Notes, Highlights, and Additional Resources from the 7th Annual Meeting Presenters, Panels, and Moderators

Below you’ll find notes on the various presentations from the presenters at this year’s meeting. See their slides on our website and any pertinent links to resources at the end of each presentation summary.

- **Update on HHS National Viral Hepatitis Action Plan and HCV Medicaid Affinity Group**, Corinna Dan, U.S. Department of Health & Human Services
  - 91% of the 2013 Actions committed were initiated despite lack of funding and support
    - See the [2013 Actions](#)
  - Systematic lack of Compliance with HBV/HAV for healthcare workers
  - National Viral Hepatitis Action Plan (NVHAP) priorities for 2017-2020:
    - Address health disparities and vulnerable populations, including correctional populations
    - Enhance provider education
    - Increase treatment access
    - End Medicaid suspension during incarceration to increase linkage to care
    - State teams made up of Medicaid, State Department of Health and county agencies, and State Department of Corrections and local probation and parole systems should use the Partner Planning Guide to develop state-specific action plans
    - Federal partners provide technical assistance
  - NVHAP priorities in next cycle
    - Encourage SAMSHA to have more HCV requirements for grantees
    - Add HAV priorities to next iteration
  - View the [National Viral Hepatitis Action Plan](#)
  - View the National Viral Hepatitis Action Plan [Partner Planning Guide](#)
  - See who is a participant in the [HCV Medicaid Affinity Group](#)

- **State of Medicaid HCV Treatment**, Michael Ninburg, Hepatitis Education Project
  - Old requirements of HCV treatment on state Medicaid: fibrosis, sobriety, and prescriber restrictions
    - Washington State sued state Medicaid to remove these restrictions
    - Still >10 states with fibrosis restrictions
    - Still >20 states with sobriety restrictions
    - Most states still have provider specialist requirements, which is why we need more awareness, interest, and education for providers
    - The threat of litigation may encourage states to remove restrictions pre-emptively
  - The state-by-state [HCV Medicaid Restrictions](#)

- **Anatomy of a Hep C Lawsuit**, Rob Katz, Indiana University Robert H. McKinney School of Law
  - Key litigation choices to improve plaintiff negotiating position:
    - Preliminary Injunction: pre-order state to provide treatment (example: Florida)
    - Motion for Summary Judgement: no trial due to the likelihood of a win without a doubt (example: Indiana, and opposite ruling in Pennsylvania)
    - Settlement: an official agreement reached to avoid trial (example: Massachusetts)
    - Pre-emptive policy mandates that address issues before litigation (example: Colorado)
  - Resolution checklist:
    - Policy change that is universal? (F0-F4)
    - Is this a permanent change to policy or a temporary initiative?
    - How will it be funded?
    - What is the time table?
    - What will the testing guidelines be?
☐ How will fibrosis be assessed?
☐ How will compliance be monitored?
☐ How will enforcement work?
☐ What will success look like?

- Considerations and attendee questions posed:
  - Can cost be a defense in a state lawsuit?
  - Are states following the community standards of care?
  - Is it feasible to extend Medicaid eligibility to correctional settings?
  - Is this replicable at the county level?

