



NURSING  
CARE  
*of the*  
HIV-Infected  
INMATE

HEALTH  
MAINTENANCE  
of the  
HIV+ INMATE  
Module 5 of 5

WINTER 2004



Albany  
Medical  
Center

Department of HIV Medicine and  
The Albany Medical Center  
Hospital Nursing Continuing  
Education Provider Unit

## **MISSION:**

This learning series is designed to equip correctional nurses with the basic knowledge needed to provide safe, comprehensive care to inmates infected with HIV. Each learning module will provide an overview of a pertinent topic, and will serve as a foundation for the succeeding module. At the completion of the 5-module series, each participating facility will have a valuable resource readily available for issues regarding nursing care for HIV-infected inmates. To obtain copies of Modules 1 – 4, please visit Albany Medical College's website at:

[www.amc.edu/Patient/hiv/index.htm](http://www.amc.edu/Patient/hiv/index.htm)

(go to *correctional education*).

## **LEARNING OBJECTIVES:**

*After reading this monograph, the corrections nurse should be able to:*

- 1) Describe routine laboratory monitoring for HIV-infected patients.
- 2) Describe preventative measures for HIV-infected patients.
- 3) Outline recommended consult guidelines for the HIV-infected patient in the correctional setting.
- 4) Discuss appropriate education for HIV-infected patients regarding proper nutrition and stress management both in the correctional facility and upon their return to the community.
- 5) Describe necessary patient education content on disease transmission and lifestyle.

## **DISCLOSURE STATEMENT:**

The monograph author, Minda Hubbard, is a member of the following company's Speaker's Bureaus: Abbott Laboratories Inc., Agouron Pharmaceuticals, Inc., Bristol-Myers Squibb Virology, and Ortho Biotech Immunology.

## **ACKNOWLEDGEMENTS:**

This publication is supported by an unrestricted educational grant from Gilead Sciences, Inc.

## **EDITORIAL BOARD:**

*Course Director*

**Minda J. Hubbard, MSN, ANP-C**

Clinical Research Administrator

Division of HIV Medicine

Albany Medical College

Albany, NY

**Peter J. Piliero, MD**

Director of HIV Research

Division of HIV Medicine

Medical Director

Clinical Pharmacology Studies Unit

Albany Medical College

Albany, NY

**Charles J. Moehs, MD, MPH**

Facility Medical Director

Cape Vincent Correctional Facility

Cape Vincent, New York

*Project Manager*

**Sarah J. Walker, M.S.**

Correctional Education Coordinator

Division of HIV Medicine

Albany Medical College

Albany, NY

*Production Assistant*

**Jim Ybarra**

Education and Outreach Assistant

Division of HIV Medicine

Albany Medical College

Albany, NY

## **NURSING ACCREDITATION:**

This learning activity is co-sponsored by the Albany Medical Center Nursing Continuing Education Provider Unit for 1.0 nursing contact hour.

The Albany Medical Center Hospital is accredited as a provider of continuing education in nursing by the American Nurses Credentialing Center's Commission on Accreditation.



# NURSING CARE *of the* HIV-Infected INMATE

## LEARNING MODULE 5: HEALTH MAINTENANCE of the HIV+ INMATE

### MODULE DIRECTIONS

#### ABOUT CONTINUING EDUCATION CREDIT:

To obtain Continuing Nursing Education credit, a minimum of 80% of the questions must be answered correctly on the self assessment test on page 9. This activity is eligible for nursing credit through **September 30, 2004**. Individuals who mail the completed self assessment test, program evaluation, and reader information form after this date will be ineligible for credit. The estimated time for completion of this activity is 1-hour.

There is no fee for the nursing continuing education credit for this monograph.

### IMPORTANT: READ THESE INSTRUCTIONS BEFORE PROCEEDING!

#### DIRECTIONS:

1. Time yourself throughout all portions of this activity.
2. Read the enclosed monograph.
3. Take the self assessment test.
4. Fill out the program evaluation. Please be sure to include the length of time it took you to complete the activity, self assessment test, and evaluation.
5. Complete the reader information form including your name and address.
6. To assure your receipt of Continuing Nursing Education credit, please provide all of the information requested and mail your completed self assessment test, program evaluation, and reader information form to:

Jim Ybarra  
Albany Medical College  
47 New Scotland Avenue, Mail Code 158  
Albany, NY 12208

If you have any questions, please contact Jim Ybarra  
at (518) 262-4674 or [ybarraj@mail.amc.edu](mailto:ybarraj@mail.amc.edu).



*Awarding of Nursing Continuing Education Contact Hours  
and/or the Accreditation of Albany Medical Center Hospital Nursing  
Continuing Education Provider Unit by the American Nurses'  
Credentialing Center's Commission on Accreditation does not imply that  
the Commission on Accreditation or Albany Medical Center  
endorses or approves of any product or vendor.*

# NURSING CARE *of the* HIV-Infected INMATE

## LEARNING MODULE 5: HEALTH MAINTENANCE of the HIV+ INMATE

### INTRODUCTION

HIV seroprevalence rates are substantially higher among prison inmates than in the non-incarcerated population (Maruschak, 2001). Therefore, correctional nurses are caring for large numbers of people with HIV across the spectrum of the disease. With the advent of highly active antiretroviral therapy (HAART) HIV has become more of a chronic disease, as those who have access to the medications are living longer. Previous nursing modules in this series have provided the foundation of knowledge required for understanding HIV disease: pathogenesis, medications, viral resistance, treatment issues of adherence and long term toxicities. In this module, the correctional nurse will be presented with the key components of routine health maintenance for the HIV+ inmate.

