NHCN
National Hepatitis Corrections Network
An Initiative of the Hepatitis Education Project

HEP
Hepatitis Education Project

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DISCLOSURE

- Gilead Advisory Board
- Janssen Speaker Fee
Describe epidemiology of the hepatitis C virus (HCV) in US prisons and jails.

Explain how recent changes in HCV treatment options have impacted correctional settings.

Identify practical efforts that increase quality of hepatitis prevention and care in correctional settings.
• Direct services
• Patient Support
• Education
• Advocacy

HEP has worked in the correctional setting since 2001.
Launched by Hepatitis Education Project in 2013
Growing network of experts

What we do:

- Connect colleagues and foster collaboration
- Share new and valuable resources and best practices
- Professional development
- Annual meeting, webinars, conference calls, e-newsletter, google group, networking

www.hcvinprison.org
QUESTION

Why did you come to this session?
Hepatitis C – Basic Epidemiology

- CDC estimates **2.7-3.9 million** living with HCV (Actual number probably ~5 million)
- Most common blood borne infection in US
- Most recent est: ~24,700 new **infections in 2012**
  - Epidemic among young PWID...who we incarcerate
  - Range for new infections is 19,600-84,400
- About 75% of those with chronic HCV are **baby boomers** (birth year 1945-1965)
- 50-70% of those with HCV **unaware** of their infection
HEPATITIS C – BASIC EPIDEMIOLOGY

- 19,368 death certificates listed HCV in 2013
  - “Fraction” of deaths attributable to HCV

![Graph showing the number of deaths over time]

HEPATITIS C – TREATMENT

- This is an urgent issue!
- 90% + can be cured
- Treatment options now shorter duration, better efficacy, fewer side effects
- Curing hepatitis C improves health beyond just hepatitis C
- Treating active injection drug users and women of child-bearing age could result in significant transmission reduction (NVHR)
- HCV is a communicable disease – treatment is prevention – ensuring we cure those populations means that we can dramatically decrease new infections (NVHR)
Hepatitis C Cascade of Care in United States

100% of 3,200,000 people have Chronic HCV. 50% are detected, 35% referred to care, 9% treated, and 6% achieve sustained virological response (SVR).

More than 2.2 million people incarcerated (1 in 3 Americans have been incarcerated)\(^4\)

Higher likelihood of past risk behavior for hepatitis C (HCV)

We know that risk behaviors persist in prisons and jails despite zero-tolerance policies and that disease transmission occurs\(^6\)

**Result = HCV rates:** 1-2% general pop vs. \(~17.4\%\) corrections\(^7\)

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IN SOME WAYS, NOTHING HAS CHANGED

- No national epi surveillance system for prisons/jails
- Correctional systems are not uniform:
  - Prisons vs. Jails, Federal vs. State, Private vs. Public
- The priority for corrections is security, not public health
- HCV treatment is expensive
- Screening practices vary widely
- Disincentive to test if unable to offer treatment
- Corrections/community integration is weak
- Change is hard in corrections
WHAT HAS CHANGED?

Testing:
- Adults born during 1945 through 1965 should be tested once (without prior ascertainment of HCV risk factors)
- **Impact**: increase in awareness, less stigma around testing, new push for testing this cohort in some correctional systems

Treatment:
- Multiple new drugs available since 2013
- Cost of treatment skyrocketed, cost pure cure lower
- **Impact**:
  - Shorter duration – eliminates length of stay rationale
  - Fewer side effects/higher efficacy – more demand
  - Easier treatment to manage – less need for specialists
WHAT HAS CHANGED?

- Growing awareness of the interrelationship between community and correctional health

- “Noise” around hepatitis C right now – more needed

- Evolving standard of care in community forcing many systems to make changes

- Competition among drug makers
How do the guidelines for testing and treatment compare to reality on the ground?
HEPATITIS IN CORRECTIONS: TESTING THE GUIDELINES

“CDC recommends that correctional facilities ask inmates questions about their risk factors for HCV infection during their entry medical evaluations. Inmates reporting risk factors should be tested for HCV infection and those who test positive for HCV should receive further medical evaluation to determine if they have chronic infection and/or liver disease.”

- Adults born during 1945 through 1965 should be tested once (without prior ascertainment of HCV risk factors)

- Others: PWID, certain medical conditions, exposure, some transplant/blood recipients
HEPATITIS IN CORRECTIONS: TESTING
WHAT WE KNOW

- Testing practices vary widely when they exist
  - With symptoms, by request. risk based, universal opt-out
  - Entry vs. release

- Only 12 state prison systems routinely tested for HCV between 2001 and 2012

- Universal, opt-out testing catches the most cases, is cost-effective*, is more labor intensive
  - Pennsylvania study: “Targeted testing of the 1945 to 1965 birth cohort would produce a high yield of positive test results but would identify only a minority of cases. We recommend universal anti-HCV screening in correctional settings to allow for maximum case identification, secondary prevention, and treatment of affected prisoners.” – Larney et al, AJPH, 2014

- Access to confirmatory testing?
- Tested inmates often not treated, linked to care
- Different considerations in prison vs jail
HEPATITIS IN CORRECTIONS: TREATMENT
THE GUIDELINES

- **AASLD/IDSA:**
  - “Successful hepatitis C treatment results in sustained virologic response (SVR), which is tantamount to virologic cure, and as such, is expected to benefit nearly all chronically infected persons. Evidence clearly supports treatment in all HCV-infected persons, except those with limited life expectancy (less than 12 months) due to non–liver-related comorbid conditions”
  - “Immediate treatment is assigned the highest priority for those patients with advanced fibrosis (Metavir F3), those with compensated cirrhosis (Metavir F4), liver transplant recipients, and patients with severe extrahepatic hepatitis C. Based on available resources, immediate treatment should be prioritized as necessary so that patients at high risk for liver-related complications and severe extrahepatic hepatitis C complications are given high priority.”