- 2019 Minnesota Settlement

- Advocating for HCV Treatment with Policy Makers, Robert Lawrence, Alaska Department of Corrections
  - With the impending threat of litigation, it is pertinent that DOC medical staff to know how to advocate to lawmakers about HCV treatment in corrections
  - Ethical elevator speech to answer the question of “why now?” key focuses were:
    - “We’re entering the eye of the storm when it comes to the cost of treating HCV with DAAs.”
      - The number of patients who are infected with HCV is only going to continue to rise if we do not screen, educate, and treat people
    - “The number of people acquiring and transmitting HCV is increasing.”
      - Both incidence and prevalence continue to rise across the State of Alaska
      - Rate of new infections in prison per year: 1.4 per 100 people
      - Rate of new infections in PWUD in the 6 months after re-entry: 16.4 per 100 people
    - “Prisons are HCV factories that have an increased rate of risky behaviors and a decrease in access to harm reduction strategies.”
      - Of the people in Alaska DOC who are diagnosed with Opiate Use Disorder, 45% of them have chronic HCV
      - 25% of HCV infections in Alaska are in prisons and jails, but they aren’t staying there
    - “Every treatment for a person in prison is treatment for a neighbor.”
      - Correctional populations are not static, 95% of people who are incarcerated will return to the community
      - Universal opt-out screening has community cost savings beyond money
    - “HCV is a silent assassin because it is a chronic communicable disease.”
      - No longer true that the only risk of untreated HCV is long-term HCC or liver disease
      - HCV increases the risk of developing type two diabetes due to its causative effects on hepatic diseases like insulin resistance
        - This may also lead to an increase in heart disease
        - 400% increased risk of type 2 diabetes with chronic HCV infection
        - 1100% increased risk if the person also has underlying risk factors
      - This is not an argument for treatment of everyone right now, but means that the chronic illness argument is no longer an argument against
        - “Eradication is possible and focusing on corrections is cost effective and impactful.”
  - See Alaska Office of Management and Budget announcing an increase in DOC allocations here

- Panel – Interventions to Support Linkage to Care in the Community, Lisa Puglisi, Transitions Clinic Network, Anna Steiner, Transitions Clinic Network, John Cocco, Step-Up, Inc., and Loftin Wilson, North Carolina Harm Reduction Coalition
  - Indiana: Inside out model: peer educators build relationships with people before they are released to establish a sense of community and encourage people to utilize resources and stay engaged
    - Emphasis in community corrections and diversion from long-term incarceration
    - State-funded re-entry homes
    - Peer educators are people who were formerly incarcerated or have lived experience with re-entry
North Carolina: In and out model: Community health workers enter prison pre-release to engage people and build relationships before re-entry
- Linkage to testing, treatment, harm reduction, and prevention from jail
- Naloxone upon release
- Texting support from community health worker
- Connection and warm hand off to resources upon re-entry

California: Community based case management model: providers do screening and identify patients in the correctional facilities, but people are referred out for treatment upon release
- Community providers go to test in jails and provide Opiate Use Disorder medications
- At re-entry patients are referred to case management programs or organizations upon release

Best practices to address maladaptive behaviors in response to “slip-ups” with people in treatment
- Non-judgement or suspension of judgement
- Engage client in their care to identify their goals and readiness
  - “What does success look like today?”
- Harm reduction with open framework
  - Allow it to be okay for people to have “slip ups” and engage with their vices, remember your own vices and practice compassion
- Community health workers
  - Remind people that life will improve, but life will still be tough
  - Identify coping mechanisms and encourage people to reach out
  - Set achievable goals
  - Remember boundaries and manage your own expectations of what success is
- People ≠ outcomes

How to address treatment suspension when people go to jail
- Get people’s meds to follow them to jail through an agreement with hospitals, jails, Medicaid, providers, or family members
- Case managers can follow people to jail with meds and enroll in Medicaid before release for easy continuation upon re-entry
- Coordination of care between patient’s community, providers, and organizations to keep people engaged

How to address competing priorities upon release
- Identify and address social determinants of health to address HCV treatment
- Drop-in centers with wraparound services all on site at the provider location
  - Housing, identification, job readiness, transportation, MOUD, HCV treatment, etc.

Build coalitions of advocates to voice issues to the city
- End Medicaid ineligibility or Medicaid termination while incarcerated
- Provide appropriate housing options that offer stable housing for active users
- Re-define what it means to be “chronically unhoused” to include formerly incarcerated populations
- Provide state-funded residences for people to live after incarceration

Barriers:
- How do you know who is ready to engage?
- How do you support active users?
- What about rural populations?

North Carolina Harm Reduction Coalition
Recovery Works, Indiana re-entry services for people who were formerly incarcerated and have a diagnosed substance use disorder or serious mental illness.