### HEALTH MONITORING

It is recommended that the stable HIV+ patient have a medical visit with the physician, nurse practitioner or physician assistant every 3 months (NYSDOH, 2004). More frequent visits are required if the patient is newly-diagnosed with HIV, starting a new HAART regimen or is ill. Patients with advanced HIV disease indicated by CD4 counts below 200 often need closer monitoring as well. At each of these quarterly visits, the nurse should question the inmate regarding any **new complaints** that might indicate disease progression: fever, sweats, loss of appetite, weight loss, nausea, diarrhea, shortness of breath and/or cough.

A **pain assessment** should be done at each visit. Any complaint of new or worsening pain should be brought to the attention of the medical provider for further evaluation.

- **Headache:** new-onset headache may be seen in patients just starting zidovudine (AZT); in patients with low CD4 counts this finding warrants further medical evaluation for opportunistic infection.
- **Abdominal pain:** may indicate pancreatitis among patients taking didanosine (ddI); may indicate hepatic, renal or other complications.
- **Extremity pain:** paresthesias of the lower extremities (usually bilateral) may be due to distal peripheral neuropathy (DPN), a common cause of pain in people with HIV. DPN can be related to medications (didanosine or stavudine) or HIV disease.
- **Arthralgias:** new-onset hip pain may be an early indicator of avascular necrosis, a complication of HIV disease that requires evaluation and treatment.
- **Myalgias:** may occur as a side effect of zidovudine treatment or HIV-disease.

Patients should be asked to rate the pain on a one to ten scale. Additionally, patients should be asked to try to describe the quality, pattern, location, onset, duration and any palliation of the pain. Often HIV+ inmates have addiction histories. It is important to avoid assuming the inmate complaining of pain is 'drug-seeking'. Pain is under-diagnosed, under-treated and is a common complication of chronic HIV disease (Portenoy,

1997). Patients with addiction histories can be more complicated to treat, requiring higher doses of pain medication. Pain is often exacerbated by fear and anxiety. The nurse can minimize the patient's distress by assuring the patient that his/her complaints will be taken seriously and addressed.

The patient should be questioned about **medication adherence** at each quarterly visit. While some facilities have a directly-observed therapy (DOT) policy, inmates who are self-administering their HAART should be asked about any missed doses. An honest answer is more likely to be elicited if the question is asked in a non-judgmental manner, and if the inference is that non-adherence is not unusual: "How many doses have you missed in the past week?" instead of "Have you missed any doses in the past week?" The reason for missed doses should be elicited and addressed. If the inmate is forgetting doses, tips about reminder cues would be helpful. If side effects are the issue, these should be addressed. For example, if the inmate is experiencing nausea or diarrhea, anti-emetics or anti-diarrheals should be made available. A rising viral load can be a clue to nonadherence. If the viral load was previously <50 copies even a slight rise in viral load could suggest adherence issues. A review of pharmacy records and renewal patterns can help identify adherence issues. HAART regimens need to fit into each patient's schedule and lifestyle. This becomes a bigger issue when the inmate is close to release. Education should begin well before the inmate is discharged back to the community. The importance of adequate adherence to HAART should be reinforced at each clinic encounter. Patients need to be educated that >95% adherence to HAART is needed to avoid viral resistance. A comprehensive review of adherence and resistance is available in module #3. **Copies of all modules in this series can be downloaded at:** [www.amc.edu/patient/hiv/index.htm](http://www.amc.edu/patient/hiv/index.htm) (go to correctional education).

In addition to asking about adherence to HAART, be sure to assess adherence to medications the patient may be on to prevent opportunistic infection. Refer to learning module #1 for a review of prophylaxis against opportunistic infections.

Routine **laboratory tests** are done at each quarterly visit as outlined in Table 1.

### TUBERCULOSIS SCREENING

Inmates are considered a high risk group for tuberculosis and routine screening is recommended. There is an increased risk for active tuberculosis in the setting of HIV infection that can occur by either reactivation of latent disease, or new disease that presents as an opportunistic infection. Intradermal purified protein derivative (PPD) testing is currently the method for routine screening for latent tuberculosis and should be done annually on all inmates. In HIV+ individuals, a reading of 5 mm of induration is considered positive. Those with a reading of > 5 mm induration should receive prophylactic treatment to prevent activation of latent tuberculosis infection. The recommended treatment is isoniazid (INH) 300 mg po plus pyridoxine 50 mg po daily or INH 900 mg po plus pyridoxine 100 mg po two times a week for nine months (CDC, 2002).

