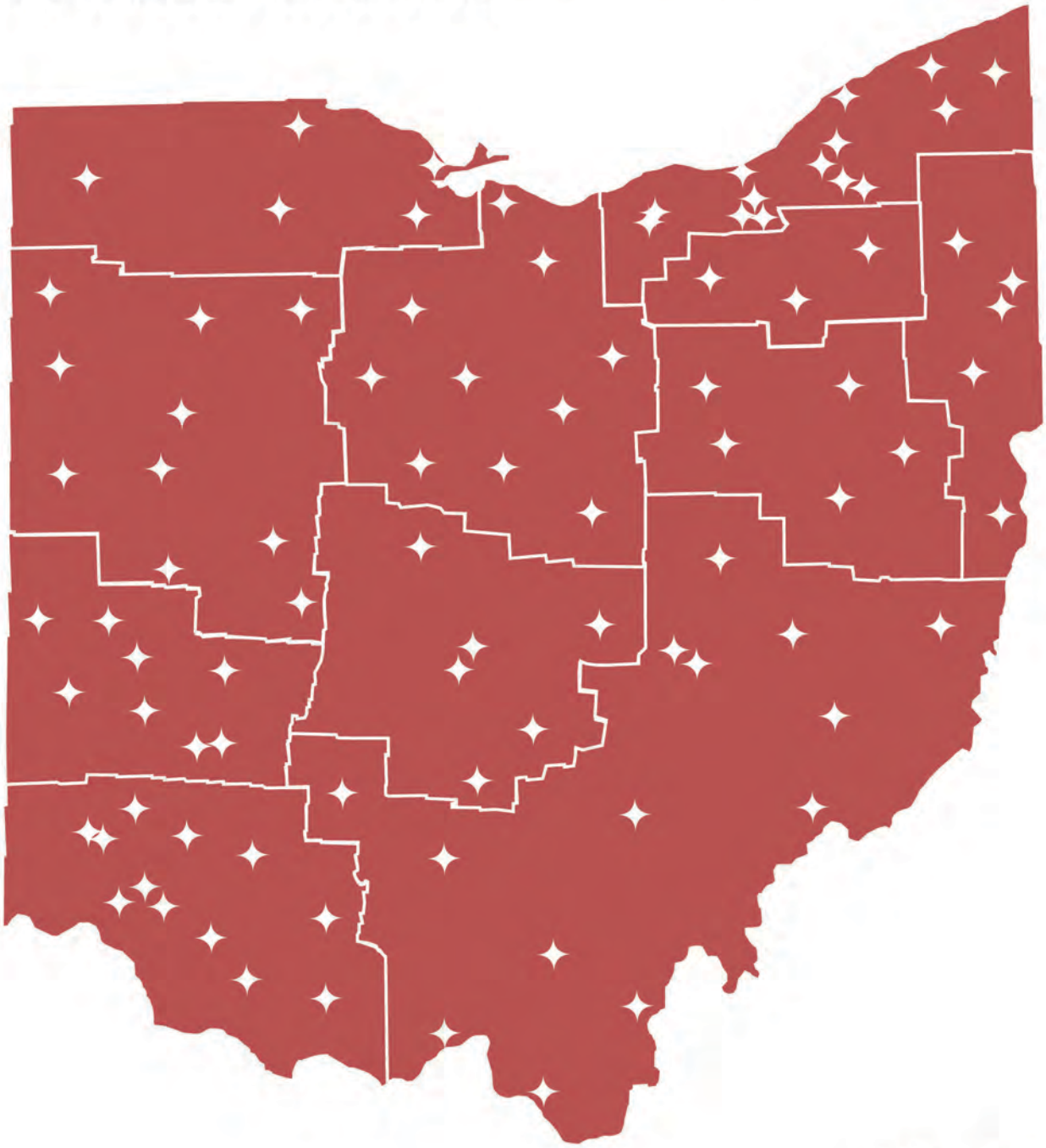
HIV Care in Ohio's Full Service Jails

A Study for the Ohio Department of Health,
HIV Care Services Section



OHIO UNIVERSITY
Voinovich School of
Leadership and Public Affairs

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Ohio University

2009

Prepared By The Voinovich School of Leadership and Public Affairs

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Most importantly, we offer our sincerest appreciation to the jail personnel, who took the time to answer our many questions about HIV care in Full Service Jails. This study would not have been possible without their willingness to help.

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Introduction

In 2008, the Ohio Department of Health (ODH), HIV Care Services Section, contracted with Ohio University's Voinovich School of Leadership and Public Affairs to conduct a study of HIV care in Ohio's Full Service Jails (FSJs). From September 2008 to October 2009, the Voinovich School gathered qualitative and quantitative data on the various aspects of HIV care provided to inmates living with HIV/AIDS in Ohio FSJs. To collect these data, the Voinovich School conducted interviews with jail personnel from FSJs throughout Ohio and sent a survey to all Ohio FSJs. In addition, the Voinovich School made contact with Ohio's Ryan White Consortia coordinators to learn about any HIV care provided to FSJ inmates by community organizations. Voinovich School staff also communicated with the Bureau of Adult Detention and the Buckeye State Sheriff's Association. In addition to these statewide resources, the Voinovich School drew on the expertise of Ohio University faculty, including Bernadette Heckman, PhD (College of Arts and Sciences, Department of Psychology), and Timothy Heckman, PhD (College of Osteopathic Medicine, Department of Geriatric Medicine/Gerontology), whose research focuses on individuals living with HIV and AIDS.

"HIV care" can encompass a broad spectrum of services provided to persons living with HIV/AIDS. The study conducted by the Voinovich School primarily focused on the following aspects of HIV care:

- *Identifying inmates living with diagnosed cases of HIV/AIDS:* This study examines the procedures FSJs use to identify inmates who have existing diagnoses of HIV/AIDS.
- *HIV testing:* Survey and interview data were collected on HIV testing policies in FSJs. In particular, Voinovich School staff asked about the conditions under which HIV testing is available to inmates and whether inmates, jails, or other parties bear the cost of testing.
- *Medical care providers:* Voinovich School staff solicited information about the jail personnel. local specialists, and community organizations providing medical care to inmates living with HIV/AIDS.
- *Medical care:* Voinovich School staff collected data on various aspects of medical care for inmates living with HIV/AIDS, including HIV testing, genotype testing, initiation or continuation of antiretroviral therapy, and the monitoring of an inmate's condition (and comorbid conditions) over time.
- *Medications:* Voinovich School staff queried jail personnel about whether they provide HIV-related medications to inmates, whether they allow inmates to provide their own medications, how medications are obtained and administered, and the most common causes of medication interruptions.
- *Non-medical care:* Voinovich School staff asked FSJ personnel about the non-medical aspects of HIV care available to inmates, including HIV/AIDS education, case management, and counseling.

- *Other HIV policies:* Voinovich School staff also asked FSJ personnel about housing, transfer, and confidentiality policies relating to inmates living with HIV/AIDS, as well as about any HIV/AIDS education or training that non-medical personnel may have received.
- *Community Linkage:* Voinovich School staff gathered data to provide a picture of the extent to which FSJs have established relationships with community-based providers of HIV care.
- *Release planning:* Voinovich School staff asked the jail staff about any measures they or community organizations take to ensure that an inmate's HIV care continues after release. Release planning may include assistance with making follow-up appointments, establishing contact with community providers of HIV care, locating housing, and reapplying for insurance or other health benefits.

Findings from the study are presented in this report in the following sequence:

- The first sections of this report provide information on the research methods of the study and a description of overall jail participation.
- The next section provides an overview of some of the guidelines for medical care in jails, as well as a description of some of the salient aspects of the correctional setting that impact the availability and delivery of HIV care.
- The report then provides a synopsis of jails' self-appraisals of HIV care in their facilities and an overview of the number of known cases of HIV/AIDS in Ohio FSJs in the last year.
- The next several sections provide the study's findings for the various components of HIV care.
- The final sections of the report include comparisons of various jail types (managed care and non-managed care jails, large and small jails, urban and rural jails, and county/municipal jails and regional jails) and the HIV care they provide.
- The report concludes with suggestions for potential best practices.

Methodology

There were two sources of evidence for this report: interview information and survey data.

Instrumentation

The research team developed survey items and interview questions based upon guidance from the project sponsor (ODH), a literature review (Amankwaa, Bavon, & Amankwaa, 2001; Fontana & Beckerman, 2007; Frank, 1999; Laufer, Arriola, Dawson-Rose, Kumaravelu, & Krane Rapposelli, 2002; Schady, Miller, & Klein, 2005), and a study of jail medical care standards for Ohio FSJs (Ohio Bureau of Adult Detention, 2003, 2008).

Interview Information

For each interview, the research team utilized a standardized open-ended interview protocol. This protocol uses an interview guide (Appendix A) to facilitate the discussion. Patton (2002) advocates the use of an interview guide for the following two reasons: (a) the limited time in an interview session is optimally utilized, and (b) a systematic approach is more effective and comprehensive. Further, an interview guide is essential when there are multiple researchers conducting interviews. The research team invited informants to participate in face-to-face interviews. If the point of contact at the FSJ declined to participate in a face-to-face interview, then the research team offered the option of participating in a telephone interview. Through the course of the project, six researchers completed 49 interviews. Five of the interviews were with respondents who were providing information for more than one jail in their county.

At the beginning of each interview, the research team read a script which clearly stated that informants were participating in the interview voluntarily and had the option to refuse to answer any of the questions. When permitted by the informant, the interviewer digitally recorded the interview. Interviewers also took notes during the interviews. The interviewers then input data from each interview into a Microsoft Access database. The research team generated a summary of all of the information collected from each interview using the database.

Survey Data

Each FSJ received a copy of the survey (Appendix G) to complete via US Mail. If the research team had already made contact with an interview respondent, the survey was mailed directly to him or her. If no informant had been identified, the survey was mailed to the jail administrator. The cover letter (Appendix F) accompanying the survey explained that the survey was voluntary and confidential. For those informants who had not returned the survey at the time they were interviewed, another copy of the survey was hand delivered to the informant at the time of the interview. Informants returned the survey to the Voinovich School using a postage-paid envelope.

Data Analysis

The initial data analysis focused on the eleven Ryan White Consortia. Because some consortia contain as few as three jails, the research team decided to combine some consortia for purposes of analysis in order to protect the confidentiality of the informants' responses. This was especially necessary in the case of the consortium-level reports. As a result, the research team treated the eleven Ryan White Consortia as if they were eight consortia.