Outcomes of HCV Treatment in a Jail Population: Successes and Challenges Facing Scale Up of Care, Justin Chan, NYC Health & Hospitals Correctional Health Services
- No difference in SVR between treatment in jail or the community
- Implemented length-of-stay-based treatment protocols
- NYC Health and Hospitals Correctional Health Services Report on MAT
World Café: these notes highlight the key discussion points from each table but are not inclusive of all the valuable ideas that were exchanged during this activity. In the future, we will provide additional time for this invaluable exchange of stakeholder perspectives.

o Improving HCV Care Through Countywide Partnerships, Prabhu Gounder, Los Angeles County Department of Public Health
  - Health departments can assist with coordination of efforts, asset mapping, gap identification, and surveillance
  - Utilize partnerships and advocates within health departments to facilitate better programs for case management

o Medication for Opiate Use Disorder in State DOCs, Lara Strick, Washington State Department of Corrections and Mike Selick, Harm Reduction Coalition
  - Strategies to get staff on board
  - The challenge of the jail → prison → community transition
  - Methadone facilities as Opioid Treatment Program providers

o Legal Actions for HCV Tx, Sonia Canzater, Georgetown University and Gabe Eber, ACLU Prisons Project
  - Unintended consequences of litigation
  - Is cost a valid consideration?
  - Should the community standard of care be required in correctional facilities as an 8th amendment right?
  - How do we define “classes” for class action?
  - What are the consequences of an unfunded federal mandate?
  - How do you measure compliance?

o Corrections and the National Viral Hepatitis Action Plan, Liesl Hagan, CDC
  - Differences between jails and prisons
  - Need to include HAV, HBV, and HCV
  - Should include harm reduction and peer education
  - Alter policies around Medicaid restrictions while incarcerated to help with continuity of care
  - How do we measure compliance?
  - How do we measure incidence?
  - Need to pressure lawmakers
  - Need to identify new strategies to collect data for screening outcomes

o Re-Entry Linkage to Care Successes and Challenges, Anna Steiner, Transitions Clinic Network
  - People disappear and either don’t want to be found or don’t have access to care
  - No one in the community to hand off to due to lack of providers who prioritize these populations
  - Lack of education about HCV amongst patients, providers, correctional staff, families, and people who are incarcerated
  - People are under or uninsured

o HCV Treatment in Jails, Maya Yoshida-Cervantes, San Francisco Department of Public Health and Kristin Walsh, Santa Clara County Jail
  - Use length of stay as a way to determine treatment eligibility while in jail
  - Improve programs and partnerships to link to care
  - Need to identify patient’s access where they are at

o Criminalization of HCV, Philip Waters, Harvard and Jada Hicks, HIV Law and Policy
  - How do we deal with the Legislature?
  - Need to educate corrections officers, lawmakers, and patients about actual risk behaviors and harm reduction strategies
  - Medicaid report card grades
  - Public health implications of criminalizing a chronic illness

o HCV Treatment in Prisons, Tammy Smith, Kansas Department of Corrections, and Kim Lucas, California Department of Corrections and Rehabilitation Department of Public Health
  - No consistency with providers, training, protocols, procedures, or adherence to guidelines (AASLD vs. FBOP)
Cheaper to treat patients than to provide palliative care

- Pricing Models for HCV Treatment in Prison, Anne Spaulding, Emory
  - See below for notes
- Peer Education in Prisons, Daniel Rowan and Saul Hernandez, New Mexico Peer Education Project ECHO
  - Sustainability with length of stay and transfers between facilities
    - Need to train enough people to accommodate that
  - How do you start a peer group?
  - Identify an advocate
  - How do you serve rural areas?
  - Need to encourage people who work in corrections to take responsibility
  - How do you get funding?