## TABLE 1 LABORATORY TESTING FOR THE HIV+ PATIENT

### QUARTERLY

- CD4 Lymphocyte count (absolute and percentage)
- HIV viral load
- Complete blood count (CBC)
- Liver (LFT) and renal (RFT) panels, electrolytes, total protein and albumin

**Note:** CD4 and viral load testing will be done more frequently when a patient begins or changes HAART, or in the presence of HAART failure. CBC, LFTs and RFTs may need to be done more frequently to monitor for HAART toxicities in patients starting new HAART regimens.

### OTHER RECOMMENDED TESTING

- RPR or VDRL (baseline and annually)
- Hepatitis screening for A, B and C (see monograph #4 for a comprehensive discussion of hepatitis/HIV coinfection)
- Fasting lipid panel (baseline and periodically if on HAART but no less than annually)
- Toxoplasma gondii IgG serology (baseline)
- G6PD screening (baseline, if bactrim allergic/intolerant)

(Bartlett, 2003)

Patients with a documented history of a positive PPD reading should not be re-screened as they can have a significant cutaneous reaction. One should ensure that these patients are treated for their positive PPD. In the setting of advanced HIV disease, the patient may not be able to respond to the PPD (or other cutaneously administered antigens) and be called anergic. This could represent either a true or false negative PPD. Anergy testing is no longer recommended as there is a low risk for tuberculosis associated with anergy and a lack of apparent benefit of preventive treatment in anergic patients (CDC, 1997). In the event of an exposure to active tuberculosis, a PPD should be placed. For those inmates with a negative result, prophylactic treatment should be considered on a case by case basis by the infection control department of the facility.

Quantiferon is a new test that is now available as an alternative to PPD testing. Quantiferon is a whole blood vs. intradermal test and thus requires venipuncture. Under current recommendations, this test may be considered for use in the prison population. However, the test is currently not recommended for use in HIV+ individuals pending more information on how it performs in this population (CDC, 2003).

### GYNECOLOGIC SCREENING

All HIV+ women should have a baseline gynecologic exam to screen for the presence of sexually transmitted diseases (STDs). STDs are frequently asymptomatic and facilitate HIV transmission. Any inmate, male or female, testing positive for an STD upon entry to the correctional system should be offered HIV testing. The rate of abnormal Pap tests and cervical dysplasia is 10 times greater in HIV+ women than in HIV negative women (Maiman, 1998). Table 2 provides recommendations for Pap test screening in HIV+ women.

For many inmates, incarceration will provide the first opportunity to receive routine health care. Recommended routine age and sex appropriate screening examinations should be included in the care of the person with HIV: mammography, colonoscopy, prostate and testicular examination. Health education should include teaching self breast/testicular examination and encouraging smoking cessation counseling.

### CONSULT SERVICES

- **Dental:** Patients with HIV are at increased risk for oral complications. Decreased immune status is associated with a change in salivary flow rates and contributes to periodontal disease. Infections such as gingivitis can be especially severe and require prompt diagnosis and treatment. Oral lesions can occur at all stages of HIV disease, sometimes indicating opportunistic infection or malignancy. Untreated oral complications can lead to pain and difficulty eating, resulting in nutritional compromise. A routine dental examination and cleaning should be done annually, or more often if there are complaints of oral pain or bleeding.
- **Ophthalmology:** Patients with CD4 counts < 50 cells/mm are at an increased risk for cytomegalovirus (CMV) retinitis, an opportunistic infection that can be asymptomatic initially but can progress to blindness if untreated. A dilated fundoscopic examination by an ophthalmologist is recommended every six months to assess for CMV retinitis. Patients with CD4 counts > 50 should be seen annually for ophthalmologic assessment.
- **Infectious disease:** The management of patients with HIV is complicated. Periodic consultation with an HIV specialist

## TABLE 2

### RECOMMENDATIONS FOR PAP TESTING IN HIV+ WOMEN

<b>ALL PATIENTS</b>	Baseline testing twice in the first year of HIV diagnosis; if normal, annually screening thereafter; if abnormal, refer for colposcopy and screen every six months if abnormal
<b>LOW GRADE ABNORMAL PAP</b>	Screen every four to six months
<b>POST-TREATMENT OF PREINVASIVE LESIONS</b>	Screen every four to six months for the first year, then every six months

(AAHIVM, 2003)

ensures that the patient is being managed properly. Of particular concern are patients who are failing their current HAART regimens, are declining clinically or are co-infected with other infectious diseases such as tuberculosis or hepatitis B/C. In the case of hepatitis/HIV coinfection, consultation with a GI specialist is often warranted as well.

- **Nutrition:** Consultation with a dietician is a key component to health maintenance for people with HIV. Patients should have a baseline assessment of their overall nutritional status, evaluating for weight loss and changes in body mass that are common in HIV disease. The patient's diet orders may need to be altered to ensure proper caloric and protein intake. Nutritional supplements may also be indicated. Patient education should include the importance of adequate nutrition in living with HIV and how to make good food choices.
- **Mental health:** Undiagnosed mental health disorders are common among inmates. Additionally, psychiatric problems are prevalent among people with HIV. Inmates who are at especially high risk for mental health disorders include those who are in declining health, newly-diagnosed with HIV, older individuals or those serving their first sentence (Canning, 2003). A mental health consult is useful in identifying inmates with psychiatric needs. Subsequent treatment of mental health disorders is important to facilitate medication adherence to HAART.

