CONNECTING CARE PODCAST // EPIDSODE #12 // TRANSCRIPTS

HIV and Substance Use Care in the Jail or Prison System: Spotlight on care delivery

Dr. Alex Walley:

Navigating the HIV and substance use systems of care presents a number of unique challenges, many of which can become more complex depending on a person's housing employment, mental health or economic situation. One system that immediately complicates a person's access to HIV and substance use care is the jail and prison system.

Dr. Alysse Wurcel:

I don't know if people back in 2016 realized that not having buprenorphine in the jails encourages higher risk activity, because there's this hope for control. When people are upset and sad and isolated, they don't want to be in that reality anymore, and when they're withdrawing they will do anything to feel better. Providing this is absolutely necessary to keep people healthy.

Dr. Alex Walley:

You're listening to Connecting Care. I'm Alex Walley, an HIV primary care doctor and addiction medicine and specialist in Boston, Massachusetts. This month, my colleagues, Dr. Jessica Taylor and Dr. Sim Kimmel talk with Dr. Alysse Wurcel, a doctor who provides HIV and substance use care in Massachusetts jails. Among a robust breadth of topics they cover the complex realities of providing HIV and substance use care for people who are incarcerated, how these complexities are perpetuated and affect a person's access to care, both in and out of the jail and prison system. And how HIV and substance use care in the jail and prison system is slowly starting to change.

Dr. SIm Kimmel:

You're listening to Connecting Care, the intersection of HIV and opioid use disorder. I'm Sim Kimmel, and I'm an HIV primary care doctor, infectious disease and addiction medicine specialist in Boston, Massachusetts. I'm joined again by my colleague, Dr. Jessica Taylor, and we're flying solo this week while Alex Walley takes a well deserved day off. Do you think we're up to it, Jess?

Dr. Jessica Taylor:

I think so, Sim. Especially because we have our wonderful friend and colleague Dr. Alysse Wurcel here with us today. Dr. Wurcel, for folks who may have not met her in the past, is an assistant professor at Tufts University School of Medicine and an infectious disease specialist, and actually the HIV specialist at several of the county jails in Massachusetts. So today with Dr. Wurcel, we have the chance to dive in and talk more about taking care of people with HIV and substance use disorders, and sometimes HIV and substance use disorders when they face periods of incarceration. And like we've done in past episodes, we'll use a couple of cases to sort of prompt our discussion about some of the systems that impact the care that provided, and also talk about models that work well in situations where we could advocate for policy change to try to improve patient outcomes. So thank you both so much for being here.

Dr. Alysse Wurcel:

Thanks for having me. This is great.

Dr. SIm Kimmel:

Alysse, thanks for being here. We've touched on this podcast on the impact of systems of care for people with HIV and substance use disorder in previous episodes, and obviously people who are incarcerated are greatly impacted by these factors. Could you start by talking a little bit about the different settings where people can be incarcerated and how that impacts their care, their addiction and their HIV care?

Dr. Alysse Wurcel:

Yeah. When someone is picked up and put in jail or put in prison, it can actually be really different scenarios. They may be picked up and put into a police office holding cell and then transported to jail. They may be taken directly from the court. There are lots of different scenarios, but I guess the biggest thing to think about is the difference would between jail and prison. So just to think a little bit about that, I think about jail as a place that's run at the county level. In Massachusetts, we have sheriffs and they run it, they're elected officials. And so South Bay and Nashua Street are two of the Suffolk County jails. There's Bristol County, so all these different jails, even Nantucket has a jail.

Dr. Alysse Wurcel:

And then those are for people who are either pretrial, so they haven't been sentenced yet, or they have sort of "shorter" periods of incarceration, meaning usually less than two years, whereas people in prison are there for a longer period. I usually think of two years as the cutoff between those two times, but I've had people in jail for a really long time because they've been pretrial for two or three years, so they stay in jail as they're awaiting trial. So there are little nuances there. The reason why these kind of separations matter is because the jail population and the prison population have a lot of differences. The jail population is younger overall, the prison population is older overall. And then in jails where I work, the average length of incarceration could be quite short. Sometimes I see two days as being the average length of incarceration, other times they see 30.

