Promoting Continuity of Care after (Federal) Custody

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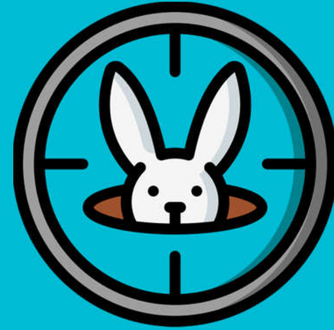
Disclaimer

- It takes a village! Thanks to all those that contribute to case management!
  - **CureTB**
  - **Immigration and Customs Enforcement (ICE)**
- Systems based approach: what can we do to improve the system?
- I am a PHN. I'm sharing my knowledge as an outsider who happens to partners with corrections.
- *Any examples used for inmate locators are random names chosen for demo purposes only. Online locators are publicly available.*

Today we will cover:

- General Corrections Overview
- Important Nuances of Federal Custody (for public health awareness)
- Continuity of Care After (Federal) Custody:
  - Challenges
  - Tips for Success
  - Way Forward?
  - Thoughts to ponder?



Polling slide: Where do you work?

- Local Health Department
- State TB Program
- Correctional Facility
- Other (add type of work environment in chat)

Polling slide: What is your experience with corrections?

- 0: Ziltch
- 1: Beginner.
- 2: I know the difference between jail and prison, but I still feel a bit lost in the correctional world
- 3: Medium-ish
- 4: While not an expert, I feel comfortable maneuvering through the system intricacies
- 5: Subject matter expert!

"We have an inmate. . ."

Custody

- Whose custody are they under?
- What is their inmate ID?
  - If ICE, what is their country of birth?

  Tip: Use inmate locator to find location of patient. Inmate ID is the most straightforward method.

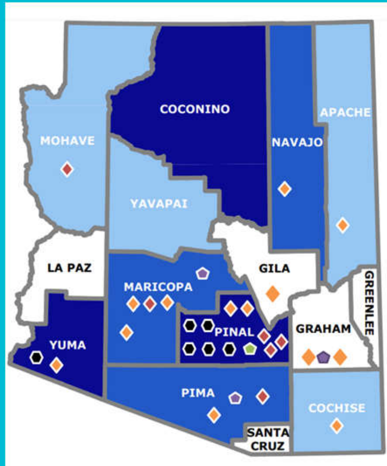
Tip: Safety is of paramount concern in the Correctional setting. Rules are based with that in mind.

Facility

- Which facility are they assigned to?
- Might be a private facility, that houses inmates through contracts
- Medical care provided by facility
- **Tip:** Medical services may be contracted out to another organization
- Primary contact usually medical, but Warden is in charge of the facility
- Do you know your local facilities? Who in your health department has contacts?

AZ Map of Correctional Facilities by County

*location on map is not necessarily geographically accurate



Does not include:

- Jails (city/county/tribal)
- Juvenile detention centers
- “other” categories

DOC Facilities
DOC, privately run
ICE
BOP
Private Facilities

Tip: build relationships with key partners before TB shows up

Are there routine meetings or networking events that you can join?

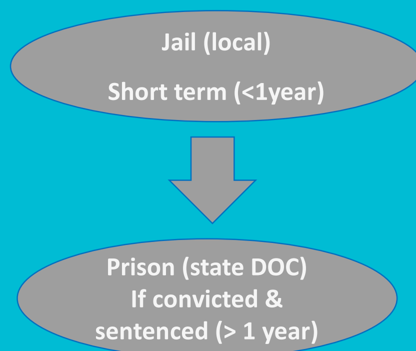
Q: If the facility is providing care, what is the role of the health department?

Reporting, technical support for case management and treatment, IJNs on transfer, Contact investigation technical support and coordination. . .

Tips for Local Health Departments:

- What is their custody history? Was this detected on intake? Where were they during infectious period?
- Interview patient for community CI (and continuity of care)
- Find out what the custody plan is. Length of sentence? Next court date?
- Initial review of treatment plan
- Monthly review of MARs & Labs?
- Other tips? Add to chat

First. . . An Overview of the Domestic Correctional System



- Know custody to look up in inmate locator.
- *random names chosen for demo purposes only*