## VACCINES

Routine vaccination for adults with HIV is recommended to protect against vaccine-preventable illness. Live vaccines are contraindicated. These include: smallpox, varicella, oral polio and yellow fever. The exception to this is the measles/mumps/rubella (MMR) vaccine that is only contraindicated in patients who are severely immunocompromised.

The following immunizations are recommended as part of the routine health maintenance of adults with HIV infection:

- **Influenza:** recommended annually in the fall
- **Pneumococcal:** recommended twice in a lifetime with the second vaccine 5-7 years following the first
- **Tetanus, diphtheria:** recommended every 10 years; for those who did not have the primary series of three vaccinations, it is recommended to complete the series as follows: baseline, one month later, and six months following second dose
- **Hepatitis A:** recommended for those with a history of intravenous drug use (IVDU), men who have sex with men and all patients with a positive antibody for hepatitis C. This is a series of two vaccinations: baseline and 6 or 12 months following the first dose. Patients with a positive hepatitis A antibody are already immune and thus do not require vaccination.
- **Hepatitis B:** recommended for all patients with HIV who are hepatitis B surface antibody negative. This is a series of three vaccinations: baseline, one month later and 5 months following the second dose. A booster dose may be necessary if the HBsAB titer remains negative following the series. For inmates who will be released prior to the completion of the vaccine series, it is important to provide documentation of the dates of the vaccines given and information as to where the inmate should seek medical care post-release in order to complete the series.

*Note: a combination vaccine is available that immunizes against both hepatitis A and B (Twinrix). It is given in a series of three vaccinations following the same timeline as the hepatitis B vaccine. (CDC, 2002)*

## ADVANCED DIRECTIVES

A frequently overlooked aspect of health maintenance is the area of advance care planning. Even though HIV is often a chronic, manageable illness, it is important that patients be educated about the importance of addressing this issue in the event that they become incapacitated. Advanced directives are the patient's instructions which direct health care providers regarding his/her wishes for medical intervention. These directives are valid in all states but specific legal aspects can vary by location. Social workers and case managers are a good resource for learning the legalities of advanced directives and can be helpful in broaching this subject with patients. It is important for patients to be told that the planning of advanced directives does not indicate that they are close to death, but rather the best time to plan them is prior to the onset of a serious disease complication.

## OCCUPATIONAL AND ENVIRONMENTAL EXPOSURE RISK EDUCATION

Patients with HIV need to be advised of potential exposures to pathogens that can put them at risk for infections. Animals can be a source of infection and special precautions should be taken with pets or for those working with farm animals. Some correctional facilities have programs involving domestic animals. Inmates should also be provided with this information for the post-release period. Cats can put patients at risk for toxoplasmosis, cryptosporidiosis, salmonellosis, campylobacteriosis and Bartonella infections. Cats should be kept indoors, not allowed to hunt and not fed raw or undercooked meat. It is recommended that litter boxes be cleaned daily by a non-HIV infected person. Alternatively, good handwashing is essential after handling the animal or cleaning the litter box. Contact with young farm animals, especially those with diarrhea, should be avoided. In some areas, histoplasmosis and coccidioidomycosis are a risk and patients should avoid activities that will create dust when working with soil, and avoid cleaning chicken coops. Since soil can be contaminated with multiple organisms, gloves are recommended for any gardening/agricultural activities along with good handwashing. Reptiles carry a risk for salmonellosis and contact should be avoided.

### Food preparation instructions should include:

- Avoidance of raw or undercooked eggs, poultry, meat, seafood and unpasteurized dairy products
- Poultry and meat should be cooked to an internal temperature of greater than 165 degrees F (until no longer pink in the middle)
- Produce should be washed thoroughly before eating
- Cooking utensils such as cutting boards, knives and countertops should be washed thoroughly after contact with uncooked foods

An additional environmental consideration pertains to lake and river water. Lake and river water should not be consumed and care should be taken when swimming in fresh water areas as water can be swallowed when swimming (CDC, 2002)

## PREVENTION EDUCATION

A critical strategy for reducing the spread of HIV disease is prevention counseling. The World Health Organization (WHO) has stated “All inmates and correctional staff and officers should be provided with education concerning transmission, prevention, treatment, and management of HIV infection. For inmates, this information should be provided at intake and updated regularly thereafter.” (<http://www.who.org>). There are many misconceptions about HIV. Frequently, inmates will enter the correctional system lacking accurate knowledge about how to protect themselves from becoming infected, or how to reduce the risk of infecting others if they are already positive. Often the behaviors and lifestyles of inmates that led to their incarceration put them at high risk for HIV, HCV and other infectious diseases. High rates of recidivism coupled with high HIV seroprevalence rates result in public health concerns. Inmates need adequate HIV prevention counseling before release both to protect themselves, and to decrease transmission of HIV to others in their communities (Gaiter, 1996). The correctional nurse is in a key position to educate this high-risk group about HIV prevention.