Dr. Alysse Wurcel:

So when you hear about a revolving door, when people are coming in and out or in and out, that's kind of the jail situation, and then the prison situation is sort of a longer term. And that really impacts how we deliver care. As a prison doctor, if someone comes in with HIV, there's a longitudinal relationship that's often set up with the same doctor over a long period of time. And then there's an element of kind of knowing everything, knowing the medicines. And in jails that can be quite in and out, who's my doctor this time, depending on which county they're incarcerated in. As it relates to HIV, there's a lot of shifts related to insurance and communication with the outside doctor and the inside, and so I think kind of jail HIV care as being a little bit more challenging than prison HIV care, but of course I'm a jail HIV doctor so maybe that's just what I'm going to say.

Dr. Jessica Taylor:

I think with all of the sort of uncertainty and length of stay differences, that inside/outside communication and collaboration becomes a piece that is incredibly important and also really difficult. And I'm wondering if you could just share with folks listening, sort of what your workflow looks like when you're caring for someone with HIV in a jail, in terms of the care that they may be familiar with, like getting labs, prescribing medications, choosing medication. And then how you support people in landing in a safe and stable way after a very often traumatic event of an incarcerated and also making sure that they're prepared for a smooth transition back to the community, and what barriers you face, how you try to navigate them.

Dr. Alysse Wurcel:

So on most of the intake forms there are questions saying, "What illnesses do you have?" Jail intake is something that happens usually within 24 hours of incarceration. It's the only mandated interaction with a clinician, it's usually a nurse. So all other interactions can be refused with medical care inside the jail or inside the prison, I think. Well, at least inside the jail. So on that form usually it comes out that someone says, "Okay, I have HIV." It's not always, actually. And sometimes later on during their incarceration, someone will ask and will be like, "Ah, actually, I have HIV, but I didn't tell anyone." So usually what happens is they come in and then there's this whole process where we need to confirm their meds on the outside, which is actually really complicated sometimes because sometimes people don't know which CVS or Walgreens they're getting it at. So they'll say, "Okay, this is my med." But then we need to confirm it.

Dr. Alysse Wurcel:

So there's sometimes going to be a little bit of a delay in getting people their HIV meds, that is very upsetting to the people, obviously, because as HIV providers we say, "Don't miss a dose, don't miss a dose." And then they have this... We try to make it as seamless as possible, but there's just a lot of things and barriers to keep that seamless dose from the outside to the inside. So when they get in, what happens is they actually lose their health insurance, which is one of those things that makes care actually call quite challenging. What we have in Massachusetts is called the HIV Drug Assistance Program. So it ends, and then it has to be refiled. That pays for all of their HIV medications. In order to get the HIV drug assistance up and running, they have to have an HIV viral load and CD4 count drawn. It used to be while in jail, fortunately we are now allowed to use ones used six month before.

Dr. Alysse Wurcel:

But usually they come in and they're put on the list to see me. I go to each jail about every five weeks, and I rotate through five jails. And so yesterday I saw about 10 people, today I saw about six people or eight people, most of them were HIV. So they wait to see me and I see them and we discuss, we look... It actually, all HIV meds are directly observed therapy, so they're given by the nurse at something called Medline. This is a, I would say, a huge barrier to care for most people. It means that they have to... If the first med pass happens at 5:00 AM and the nurse comes in to a large, large cell block and says, "Med pass." If the person's sleeping, they may not hear that. And so then they could miss their meds and it might just say refused as marked on the actual form, but they were sleeping.

Dr. Alysse Wurcel:

So I like to put patient's meds at night. That can be hard for some people who've already taken it during the day. I obviously let people decide whether they want it in the morning or the night. But I can check, based on this, what their adherence to the meds are because the system will actually give me a percent adherence, and so we'll review that. Today, most of my patients had near a hundred percent adherence. We'll review any challenges. We'll review any new meds that were started, because sometimes meds are started and they may interact with their HIV meds. We'll review Hep C, which I will treat as soon as possible. We'll review substance use disorder. And then I try to get their labs and get them COVID vaccinated and flu vaccinated and sort of send them on their way.