- HCV Screening in Santa Clara Jail - Progress and Feedback, Kristin Walsh, Santa Clara Valley Medical Center
  - Santa Clara Jail HCV Screening Report
  - California Viral Hepatitis Prevention Strategic Plan

- Medicaid Agencies and Re-Entry AZ, LA, & OH, Maria Schiff, Pew Charitable Trusts
  - Managed care organizations should become Medicaid-qualified agencies
  - More places are shifting to Medicaid eligibility for corrections if it is an inpatient stay
  - We need to re-define “high needs”
  - Need to extrapolate and share data more between agencies
  - We should start co-locating PCPS, social workers, probation officers, and parole officers
  - Pew Charitable Trusts article on HCV in Corrections

- Panel – Health Departments and Corrections: Models of Collaboration, Alyssa Kitlas, NASTAD, Debra Nichols, Indiana State Department of Health, Prabhu Gounder, Los Angeles County Department of Public Health, and Candice Givens, Durham County Department of Public Health
  - Indiana:
    - HCV screening in DOC lab results are sent to Department of Health (DOH) for surveillance
    - Created an app for patients
    - Increased program staff for integrating prevention, surveillance, and services
    - Build partnership with Project ECHO and Peer Education Project
  - Los Angeles County:
    - Screening is difficult due to large population
    - 500+ intakes per day makes blood draw screening impossible
    - Need to create a registry of jail population to facilitate care, identify people with HCV, and reduce duplication of labs
    - Doctors work for Correctional Health Services and DOH, but sheriff owns the space
    - Need sheriff booking data and estimated release date (ERD) with previous screening data for chronic HCV
    - Funding is only for people in jail over one year
    - Transitions team addresses competing needs such as housing, finding a PCP, transportation, licensure, and making appointments
  - North Carolina:
    - Received infectious disease grant-funding through University of North Carolina
    - Reflex HCV testing is state funded at the county detention centers
    - State medical and lab director oversees all jail HCV screening
      - Four days a week opt-in HCV, HIV, STI screening with incentives
      - Includes testing, processing, post-testing counsel and referrals to bridge counselors
    - Bridge counselors:
      - Intense short-term case management for 3-6 months
      - Bio-psycho-social assessment
      - Patient-centered identification of all barriers and social determinants of health
      - Supportive service referrals
      - Linkage to HCV treatment
Ineffective to link upon re-entry only
- Address behavioral and mental health services, SUD treatment, housing, and other competing priorities
- Need to increase capacity of programs to give case management to more people
- Current new interventions:
  - Resource page on re-entry in belongings
  - Referrals to North Carolina Hepatitis Academic Mentorship Program (N CHAMP)
  - Opioid Task Force
  - Two cans of naloxone on release
  - Hygiene kits
  - Safe syringe program
- There is currently only $39.5 million in the federal government for HCV which equates to one staff person per state
- There is lots of momentum for elimination, but there are lots of gaps in money and political will from the public
- Health departments should be working with jails and prisons to increase data surveillance, programming efforts, staff, testing, funding, and health education
  - Connect with your state’s HCV coordinator
  - Call and email facilities to identify an advocate who is willing to be a champion
  - Utilize Medicaid Affinity Group for sustained focus and engagement
- Hepatitis Testing Partnership Coalition a division of NASTAD
- RedCap surveillance data analysis tool
- NC CHAMP is a telemedicine training platform for providers
- Peer Education Project (PEP)