- **FBOP Guidelines** very similar.
HEPATITIS IN CORRECTIONS: TREATMENT
WHAT WE KNOW

- Reality check -
  - Cost
  - Demand vs. Institutional and provider capacity
  - Political feasibility

- Treatment in prisons usually:
  - F3 or higher
  - Case-by-case decision
  - Caps on # of inmates based on budget/capacity
  - Length of stay/other limitations not = community
  - Interferon/Ribavirin still being used

- Many challenges, few solutions
- Bottom line: highly variable, system dependent, significantly limited
- Community vs incarceration – when to treat?
But Rich, What About Solutions?!
WHAT NOT TO DO

Price paralysis gets us nowhere.
**Opportunities Vary in Prison vs. Jail**

**Prison**
- Longer sentences (2-3yrs)
- Bigger HS’s budgets
- Better healthcare infrastructure
- Screening limited/variable
- Treatment more feasible
  - Many don’t treat
  - Treatment limited when available

**Jail**
- Short length of stay (days or weeks)
- Treatment less feasible (but not impossible)
  - Limited infrastructure
  - Short sentences
  - Smaller budgets
- Testing varies but happens: linkage to care is key
- Treatment may be feasible with shorter duration
- Education and prevention
4 Easy (-er) Solutions

(That you can work on right now)
(While keeping eyes on the prize)
#1: TEST MORE

- Inexpensive

- Helps gather real data needed to make decisions

- Makes an impact on individual and institution even if no treatment

- Universal opt-out testing has been shown to be feasible and most effective, but a wide variety of models exist

- What about the legal concern?
  - Must display deliberate indifference
  - No known increase in lawsuits in opt-out systems
  - Well-written treatment protocols based on guidelines may reduce risk
#2: Establish Real Care Continuity

- Create and utilize linkage specialists
  - Case management model works in HIV

- Leverage ACA when possible

- Integrate prisons and jail health with community corrections: case management, probation, parole

- Know what linkage to care really is and what it isn’t

- Work on corrections/community integration – re-entry starts inside
#3: **Educate and Prevent**

- Incarceration is a teachable moment

- Education empowers healthcare consumers and makes your facilities healthier and safer

- Prevention education and peer education

- **Harm Reduction**
  - Condom access - ~ 5 cities distribute in jails, 2 states in prisons
  - Syringe exchange – at least 11 countries
  - Tattoo vocational program – Correctional Service Canada

#4: Be Proactive - Prepare for the Near Future

- Prices already coming down?

- Think innovatively
  - Negotiate on prices
  - Develop and utilize technology such as telemedicine
  - Talk to decision-makers in your system and in your legislature

- Create the infrastructure
  - Putting the pieces in place now keeps you ahead

- Make a real plan and follow through
BONUS! – DON’T FORGET

- We are short on time!
- HCV treatment:
  - Is highly effective
  - Is (much!) easier to manage than it used to be
  - Is a prevention tool (and a word on re-infection)
  - Reduces all cause mortality
  - Improves the health of the individual
  - Improves the health of your institutions
  - Improves the health of your community
  - Is cost effective to society
  - Is the right thing to do
**Really, What Can You Do?**

- Think – what *can* I do?

- Talk to your decision makers – corrections can’t tackle hepatitis C alone

- Advocate for resources, capacity, improved services

- Do research and share data

- Be creative and think outside the box

- Participate in the conversation

- Humanize people in prisons and jails
Powerpoint Presentations from Experts

**Click here** to view powerpoint presentations from past NHCN annual meetings only.

**WEBINAR: Telemedicine and Telehealth in Corrections**
Webinar broadcast is available by clicking here: [Webinar Video]
Melissa Badowski, University of Illinois/Illinois DOC
Karla Thornton, University of New Mexico Project ECHO
Lara Strick, Infectious Disease Physician, WA DOC

**Hepatitis C: A Public Health Opportunity in Our Prisons - Part I - Epidemiology**
Rich Feffer, Correctional Health Programs Manager, Hepatitis Education Project
November, 2014

**Hepatitis C: A Public Health Opportunity in Our Prisons - Part II - Medical Treatment**
Lara Strick, Infectious Disease Physician, WA DOC
November, 2014

**Hepatitis C: A Public Health Opportunity in Our Prisons - Part III - Economic Considerations**
Ben Linas, Assistant Professor of Medicine and Epidemiology, Boston Medical Center
November, 2014

**Condom Access Programs in Correctional Settings: A Harm Reduction Approach**
Erin Bortel, ACR Health
Breaking Barriers Summit, September, 2014
The Growth of Incarceration in the United States

Exploring Causes and Consequences

Source: Bureau of Justice Statistics Prisoners Series.
QUESTIONS/DISCUSSION