Dr. Alysse Wurcel:

Actually at that meeting I will ask them who their outpatient HIV provider is or clinician. And when they say it, I try to email their clinician with them right there with me, because they have such a bond with their outside doctor and it's not the same as the bond with me. They don't know who I am. And that

usually makes people really, really happy. I'll say, "Oh, I know Dr. Taylor." "Oh, I know Dr. Kim." "Oh, I know Dr. Walley." Like, "You're so lucky. You've got those doctors?" And they're like, "You know them?" I say, "Yes, I know them." And so I all them, and I tell them that everyone's in the same loop, because also they're worried that their doctors don't know where they are. Usually there should have been a release of information, and often the actual facilities can't give me information on them unless this release of information is done. So often I think the jail thinks that the doctor knows they're there because this form has been sent, but often the doctor doesn't know they're there.

Dr. Alysse Wurcel:

So I see them every three months, that's sort of mandated and it's potentially a little overkill, I would say, given the way that our HIV meds work. And then I try to arrange a safe follow up, usually with whoever they leave to go see. And I can say that is so challenging. They don't know when they will leave. I don't know when they will leave. And so it's really, really, really challenging to figure out when they're going to leave, especially with substance use disorder to get that plan, to get them in the right hands right away. There's all these really interesting things that happen in jail where you have good time that takes away... Good time, meaning you did something and so you don't have to go for a longer stay, you can get a day or two off. I try to get them connected with their outpatient doctor. I'll try to email them. Another hard part is that their insurance won't be activated, so many places will not schedule them for an appointment until they physically leave. And then they don't know which insurance to choose. It's just, they're a lot of barriers.

Dr. Jessica Taylor:

Can we hear more about that, because that is a huge issue. And if listeners on work with people coming out of carceral settings, it comes up often where someone can arrive at a medical visit after release and not have active insurance. And so I'm wondering, are you able to give any more background on just what happens to insurance, specifically state Medicaid, when someone's incarcerated? And kind of what we're talking about here, that someone loses insurance when they go into a state facility.

Dr. Alysse Wurcel:

So you lose your insurance when you go into jail. They try to align the whole process of your insurance being reinstated when you leave jail. But since we don't know when you're going to leave jail, the date that they think you're going to leave jail on the paperwork that they've submitted for the insurance may not align. And so there's a possibility, and this happened a lot during COVID, or the first wave of the pandemic where people would leave a week or two before we thought they were going to leave. And in that situation, they went out, they went to their CVS or wherever, and there was no way to fill their meds because their insurance was not activated yet. So there's this deactivation process of your insurance when you come in and then a reactivation.

Dr. Alysse Wurcel:

So if someone has their doctor and they know where they're going to go, each university or each hospital actually changes the type of insurance that they take. And so it's on the person who's incarcerated to often choose which type of insurance to take, and that may not align with the insurance that their HIV clinician takes. And that happens all the time, they have a list maybe of all the different types of insurance and the case worker says, "Well, I heard this one's pretty good. I'll take it." But then they show up and that insurance is not accepted by their HIV clinician. And it's just so much back and forth. I can't even tell you which... I don't even know all of the different places my hospital accepts or

not. So when the patient says to me, "Oh, which one should I take?" I say, "I don't know. I don't know, and that could change in a week."

Dr. Alysse Wurcel:

It's also really hard for people... I mean, Massachusetts is a smaller state. So when I think about someone who might go to Worcester for a month, but then end up relocating to Quincy, having your HIV clinician close by is important. So then there's these challenges of where, well, they want their HIV clinician close by, and so they chose this insurance to see someone in Worcester, but now they're in Quincy. And there's just so many very hard challenges to figure out how to get all these ducks in a row and actually have our patients be able to see us.

Dr. SIm Kimmel:

This is really insightful and helpful information as we think about the experiences of our patients. It seems so ironic because although jail or prison is destabilizing, there's this moment where people are present, there's clinical care, there's food. Oftentimes my patients when they come back from jail, they've gained weight. In some ways they look better, but as they leave there's this incredible destabilization.