Inmates should first be counseled regarding the importance of learning their HIV status. There is often a lot of fear surrounding HIV testing. Reassurance should be offered regarding the following:

- In the event of a positive result, awareness of HIV status allows the inmate to receive medical treatment with improved health outcomes. Earlier intervention carries a better prognosis than entering care when already ill. In addition, the inmate can then take appropriate steps to avoid transmitting HIV to others.
- In the event of a negative result, information will be provided to help the inmate protect him/herself from acquiring HIV. This information is referred to as **primary prevention** counseling. Inmates should be educated regarding HIV transmission (see Table 3). HIV is transmitted by contact with blood, semen or vaginal secretions onto a penetrable area (non-intact skin, mucous

membrane) or into the circulatory system. Therefore, the most common modes of transmission of HIV are unprotected anal or vaginal intercourse, and needle sharing. Inmates should be educated regarding the importance of using safer sex practices. Those with a history of IVDU should be educated about the high risk needle-sharing carries for transmission of HIV, HCV and HBV. Substance abuse programming should be provided.

It is also important to correct common misconceptions by educating the inmate in ways that HIV is **NOT** transmitted including: coughing/sneezing, casual contact/handshaking, ordinary kissing, insect bites, and contact with toilet seats, utensils, clothes, phones. HIV is not found in tears, sweat, nasal secretions, vomitus, urine, feces, or saliva (unless these contain blood).

**Secondary prevention** counseling refers to educating the HIV-infected person about ways to avoid infecting others. The HIV+ inmate should also be counseled regarding HIV transmission. It should be reinforced that condoms should be used with all sexual activity even in the event that both partners are HIV+. It is possible to become re-infected with a different viral strain if one partner is infected with resistant HIV. In this scenario known as superinfection, a person whose HIV is well-controlled on HAART may lose viral control if re-infected by a person whose virus is drug resistant. Inmates should be counseled that HIV ‘hides out’ in sanctuary sites that include the rectal and vaginal mucosa. These viral particles are not reflected in the viral load testing that we use to monitor patients. Therefore, even in the setting of complete viral suppression on HAART, (indicated by a viral load of less than 50 copies/ml), it is possible to transmit HIV.

**Risk reduction** is a key element of both primary and secondary prevention counseling. Sexual abstinence is the only completely sure way to prevent sexual transmission of HIV. Methods for reducing risk of HIV transmission should be clearly communicated. Latex condom use with all sexual activity remains the major public health strategy for reducing sexual transmission of HIV. Although they are not available in

**TABLE 3**

## MODES OF HIV TRANSMISSION

### Sexual Transmission Risks:

- Unprotected sexual intercourse: receptive and/or insertive anal, vaginal or oral
- Rate of risk varies with receptive anal intercourse carrying the greatest risk, receptive vaginal intercourse approximately half the risk, and insertive oral intercourse carrying the least risk. Although unprotected oral sex carries less risk than either anal or vaginal sex, transmissions have been documented and condom use should be encouraged (Varghese, 2000).
- Two important factors affecting the risk of any unprotected sexual behavior are: 1) the viral load of the HIV-infected partner (the higher the viral load the greater the risk of transmission) and 2) the presence of open sores, ulcers, cuts or other trauma resulting in damage to the vaginal/rectal/oral mucosa (facilitating the transmission process).

### Non-sexual Transmission Risks:

- Perinatal (the majority of transmissions occur during labor and delivery)
- Breastfeeding
- Parenteral: needle sharing in IVDU, tattooing, piercing
- Transfusions prior to 1982
- Accidental needle stick
- Exposure to infected blood on mucous membrane or non-intact skin

*\*HIV is not easily transmitted and usually requires exposure to a large amount of infected body fluid (blood, semen, vaginal secretions, central nervous system (CNS) fluid, synovial fluid, pericardial fluid).*

most prisons and jails, the inmate should receive education regarding proper use of condoms and dental dams. Handouts can be used to reinforce teaching. Latex condoms lubricated with nonoxynol-9 should **not** be used as they have been linked to increased transmission of HIV (DHHS, 2000). Polyurethane condoms should be used in the event of a latex allergy. Female condoms (Reality condoms) are an effective way for women to protect themselves against transmission of HIV and other STDs. The Reality female condom is made of polyurethane, is available without a prescription and comes with instructions.

For inmates with a history of IVDU recovery from addiction is often a chronic process and relapses are common. The main risk reduction strategy is to provide adequate substance abuse recovery programming that includes planning for post-release support. Inmates should be counseled regarding the high risk of disease transmission associated with needle sharing and prior to release, information should be provided regarding needle exchange programs in their communities. These programs have proven to be quite effective in decreasing the rate of parenteral HIV transmission (CDC, 1999). The use of all recreational drugs and alcohol can lead to decreased inhibitions that can result in risky sexual behaviors. This is another important point to include in prevention counseling.

**Partner notification** should be addressed with all inmates testing positive for HIV. The need to inform sexual and needle sharing partners of HIV+ individuals is mandatory in several states. Partner notification programs are widely available to assist with the process. Health departments in each state can provide information about accessing these programs. Inmates should be advised that this is an anonymous process.

