Challenges and Solutions Identified at NHCN Meeting 3.18.15

Challenges

Lack of Data
- Lack of National Prevalence data
- Data collection/lack of resources

Poor standards/Unknown standards
- No national stands for prisons and jails
  - Price
  - Care and quality of care
  - EMR
- Lack of consistent national guidelines for treatment
- Lack of National treatment recommendations specifically for inmates
- Not having reasonable guidelines
- Access to screening, including a “screening standard”

Prison health as public health
- National unified voice
- Making case convincingly that prison health = public health
- Public health vs. prison health
- Using the perspective of protecting “workplace” health – corrections staff, etc
- Presenting as social justice issue

Infrastructure
- Infrastructure to support re-entry and continuity of care
- Linking to prevention and treatment
- DOC/Detention/Public Health communication
- Limitations from institutions
- Policies/restrictions on who receives treatment and what kind
- Testing
- Communication and collaboration with corrections staff and medical department
- Linkage to community care including health insurance
- Include probation and parole

Budgets/Funding
- Budget – III
- Cost controls by adjusting costs, not by limiting treatment access
- Price paralysis
- Funding (need a national approach)

Other
- Converting from abstinence only to harm/risk reduction strategy in corrections
- How to break into correctional systems that are not doing anything
- Stigma
- Perception of HCV treatment – need to shift culture and more evidence based – reinfection concerns
- Sustainability
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- Buy-in top-to-bottom

Solutions

Lack of Data
- EMR Data Extraction/Using IT staff to support pulling data from EMR – II
- Present DOCs and Institutions with data (collecting data on program effectiveness)
- Data
  - Evaluation
  - Cost-effectiveness for community and for corrections
  - Surveillance – incidence and prevalence

Poor standards/unknown standards
- Use NHCN or other forums to develop a unified message
- Work with BOP and use their guidelines, AASLD guidelines are good standard, have corrections adopt these guidelines

Prison health as public health
- National Advocacy coalition – update/collaboration
- Unified position statement
- Political champions

Infrastructure
- Develop measurable action steps/goals – Examples:
  - Increased testing
  - Increased referrals to CBO/Community Health etc
- Identifying and utilizing existing community agencies/resources
- Patient assistance program to address the “gap” between release and community meds/Tx
- Linkage specialists/case management, utilize specialty pharmacies
- Adult Viral Hepatitis Prevention Coordinators create a needs assessment template for DOC – How VHPCs can serve their DOCs
- VHPCs should bring corrections to table and corrections should bring VHPCs to table (aka better partnerships between DOC and public health for hepatitis)
- Public health and correctional health to talk and collaborate to share info
- Medicaid expansion
- 340b

Budgets/Funding
- Keep focusing on cost-effectiveness research
- Maximize existing funding opportunities
- Unified correctional negotiating group – collaborate on pricing with the VA or FBOP (?)
- $ buy-in from DOCs; increase part of medical budget
- Balancing benefits for both parties
- Stop monopolizing drugs

Other
- Lawsuits (testing, inst. Limis, policies)
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- Lawsuits, the targeted, “friendly” kind
- Prime time to promote prevention
- Work with society of correctional physicians
- Involve families of incarcerated people
- Create a list of terms to stop/start using to work on de-stigmatization
- Stop arresting/criminalizing people who use drugs (all other points become almost irrelevant)
- AASLD/IDSA HCV Guidelines should be implemented on inside too (policy, testing)
- Digital/shared medical records and data statewide – good technology
- Negotiation leverage by DOC medical directors
- Better treatment in the community
- Community health workers
- Lawsuits
- Media campaign