Dr. SIm Kimmel:

I just saw a patient not too long ago who walked into our drop in clinic, somebody with HIV and opioid use disorder and hepatitis C. And he had been taking his HIV medications prior to incarceration, but had been using, and hadn't had his hepatitis C treated. And when he was incarcerated, he was started buprenorphine, which is amazing and a huge change from five years ago. His hepatitis C was treated and he was continued on his HIV medications. I mean, it's an amazing success. And he walked in a week after having been released, and in that week he... He wasn't able to pick up his HIV medications. He had started using again because he couldn't fill his buprenorphine, right? And I've seen him a few times now since then, and unfortunately his hepatitis C was reinfected. And the stability that he had had, medical stability was all kind of lost in that transition. Do you have ideas about how we can do that better?

Dr. Alysse Wurcel:

Yeah. I mean, I think there are models like Tom Lincoln, who's at Hampden County, I think his model is the model I wish we could all strive for. The idea that your HIV or your clinician on the inside, your STD clinician on the inside is the same as your outside. I mean, I think that is just... I've diagnosed a lot of people with HIV, and when I'm their doctor on the outside I can smooth those transitions a lot more. I don't know if that's possible in the short term, there's a lot of things that would have to happen towards that.

Dr. Alysse Wurcel:

I also think there's this kind of thought process like, when they're with me in the jail, they are my responsibility. And when they leave, they are a public health or they're doctors or someone else's responsibility. And there are these programs that have shown success, linkage programs. They're the most successful when the person who's the navigator comes into the jail and is in the community and is the known person that can be reached out to just in the community. So they're a friendly face. They saw them in jail. They've made that warm hand off. They know they're the person to go to. And usually these navigators, everyone knows them. They're friendly. Everyone knows them. They know how to find them. And if you don't know how to find them, someone will find them for you.

Dr. Alysse Wurcel:

We need that linkage, and I think it might be through that person. The most success I've had in the two places with patients who've really historically struggled with that transition has been when a non-clinician has been that point for them to ask, and can almost be a translator almost with the really difficult to interpret medical system. When our patient shows up to CVS for their buprenorphine and it's not there, they're pissed off. Rightfully so, and I think it's just they need that actual translator to say, "Oh." To call up the doctor and say, "So and so, their HIV meds didn't get sent here, there's something wrong. If you send the meds to this pharmacy, I can pick it up and bring it to them." So I think it's not on the clinician as much as these allied professionals that are embedded in the community that can help us, honestly.

Dr. SIm Kimmel:

Can you also talk a little bit more about the addiction treatment in jails? That's such a dramatic change, and what that looks like now?

Dr. Alysse Wurcel:

I think we've made a lot of progress, and I try to look at the progress that we've made in Massachusetts compared to a lot of other states who don't have this. Some places like Hampden County, and I think Franklin County Jail, were both providing either buprenorphine or methadone. And then there was this pilot project and several other counties, Middlesex, Essex, a lot of other places started offering it. Where I was today, they offered buprenorphine to help people through the period of withdrawal, which I thought was mind blowing. I'm so happy that's happening. That's the next level. We're not only initiating or continuing people on methadone or buprenorphine, but we're actually easing the withdrawal for the person who may not want to be on it long term.

Dr. Alysse Wurcel:

So I see it happening. I think it's working well. I think there are still barriers that exist. I think there's a misconception that everyone on methadone or buprenorphine needs to be involved in therapy, and that relates to the old term medication-assisted treatment. And I think there's this concept that everyone who's taking this needs to be in group therapy or... I don't think we should make anyone who's in jail, air their traumas in front of other people in order to get methadone or buprenorphine. And we know that's not evidence-based, so I think that would be the biggest changes I would make to allow it. Some people who are not on it in the community cannot be initiated on it until they're soon going to be released. I saw one such woman today and she's like, "Listen, I'm not going to leave for another four to five months, but I feel the cravings constantly. It makes me feel uncomfortable." But there's not a system in place for those people who did not come in and are not leaving soon to get on meds, even though they still feel uncomfortable in their body.

Dr. Alysse Wurcel:

And then the last thing would be, I think a lot of jails require a urine toxicology screen before people start on medications for opioid use disorder. And I mean, I think one of the biggest concerns when we started using methadone and buprenorphine in the jails was diversion. And I think it happens, I don't know how often it happens, but if someone potentially was feeling crappy and found buprenorphine in order to not feel crappy, that they would be disinclined to give that urine toxicology to get on buprenorphine because it would find them and then they would get punished. And so I think, if someone comes to you and says, "Listen, I want to be on buprenorphine." I don't know why you need a urine toxicology. You don't tell someone if they come to you on prep, "Show me when the last time you

had oral sex or vaginal sex, and how risky was it?" Usually were just like, "Okay, you say you need it, sounds good." So those are kind of the things that I wish. It is vastly better than it was, and it is just vastly improved. I have to say that.