Example: Jail

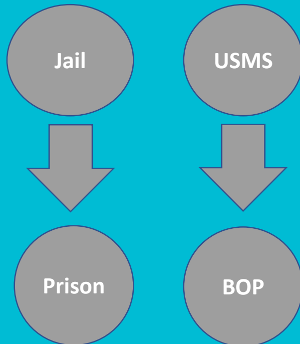
https://www.mcso.org/custody-bureau-information/inmate-information

https://inmatesearch.yumacountysheriff.org/NewWorld.InmateInquiry/AZ0140000/

Example: DOC

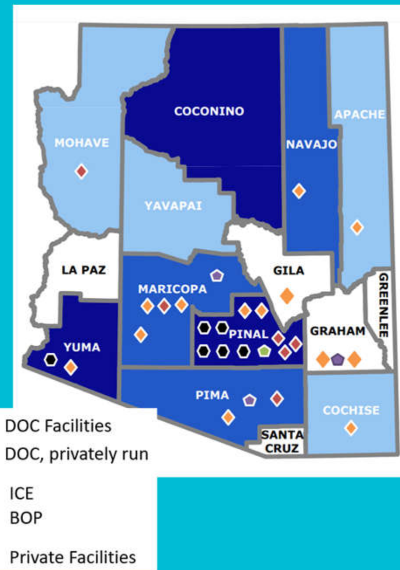
https://corrections.az.gov/public-resources/inmate-datasearch

Federal System: USMS & BOP

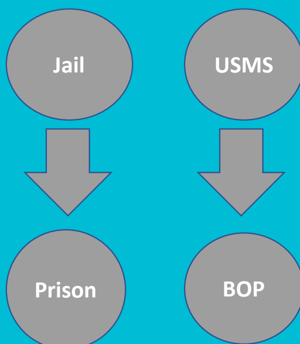


No facilities. 100% contracts
No online inmate locator
Uses BOP number

Inmate locator includes location and release date
https://www.bop.gov/inmateloc/



Federal System: ICE



ICE:
Detainees due to immigration
No criminal charges
No US citizens
Online Locator:
https://locator.ice.gov/odls/#/index
Tip: Know A number! & Country of birth
Facility types vary

TIPS:
"ICE Detainer" = **Transnational Referral Needed**
"ICE picked them up" but not in ICE system = Deported??

TIP: interagency agreement with **CureTB**, should have referral. Confirm referral early.

TIP: if bonded out, they cannot hold them. Should be released with meds (2 weeks or 30 days).

AZ TIP: If going to Mexico, can set up Meet & Greet

Questions to include in routine case review for this population:

- Patient Location?
- Patient Custody?
  - ID number
  - If ICE, country of birth
  - If known, custody plan? (court date?)
- If not a US resident, **Cure TB** referral?

Meet & Greet: AZ innovation

Simple Concept, Lots of Partners!

Protocol includes Communication

AZ Innovation: MEDSIS as (Binational) Communication Tool

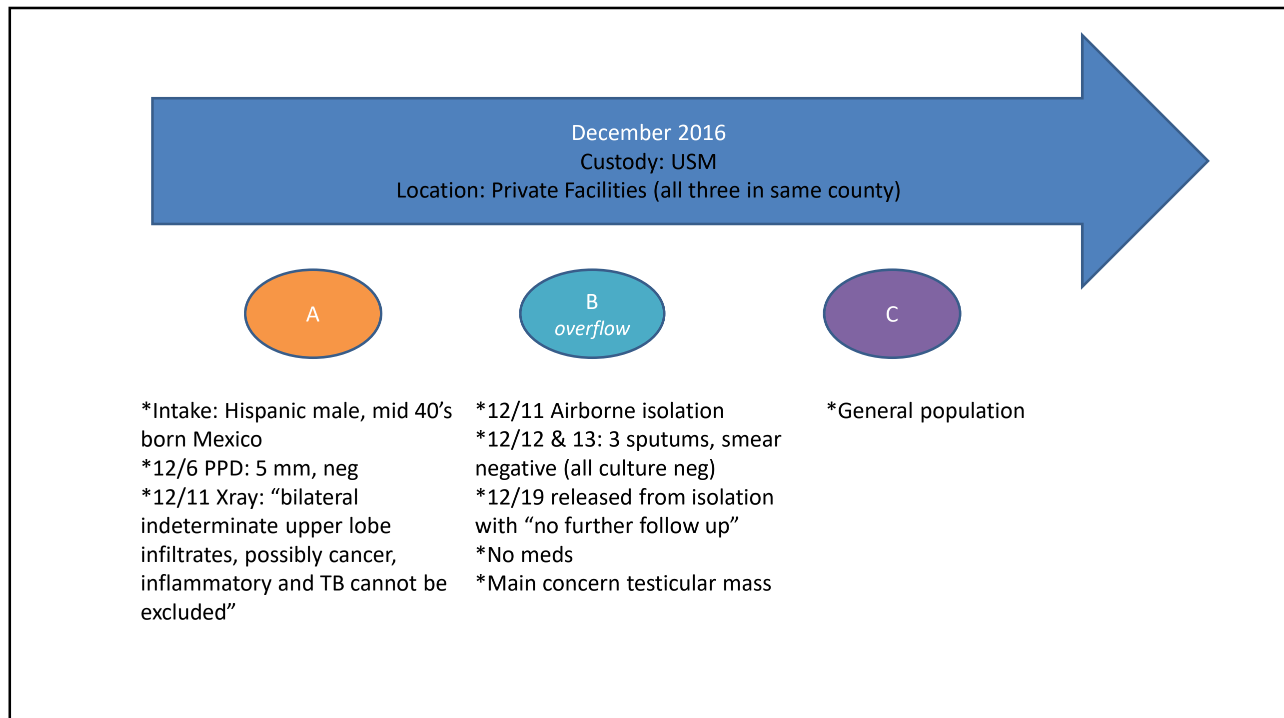
- Users can share/transfer with other AZ jurisdictions (county/tribal)
- Innovation: Sonora included as user!
- Innovation: CureTB included as user!
- Q: What if there was a national platform for IJ's?