The data analysis team consisted of six researchers. To ensure credibility of both the procedures and the conclusions, the research team used analyst triangulation (Lincoln & Guba, 1985). Patton (2002) defines analyst triangulation as "having two or more persons independently analyze the same qualitative data and compare their findings." We assigned two researchers to each consortium. Typically, one researcher had conducted interviews within the consortium and the other had no experience in the consortium. To prevent interviewer bias, the researcher without experience in the consortium did the initial data analysis. Once the consortium report was complete, the researcher with experience in the consortium reviewed the report for any inconsistencies with their experiences as an interviewer in the region. Finally, the two researchers worked together to develop consensus on the findings.

To facilitate data analysis for the consortia-level reports, the research team prepared a guidebook for consortia report preparation (Appendix M). The guidebook contained the guiding research questions from the study and listed the items from the interview guide and the survey questionnaire that pertained to each of the guiding research questions.

After the consortia-level reports were complete, the data and information were aggregated to complete the state-level report. The state-level report was written using the same guidebook as the consortia-level reports, with a few additions. To ensure credibility of the findings and offer multiple opportunities for analyst triangulation, four researchers were assigned to work on the state-level report. One researcher had experience with eight consortia, two

researchers had experience working in at least one consortium, and one researcher had no contact with any of the informants in the study.

The research team used qualitative data analysis techniques to analyze information from the open-ended items in the survey and interview guide. Content analysis was used to see what phrases, concepts, and words were prevalent throughout the participants' responses (Patton, 2002). During this stage of the analysis, coding categories were identified. Through the coding process, information was sorted and defined into categories that were applicable to the purpose of the research. Codes were defined and redefined throughout the analysis process as themes emerged. At the end of the analysis, major codes were identified as central ideas or concepts (Glesne, 2006). These central ideas were assembled by pattern analysis for the development of major themes. From the major themes, we drew conclusions (Patton, 2002). To indicate the source of the information was the interview participant, the term *interview informants* was used in the report.

For the items in the survey and interview guide that yielded information that could be analyzed quantitatively (e.g., How many inmates do you house?), data were analyzed using descriptive statistics (i.e., frequency distributions, means, standard deviations, and crosstabulations). In the report, the term *survey respondent* indicates that the source of information is from the survey.

Participation in the Study

Recruitment of Jails

Working from a list of 92 FSJs provided by ODH, Voinovich School staff verified the addresses and contact information for each jail and, in the process, learned that one of the jails had been closed, which reduced the total population of FSJs to 91. Voinovich School staff then attempted to make contact with each jail to secure their participation in the study.

The Bureau of Adult Detention and the Buckeye State Sheriff's Association played an instrumental role in Voinovich School recruitment efforts. Eugene "Butch" Hunyadi, Chief of the Bureau of Adult Detention, sent an e-mail to all 91 FSJs to introduce the study and to pass on a letter of introduction from ODH. Robert Cornwell, Executive Director of the Buckeye State Sheriff's Association, sent an email to all county jails to introduce the study and encourage participation. After this initial round of emails, the Voinovich School attempted to contact each jail up to four more times in order to answer any questions about the study and to ask for their participation. These contacts were made primarily through telephone calls, but also by email and occasionally by fax. In the case of county jails, Voinovich School staff contacted the sheriff's office to ask the sheriff's permission for the jail to participate in the study. When the Voinovich School was aware that a jail was a managed care jail, Voinovich School staff contacted the managed care provider to ask permission for medical staff to participate in the study. In addition to these contacts, Voinovich School staff also sent out a bi-monthly electronic newsletter to all FSJs. The newsletters provided details and updates on the study as well as information about HIV care that jails might find useful. In all, Voinovich School staff made over 400 individual contacts with the jails in an effort to secure participation and schedule interviews. This number is in addition to the contacts made by the Bureau of Adult Detention and the Buckeye State Sheriff's Association and does not include the periodic newsletters sent out by the Voinovich School.

Overall Participation

Seventy-one percent of Ohio's FSJs participated in the study. Four jails explicitly declined to participate. Two jails declined to participate because recent staffing cuts made it too difficult to spare the time for the interview. One jail gave no explanation for the refusal. One jail explained that the medical team was undergoing a transition to new procedures and was too busy. The vast majority of the jails that did not participate in the study did not explicitly decline to participate, but instead were deemed "contacted out" after the Voinovich School made four or more unsuccessful attempts to contact the jail and secure its participation. At the conclusion of the study, 18 jails had been deemed contacted out. An additional four jails initially agreed to

provide interviews, but failed to schedule them despite repeated efforts by Voinovich School staff.

By the conclusion of the study, a total of 55 jails completed either a face-to-face or telephone interviews[1] and a total 56 jails completed and returned the survey questionnaire. Table 1 provides detailed information on the participation in the project.

Table 1. *Overall Participation in the Study*

Participation	Number	Percent
Jails completing survey only	10	11.0%
Jails completing interview only	9	9.9%
Jails completing both survey and interview	46	50.5%
Jails not completing any study component	26	28.6%
Total	**91**	**100.0%**

Profile of Participating Jails

Table 2 provides an overview of the jails that participated in the study. Jails are considered small if they have less than 200 beds and large if they have 200 or more.[2] Jails are considered urban in they are located in a county that is home to one of the top eight most populous cities in Ohio. Specifically, jails are considered urban if they are in Cuyahoga, Franklin, Hamilton, Lucas, Mahoning, Montgomery, Stark, or Summit Counties (US Census Bureau, 2002). *Managed care jail* refers to any jail that hires a managed care organization to provide health care to its inmates. Regional jails are "joint cooperative efforts and agreements between normally adjacent counties and/or municipalities for prisoner detention or ‚county jail' services."[3] Municipal and county jails are jails run by their home municipalities and counties, respectively.

[1] Eleven of the interviews were conducted by telephone.
[2] This criterion was provided by ODH.
[3] Ohio Jail Administrator's Handbook, 2nd Edition.

Table 2. *Profile of Participating Jails*

Type of Jail	Number	Percent
Managed Care	25	38.5%
Not Managed Care	40	61.5%
Total	**65**	**100.0%**
Large	25	38.5%
Small	40	61.5%
Total	**65**	**100.0%**
Urban	15	23.1%
Rural	50	76.9%
Total	**65**	**100.0%**
County	56	86.2%
Municipal	5	7.7%
Regional	4	6.2%
Total	**65**	**100.0%**

Profile of Respondents

Health Services Administrators, Medical Directors, and members of the medical staff made up three quarters of the respondents for the interview portion of the study. Slightly more than 20 percent of the interview respondents were jail administrators, wardens, or corrections officers.[4] The average length of a respondent's employment at the jail was 11.5 years, with a maximum of 33 years and a minimum of four months. The profile of survey respondents follows roughly the same pattern as the interview respondents, with two thirds of respondents on the medical staff or serving as health services director and over a quarter of survey respondents serving as jail administrator, warden, or corrections officers. No data were collected on survey respondents' length of employment at the jail. Table 3 provides more detailed information on the study participants. Note that some study participants provided information for more than one jail (as in the case of counties with more than one FSJ served by the same medical staff).

[4] Those members of a jail medical staff who have also gone through the Corrections Academy are grouped into the medical staff category because of their specialized medical training and because their primary responsibilities are medical.

Table 3. *Study Participants' Positions*

Note. Percents may not sum to 100% due to rounding.

Position at the Jail	Survey		Interview	
	Number	Percent	Number	Percent
Medical Director	0	0.0%	8	14.0%
Health Services Administrator	8	15.7%	2	3.5%
Medical Staff Member	26	51.0%	32	56.1%
Jail Administrator or Warden	13	25.5%	9	15.8%
Corrections Officer	1	2.0%	4	7.0%
Other	3	5.9%	2	3.5%
Total	**51**	**100.0%**	**57**	**100.0%**

HIV Care in the Correctional Setting

Full Service Jails (FSJs) are defined as local confinement facilities "that allow for the incarceration of prisoners beyond twelve days and provide a full array of services" (State of Ohio, Department of Rehabilitation and Correction, Bureau of Adult Detention, 2007). This distinguishes them from minimum security jails and facilities that house inmates for stays of shorter duration. All FSJs are under the authority of the Ohio Department of Rehabilitation and Correction, which establishes guidelines for inmate healthcare.

Minimum Standards

Section 5120.10 of the Ohio Revised Code requires that the Director of the Department of Rehabilitation and Correction set standards for Ohio jails in order to establish the "minimum conditions necessary to ensure the safe, efficient, effective, and legal operation of a jail." These standards are found in section 5120:1-8-09 of *Minimum Standards for Jails in Ohio: Full Service and Minimum Security Jails* (State of Ohio, Department of Rehabilitation and Correction, Bureau of Adult Detention, 2003). The *Minimum Standards* establish general requirements for several areas relevant to HIV care:

- *Jail Physician:* Section A establishes that each FSJ should "have a designated jail physician, licensed to practice medicine in Ohio, who shall be responsible for health care services pursuant to a written agreement, contract, or job description."
- *Intake Screening:* Section C requires that "health-trained personnel shall perform a medical, dental and mental health receiving screening on each prisoner upon arrival at the jail."
- *14-Day Health Appraisal:* Section D calls for a more detailed health appraisal, conducted by "qualified health care personnel," within 14 days of an inmate's arrival. The health appraisal should include but is not limited to: a review of the intake screening; collection of additional medical, dental, mental health, and immunization data; tests to detect tuberculosis or other suspected communicable diseases; a medical examination; and "initiation of therapy when determined necessary by the jail physician."
- *24 Hour Emergency Health Care:* Section E establishes that "the jail shall provide, or make provisions for twenty-four hour emergency health care."
- *Sick Call:* Section F calls for a physician or other "qualified health care professional" to conduct sick call a certain number of times per week, depending on the average daily population of the jail.
- *Authority of Jail Physician:* Section G establishes that "medical care shall be performed by health care personnel pursuant to written protocol or order of the jail physician."

- *Medical Complaints:* Sections H and I require that inmates be afforded daily opportunities to report medical complaints to health care personnel and establishes the procedure for these complaints.
- *Confidentiality:* Section K establishes that inmate health records are confidential and only those persons designated by the jail physician may have access to them. It also stipulates that "staff may be advised of prisoners' health status only to preserve the health and safety of the prisoner, other prisoners or the jail staff."
- *Access to Healthcare:* Section M states that no prisoner should be denied healthcare.
- *Infectious Disease Control Programs:* Section R says that "there shall be a written infectious diseases control program implemented in the jail."