Dr. Jessica Taylor:

And for folks across the country that maybe in states that are either ahead of us, or earlier on in terms of implementing buprenorphine and methadone in correctional settings, you've sort of had this experience of seeing new systems come into place where in the past people didn't have access to either BUP or methadone, that started to change, like you were saying. I know one sort of fear that we hear when we talk about implementing meds for opioid use disorder is the diversion piece. And we sometimes hear the objection, "Well, if people have access to these medications while they're incarcerated, they'll be sold, or bought or traded." Or, "They'll be victimized for their prescription. Or, "It will create more unrest and safety, custodial concerns." I'm curious kind of what you have seen in terms of how that's played out. If you're hearing any input from corrections officers, leadership, sheriffs, around what their experience has been?

Dr. Alysse Wurcel:

Yeah, I have heard it happen and I have seen some of my patients who have been on it being taken off of it. I can't see the custodial or correction side of the chart of why they're in segregation or why something happened. I don't see, but they'll say to me, or someone else will say to me, "Yes, they were caught diverting." The way that it works right now is it's observed, there's a lot of systems in place to prevent diversion. It was something that was talked about, but it was not something that played out as being something that took a lot of their time. And it was only really a minority of people, a real small... That's my impression of it. Yeah, so that's sort of my impression of that side.

Dr. Alysse Wurcel:

I mean, on the other side, I forgot to say this, we all had patients who wanted to be detoxed off their buprenorphine or wouldn't go on methadone for fear of being incarcerated and not getting that, and I don't hear that as much. And I do know that there are transfers within facilities, even when there are certain facilities that don't offer it to transfer the person to the facility. They have to have a medication, an active script within 30 days. So if it's 32 or 33 or 34 days, then that doesn't count. I mean, we all let meds lapse, whether or not we had extra. So I wish there was a little bit more leniency, but no.

Dr. Alysse Wurcel:

To your question, I haven't seen it, but it may just be that they're not discussing it with me. One of the also challenging parts of medications for opioid use disorder in jail is it's a totally different group of people prescribing it. So there are these things like Spectrum Health or [Colin Health 00:22:49] or these... So they're different people from the... I can prescribe buprenorphine, but I am not the prescriber. So they're different people that come in and prescribe these meds. So it's also another silo of all the different silos.

Dr. Jessica Taylor:

Which is fascinating, especially here on a podcast about the intersection of HIV and substance use disorders, and COVID 19. But we've really been making the point throughout the series that HIV and STD care go hand in hand and really should be co-located, and you're describing a system where they are by design completely separate, and of course that has downstream consequences. I was going to say, the reason I asked about just the experience with diversion was... I remember getting to BMC in 2016 and

starting to practice in Faster Paths, which is our bridge clinic, taking care of a lot of people recently post-released, and being told that the sort of market value or street value of a single buprenorphine strip, an eight milligram strip, in our local jails, was between a hundred and $200 for an eight milligram BUP script.

Dr. Jessica Taylor:

And just for context, if you pay out of pocket at a pharmacy, typically $16 would be, if you didn't use insurance, you just paid out of pocket for that same amount of medication. And the sort of street value in the neighborhood around where we practice, I used to hear $10, then eight, then six. Now people tell me four. So really we're talking about a scale of markup that was just shocking for me to hear. And as someone that doesn't work in a house of corrections, my impression has always been that nothing could be more dangerous than that sort of scarcity and very, very high value for a very low amount of milligrams of buprenorphine.

Dr. Jessica Taylor:

Because, of course, the security issues. But from a physician's perspective, it drives use by more risky routes. So for example, injecting buprenorphine compared to taking it under the tongue and letting it dissolve the way that it's prescribed, and all the risks that accompany injection risks in a situation where people are not necessarily permitted to have harm reduction equipment. So yeah, I'm curious if you have any thoughts on that piece? If you're hearing about more or less risk as it relates to substance use in the houses of corrections?