**Opiate Use Disorder: How Treatment Medications Support Recovery and Save Lives**, Lara Strick, Washington Department of Corrections, University of Washington Harborview Medical Center
- We need to address personal and institutional stigma about Opiate Use Disorder (OUD)
  - Shift from Medication Assisted Treatment (MAT) to Medications for Opiate Use Disorder (MOUD) to de-stigmatize treatment
    - MAT implies that medication is second to therapy for treatment
  - Change language from diversion to self-treatment in jail
  - Move away from referring sobriety as “clean” to remove the implication that to use is “dirty”
    - These stigmas impact the lives of individuals
  - SUD treatments have dealt with as much stigma as the disease has
    - The treatment and recovery community require complete abstinence
    - Ongoing MOUD is seen as a failure of morals/will as opposed to medication
    - We need to alter these mindsets and begin to view MOUD as favorable for life-long treatment, like insulin or medication to treat heart disease
- Many people with Substance Use Disorder (SUD) do want to use drugs or are at least somewhat interested in reducing or stopping their use
  - Forced abstinence is not a cure for addiction
  - SUD is a chronic condition: 80-90% of people relapse within one year after re-entry regardless of the length of their incarceration
- Opiate Use Disorder has three components
  - Bio: opiate use creates tolerance/dependence and would eventually happen to anyone
    - It changes the brains natural endorphin receptors and may cause long-lasting or permanent damage.
    - One quarter of users develop OUD
  - Psycho: people spend lots of time recovering from using or worrying about withdrawals which can often feel like it consumes the mind
    - Strong link between childhood trauma and OUD – the link is greater than that of the link between obesity and diabetes
  - Social: it can make you do things you normally would not do to get more drugs or money for drugs
- You can’t treat psycho/social damage with medication, but you can’t treat physiological dependence and brain changes with counseling and social support either.
  - You can behave your way into OUD, but you can’t behave your way out
- >30% of people in prisons in the US have OUD, yet the national recognition for the need for MOUD has not translated to all state and county correctional facilities
- MOUD upon re-entry leads to:
  - Increased engagement in care
  - Increased treatment adherence
  - 50% fewer deaths than with counseling alone
  - Reduction in crime rate and recidivism
  - Increase in social function
  - Reduction in rate of relapse
- Better retention with pre-release initiation of Methadone as opposed to referral upon release
- Prison-initiated buprenorphine has a 40% higher 6-month sustained adherence than post-release initiation
- Naltrexone has much lower maintenance rate after re-entry and much higher overdose death rate
- Prisons that offer comprehensive MOUD programs have reductions the amount of drug-related contraband
- There is no one size fits all solution and all methods have had failures
  - Ultimately, the patient knows what will work for them best
  - Should be mandatory in DOC for all providers to become registered providers
  - **Analysis of National MOUD Use in Corrections**

- **When Will the Price be Right? Mapping the Course**, Anne Spaulding, Emory University Rollins School of Public Health
  - It currently costs a minimum of $9,000 to treat HCV in the United States, in India, it currently costs $1,600
  - Pooled procurement rebate may lead to a 10% discount
  - Nominal Pricing: permits manufacturers to sell drugs to safety-net(340B) facilities at a low price without disrupting the Medicaid market
    - Safety net providers are those that serve vulnerable populations
    - Drug manufacturers can still sell drugs above the production price and make a profit
    - Currently, correctional facilities do not qualify as 340B so prisons and jails must apply for a partnership with a 340B-registered institution like a hospital and then complete all HCV treatment outpatient within that facility
      - Can only provide a 23% discount
      - Only a few facilities have made these partnerships
      - Each facility must negotiate individually
      - Some facilities can’t even find partners when they look
    - Maricopa County has seen success with negotiating with the state STD program instead of a hospital
    - We need to advocate to congress to grant correctional facilities 340B status or change the best price statutory
  - Netflix Model: medication companies bid to be the sole provider of medication to a state for a fixed price and amount of time and in that time, they have unlimited access to medication
    - Can potentially access treatment for many people
    - Does not cause loss in earnings to medication supplier due to high volume of need and them being the sole provider
    - Difficult with the Best Price for Medicaid and Federal Bureau of Prisons (FBOP) statutory
    - Would require tremendous amount of resources and coordination to effectively treat all people in a short time frame, may not be feasible in states that don’t have universal screening because they don’t know who all the patients are
  - Need to have a combination of Netflix model for Medicaid/FBOP and Nominal Pricing to bypass the Best Price for Medicaid/FBOP issue
  - Please submit your state, county, or facility data to Anne and her graduate students to enhance this research and data collection tool
  - Read more about the **Nominal Pricing Structure**