The Correctional Setting

There are many aspects of the correctional setting that affect the ability of medical personnel to provide HIV care services. The need to maintain order and to provide for the safety of inmates, jail personnel, and the community are fundamental priorities of correctional institutions. Medical staff must operate within parameters established to achieve these goals. For example, outside providers of care may find it difficult to gain access to inmates because of the background checks and security screenings required by many facilities. The security procedures required to transport inmates to local health care specialists can be costly and time consuming. Certain types of medications are often not allowed in facilities for security reasons (e.g., narcotics or drugs that must be administered intravenously). Interactions with inmates are monitored by corrections officers, which impacts patient confidentiality. When these necessary security measures are paired with limited staff and limited budgets, it can be quite difficult for jail personnel to provide for all the HIV care needs of inmates.

> "Due to a range of issues and characteristics of prisons and jails, it is often difficult for HIV-infected inmates to access HIV counseling, testing, early HIV intervention, and ongoing clinical management that meet the community standards of care."
>
> -Linda Frank, *Journal of the Association of Nurses in AIDS Care*, (1999)

In addition to the security constraints inherent in any correctional setting, staff in FSJs face challenges unique to the jail setting. Unlike prisons, the county or municipality in which the FSJ is located operates the facility.[5] This variation in operating authorities means that separate policies and procedures need to be established in every jurisdiction. Their budgets are provided by these cities and counties and are generally much more limited than prison budgets. Because jails house individuals who are awaiting trial or who are serving short sentences, jail inmates are also incarcerated for much shorter periods of times

[5] In the case of regional jails, a group of counties operates the jail.

than prison inmates. In 2007, the average length of stay for an inmate in a FSJ was 22.4 days (State of Ohio, Department of Rehabilitation and Correction, Bureau of Adult Detention, 2007). This gives jail personnel a very condensed timeframe in which to establish medical care. Release dates for jail inmates are also much less predictable, which makes release planning particularly difficult.

It should be noted that the correctional setting may also provide some advantages for certain aspects of HIV care. In particular, the highly regimented nature of incarceration is said to provide the setting needed to stabilize inmates who enter the facility malnourished or addicted to drugs and alcohol. It may also provide a setting in which difficult HIV medication regimens may be administered consistently and predictably (Spaulding, et al., 2002).

> "The structure provided within these sites allows individuals to focus on health-seeking behaviors rather than devoting much of their time to acquiring basic needs"
>
> -Sandra Springer & Frederick Altice, *Current HIV/AIDS Reports,* (2005)

Jails' Perceptions of HIV Care

Survey respondents generally perceived jails to be most successful at ensuring that inmates do not miss doses of medication once medications have been obtained. The consistent administration of HIV-related medications to inmates is critically important because even occasional periods of non-adherence can lead to more rapid viral replication and treatment resistance. The regimented nature of the jail setting allows jail medical staff and corrections officers to administer medications in a highly regularized manner. Survey respondents also generally viewed jails as being good at identifying inmates with existing HIV/AIDS diagnoses; although some reported difficulty with uncovering undiagnosed cases of HIV/AIDS. The aspect of HIV care that respondents typically found the most challenging was ensuring that an inmate continues HIV care after release from jail. Most difficulties that survey respondents reported stemmed from the expensive nature of HIV care and the limited nature of funding in the jail setting.

The following section of this report provides the results of survey questions that probed the respondents' perceptions of the HIV care provided to inmates. This section concludes with select interview findings regarding perceptions of HIV care in Ohio's FSJs. The purpose of this section is to provide a context for the data that will be presented in the rest of the report.

Survey Data

Table 4. *Perceived Strengths Related to Caring for Inmates with HIV/AIDS*

Note. Higher mean scores indicate better performance (1 = *poor*; 2 = *fair*; 3 = *average*; 4 = *good*; 5 = *excellent*).

In your opinion, how well does your jail perform with the following aspects of HIV care? (If your jail has not housed inmates with HIV/AIDS, how well do you think it would perform with the following aspects of HIV care?)	*M*	*SD*
Ensuring that inmates rarely or never miss doses of HIV-related medications while in jail	4.2	0.9
Identifying inmates with HIV/AIDS when entering jail	3.9	1.0
Providing access to HIV specialists	3.9	1.3
Developing courses of treatment appropriate to an inmate's specific condition	3.8	1.2
Providing HIV-related medications immediately when an inmate arrives at the jail, regardless of whether the inmate enters on a weekend or after business hours	3.6	1.2
Keeping up to date with developments in the treatment of HIV/AIDS	3.4	1.1
Providing counseling, education, or other types of non-medical services to inmates with HIV/AIDS	3.2	1.2
Finding undiagnosed cases of HIV/AIDS among inmates	3.0	1.1
Ensuring that inmates' HIV care continues after they are released from the jail	2.8	1.1

- On average, the only aspect of HIV care for which survey respondents perceived jail performance to be *good* is "ensuring that inmates rarely or never miss doses of HIV-related medications while in jail." Interview data, while suggesting that missed doses may be more likely as an inmate enters and exits the facility, corroborate that once a facility obtains medications, missed doses occur infrequently unless an inmate refuses medication.
- The only aspect of HIV care for which the survey respondents reported a mean score of *fair* is "ensuring that inmates' HIV care continues after they are released from the jail." Interview data corroborate this as well, especially regarding release care for inmates who are in later stages of the illness.
- On average, the survey respondents rated jail performance with the other seven listed aspects of HIV care as *average*.

At ODH's request, Voinovich School staff separated the results of this question into answers provided by those jails that reported housing zero inmates with HIV/AIDS in the last year and those that reported housing at least one inmate with HIV/AIDS in the last year. The results are listed below in Table 5.

Table 5. *Perceived Strengths Related to Caring for Inmates with HIV/AIDS: Comparison of Jails With and Without Recent Experience*

Note. Higher mean scores indicate better performance (1 = *poor*; 2 = *fair*; 3 = *average*; 4 = *good*; 5 = *excellent*).

In your opinion, how well does your jail perform with the following aspects of HIV care? (If your jail has not housed inmates with HIV/AIDS, how well do you think it would perform with the following aspects of HIV care?)	**No Experience**			**Experience**		
	M	*n*	*SD*	*M*	*n*	*SD*
Ensuring that inmates rarely or never miss doses of HIV-related medications while in jail	4.2	6	1.0	4.2	45	0.7
Developing courses of treatment appropriate to an inmate's specific condition	4.0	6	1.1	3.8	45	1.1
Identifying inmates with HIV/AIDS when entering jail	3.8	6	0.8	4.0	44	0.9
Providing access to HIV specialists	3.8	6	1.3	3.9	45	1.3
Providing HIV-related medications immediately when an inmate arrives at the jail, regardless of whether the inmate enters on a weekend or after business hours	3.8	6	1.0	3.5	45	1.2
Providing counseling, education, or other types of non-medical services to inmates with HIV/AIDS	3.7	6	1.2	3.2	45	1.2
Finding undiagnosed cases of HIV/AIDS among inmates	3.7	6	0.8	3.0	41	1.1
Ensuring that inmates' HIV care continues after they are released from the jail	3.3	6	1.0	2.7	44	1.1
Keeping up to date with developments in the treatment of HIV/AIDS	3.0	6	1.3	3.4	45	1.1

- On average, respondents from jails without recent experience with HIV care may perceive jails to be slightly better at providing non-medical services, finding undiagnosed cases of HIV/AIDS, and continuing an inmate's care after release, when compared to respondents from jails that have housed inmates with HIV/AIDS in the last year.

Table 6. *Perceived Challenges Related to Caring for Inmates with HIV/AIDS*

Note. Higher mean scores indicate greater challenges (1 = *not at all challenging*; 2 = *not very challenging*; 3 = *neutral*; 4 = *somewhat challenging*; 5 = *very challenging*).

How challenging is it for your jail to provide the following components of HIV care?	*M*	*SD*
Ensuring that inmates' medical HIV care continues after they are released from the jail	3.8	1.1
Finding undiagnosed cases of HIV/AIDS among inmates	3.8	1.0
Paying for HIV-related medications for inmates	3.8	1.3
Keeping up to date with developments in the treatment of HIV/AIDS	3.2	1.1
Providing HIV-related medications within 24 hours after an inmate enters the jail, regardless of whether an inmate enters on a weekend or after business hours	3.2	1.4
Paying for HIV testing for inmates	3.2	1.4
Identifying inmates entering jail with HIV/AIDS	3.1	0.9
Providing counseling, education, or other types of non-medical treatment	3.1	1.1
Providing access to HIV specialists	3.0	1.4
Developing courses of treatment appropriate to an inmate's specific health condition	2.9	1.0
Ensuring that inmates rarely or never miss doses of HIV-related medications while in jail	2.6	1.3

- Survey respondents, on average, did not perceive that any of the listed aspects of HIV care are *somewhat challenging* or *very challenging* for jails.
- Survey responses to this question were very consistent with the responses listed in Table 4. On average, the most challenging component of HIV care was perceived to be ensuring that medical care continues upon release; the least challenging component was perceived to be ensuring that inmates rarely or never miss doses of HIV-related medications while in jail.

Table 7. *Factors Contributing to Challenges Related to Caring for Inmates with HIV*

Note. Higher means indicate greater frequency (1 = *never*; 2 = *rarely*; 3 = *sometimes*; 4 = *often*; 5 = *very often*).

When your jail encounters challenges with HIV care for inmates, how often are the following issues the source of the challenges?	*M*	*SD*
Insufficient finances	3.0	1.5
Not enough time	2.8	1.2
Insufficient staffing	2.4	1.1
Insufficient/inadequate health care space	2.2	1.3
Jail's relationship with the community and elected officials	2.0	1.1

- According to the respondents from the surveyed jails, the most common cause of HIV care challenges was, on average, a lack of finances. While the survey respondents reported this factor occurred, on average, *sometimes*, the interview data suggest that this was very often the case.

> "The cost is overwhelming…it's very burdensome."
>
> -A medical staff member from one of Ohio's FSJs

- According to the respondents from the surveyed jails, the issue that least often contributed to the challenging nature of HIV care is a jail's relationship with the local community and elected officials. The respondents from the surveyed jails perceived that this happens, on average, *never* or *rarely*. This issue also was not frequently raised during the interviews.