Dr. Alysse Wurcel:

I guess one story I just want to tell related to that is, in jail... I don't know, people may have watched Orange is the New Black or one of any types of things, and there are some parts of those, they're not all realistic. One part is this sort of commoditization of anything. And I can say, I used to give Boosts and Ensures to all of my patients who asked for Boosts and Ensures. Because the food sucks, they want Carnation Instant Breakfast or a Boost or Ensure. And then I realized that I actually created some person who had 300 Ensures and that was being sort of like used as currency. So I think it's interesting, the small things that we can get on the outside are made into things for trading.

Dr. Alysse Wurcel:

I don't know if people back in 2016 realized that not having buprenorphine in the jails encourages higher risk activity, because there's this hope for control. And it's interesting, even if there wasn't buprenorphine, at one point there was letters being... They stopped allowing mail in because of strips of buprenorphine being potentially put mean the sheets of the mail. Or dunked, I guess you can have a specific type of letter that you would write a message to someone on and sort of dunk it in some sort of drugs, I don't know.

Dr. Alysse Wurcel:

So I guess my point being that, when people are upset and sad and isolated, they don't want to be in that reality anymore and when they're withdrawing, they will do anything to feel better. And so providing this is absolutely necessary to keep people healthy, not only from the substance use disorder perspective, but for tattoos and for HIV and for all these things that could be passed in jail. I would love to see someone do a before and after on sort of how many incident cases of HIV or Hep C that happened before things like this were rolled out and then after.

Dr. SIm Kimmel:

These changes, it seems like in part have been driven by what's good clinical practice, but they've also been driven by lawsuits against the state, lawsuits related to the Americans With Disability Act, a variety of lawsuits. And I was wondering if you could talk a little bit about how you see change happening in these spaces? Do you feel the effect of the lawsuits? Do you feel that there's change agents that are empowered by the lawsuits like yourself? How does it work?

Dr. Alysse Wurcel:

I think the biggest change agents are the nursing staff, honestly. And maybe the corrections often serves, honestly. And the reason I say that is, a lot of times in certain communities around Massachusetts, there are neighbors and one ends up in jail and one ends up as a corrections officer, or one ends up in jail and ones ends up a nurse. And it's just very common in all the jails that I go to where there's a knowledge of each other's families and histories. And that being said, the communities that they're from have been affected by opioid use disorder, the corrections officer's community, the nurse's community, I mean everyone's community has, but I think that just like the person who comes into jails and incarcerated in jail, you will often find the corrections officer's best friend overdose or the nurse's sister overdose. It's just very common.

Dr. Alysse Wurcel:

And so I think what's been happening, and I've seen a little bit of a change recently, previously, the COs and the administration and the nurses have had such heartache over seeing people come in and using, and they really kind of were convinced that abstinence was the only way. The cold turkey, this is the way to do it. Just get it out of your system, things like that. And I think slowly because there's successes, it's in the power of the success. Jails don't see the power of success. They will never see the person that never comes back into jail again. They will never see that success. We see them, they don't see them. So I don't know if you would call it a numerator issue. I wish that would be the way of showing it.

Dr. Alysse Wurcel:

There are people who leave jail and don't come back. There are, right? We know these people exist. And what sort of special sauce, what kind of community was around them, whatever it was, and we know it has to do with money, and it has to do with race and it has to do with ethnicity and language, and there's all these things that go into it, I think that's the special sauce. That's the change. And maybe what's happening is they're seeing it. I don't know if they're seeing their friends get on buprenorphine or they're seeing their family members. Or I don't know, it's just something about it.

Dr. Alysse Wurcel:

So I think change is happening. And I also think it's much easier to take care of people who have their opioid use disorder treated in jail than if they don't have their opioid use disorder treated in jail. Now, granted there's comorbid mental illness and there's ADHD and bipolar and all these other things, so that can make it a little bit harder and more challenging. I have to say, honestly, I've had interactions this past week with people which were really challenging and it was not related to substance use disorder, it was related to mental illness. So that still needs to be treated. Those are the people who have the most time with people who are incarcerated with opioid use disorder. They are on our front lines, and I really think they are our change agents.

Dr. SIm Kimmel:

That's amazing to hear. You put that so nicely, so thank you for sharing that.