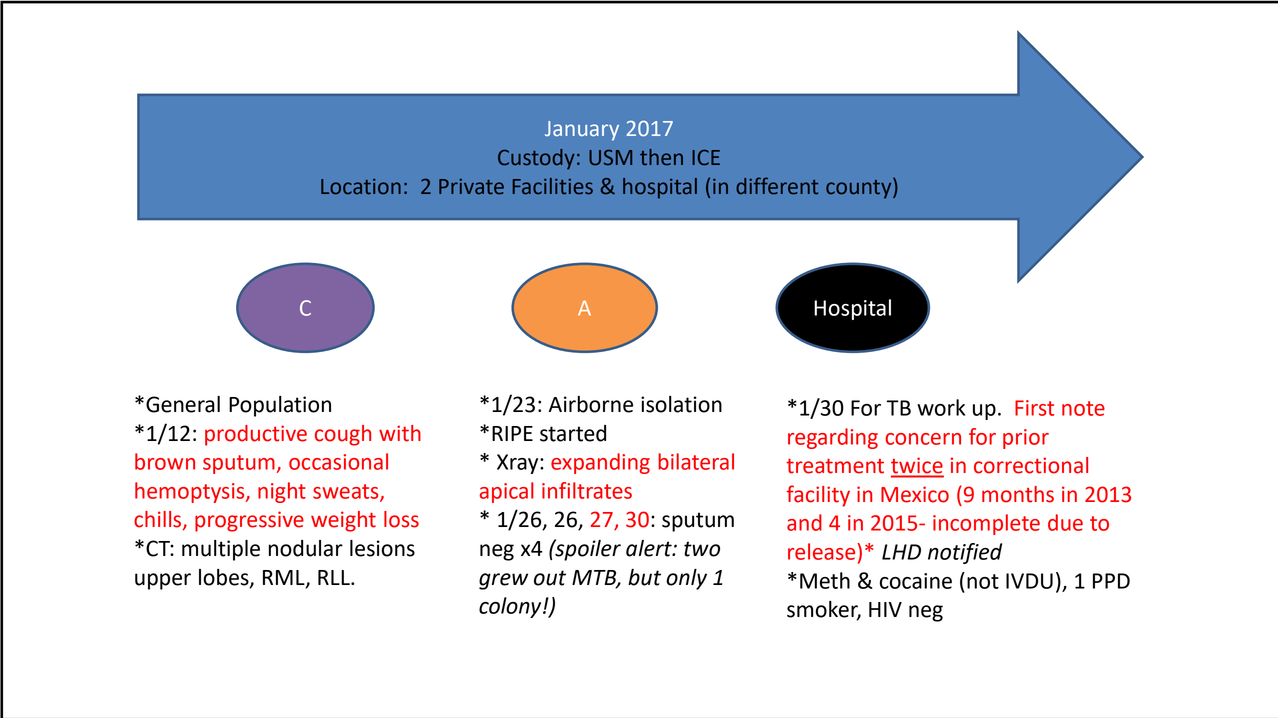
Key communication tool for Meet & Greets