Table 8. *Overall Assessment of the Jails' Capacity to Care for Inmates with HIV/AIDS*

Note. Higher means indicate stronger agreement (1 = *strongly disagree*; 2 = *disagree*; 3 = *neutral*; 4 = *agree*; 5 = *strongly agree*)

Please indicate how strongly you agree with the following statements.	*M*	*SD*
We would like local organizations to be more involved in providing care for inmates with HIV	3.6	0.8
Inmates at this jail have adequate access to HIV specialists	3.6	1.2
This jail is taking full advantage of the local resources for HIV care for inmates	3.3	1.1
Jail personnel are adequately trained to identify those inmates entering the facility who have HIV/AIDS	3.3	0.9
Jail personnel are able to provide a course of treatment for inmates with HIV/AIDS that is tailored to each inmates' particular health condition	3.1	1.2
Jail personnel keep up to date on the latest medical and treatment options for HIV/AIDS	3.0	1.1
Adequate release planning is provided to inmates with HIV/AIDS	3.0	1.1

- On average, the item with which the respondents from surveyed jails most agreed was "we would like local organizations to be more involved in providing care for inmates with HIV." This was consistent with the interview data, including statements made by jails that already have existing partnerships with community HIV care providers.
- On average, the items with which the respondents from the surveyed jails expressed the least agreement were "adequate release planning is provided to inmates with HIV/AIDS," and "jail personnel keep up to date on the latest medical and treatment options for HIV/AIDS." This was consistent with the data presented in Table 4 and Table 5, as well as with the interview data.

Interview Data

The concluding questions of the interview guide asked informants to discuss the strengths and weaknesses of the HIV care provided by their facility.

Strengths. Interview informants provided a variety of answers when asked about their facility's greatest strengths, but no clear pattern emerged from these answers. Among the strengths listed by the informants were: compassionate, proactive medical staff; professional non-medical staff; good relationships with community providers of HIV care; the ability to get lab results and medications quickly, and good screening for inmates with HIV/AIDS.

Gaps in care. There were clearer trends in informants' answers when asked about gaps in HIV care provided by their respective jails. The most frequently identified gap was funding; especially funding for medication and testing. Many informants also reported that they would benefit from more information for medical and non-medical staff about how to treat HIV/AIDS, types of protocols to be used with inmates living with HIV/AIDS, and what HIV care resources are available in their area. A smaller number of informants also mentioned difficulties accessing HIV specialists and providing HIV education and counseling to inmates.

Other themes. In addition to responses regarding strengths and service gaps, some other themes emerged over the course of the interviews related to jails' perceptions of HIV care. While survey data indicates that many jails are frustrated with the prescription verification procedures, this theme emerged even more strongly in the interview data. HIPAA regulations were cited frequently as obstacles to quick prescription confirmation. Specifically, many informants stated that private care providers frequently fail to understand that HIPAA regulations do not apply to inmates in the same way that they apply to non-incarcerated individuals. Informants also expressed frustration with particular care providers, such as the Veterans' Administration and the Department of Corrections and Rehabilitation, stating that obtaining medical information from these organizations can be very time consuming.

One theme that emerged during the interviews that did not appear strongly in the survey data was the importance of the quality of the interactions between inmates and medical staff. Many interview informants reported that one of the biggest challenges of HIV care in the jail setting is the interaction with inmates themselves.

> "We would love it if inmates were more forthright."
>
> -A medical staff member from one of Ohio's FSJs

Some interview informants expressed frustration with what they perceive to be a lack of candor on the part of inmates. Some respondents said that many inmates are unwilling to disclose their HIV serostatus, perhaps because of fear of stigmatization or possibly because they think they will not be in jail for long and do not want the hassle of establishing their medical care. Other informants said that medical staff are sometimes purposefully "sent on wild goose chases" by inmates who provide false information about prescriptions and medical care providers. It should be noted that not all informants expressed these sentiments, although it did emerge as a clear theme throughout the interviews.

Other informants noted that one of the biggest challenges of HIV care in the jail setting is dealing with inmates who have not been adhering to their medication regimen before entering the jail and whom jails perceive to be unlikely to adhere to their prescribed regimens upon release. Many informants, especially medical staff members, expressed a concern that by initiating treatment they might be contributing to an inmate's resistance to that medication if the inmate fails to remain adherent upon release. The perception among many informants is that inmates

will request any resources that the jail is willing to provide, so a request for antiretrovirals may not represent a sincere effort to become adherent to a treatment regimen. In addition to more resource-based barriers to care such as funding and the availability of community resources, many jails appear to perceive that one of the biggest challenges of HIV care is dealing with the potential for medication non-adherence among inmates.

HIV Statistics

Information on the number of inmates known to be diagnosed with HIV/AIDS was collected through several interview questions and one survey question. Several difficulties arose when collecting and analyzing this data. First, staff from many jails simply did not know how many inmates with HIV/AIDS have passed through their facility in the last year. Over 85 percent of the informants from the interviewed jails reported that they had no formal system for tracking inmates with HIV/AIDS. Sixteen percent of the informants from the interviewed jails said their numbers might include the same inmate multiple times if the inmate entered the facility more than once in the last year. An additional problem was that some survey respondents and/or interview informants were providing statistics for multiple jails (e.g., counties that run more than one FSJ) and, in some cases, the survey respondent and/or interview informant did not have the information needed to disaggregate the data down to the level of the individual jail. When analyzing the data provided by the survey respondents and interview informants, Voinovich School staff omitted those statistics that were based on potentially duplicative tracking systems. In those cases in which an aggregate figure was provided for more than one jail, that number was used only in the calculation of the average number of inmates known to have HIV/AIDS.

It was not feasible to calculate prevalence rates for HIV/AIDS in FSJs due, in large part, to the highly fluid nature of jail populations. The number of inmates in a jail varies daily, complicating efforts to pinpoint the population (i.e., the denominator) on which to base the prevalence rate. In addition, when jail population statistics were requested, some respondents provided the number of beds in their facility, some gave the average daily population, and others gave the total number of inmates booked in to their facility in the last year.

> "Some people believe that HIV/AIDS are widespread in jails, which is not true. We have more cases of Hepatitis C than HIV/AIDS."
>
> -An Ohio FSJ Health Care Administrator

Despite these difficulties, it is clear that the vast majority of jails have, at one point or another, housed inmates known to be living with HIV/AIDS,[6] but that the number they have housed is typically small. After combining the interview and survey data, the average number of inmates known to have HIV/AIDS housed by each jail in the past year fell in the range of 6 to 8 inmates.[7] The highest number of inmates living with HIV/AIDS reported to be housed by a jail was 174 inmates. The lowest report was 0 inmates. Table 9 provides more details on the number of inmates known to have HIV/AIDS housed by FSJs in the last year.[8]

[6] All but one of the interviewed jails reported that, at some point in their history, they have housed an inmate known to have HIV/AIDS.
[7] The average is expressed as a range because survey data were collected in the form of ranges.

Table 9. *Number of Inmates Known to Have HIV/AIDS Housed in the Last 12 Months*

Number of Inmates	Number	Percent
0	8	17.4%
1-10	33	71.7%
11-25	3	6.5%
26-50	1	2.2%
51-100	0	0.0%
Over 100	1	2.2%
Total	**46**	**100.0%**

It is noteworthy that only a small number of respondents and/or informants reported their respective jail to have housed over 10 inmates known to be living with HIV/AIDS in the last year. However, these figures represent very conservative estimates. Several factors contribute to the probable underrepresentation of the number of inmates with HIV/AIDS:

- Lack of systematic tracking systems in most FSJs mean that respondents and/or informants from several jails did not know how many inmates with HIV/AIDS they had housed.
- Due to duplicative tracking systems, several counts of inmates with HIV/AIDS had to be omitted from these calculations.
- When counties operate multiple FSJs, the respondents and/or informants were not always able to provide data in a way that could be incorporated into these calculations.
- These counts represent only *known* cases of HIV/AIDS.
- Limited HIV testing policies in many FSJs may prevent jails from uncovering undiagnosed cases of HIV/AIDS.
- Real or perceived stigmatization of inmates with HIV/AIDS may prevent inmates from disclosing their HIV serostatus.

> "There are so many people out there that you know haven't been tested…I think we probably have a lot higher number than we're aware of."
>
> -A medical staff member from one of Ohio's FSJs

[8] Table includes combined survey and interview data. Data from seven jails were not included because the jails reported having potentially duplicative tracking systems. Data from six jails were not included because interview and survey data were inconsistent.

Identifying Inmates with HIV/AIDS (New and Diagnosed Cases)

Respondents from Ohio's FSJs reported confidence in the ability to identify inmates who are living with HIV/AIDS. They are especially confident when it comes to identifying those inmates with diagnosed cases of HIV infection. Finding undiagnosed cases was perceived to be more difficult. Figures 1 and 2 provide more information on the surveyed jails' perceived performance at identifying new and previously diagnosed cases of HIV/AIDS.

