheduled to meet the parole board within 18 months so that treatment does not have to be terminated if an inmate is released (Wolfson, A. The Courier-Journal, September 21, 2000).

"Liver Failure Common in HIV-Infected Patients"

A report in the September issue of the Journal of Acquired Immune Deficiency Syndrome shows that HIV-infected individuals often die from liver failure. Italian researchers studied 1,900 HIV-infected patients for eight years, during which time there were 467 deaths. Among the 308 in-hospital deaths, AIDS was a key factor in 89% of the deaths, while liver failure was the primary cause of death for 5% of the patients and a concurrent cause of death in an additional 6%. Dr. Massimo Puoti-who also found that 80% of the patients who died in the hospital tested positive for antibodies to hepatitis C-said that key strategies to prevent liver failure among HIV-infected individuals include working to prevent hepatitis B, treating existing hepatitis B infections, and reducing alcohol use. (Puoti et al. JAIDS, Sept 18 2000;24:211-217.)

Resources & Opportunities

A corrections edition of Bartlett and Gallant's 2000-2001 Medical Management of HIV Infection is now available. The only difference between the corrections edition and the regular edition is the first chapter. The HIV Management Guidelines are outlined in this book and updated every week on the web at http://www.hopkins-aids.edu.

HRSA's HIV/AIDS Bureau has recently published A Guide to the Clinical Care of Women with HIV. This 2000 Preliminary Edition is available at no cost and will be updated at http://www.hrsa.gov/hab.

Expert Perspectives: Strategies for the Management of HIV/HCV Co-infection

Dr. Douglas Dieterich of Cabrini Medical Center and Drs. John Bartlett and Mark Sulkowski of Johns Hopkins University School of Medicine recently co-chaired a meeting of researchers and experts on HIV and hepatitis to assemble guidelines for the treatment of HIV and hepatitis C co-infected patients. The guidelines appear online in a continuing medical education monograph at http://www.projectsinknowledge.com/hiv-hcv/index.html

Grant and Funding Websites

NIH Grants and Funding Opportunities
http://grants.nih.gov/grants/index.cfm

CDC's Procurement and Grants Office
http://www.cdc.gov/od/pgo/funding/grantmain.htm

Guide to Winning Grants
http://www.grantstech.com/

Grantspring
http://www.grantspring.com/research.htm

HIV Treatment Websites

AIDSline
http://www.igm.gov

National Institute on AIDS
http://www.niaid.nih.gov

Virology on the Web
http://www.virology.net

Health Resources and Services Administrations HIV/AIDS Bureau
http://www.hrsa.gov/hab

National Commission on Correctional Health Care
http://www.ncchc.org

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 Nov. 30, 2000. The estimated time for completion of this activity is one hour and there is no fee for participation.

1. A patient presenting scaling, patches, and plaques with active borders and central clearing lesions involving skin or nails may have:
   a) Psoriasis
   b) Candidiasis
   c) Icthyosis vulgaris
   d) Scabies
   e) Dermatophytes

2. A patient presenting with pruritic papules and pustules on web of hands and feet may have:
   a) Drug reaction
   b) Psoriasis
   c) Folliculitis
   d) Scabies
   e) Dermatophytes

3. The preferred prevention for Toxoplasma gondii is:
   a) Dapsone 100mg qd
   b) Dapsone 50mg po qd plus pyrimethamine 50mg/wk plus leukovorin 25mg po/wk
   c) TMP-SMX 1 DS/day
   d) Clarithromycin 500mg

4. Indicate which of the following statements is true:
   a) The lifespan of an HIV-infected person on HAART with CD4<100 is close to that of someone who is HIV-seronegative.
   b) HIV drug resistance is less common in inmate populations than in the general population.
   c) HAART is a less expensive intervention per year of life saved than mammography or coronary artery bypass.

5. Strategies for preventing liver failure in HIV infected patients include:
   a) Strategic treatment interruptions
   b) Using enteric coated ddI (Videx) instead of the buffered ddI.
   c) preventing Hepatitis B by vaccinating
   d) a and b
   e) All of the above

6. An HIV infected patient currently on protease inhibitors, was recently exposed to an INH resistant strain of TB, and is now PPD-positive. The appropriate treatment for latent TB infection in this case could be:
   a) Rifampin 600mg/day + pyrazinamide 20mg/kg/day with ≥ 60 doses x 2 mos or up to 3 mos with interruptions.
   b) INH 300mg/day + pyridoxine 50mg/day ≥ 270 doses, 9 mos. or up to 12 mos with interruptions
   c) Rifampin + pyrazinamide 20mg/kg x 2 mos
   d) Rifabutin.pyrazinamide 20mg/kg/day with = 60 dose x 2 mos. or up to 3 mos with interruptions;
   e) Rifabutin 300mg po qd x 4 mo.
   f) a and c
   g) d and e
   h) All of the above

HEPP News Evaluation

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

1. Please evaluate the following sections with respect to:

	educational value	clarity
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HEPPigram	5 4 3 2 1	5 4 3 2 1
HIV 101	5 4 3 2 1	5 4 3 2 1
Spotlight	5 4 3 2 1	5 4 3 2 1
Save the Dates	5 4 3 2 1	5 4 3 2 1

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3. What future topics should HEPP News address?

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5. Do you have specific comments on this issue?

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