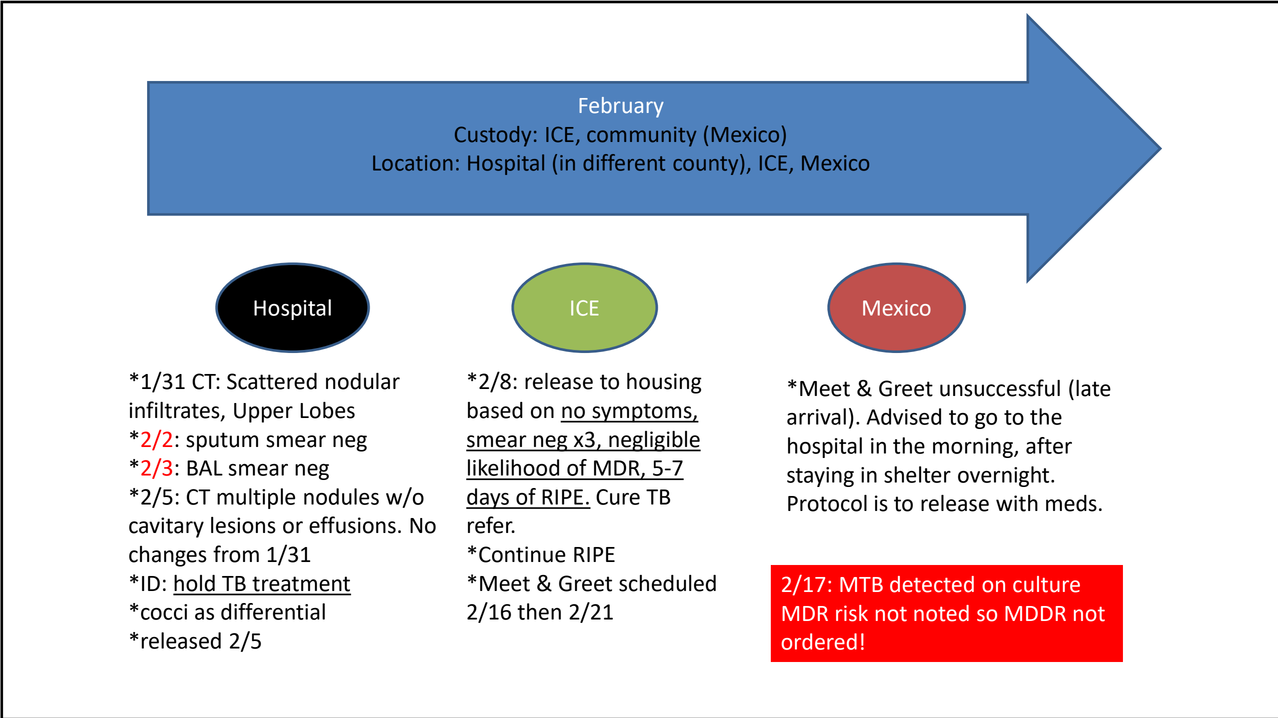
CureTB: How does referral process work when patients are in custody?

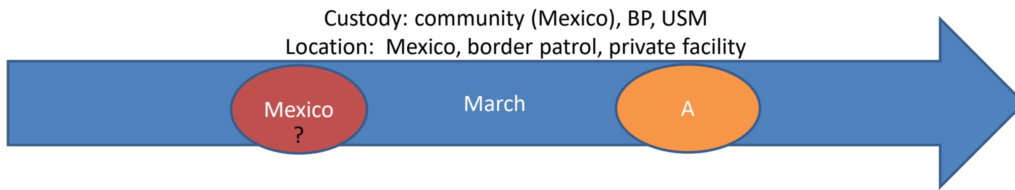
Example: MDR (pre BPaL)

- Note the number of transfers within Arizona and outside of Arizona
- Good example of teamwork. Thanks to everyone involved, there was a positive outcome with a challenging situation!