Figure 1. *Identifying Inmates with HIV/AIDS: Perceived Strengths*

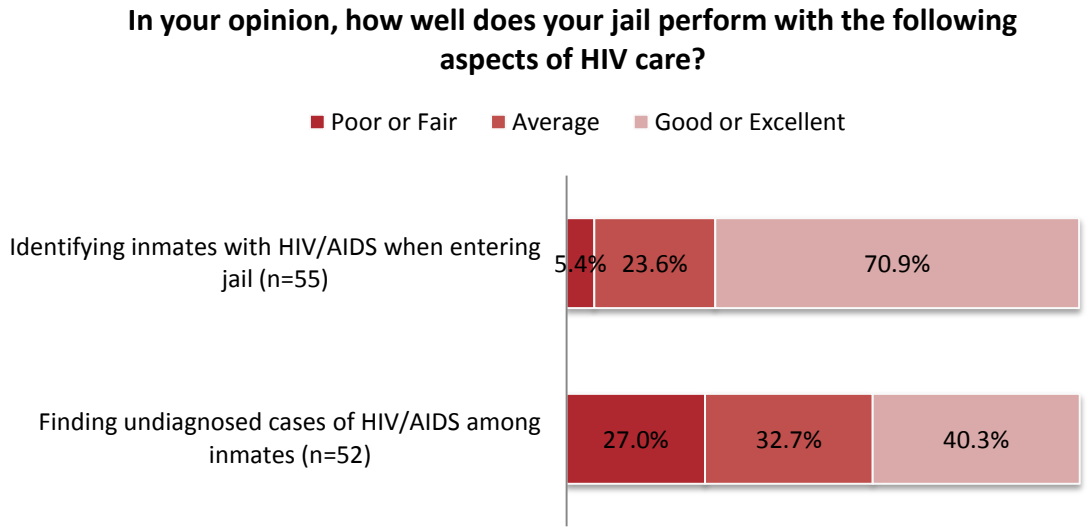
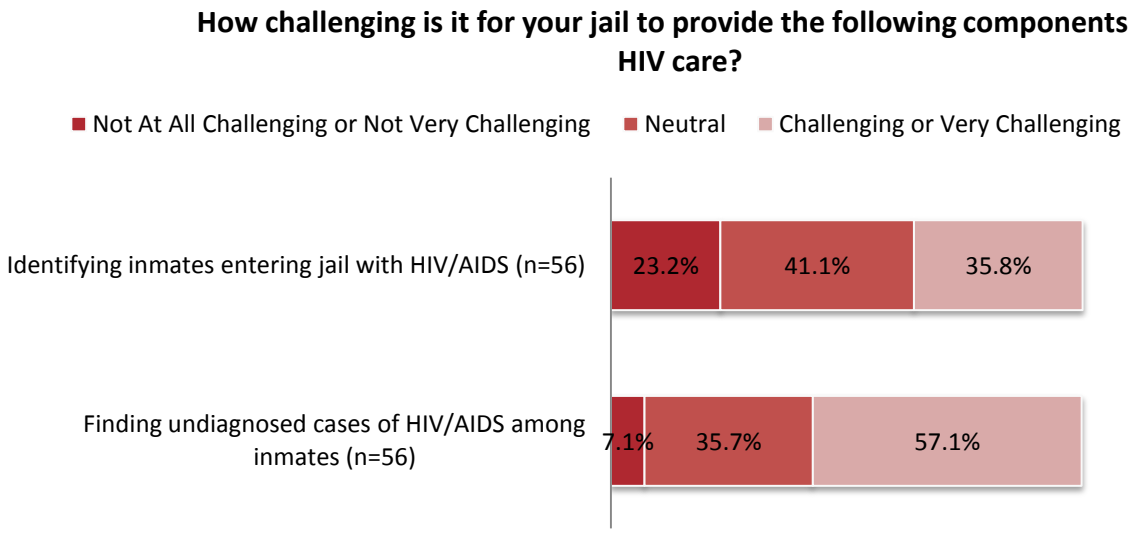


Figure 2. *Identifying Inmates with HIV/AIDS: Perceived Challenges*



Identifying Diagnosed Cases

The vast majority of inmates known to be living with HIV/AIDS in Ohio jails have already been diagnosed prior to incarceration. Because of the limited availability of HIV testing, jails typically rely on inmate self-identification as the primary means of identifying inmates with HIV/AIDS. When asked what point of time inmates typically disclose their HIV serostatus, the most common answers were: the intake screening, the medical screening, "kites," sick call, and interactions with mental health staff.

> "We depend on the person coming in. We try to ask the right questions and hope they give the right answers."
>
> -An Ohio FSJ Health Care Administrator

Intake screening. It appears that many inmates who know they have HIV/AIDS disclose their HIV serostatus as they are booked into jail. In most jails, this means that they revealed their HIV serostatus to a corrections officer who conducts the initial intake screening (only seven of the informants from the interviewed jails reported that members of the medical staff conduct the intake screening performed when an inmate arrives at the jail).[9] Fourteen of the informants from the interviewed jails volunteered that their intake questionnaire asks specifically about HIV/AIDS. Many other interview informants reported asking questions about sexually transmitted diseases and chronic health conditions that provide opportunities for inmates to report their HIV serostatus. Regardless of whether inmates identify themselves as having HIV/AIDS, if they report that they are on any medications this usually triggers a quick meeting with the medical staff so that medications

[9] Some intake screenings are done electronically, with either the jail staff member entering the inmate's information into the screening program or the inmate entering his or her information directly.

and/or prescriptions can be verified and the process of obtaining medications can begin, if needed. At this point, members of the medical staff are very likely to determine an inmate's HIV serostatus by the types of medications the inmate reports taking.

Medical screening. If an inmate's HIV serostatus is not reported or discovered during the intake screening, the next opportunity to identify his or her HIV serostatus is normally the mandated 14-day health screening. A very small number of informants reported that medical staff routinely conducted a medical screening much earlier than the mandated 14 days, sometimes as early as within hours of book-in. Most informants reported that, with healthy inmates, the medical staff will conduct the screening around ten to 14 days after an inmate was booked into the facility. Some informants stated that they prefer to wait the 10 to 14 days so that they do not expend limited resources on inmates who will soon be leaving their facility. However, if inmates reported that they were living with HIV/AIDS at their intake screening, or if they otherwise raised a red flag for the person doing the intake screening, medical staff typically made arrangements to conduct the health assessment much sooner. Several interviewed medical staff members reported that they were called in on weekends if inmates arrived and reported that they were taking HIV medications.

A member of the medical staff (typically the jail doctor or a nurse) conducts the medical screening. Some respondents reported that they directly asked inmates about their HIV serostatuses at this screening, but not all facilities did so. The screening also gives medical staff the opportunity to observe signs or symptoms that may prompt them to investigate further into an inmate's HIV serostatus.

"Kites" and sick call. If inmates do not self-disclose their HIV serostatus at the intake screening, they may request to see a member of the medical staff through a process often referred to as *kiting*, a request for a medical consultation. This may be a request to be allowed to go to a regularly scheduled sick call or it may be a more urgent request to see a member of the medical staff sooner than the next sick call. Inmates sometimes use this option if they do not feel comfortable reporting their HIV status directly to a corrections officer at intake, or if the conditions at intake are such that many people will overhear the details of the inmate's health conditions. While corrections officers are typically present whenever an inmate interacts with a member of the medical staff, the setting of a medical consultation is usually much more private.

Mental health screenings or appointments. A small number of interview informants reported that there are inmates who are not comfortable disclosing their HIV serostatus to corrections officers or medical staff, but instead prefer to discuss their health conditions with mental health care workers. In these cases, inmates reveal their HIV serostatus at mental health screenings or by kiting requests to see mental health care workers, if these services are available at their facility (83.6 percent of the interviewed jails reported that jail-provided or community-provided mental health care is available to their inmates, though sometimes on a very limited

basis). Mental health care workers will typically encourage the inmate to get in touch with the medical staff.

Identifying New Cases

Much of the medical and scholarly literature on HIV in the correctional setting views incarceration as a public health opportunity (Frank, 1997; see also Spaulding, et al., 2002, 2007; Springer & Altice, 2005). Because the prevalence rates for HIV/AIDS are said to be significantly higher in correctional institutions than in the general population, incarceration affords health care providers access to a larger than normal population of individuals affected by the illness. Incarceration reportedly can also provide the structured setting needed to treat HIV/AIDS in a consistent way, thereby improving the health of a population that will be returning to the community. Treatment services that reduce an inmate's HIV viral load may render him or her less infectious after being released from jail. Incarceration is also reported to provide the opportunity to identify and educate persons with HIV/AIDS or at risk for HIV/AIDS, which is predicted to reduce the spread of the disease when inmates with HIV/AIDS return to the community. Voinovich School staff solicited the jails' view of this issue by asking interview respondents the following question, "We've talked about existing conditions, what about conditions inmates might not know about? Do you view it as your role to uncover these conditions, in particular HIV/AIDS?" Slightly more than half of the interview informants answered no, often reluctantly. Specifically, 53.7 percent of respondents said no, and 46.3 percent of respondents said yes.[10] Many informants remarked on the difficulty of the question or called the question "tricky." Typical answers to this question included, "I sure wish we could," and "we can only do so much." Some respondents said that they do work to uncover some undiagnosed health conditions, but not HIV/AIDS because that condition is far too costly to treat.

> "Correctional settings are important sites for screening, detection, and treatment of HIV and can serve as a conduit to care after release into the community. They represent structural sites of contact where many individuals with or at high risk for HIV interface on a daily basis."
>
> -Sandra Springer & Frederick Altice, *Current HIV/AIDS Reports,* (2005)

> "Medical expenses wiped out our budget last year. We cannot afford to do more than maintain already established care."
>
> --An Ohio FSJ Health Care Administrator

The general answer that this question elicited is that, ideally, jail medical staff would like to be able to identify new health conditions and help inmates get treatment for them, but this is not fully possible. Jails identified three main impediments to diagnosing new

[10] $N = 41$; 14 interview respondents did not answer this question.

conditions. First, inmates may be unwilling to be diagnosed or unwilling to be adherent with difficult medication regimens. Second, jail medical staff reported being extremely busy, and the extra work of diagnosing and initiating new treatments may be more than overburdened staff members can manage. Third, diagnosing and medicating, especially in the case of HIV/AIDS, is an extremely expensive task, and jails overwhelmingly reported that they simply cannot afford to treat any more cases than they already do.

HIV Testing

Voinovich School staff solicited information on jails' HIV testing policies through several interview questions and one survey question. The survey asked respondents to select statements that accurately described their testing policies. The interview asked open-ended questions about the conditions under which HIV testing is available to inmates. Tables 10 and 11 provide the survey and interview results, respectively.

Table 10. *HIV Testing Policies Reported in Survey*

Testing Policy	Number	Percent
All inmates entering the facility are offered an HIV test (N = 53)	1	1.9%
All inmates entering the facility may request an HIV test (N = 53)	14	26.4%
Inmates admitting to certain risk behaviors associated with HIV/AIDS are offered an HIV test (N = 53)	14	26.4%
Inmates with certain medical diagnoses or inmates who are exhibiting symptoms of certain medical conditions associated with HIV/AIDS are offered an HIV test (N = 53)	34	64.2%
HIV testing is not available for our inmates (N = 53)	9	17.0%

Table 11. *Conditions for HIV Testing Most Frequently Mentioned During Interviews*

Testing Condition	Number	Percent
HIV testing offered to all inmates (N = 54)	6	11.1%
HIV testing offered on request (N = 54)	23	42.6%
HIV testing if inmate admits to risk factors (N = 54)	14	25.9%
HIV testing if inmate is symptomatic (N = 54)	18	33.3%
HIV testing after altercation/exchange of fluids (N = 54)	16	29.6%
HIV testing if court ordered (N = 54)	18	33.3%

In the survey, the most frequently selected condition for HIV testing was "inmates with certain medical diagnoses or inmates who are exhibiting symptoms of certain medical conditions associated with HIV/AIDS are offered an HIV test." Over half of survey respondents selected this condition. The statement "all inmates entering the facility are offered a test" was selected by one jail only.

When interviewed, many jails reported that they offer HIV testing on request, but frequently qualified this answer. Many jails will not provide an HIV test to an inmate upon request unless the inmate also demonstrates signs of the illness, reports recent risk behaviors, or secures the approval of the jail physician.