Dr. Jessica Taylor:

And Alysse, you were just alluding to some of the comorbidities that make delivering care and being a person incarcerated, incredibly challenging. One thing we haven't touched on yet is stimulate use disorder. And I was wondering if you could share what new challenges you're facing as stimulant use disorder has really ramped up in our state, and any best practices you use or any strategies that have helped you connect people that do have a primary stimulant use disorder to care on the outside?

Dr. Alysse Wurcel:

The stimulant use disorder feels like this black box in the jail and that I'm not offering them anything. And I know we share a patient, Jess, and I just saw him. And when I see them in jail, I often don't ask what drugs they use, I just treat them and then they'll sort of tell me. And then we talk about strategies for when they get out. And I really worry, because there's not a lot of... I mean, I don't have any strategies to off for them. I feel at a loss, honestly, in the time that I'm there as an HIV doctor to figure out how to offer them these strategies. And I don't know, they are one of the hardest populations to link to care, I'd say. It's mostly just getting them back to their doctor and sort of saying, "Even if you're still using meth, see your doctor." Yeah, but it is really challenging to figure out how to help them.

Dr. Jessica Taylor:

And something that we definitely struggle with in a regular outpatient setting too. So really an area where our systems could do better.

Dr. SIm Kimmel:

So Alysse, one of the things that you were talking about is control, how much control, control of the people who are incarcerated, control of the medications, control over the economies in the jail. It seems like COVID has really changed the ability to control what's happening. There have been outbreaks in jails, and that sense of control has been lost a little bit. Can you talk a little bit about how COVID has impacted your patients and impacted the system of care in the jail?

Dr. Alysse Wurcel:

Yeah, I can. I should also let you know that 25% of my salary is paid by the Massachusetts Sheriff's Association, so I oversee all COVID things in the jail. So I guess that's my disclaimer to say that I've sort of been involved very early on in a lot of the jails. So yeah, I think COVID... I almost think about COVID as pre-vaccination and post-vaccination,. The pre-vaccination period, especially early on, it was very chaotic. We tried to get testing. We experienced uncertainty on the outside and we had relatively free access to information. And so I think that when I talk to people who were incarcerated, especially March, April, May of 2020, they are just so upset about how the message was changing and how it would be, "No one can come out..." It was long periods of time for personal and public health spent alone.

Dr. Alysse Wurcel:

And I think that thinking about what that did to that population, who still, actually now even the post-vaccination days, will experience these sort of periods of time of uncertainty. I don't know if I'm going to be able to make my phone call. I can't see my family in person anymore. All these things that brought

joy to my life, all in the name of doing what's best for public health, but really, really hurting a lot of people's things that keep them motivated.

Dr. Alysse Wurcel:

So now we have the post vaccination sort of stage, so we rolled out vaccines in January of 2021. And I would say, I think the current estimate is about 70 to 80% of people who are incarcerated are vaccinated in jails, which is not too bad, actually. We need to give boosters. I mean, the booster train needs to you rolling through. I think the hard part right now is we are tired of it, people who are in jail are so tired of it. People who are working in jail, they're trying to keep up with the testing and the vaccination in the light of a nursing shortage. And so I think we're pushing forward.

Dr. Alysse Wurcel:

Almost all the people who I see with HIV are vaccinated. I think that's just something... There's the bond and the trust of someone with HIV with medical care in general, that very rarely have I had anyone say no. Yes, previously, maybe in February, March, April, but as of now in December, I would say I hardly ever see someone who's on vaccinated, so at least they have one or two in. I think unfortunately the recent news about the J&J vaccine not being as good, is very hard because we used it preferentially in the jails to give people who are "transient" the best chance of getting fully vaccinated.

Dr. Alysse Wurcel:

So the messaging around that is really challenging. So basically what I'm saying is the messaging is changing. It's difficult to keep everyone up to date on it. And I think people who are in jail really feel they cannot trust anyone. You told me if I got the vaccine, I don't need to be quarantined anymore. Well, that's not true anymore. And these are changes we're making at the institutional and at the... The state, everyone's doing this. What a vaccine means now is not the same thing as what a vaccine meant in June, but it's just constant blows to their confidence and how much they trust medical systems, so I'm worried about that. And I'm hopeful that... I'm very worried about Omicron in the jails, the sheriffs are too. I can say we're trying as hard as possible but I am worried.