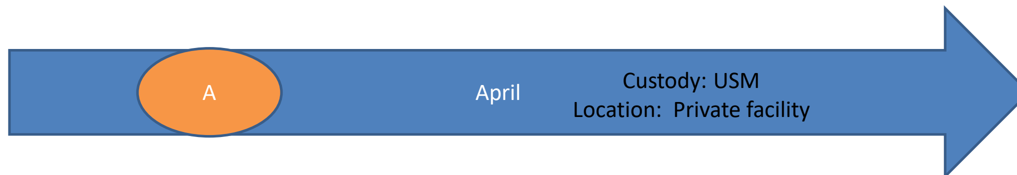



January 2017
Custody: USM then ICE
Location: 2 Private Facilities & hospital (in different county)
C
A
Hospital
*General Population
*1/12: productive cough with brown sputum, occasional hemoptysis, night sweats, chills, progressive weight loss
*CT: multiple nodular lesions upper lobes, RML, RLL.
*1/23: Airborne isolation
*RIPE started
* Xray: expanding bilateral apical infiltrates
* 1/26, 26, 27, 30: sputum neg x4 (spoiler alert: two grew out MTB, but only 1 colony!)
1/30 For TB work up. First note regarding concern for prior treatment twice in correctional facility in Mexico (9 months in 2013 and 4 in 2015- incomplete due to release) LHD notified
*Meth & cocaine (not IVDU), 1 PPD smoker, HIV neg


February
Custody: ICE, community (Mexico)
Location: Hospital (in different county), ICE, Mexico
Hospital
ICE
Mexico
*1/31 CT: Scattered nodular infiltrates, Upper Lobes
*2/2: sputum smear neg
*2/3: BAL smear neg
*2/5: CT multiple nodules w/o cavitary lesions or effusions. No changes from 1/31
*ID: hold TB treatment
*cocci as differential
*released 2/5
*2/8: release to housing based on no symptoms, smear neg x3, negligible likelihood of MDR, 5-7 days of RIPE. Cure TB refer.
*Continue RIPE
*Meet & Greet scheduled 2/16 then 2/21
*Meet & Greet unsuccessful (late arrival). Advised to go to the hospital in the morning, after staying in shelter overnight. Protocol is to release with meds.
2/17: MTB detected on culture MDR risk not noted so MDDR not ordered!



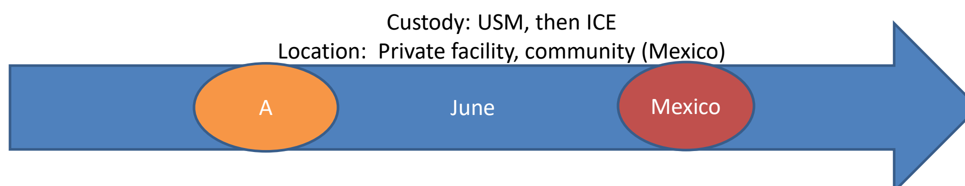
- 3/14 back in custody. Sputums smear neg x3
- 3/16 CXR RUL nodule, possibly more apparent when compared to 1/27
- 3/20 MDR TB detected by molecular tests by National Jewish from hospital sample.
- 3/22 RIPE filled
- 3/23 patient refusing meds
- 3/27 (just before 5): Hospital lab received by ADHS indicating MDR TB.
  - MDDR send out (problems with MGIT DST's, set up for agar)
  - Stakeholders notified (including USMS)
- 3/28 Private Facility noted plan to address testicular pain and mass for possible surgery. Consult to Heartland for treatment plan
- 3/31 CDC MDDR shows likely resistance to all four first line drugs. No mutations noted for second line.



- 4/6/17 MDR regimen ordered (MARS show started 4/11):
  - Amikacin 15 mg/kg Mon-Fri IM (IV if line put in) for 8 months
  - Moxifloxacin 400 mg QD
  - Linezolid 600 mg QD
  - Cycloserine 250 mg QD x 1 wk, then 500 mg QD
  - Ethionamide 250 mg QD x 1 wk then 500 mg QD
  - Vitamin B6 50 mg QD
- Baseline & monthly assessment of
  - peripheral neuropathy
  - vision & Ishihara Plate testing, while on Linezolid
  - audiogram, repeat monthly while on Amikacin
  - CBC, CMP, TSH with free T4 (for ethionamide)
  - mental status. Hold Cycloserine for several days if changes
  - Weight
- Plan: Release from isolation with sputum culture neg x3 and 1 month MDR treatment

- 4/25: began refusing meds. Side effects of myalgia, bone pain, nausea, vomiting, injection site pain. "would rather die than take the meds."
  - Visit by local public health staff
  - Plans to place PICC
  - Allowed rec time outside
  - Expanded conference call 4/27
- Weekly conference call: private facility, ADHS TB, ADHS Border Health, LHD, private facility organization, USMS, ICE, CureTB, (plus Heartland)