The manner in which counseling is provided greatly influences how the information will be received. Some factors to consider that will facilitate HIV prevention counseling include:

- People may be more willing to discuss their sexual habits and risk behaviors if questions are asked in a non-judgmental, open-ended fashion. Inmates may feel more open to discussing these sensitive issues with peer

counselors or same-sex health care providers. The counselor should consider his/her own comfort level regarding sexuality as this can affect the process.

- Counseling should be provided within the context of cultural influences. In some cultures, it is the norm for men to have multiple sex partners, including other men. These men will often not identify themselves as 'homosexual' or 'gay'. Therefore, it is best to avoid those labels; rather, refer to same-sex activity as 'men having sex with men' (MSM) or women having sex with women (WSW). The clearest way to obtain an accurate sexual history to elicit risk behaviors is to ask "Do you have sex with men, women or both?" and then proceed to ask about history of unprotected sex, multiple partners, partners of unknown HIV status or history of IVDU.
- Women do not always feel empowered or safe to ask their male partners to use condoms. A high percentage of women who abuse drugs and/or alcohol have been victims of domestic violence and/or sexual abuse. Among female inmates there is a very high rate of post traumatic stress disorder (PTSD) related to abuse. PTSD has been linked to HIV risk behaviors such as unprotected sex, multiple sex partners and needle sharing in the period prior to incarceration (Hutton, 2001). Peer counselors, support groups and role-playing activities can be helpful counseling techniques for these high risk women.

## CONCLUSION

The ongoing care and management of the HIV-infected patient encompasses screening, diagnosis and monitoring of clinical issues along with providing education on a broad range of HIV-related topics. Taking full advantage of the period of incarceration to maximize the inmates' health prior to release by providing essential health education should be the mission of all correctional health care providers. This learning module,

**TABLE 4** ELEMENTS OF HIV PREVENTION COUNSELING

<b>Goals:</b>	Decrease HIV acquisition and transmission
<b>Strategies:</b>	Promote behavior change and encourage safe behaviors through education, empowerment, and support
<b>Counseling should include:</b>	<ul style="list-style-type: none"> <li>• Individualized personal risk assessment</li> <li>• Clarification of misconceptions</li> <li>• Provision of accurate information that is culturally-sensitive and at an appropriate educational level</li> <li>• Behavior modification techniques</li> </ul>
<b>Topics:</b>	<ul style="list-style-type: none"> <li>• HIV testing (the importance of knowing your status)</li> <li>• Transmission routes</li> <li>• Risk behaviors (including relative risk of sexual behaviors {Table 2})</li> <li>• Risk reduction methods</li> <li>• Partner notification</li> </ul>

(Mayer, 2004)

the final in the series of 5, has provided information and resources to assist with this process.

## BIBLIOGRAPHY

AAHIVM (2003). Health Maintenance *The HIV Medicine Self-Directed Study Guide*. Los Angeles: The American Academy of HIV Medicine; 1:pp 10/5-10/6.

Bartlett J and Gallant J (2003). Medical Management of HIV Infection. Philadelphia, Lippincott, Williams and Wilkins.

Canning R (2003). A Primary Care Approach to Mental Health Care for HIV/Hepatitis Infected Inmates. *HEPP Report*, Vol.6 (1): 1-7.

CDC (1997). Anergy skin testing and preventive therapy for HIV-infected persons: revised recommendations. *MMWR*; 46(RR-15):1-12.

CDC (2002). General recommendations on immunization: recommendations of the Advisory Committee on Immunization Practices and the American Academy of Family Physicians. *MMWR*. 51(RR-2): 1-36.

CDC (2002). Guidelines for preventing opportunistic infections among HIV-infected persons – 2002 recommendations of the U.S. Public Health Service and The Infectious Diseases Society of America. *MMWR*; 50-733-735.

CDC (2003). Guidelines for using the Quantiferon-TB test for diagnosing latent mycobacterium tuberculosis infection. *MMWR*; 52(RR-02):1-6.

CDC (1999). HIV/AIDS prevention research synthesis project: compendium of HIV prevention interventions with evidence of effectiveness. [www.cdc.gov/hiv/pubs/hivcompendium.htm](http://www.cdc.gov/hiv/pubs/hivcompendium.htm). Accessed February 10, 2004.

Department of Health and Human Services (2000).

[www.cdc.gov/hiv/pubs/mmwr/mmwr11Aug00.htm](http://www.cdc.gov/hiv/pubs/mmwr/mmwr11Aug00.htm). Accessed February 2, 2004.

Gaiter J and Doll S (1996). Improving HIV/AIDS Prevention in Prisons is Good Public Health Policy. *American Journal of Public Health*. Vol 86 (9): 1201-1203.

Hutton H, Treisman G, Hunt W et al. (2001). HIV risk behaviors and their relationship to post traumatic stress disorder among women prisoners. *Psychiatric Services*. 52:508-513.

Maiman M (1998). Management of cervical neoplasia in human immunodeficiency virus-infected women. *Journal of the National Cancer Institute Monograph* 23: 48-49.

Maruschak L (2001). HIV in Prisons, 2000. *Bureau of Justice Statistics Bulletin*, NCJ 196023.