Dr. SIm Kimmel:

Thanks for sharing all that. Incredibly challenging situations to try to manage, they're lucky to have you. [crosstalk 00:35:45].

Dr. Alysse Wurcel:

Thanks.

Dr. Jessica Taylor:

Alysse, in our last couple minutes, we have this audience that is largely a public health focused audience, clinicians, and public health professionals, departments of public health. We usually like to wrap by sort of talking about our wishlist items. What systems changes do we need? What policy fixes would allow us to deliver better care to people with HIV who also have substance abuse disorder facing transitions into and out of houses of corrections? But if you could name your top couple wishlist items, what's really on your mind?

Dr. Alysse Wurcel:

I guess my first one is that as the HIV provider or clinician taking care of your patient, if I email you, then I think by the rules of HIPAA, since I've seen your patient, I think that's enough for you to talk with me. I can't tell you how many times that's a barrier, "Oh, I won't talk with you unless I get an ROI," a release of information kind of thing. And so I don't know if that comes from the institution and there's this fear, this HIPAA fear? And on that note, it should be the expectation, potentially, that the person who's seeing this patient for their HIV or for any chronic illness make the warm handoff. We give discharge summaries from hospitals, but we don't give them to people when they leave. So I guess I would say, decrease the barriers for the information that's within the walls to get outside of the walls, whether it be through electronic medical systems, whether it be through a reexamination of HIPAA and the problems that it's causing, investing in that administrative side would be number one.

Dr. Alysse Wurcel:

I think we have a huge opportunity with injectables, a huge opportunity. And I've spoken to people in the jail about this, injectables have been used for schizophrenia, this is not a foreign concept of injecting medicine into someone to help them feel better. Every time I go to jail, every time I go to jail, one of the patients asked about going on to the injectable, the long-acting injectables. And so we have to get that on formulary for the jails. We have to sort of convince everyone that it's worth the cost. Hopefully, someone from the DPH will... The more we can suppress our patients, the less chance that they're going to transmit the virus. And then get it for prep. I mean, just now that that's approved for prep, this is the beautiful opportunity.

Dr. Alysse Wurcel:

We know if we're not helping them necessarily connect to substance use disorder treatment as much as we can... And that risk, like Sim was saying, that risk right there, right when they get out is huge until they land. And then how beautiful would it just have that, for people that want it. Obviously, it has to be done ethically and it has to be done... There's going to have to be a lot of education around it and what this means, but that's just a huge opportunity we can't miss out on.

Dr. Alysse Wurcel:

And I guess lastly is really encouraging people to do what I do. And that might take a lot of pushing and calling people, because there's not an easy path, even in Boston, to learn about jail health. There's not an easy path. There's a lot of, if you find the right person who knows the right person, maybe you're going to be able to go into jail for a day. And it just seems really weird. There should be more trainees getting experience in this situation, that way we can have great doctors and NPs and PAs with tons of experience working in the jails.

Dr. Alysse Wurcel:

I wonder if it should be a specialization in itself, given how many different things... I am so empowered by med students and residents and how they have this energy that maybe, I sometimes feel like I've lost a little bit. So really investing in them. And I don't say that without also wanting decarceration as a goal. And I fear that if I say that people will think, "Oh no, we just need to get everyone out of jail." And I say, "I'd like to decarcerate as well. But in the meantime, let's invest in people that can give quality care in the jails."

Dr. Jessica Taylor:

That's a great note to end on, that all of our community members, including people who are incarcerated, deserve the high quality evidence-based care that we're aiming to provide across the board. So thank you so much for being here today.

Dr. Alysse Wurcel:

This was very nice. I really liked it.

Dr. SIm Kimmel:

Thank you so much for joining us.

Dr. Alex Walley:

You're listening to Connecting Care. Our program was produced day by JSI and Boston Medical Center. Connecting Care is supported by the HRSA-funded project, Strengthening Systems of Care for People with HIV and Opioid Use Disorder. The project aims to enhance system level coordination and networks of care among Ryan White HIV/AIDs program recipients and other federal and local entities. You can learn more about the project and find resources at www.ssc.jsi.com.