- 5/6: new regimen ordered due to issues with injectable (18 to 20 months). MARS show 5/10
  - Moxifloxacin 400 mg QD, Linezolid 600 mg QD, Ethionamide 500 mg QD, Cycloserine 500 mg QD
  - Once reported headache & night sweats; once "refused" and c/o nausea, but then took meds from another HCW
- Sputums collected weekly, all smear negative (all end up culture negative)
- DST results confirmed resistance to first line drugs, susceptible to 2nd line including Amikacin, Cycloserine, Ethionamide, Capreomycin, Ofloxacin



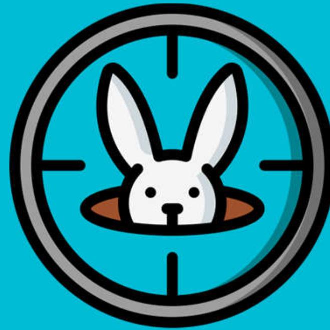
- 6/12: Meet and Greet successful! (changed from 6/10)
  - Transferred with 30 days of medications
- Issue: unusual regimens need centralized approval. Process started prior to patient returning to Mexico.
- Issue: Linezolid isn't given in Mexico. Plan is to start a PICC and start Amikacin again. (6/22 started). Linezolid given until ran out. Prothionamide given instead of Ethionamide.
- Issue: returned to hometown, not to central facility recommended by Mexico. Continued regularly with facility.

Mexico | A | September | Custody: BP, USM
Location: Mexico, BP, Private facility

- 9/2: picked up by border patrol. Immediately informed officers of TB treatment.
- 9/6: public health notified. Back to original facility, PICC line intact.
- 9/8: Heartland consult to continue with regimen of:
  - Amikacin 15 mg/kg (decrease to 900 mg) M-F
  - Ethionamide 500 mg QD (was Prothionamide 750 mg in Mexico)
  - Moxifloxacin 400 mg QD
  - Cycloserine 500 mg QD
  - Linezolid 600 mg QD (will be dropped by Mexico on return)
- Had lost about 5lbs since June. Reported food insecurity.
- Goal of 18 to 20 months per Mexico: at least 61 weeks to go in treatment.

A | BOP | 2018 | Custody: USM, BOP, ICE
Location: Private facility, BOP, Mexico | Mexico

- Jan: patient pulled out own PICC line out while in custody. Plan: continue with 4 drugs.
- March: transferred to BOP in another state. Release date for July. Plan of 18 months of treatment.
  - Phone call from facility regarding patient adherence. Patient refusing meds at times. Issue: no Spanish speaking personnel at facility. CureTB talked with patient.
- Mid July: released. Coordinated between BOP and ICE, with BOP providing meds for release back to Mexico. CureTB notified.
- January 2019: car accident resulting in hemothorax
- 3/24/19: documented COT from Mexico

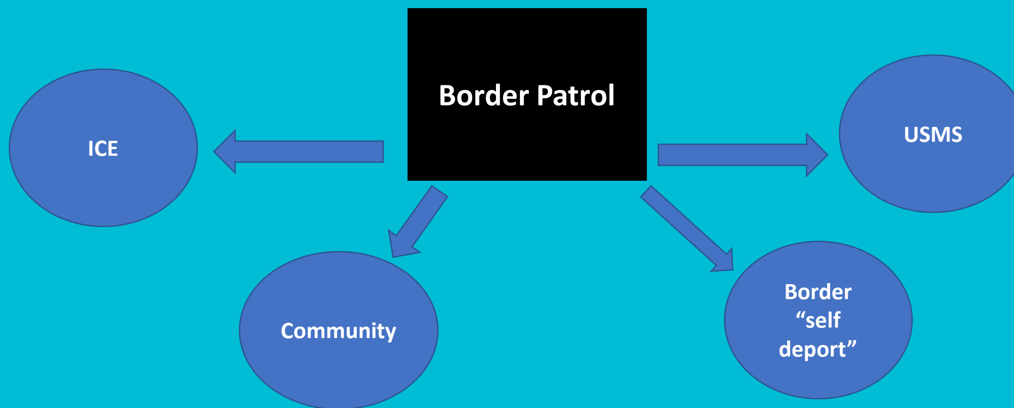


What about unaccompanied minors?

- “Custody” = ORR (Office of Refugee Resettlement)
- “Facility” = NGO (non-governmental organization) contracted with ORR. May have several sites in the community.
- “Custody plan” = reunite with family/guardian in the US. Prep for IJ!

Tip: Watch out for the 18th birthday!