Mayer K (2004). Recommendations for incorporating human immunodeficiency virus (HIV) prevention into the medical care of persons living with HIV. *Clinical Infectious Diseases*. 38: 104-111.

New York State Department of Health AIDS Institute (2004). Criteria for the medical care of adults with HIV infection. [www.hivguidelines.org](http://www.hivguidelines.org). Accessed 2/01/04.

Portenoy R (1997). Contemporary diagnosis and management of pain in oncologic and AIDS patients. Newtown, AMM Co, Inc.

Varghese B, Maher J, Peterman T et al (2000). Reducing the risk of sexual HIV transmission. *Sexually Transmitted Diseases* Vol. 29 (1): 38-43.

WHO Recommendations for the management of HIV infected prisoners. <http://www.who.org>. Accessed February 6, 2004.

## ADDITIONAL INFORMATION AND RESOURCES

### HELPFUL WEBSITES:

Association for Nurses in AIDS Care .....[www.anacnet.org](http://www.anacnet.org)  
CDC National Prevention .....[www.cdcnpin.org](http://www.cdcnpin.org)  
Information Network  
Centerforce .....[www.centerforce.org](http://www.centerforce.org)  
CorrectHelp.....[www.correcthelp.org](http://www.correcthelp.org)  
Corrections Learning Network.....[cln.esd101.net](http://cln.esd101.net)  
National Commission on .....[www.ncchc.org](http://www.ncchc.org)  
Correctional Health Care  
National Criminal Justice .....[www.ncjrs.org](http://www.ncjrs.org)  
Reference Service  
National Hepatitis C Prison Coalition .....[www.hcvinprison.org](http://www.hcvinprison.org)  
National Minority AIDS Council .....[www.nmac.org](http://www.nmac.org)  
(includes a listing of health education  
resources for inmates and corrections staff)  
(go to "treatment" --> "prison initiative"  
and scroll down to "educational resource list")

### SAVE THE DATE!

***Management of HIV/AIDS in the Correctional Setting:  
A Live Satellite Videoconference Series  
Early Identification of HIV & Newer Testing Strategies***  
Tuesday, October 19, 2004  
12:30-3:30 PM Eastern Time

Visit Albany Medical Center's website in Summer of 2004 to register as a downlink site: [www.amc.edu/Patient/hiv/hivconf/index.htm](http://www.amc.edu/Patient/hiv/hivconf/index.htm).  
For additional information, please contact Jim Ybarra at (518) 262-4674 or [ybarraj@mail.amc.edu](mailto:ybarraj@mail.amc.edu).

*Continuing Nursing Education credits offered.*

### COMMUNICABLE DISEASES: ARE YOU AT RISK?

This 30-minute videotape encourages inmates to get tested for HIV, hepatitis B & C, and sexually transmitted diseases by discussing risk factors. This resource will be available in Summer of 2004 and was developed in collaboration with Albany Medical College, the New York State Department of Correctional Services and the pharmaceutical industry

To be notified when this videotape is available, call (518) 262-4674 or e-mail [ybarraj@mail.amc.edu](mailto:ybarraj@mail.amc.edu). The cost is \$15.00.

### DID YOU KNOW?

The [aidsvote.org](http://aidsvote.org) platform is a non-partisan entity which sets the standard for responsible leadership on HIV/AIDS at home and abroad. By pledging your support for the platform, you add your voice to the call for real progress in the fight against AIDS. Dozens of the nation's leading HIV/AIDS service, advocacy, and research organizations support this platform as an educational tool for voters and candidates in the 2004 presidential election.

To learn more, visit [www.aidsvote.org](http://www.aidsvote.org).

*Please share this monograph with your nursing colleagues making photocopies of the Continuing Nursing Education documents if needed. Additional copies of this monograph can also be downloaded from Albany Medical College's website at: [www.amc.edu/Patient/hiv/index.htm](http://www.amc.edu/Patient/hiv/index.htm) (go to correctional education).*

PLEASE GO TO PAGE 9

# SELF ASSESSMENT TEST

## MODULE 5: HEALTH MAINTENANCE of the HIV+ INMATE

**DIRECTIONS:** Please select the BEST answer and circle your response directly on the self assessment test. To obtain Continuing Nursing Education credit, a minimum of 80% of the questions must be answered correctly. To assure your receipt of Continuing Nursing Education credit, please complete the self assessment test, program evaluation and reader information form.

This activity is eligible for nursing credit through **September 30, 2004**. Individuals who mail the required documentation noted above after this date will be ineligible for credit. The estimated time for completion of this activity is 1-hour. There is no fee for the nursing continuing education credit for this monograph.  
*Albany Medical College's mailing information is on the reverse side of this document.*