Some jails, according to interview statements, have limited HIV testing policies and do not want to offer more testing. Some respondents expressed trepidation about offering HIV testing because of the rapid turnover in jails. These respondents feared that inmates would not receive their testing results or would not be able to establish follow-up care in the community on their own. In order to limit this problem, some respondents stressed the need for the rapid versions of HIV testing if they were to offer testing services to more inmates.

> "I'm not sure if any investment in testing would be worth it. If an inmate is only in for a couple of days they would have to get follow up care on the outside."
>
> -An Ohio FSJ Health Care Administrator

An even more frequently expressed concern about offering more testing uncovered by the interviews is that increased testing may yield an increased caseload of inmates with HIV/AIDS, which would strain the limited resources of jails. Informants predicted that more testing would require more medical staff to do the labs and more transport deputies to transport inmates to specialists. It would also, they said, significantly increase the strain on the jail's medications budget. Additionally, an increased number of

inmates with HIV/AIDS would also mean that jail staff (medical and non-medical) would need more training in HIV care and that jails would need to find more specialists and other HIV care providers in the community.

Another reason for hesitation regarding broader testing policies was the fear that newly diagnosed inmates would not adhere to their medication regimens upon release from jail. Some respondents noted that if an inmate's illness is relatively new, they will not have many of the symptoms that give some patients incentive to adhere to their medication regimens.

> "Typically HIV cases don't have early symptoms and that is part of the reason we don't test everyone that walks through the door. If we find a new case and start meds, their chance of med compliance after they leave the jail is very low because they don't feel sick."
>
> -A medical staff member from one of Ohio's FSJs

Despite the prevalence of these concerns, there were still many informants that indicated they would welcome testing services if a local health department, free clinic, AIDS Task Force, or other organization would offer them for free. Several jails that already receive testing services from community organizations and informants from such facilities expressed great satisfaction with the arrangement. There appears to be mixed feelings on the part of jail staff about whether the potential ramifications of increased HIV testing should be viewed as prohibitive.

Availability of Trained Medical Care Personnel

Jail Medical Personnel

Information on jail medical staffs was gathered through interview questions. The size, composition, and availability of jail medical staffs vary greatly across jails. In four jails, the medical staff consists solely of one doctor. At the other end of the spectrum, another facility's medical staff consists of 43 LPNs, 11 RNs, three mental health liaisons, one dental assistant, and a contract physician service.[11] The availability of medical staff members also varies; in some jails medical staff are available one day a week while in others medical staff are available at all times. Twenty-five of the jail medical staffs in the study are hired through the managed care company that provides medical care to the jail. Forty of the jail medical staffs are hired directly by the jail or its home county/municipality.[12]

Informants from over one-half of the jails reported that their medical staff is composed of a combination of doctors and nurses (RNs, LPNs, and a small number of CNPs). Almost one-third of the jails have other types of care providers on staff in addition to doctors, RNs, LPNs, and CNPs. These are typically psychiatrists, psychologists, dentists, and physician's assistants. Three jails are staffed by a doctor and paramedics, and four jails are staffed by jail physicians only.

Informants from fifteen of the interviewed jails (27.3 percent) reported that they provide around-the-clock medical care, with members of the medical staff at the jail 24 hours a day, seven days a week. In five of the interviewed jails (9.1 percent), members of the medical staff are at the jail for very limited hours. In two of these cases, there is one doctor who visits the jail one time a week. In three others, members of the medical staff are available for limited hours up to three days a week. Most informants reported that they have on-call systems to ensure that inmates are not denied urgently needed care. In jails that have limited medical staff hours, informants reported that corrections officers are responsible for identifying inmate medical problems, screening inmate requests for medical care, and notifying on-call medical staff.

During the interviews, many jail medical staff members expressed the desire to keep more current on the latest developments in HIV care. Several expressly asked for informational materials for jail medical and non-medical staff to keep them up to date. However, the survey data did not indicate this desire as strongly. When asked how well they do at staying current with developments in the treatment of HIV/AIDS, respondents from the surveyed jails gave themselves a mean score of 3.4 (where 3 = *average* and 4 = *good*). When asked how challenging it was for them to keep up to date with these developments, respondents from the surveyed jails

[11] This medical staff is shared between two jails.
[12] These managed- and non-managed care figures include both jails that participated in interviews and jails that completed surveys. The rest of this section is based on interview data only.

gave this task an average score of 3.2 (where 3 = *neutral* and 4 = *somewhat challenging*). Interview data suggests that it may be difficult for medical staff to secure the release time and funding required to pursue continuing education opportunities in HIV care.

Access to Specialists

Informants from 34 of the interviewed jails (61.8 percent) reported using infectious disease specialists when designing and monitoring inmates' HIV treatment. In 24 of these jails, the specialist has primary responsibility for the course of treatment. In ten of these jails, the jail medical staff consults with specialists as they design and monitor treatment. Some of this collaboration with specialists is done by telephone and fax, especially in areas where specialist care is scarce, but informants from over two-thirds of the jails reported that they do, or would be willing to, transport inmates to specialists if needed. Informants from two additional jails reported that they would transport an inmate but only if the inmate has a previously scheduled appointment. Informants from three jails specifically said that they would need to furlough an inmate so that the jail would not be responsible for the transportation and the cost of the appointment. Informants from two of the interviewed jails reported that they have arranged for specialists to come directly to the jail to treat inmates with HIV/AIDS.

Informants from over one-quarter of interviewed jails reported that *no* infectious disease specialists are involved in the design and treatment of an inmate's HIV care. In some cases, the informants stressed that the jail physician has experience in diagnosing and treating infectious diseases (though only one of the surveyed jails reported being able to offer genotype testing). In other cases, this policy seems to be less a result of the jail physician's expertise and more a result of a limited need for HIV specialists, which means the jail has had little cause to search out area specialists willing to see inmates. This could be because the jails have housed few or no inmates living with HIV/AIDS or because any inmates with the disease have passed through their facilities very quickly.

When asked what would make it easier for jails to provide their inmates with access to HIV specialists, the three most common responses were: jails need closer specialists, more doctors who are willing to allow inmates into their clinics, and more staff and funds for inmate transport.

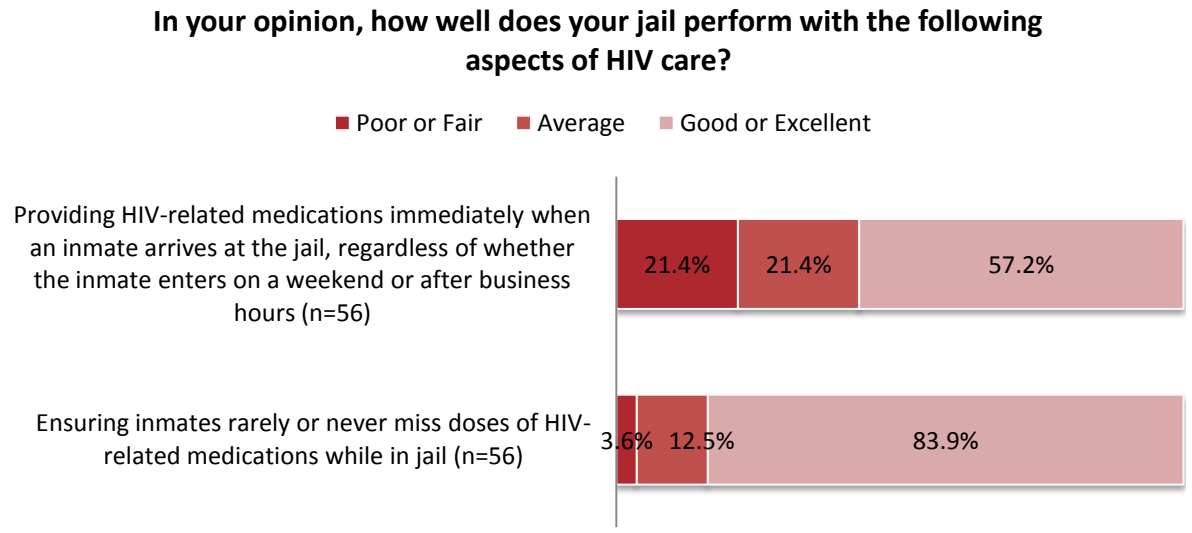
HIV Medications

Medications While in Jail

Interview and survey data revealed that obtaining medications is difficult, primarily because verification procedures require collaboration with private care providers who do not always respond to their queries in a timely fashion. Some jails also experience delays starting an inmate's medication because they need approval to administer a non-formulary medication or because they need to switch the inmate to an HIV medication on the jail's formulary. Nonetheless, on average, survey respondents perceive that jails do a *good* or *excellent* job at starting an inmate on his or her HIV medications quickly (see Table 4).

Interview informants and survey respondents reported an even greater degree of confidence in their ability to ensure that, once medication is obtained, inmates do not miss any doses. While the scholarly literature on HIV medication regimens stresses the difficulties of taking all doses at the prescribed times, many respondents/informants believed that the jail's highly controlled environment enabled them to keep inmates fully adherent to their medication regimens. Figure 3 provides more detailed information on respondents' perceptions regarding the ability to provide inmates with medications quickly and consistently.

Figure 3. *HIV Medications: Perceived Performance*



Obtaining Medications

Ohio's FSJs depend on inmates to supply their own HIV medications. When asked whether their facilities allow inmates to bring in their own medications, respondents from 54 of the surveyed jails (96.4 percent) replied affirmatively. There are few significant restrictions on the medications that may be brought into FSJs. Some jails have policies in place which do not allow liquid medications or intravenous medications to enter the facility. Policies at several jails do not allow narcotics to enter the facility. Less than 10 percent of survey respondents reported that non-formulary medications were not permitted to be brought into their facilities. The most common requirements for allowing medication into the jail are: medications must be in a pharmacy-provided container, medications must be those listed on the container label, and the prescription must be current.

When inmates cannot provide their own medications (or when their supply of medications runs out while they are still in jail), jails have a variety of procedures for obtaining medications for inmates. Jail medical staff typically verifies the inmate's prescription first. This may involve obtaining a signed release from the inmate and contacting the inmate's prescriber to ask for medical records. Informants from eight of the interviewed jails (14.5 percent) reported that the medical staff must obtain permission from the jail physician before ordering medications. Informants from two of the interviewed jails (3.6 percent) reported having to request permission from their managed care organization before ordering. An informant from one jail (1.8 percent) reported that the nursing staff will call the pharmacy to find out the cost of the medications, and then contact the local judge to ask if the jail should order the medications or if other arrangements should be made for the inmate.