Federal System: Border Patrol

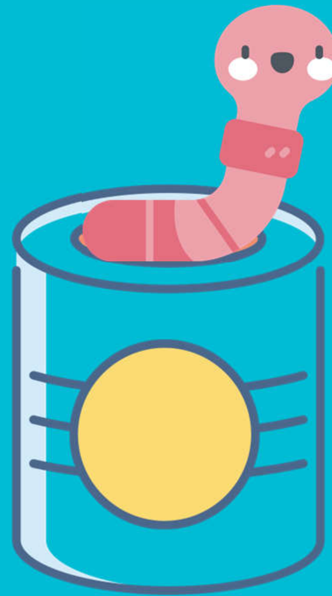


Case Study: ED Visit

- Phone call from ICP from local hospital. On review of weekend events, found an alert that Border patrol brought in a patient for ED visit due to reports of hemoptysis. ED staff determined that admission was not necessary as patient’s hemoptysis had resolved with initiating TB treatment. TB treatment reported as started within the month. Patient had pills with him. No sputums collected.
- Patient not found in surveillance system.
- Outreach to likely facilities & partners.
- Border Patrol: “self deported”.
- CureTB referral:
  - Confirmed that patient was diagnosed with TB in Mexico, on treatment, last smears collected were smear positive.

Challenges: for Discussion

- Short notice community release
- Temporary Address
- Unknown Address
- Multiple Moves
- Medical Records after Release
  - Lab reports
  - X-rays



Quick poll: Does community release from federal custody impact your jurisdiction?

- Yes
- Sort of
- No
- I don’t know
- Not applicable

Case Studies: BP & Community Release in US

- Hospital reported someone with history of incomplete treatment
  - Scenario 1
  - Scenario 2

TIP: Obtain contact info of NGO that they will be released to

TIP: WhatsAPP for calling international numbers

- Question for group: How do we case manage on a national level?
- Question for group: What is the federal government responsibility for community release?

Case Studies: Community Release, Temporary Address. . .

- Central American, in early 30's. Otherwise healthy. Abnormal Xray: "nodular consolidation Left Lung Apex." TST 18 mm. No reported signs/symptoms. Smear 1+, neg, neg. NAA MTB, no RIF mutation.
- Day 1: started on RIPE
- Day 21: not in ICE locator = where is patient?
  - Community release 5 days previous
- CureTB:
  - No US phone number (can use What'sApp)
  - Planning on moving shortly to different city/state
  - Does not want health department to come to where they are staying while in temporary housing
  - Released with 30 days of meds
- Move delayed= IJN though it would be short term (2 -3 weeks)
- Confirmed transfer after move

Polling Question: What is the rule of thumb for notifying new jurisdiction with IJ when patient is passing through?

- No minimum: any time passing through
- 2 weeks
- 1 month
- Other: put in chat

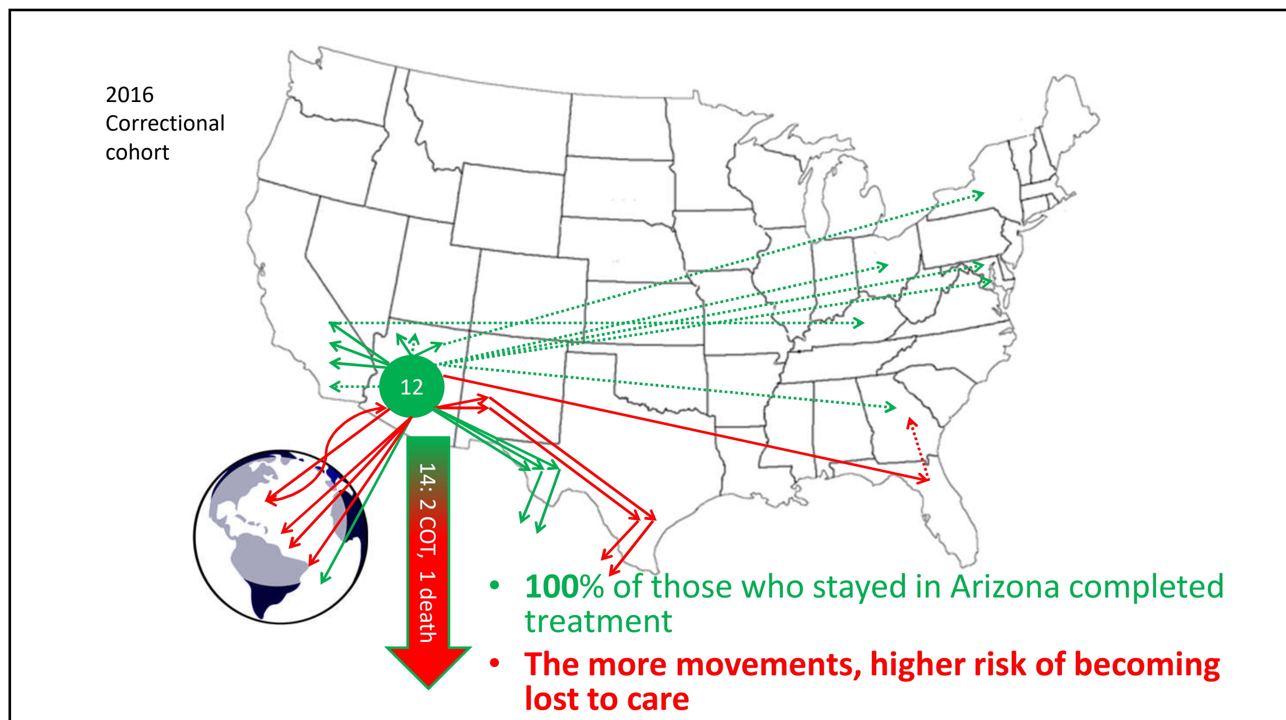
Polling question: What if we have no phone number and no address, just a vague statement? Is a "courtesy" IJN useful?