- 1) **The appropriate interval for routine health monitoring for stable HIV positive individuals is...**
  - A. Annually
  - B. Every six months
  - C. Quarterly
  - D. Every 4 months
- 2) **During routine health monitoring, Nurse J always completes a thorough pain assessment because she knows pain is...**
  - A. Frequently masked in the presence of HIV.
  - B. Commonly seen in patients with chronic HIV infection.
  - C. A drug seeking behavior.
  - D. Usually an indication of the presence of a co-infection.
- 3) **During a routine quarterly visit, Nurse D completes the medication adherence history for inmate T.J. She knows that she will get more accurate information by asking...**
  - A. How are you doing with your medications?
  - B. How many doses have you missed in the past week?
  - C. Do you ever forget to take your medications?
  - D. Are you taking all of your medications?
- 4) **Nurse K is conducting patient education classes for HIV positive inmates scheduled to be discharged in the coming weeks. In his class, Nurse K includes the fact that at least...**
  - A. 45% adherence to the HAART regimen is needed to avoid viral resistance.
  - B. 75% adherence to the HAART regimen is needed to avoid viral resistance.
  - C. 85% adherence to the HAART regimen is needed to avoid viral resistance.
  - D. 95% adherence to the HAART regimen is needed to avoid viral resistance.
- 5) **Nurse B is reading the PPD of inmate Diaz who is HIV+. The reading is 5mm induration. All of the following statements are true except:**
  - A. He should receive prophylaxis against tuberculosis.
  - B. The PPD should be repeated along with an anergy panel as people with HIV are often anergic.
  - C. Annual PPDs are no longer advised for this patient.
  - D. There is a greater risk for active tuberculosis among people with HIV.
- 6) **Which of the following vaccinations is contraindicated in all persons with HIV?**
  - A. Diptheria/Tetanus
  - B. Smallpox
  - C. Measles/mumps/rubella
  - D. Pneumovax
- 7) **The following statements regarding transmission of HIV are true except:**
  - A. It is facilitated by the presence of an STD.
  - B. It usually requires a significant exposure to infected body fluid.
  - C. The best protection is use of a latex condom lubricated with nonoxynol-9.
  - D. It is possible for a person with HIV to be re-infected with another viral strain.
- 8) **Patient BJ is preparing for discharge. He will learn in secondary prevention education ...**
  - A. How to avoid infecting others by using safer sex practices and avoiding needle-sharing.
  - B. The importance of practicing safer sex regardless of the partner's HIV status or either partner's viral load.
  - C. The various modes of HIV transmission.
  - D. All of the above.
- 9) **Female inmates with HIV should have a baseline gynecological examination to screen for STDs because:**
  - A. STDs can be asymptomatic and facilitate HIV transmission.
  - B. HIV increases the susceptibility of the woman to STDs.
  - C. STDs are 10 times more prevalent in women with HIV.
  - D. The presence of an STD indicates the need for colposcopy.
- 10) **In addressing the nutritional needs of the HIV-infected inmate, the nurse should:**
  - A. Be sure that orders always include a nutritional supplement.
  - B. Educate the inmate regarding the importance of thoroughly washing and cooking food.
  - C. Review all commissary orders placed by the inmate.
  - D. Consult with the dietician only on an as-needed basis.

OVER

# PROGRAM EVALUATION & READER INFORMATION FORM

## MODULE 5: HEALTH MAINTENANCE of the HIV+ INMATE

To assure your receipt of Continuing Nursing Education credit, please mail your completed self assessment test, program evaluation, and reader information form to: **Jim Ybarra, Albany Medical College, 47 New Scotland Avenue, Mail Code 158, Albany, NY 12208.** Please allow 6-8 weeks for education credit processing. An attendance certificate and self assessment test answer key will be mailed to you at that time. If you have any questions, please contact Jim Ybarra at (518) 262-4674 or ybarraj@mail.amc.edu.

<b>PLEASE COMPLETE THIS FORM BY COMPLETELY FILLING IN THE CIRCLES WITH BLACK PEN OR PENCIL.</b>	<b>STRONGLY DISAGREE</b>	<b>DISAGREE</b>	<b>AGREE</b>	<b>STRONGLY AGREE</b>
1. As a result of completing the program, I am able to meet the following program goal: to equip the correctional nurse to arrange the necessary care and services to optimize the health of the HIV-infected patient.	①	②	③	④
2. As a result of attending this program, I am able to achieve the following objectives:				
a. Describe routine laboratory monitoring for HIV-infected patients.	①	②	③	④
b. Describe preventative measures for HIV-infected patients.	①	②	③	④
c. Outline recommended consult guidelines for the HIV-infected patient in the correctional setting.	①	②	③	④
d. Discuss appropriate education for HIV-infected patients regarding proper nutrition and stress management both in the correctional facility and upon their return to the community.	①	②	③	④
e. Describe necessary patient education content on disease transmission and lifestyle.	①	②	③	④
3. The objectives of this program were relevant to the overall goals of the program.	①	②	③	④
4. The monograph was an effective learning tool for me.	①	②	③	④
5. The author of this monograph was an effective teacher.	①	②	③	④

Time required to complete this learning activity: \_\_\_\_\_ minutes

Comments: \_\_\_\_\_  
\_\_\_\_\_

### READER INFORMATION FORM

(Please print legibly as all information is needed for education credit processing.)

Name (first and last): \_\_\_\_\_

Degree: \_\_\_\_\_ Title: (NP, RN, LPN) \_\_\_\_\_

Facility Name: \_\_\_\_\_

Facility Address: \_\_\_\_\_

STREET

CITY

STATE

ZIP CODE

E-mail Address (if applicable): \_\_\_\_\_