Once the medical staff establishes that the prescription is valid and the medications should be obtained, some jails directly order from a local pharmacy, others order from their managed care company or a contracted supplier, and a handful of jails (roughly 15.0 percent) obtain medications from AIDS Task Forces or other community organizations. Informants from four of the interviewed jails (7.3 percent) reported having their own pharmacy from which to obtain medications. Informants from a few jails mentioned contacting pharmaceutical companies to ask about free or discounted medications.

Several jails combine these and other methods to seek out the quickest and most economical means of obtaining an inmate's medications. The source of an inmate's medications may change over the course of his or her stay in jail. An inmate may begin providing his or her own medications but run out, after which the jail might obtain the medications until it can get them through a community provider. An informant from one jail that obtains medications through a community provider described that the jail will wait until the organization begins supplying the medications and does not obtain medications for the inmate in the interim.

When asked how long it typically takes to obtain HIV-related medications for inmates, the interview informants gave a variety of answers, many of which were qualified. Most commonly, jails said that the time period they reported for obtaining HIV-related medications would be accurate so long as the prescription had already been verified, the inmate arrived on a weekday, and the pharmacy had the medications in stock.

- Informants from 30 jails reported that it takes up to 24 hours to obtain medications; 11 informants placed conditions on this answer.
- Informants from 5 jails reported that it takes up to 48 hours to obtain medications; 1 informant placed conditions on this answer.
- Informants from 4 jails reported that it takes up to 72 hours to obtain medications; 2 informants placed conditions on this answer.
- Informants from 5 jails reported that the time needed to obtain medications varies.
- An informant from 1 jail reported that it may take "weeks" to obtain an inmate's medications.
- In at least 9 of the interviewed jails, it was apparent that it may sometimes take more than 72 hours to obtain an inmate's medications.

Approximately one-third of the informants from the interviewed jails said that if an inmate's medications are very costly, the cost of their care might affect the length of time the inmate stays in the facility. Informants giving this answer were careful to emphasize that this decision is up to the court system and typically depends on the severity of the charge against the inmate. The remaining informants answering the interview question on this subject stressed that the cost of medications has not and does not affect how long an inmate stays in their facility.

Medication Administration

The vast majority of informants from interviewed jails reported that medications are always passed directly to inmates (either in the cell blocks/pods or in the medical area) and that inmates must be directly observed while taking them. Informants from three jails reported that inmates are allowed to keep HIV medications on their person under any conditions. Medications are administered by the medical staff in roughly half the jails, while in the other half medications are administered by corrections officers.

Medications at Release or Transfer

There is no single trend in Ohio's FSJs when it comes to providing release medications to inmates with HIV/AIDS. Almost one-half of the respondents from the surveyed jails reported that they provide a temporary supply of medications to inmates when leaving the jail. This

number may be slightly inflated because a few jails seemed to include in their definition of release medications any of the *inmate-supplied* medications that the jail releases to the inmate or any prescription they provide to an inmate as the inmate leaves their facility.

The interview informants who reported that they do not provide release medications gave several reasons for this practice. Among the most frequent were budget limitations and concerns about liability (several jails said they were not licensed to dispense medications outside the jail). Other informants reported that they simply do not have enough time to prepare release medications because inmates are often released with little warning. A small number of informants said that they do not have any prescribers who are willing to prescribe release medications.

Almost all of the informants from the interviewed jails reported that they do not send medications with inmates when they are transferred to prison. Many respondents said that prisons will not accept any medications except for nitroglycerin and inhalers. To ensure continuity of medical care, most informants reported that they pass on an inmate's medical information to the receiving facility. Informants typically do this by sending information with the inmate and transport deputy or by faxing the inmate's medical information to the receiving facility. A small number of informants reported that they might call ahead to a receiving facility in the case of inmates living with HIV/AIDS. One informant reported that the jail may or may not forward medical information to the receiving prison.

Medication Interruptions

Survey respondents reported confidence that interruptions in HIV medication regimes in their facilities are minimal. Respondents from the surveyed jails gave themselves a mean score of 4.2 (where 4 = *good* and 5 = *excellent*) when asked to rate how well they do at "ensuring that inmates rarely or never miss doses of HIV related medications while in jail." This was the highest score they gave to any item in that question (see Table 4). They gave a mean score of 2.6 (where 2 = *not very challenging* and 3 = *neutral*) when asked to indicate the degree of challenge posed by ensuring that inmates do not miss medication doses. This was the lowest score given to any item in that question (see Table 6). A total of 12.7 percent of interview respondents reported that there are never any missed doses of HIV medication in their facilities. Despite the widely reported complexity of HIV medication regimens and the difficulty that many patients report with adhering to them, respondents from Ohio's FSJs appear to have a high degree of confidence in their ability to administer HIV medications with very few missed doses. When missed doses do occur, respondents from most jails perceive the inmate to be responsible. Table 12 presents the survey responses to a question about the cause of missed doses.

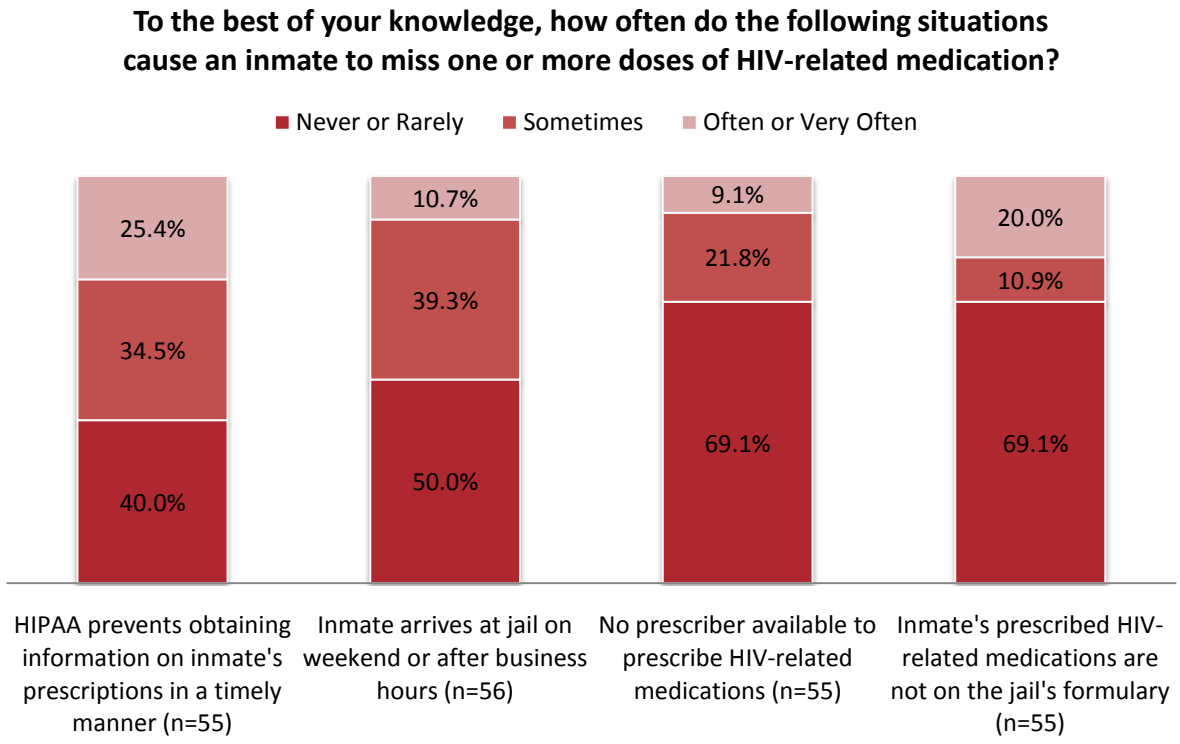
Table 12. *HIV Medications: Factors Contributing to Missed Doses*

Note. Higher mean scores indicate greater perceived frequency (1 = *never*; 2 = *rarely*; 3 = *sometimes*; 4 = *often*; 5 = *very often*).

To the best of your knowledge, how often do the following situations cause an inmate to miss one or more doses of HIV-related medication?	*M*	*SD*
Inmate refuses medication	2.8	0.9
HIPAA prevents obtaining information on inmate's prescriptions in a timely manner	2.7	1.2
Inmate arrives at jail on weekend or after business hours	2.6	0.9
Inmate is transferred between jail and prison	2.6	0.9
Inmate is transferred between jails	2.5	0.9
Inmate cannot be depended upon to take medications at correct times	2.2	1.1
Inmate's prescribed HIV-related medications are not on the jail's formulary	2.1	1.4
Inmate is away from jail for court hearing or other approved activity	2.1	0.9
No prescriber available to prescribe HIV-related medications	2.0	1.0
Staff not able to monitor all doses of medications	1.5	0.9

As an inmate enters the facility. Several of the causes of missed doses listed in Table 12 that received the highest average scores pertain to the period of time immediately after an inmate's arrival at the jail. In particular, delays in prescription verification caused by HIPAA regulations (or inaccurate understandings of HIPAA regulations) were, on average, perceived to be the second most frequently occurring cause of missed doses. One-quarter of respondents reported that if a missed dose occurs, verification delays caused by HIPAA are *often* or *very often* the reason. Another potential cause of missed doses in the time period immediately after an inmate's arrival occurs when an inmate's prescribed medications are not on the jail formulary. Roughly 20 percent of the survey respondents reported that this is *often* or *very often* a factor behind a missed dose. Figure 4 provides additional data on potential causes of missed doses that take place as an inmate enters the jail.