- Yes, please send it
- Maybe?
- No
- I don't know

TIP: **CureTB** does not do IJ's, however, if the patient has their number, they might call them.

How does it work?
CureTB contacts ADHS, and ADHS follows normal IJ process.

Multiple Moves, the New Norm?



Case Study: Multiple Moves

- From India, otherwise healthy individual in mid-forties. TST=15 mm. “Small infiltrates are identified within the upper lobe”. Smears 1+, rare, neg. NAA= MTB, no RIF mutation. Standard treatment started.
- Week 5: Mono PZA resistant (not *M. bovis*)
- *Week 6: culture converted*
- Week 7: Alert: moved correctional facilities to another state (A). *ADHS sent IJ*
- Next day, alert that they moved to another facility in another state (B). *ADHS sent IJ to new state. “canceled” IJ to state A.*
- Week 19: CureTB received a call from the patient. Now in a fourth state after release from ICE custody. *ADHS sent IJ to new jurisdiction (with available info from AZ). ADHS alerted state B.*
- Patient completed 9 months of treatment!

Challenges: Multiple Moves

- <u>**Tip**</u>: Get a CureTB referral. Then patients have a phone number.
- <u>**Tip**</u>: Google the address. Sometimes it clearly is NOT a residence.
- <u>**Tip**</u>: If I’m not counting, I fill out the follow up to go back to the original jurisdiction (so it doesn’t have to go through each chain.)

Q: How can we streamline continuity of care during multiple movements? How can we make sure the receiving jurisdiction has needed medical records, and the reporting jurisdiction has movement/outcome info?

IJ Process: Follow Up IJ's & New Forms

https://www.tbcontrollers.org/resources/interjurisdictional-transfers/

- Use Comments to indicate where follow up should go to?
- Attach original cover sheet?
- Other ideas?

Challenges: Final labs after transfer
Ideas for Communicating Culture Conversion & DSTs

- I flag lab for sending out after IJ. Check monthly, but often times I can send out earlier.

Tip: Follow up IJ's will help make sure lab reports go to the right jurisdiction

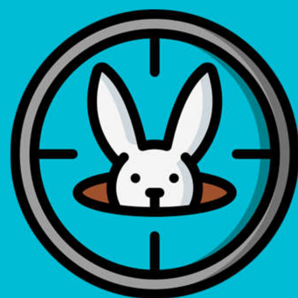
- However, what about labs that aren't sent to the state? Example: LabCorp. Options:
  - Does patient has access to online portal?
  - Can receiving jurisdiction contact LabCorp directly with accession number?
  - Can state contact regional ICE directly?
  - Other ideas?

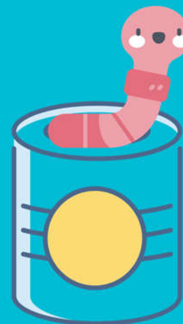
Challenges: Obtaining initial chest x-rays

- Can patient travel with them?
- Can patient access them through online portal?
- Snail mail: request to facility?
- Other ideas?

Discussion:

- How can we streamline continuity of care during multiple movements?





Resource page:

Center of Excellence Resource page:
https://sntc.medicine.ufl.edu/home/index#/corrections