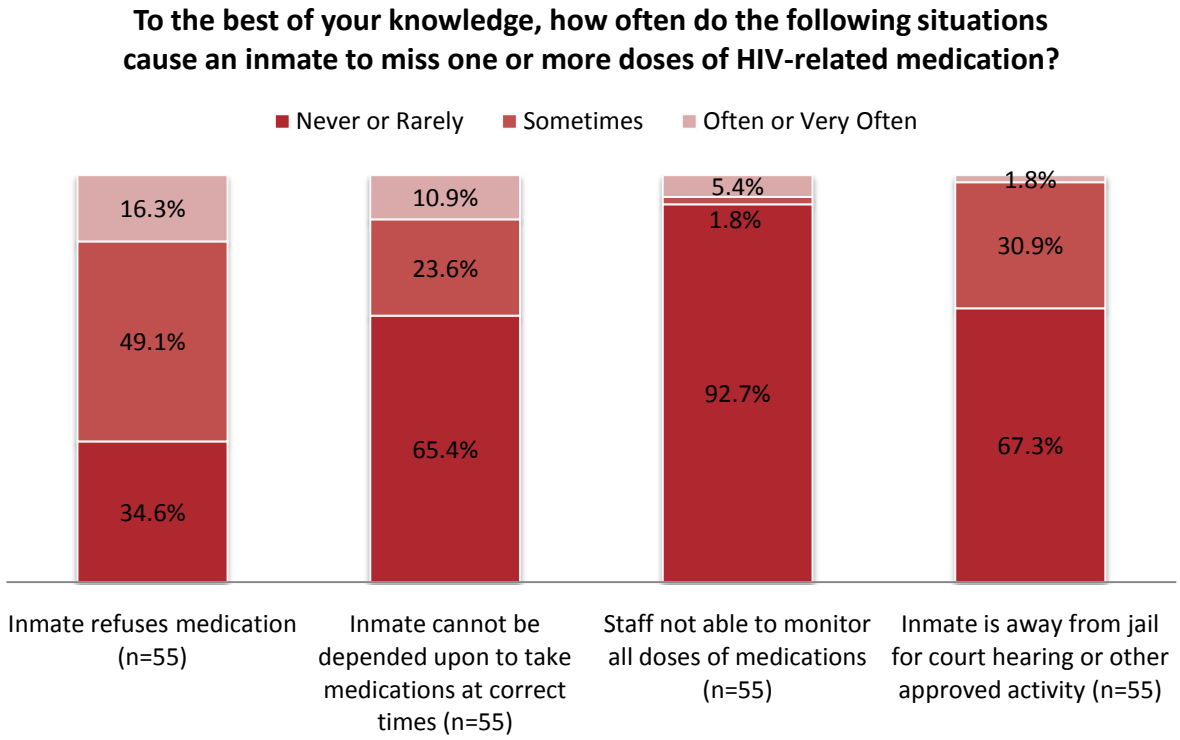
Figure 4. *HIV Medications: Potential Causes of Missed Doses As Inmate Arrives at the Jail*



After an inmate's medications have been obtained. Once an inmate's medications have been obtained, the primary reported cause of missed doses is inmate refusal. (This was the most commonly reported cause out of all the categories.) Almost two-thirds of survey respondents perceive that if a missed dose occurs, inmate refusal is *sometimes*, *often*, or *very often* the reason. This was also the case with interview informants, over one-half of whom cited inmate refusal as a cause of missed doses. Interview informants specified that refusal most often occurred at the morning medication pass, when inmates refused to wake up.

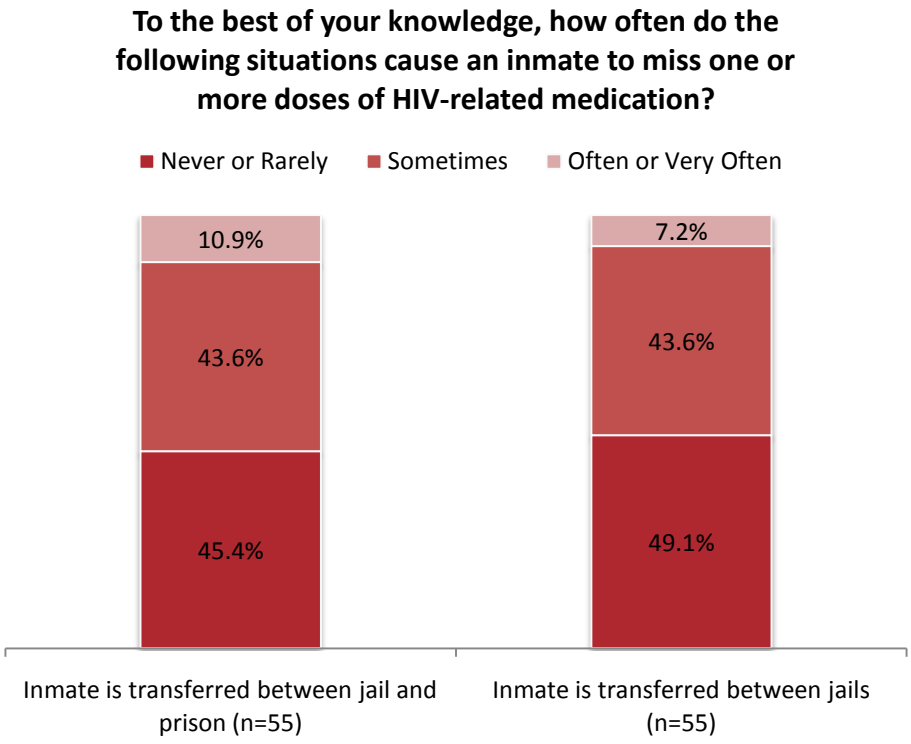
Both survey and interview data make clear that jails do *not* perceive staff inability to monitor doses of medication to be a factor behind any missed doses. A total of 92.7 percent of survey respondents reported that this is *rarely* or *never* the cause of a missed dose. Less than ten percent of interview informants cited any sort of jail error as a reason for missed doses. Figure 5 provides additional information on potential causes of missed doses that occur once an inmate's medications have been obtained.

Figure 5. *HIV Medications: Potential Causes of Missed Doses After an Inmate's Medications Have Been Obtained*



As an inmate leaves the facility. Over one-half of the survey respondents reported that an inmate's transfer to another jail or to prison may be the reason for a medication interruption *sometimes*, *often*, or *very often*. In addition, the fact that less than one-half of survey respondents reported providing release medications makes it likely that an inmate's release may occasion missed doses as well. Figure 6 provides additional data on two of the potential causes of missed doses that take place as an inmate leaves the jail.

Figure 6. *HIV Medications: Potential Causes of Missed Doses as an Inmate Leaves the Facility*



Overall causes of missed doses. While survey respondents perceive inmate refusal to be the most common cause of medication interruptions, four of the top five factors contributing to missed doses listed in Table 12 occur as an inmate enters or exits the facility. This suggests that times of transition, specifically intake and release or transfer, may make missed doses more likely. At intake, the difficulties seem mostly to be related to prescription verification. At release or transfer, the likelihood of missed doses seems to be related to the fact that over half of jails do not provide release medications and that prisons do not accept transfer medications. Overall, once medications are obtained and while an inmate is still in the facility, jail staff perceive that they provide the environment needed for inmates to remain adherent to their medication regimens as long as they wish to do so.

Non-Medical HIV Care

The literature on HIV care stresses that adherence to difficult medication regimens is significantly improved when patients are educated about HIV/AIDS, understand why their medications are necessary, and have assistance with substance abuse problems, mental illnesses, and other internal barriers to adherence. This section of the report addresses the forms of non-medical care provided by FSJs and community organizations to inmates living with HIV/AIDS.

> "Inmates on complicated antiretroviral regimens must also be provided with access to information and instruction about their medications. They must be provided with counseling, reminders, and other tools to assure timely, consistent medication adherence."
>
> --Linda Frank, *Journal of the Association of Nurses in AIDS Care*, (1999)

Survey respondents and interview informants reported little confidence in their ability to provide non-medical HIV care. The majority of non-medical services offered to inmates with HIV/AIDS are provided by community-based organizations. It is important to note that most non-medical services are not specifically tailored to persons living with HIV/AIDS. When asked how well their jails performed with "providing counseling, education, or other types of non-medical services to inmates with HIV/AIDS," the survey respondents gave themselves an average score of 3.2 (where 3 = *average* and 4 = *good*). Out of the nine components of HIV care listed in that question, this item received a lower score than most, with only two items receiving a lower average rating - identifying undiagnosed cases of HIV/AIDS and ensuring continuity of HIV/AIDS care post-release (see Table 4). When asked how challenging it is to provide "counseling, education, or other types of non-medical treatment," the survey respondents gave the HIV care component an average score of 3.1 (where 3 = *neutral* and 4 = *somewhat challenging*) (see Table 6).

Mental Health Care

It became apparent during the course of the interviews with participating jails that mental health care is a priority for many Ohio FSJs. Many informants are facing what they termed "a mental health crisis." A total of 83.6 percent of informants from the interviewed jails reported that their inmates have access to mental health care; however, it should be noted that the types of mental health care offered by jails vary widely. In some facilities, mental health care services consist of a combination of jail-provided services (psychologists and counselors) and extensive relationships with local behavioral health organizations. In other jails, mental health care consists solely of the correctional staff's willingness to call a crisis hotline if an inmate appears to be in particular distress.

HIV Education

HIV education is typically designed to reduce the transmission of HIV/AIDS in the community after inmates' release by increasing inmates' knowledge of the illness and its means of transmission as well as influencing inmates' attitudes toward HIV/AIDS prevention. Some studies suggest that HIV education is more effective when peer-led (Baxter, 1991). Fifteen percent of the interviewed jails reported that their inmates have access to some type of formal HIV education programs. HIV education is typically provided by members of the jail medical staff on an *ad hoc* basis. Many interview informants would like to have more educational materials to distribute to inmates, particularly those who are newly diagnosed. Some informants reported that their local health departments provide HIV education.

Case Management

Case management services or "the coordination of care across a system of service providers to meet the needs of a particular client or client group," help an inmate with HIV/AIDS to secure both medical and non-medical treatment services from a variety of providers (Fleisher & Henrickson, 2002). Sixteen percent of the informants from the interviewed jails reported that their inmates have access to case management services. Most jails are unable to provide these services themselves. Instead, the vast majority of jails that link inmates with case management draws on community providers for this service.

Other Non-Medical Care

In addition to mental health care, HIV education, and case management, jails may also link their inmates with substance abuse counseling, pastoral care, and other elements of non-medical care. Forty-three percent of respondents from the surveyed jails reported that they draw on community organizations to provide these types of non-medical HIV care. When asked what non-medical care is provided *directly* by the jails, slightly more than ten percent of interview informants reported providing substance abuse treatment, and many jails reported allowing clergy into jails to provide counseling. It should be noted that in most cases, these elements of non-medical care are general services, not services specifically tailored to the circumstances of an inmate with HIV/AIDS.

HIV Policies and Other Aspects of HIV Care

Housing Policies for Inmates with HIV/AIDS

Informants from almost all of the interviewed jails reported that their policy is to house inmates known to have HIV/AIDS in the jail's general population. Only two informants (3.6 percent) reported automatically segregating inmates with HIV/AIDS. One-fifth of those interviewed reported that inmates may request segregation or that an inmate's housing policy is decided on a case by case basis. Typically, an inmate living with HIV/AIDS is placed in jail's general population unless he or she has open wounds, is especially susceptible to infections, or is known to have behavioral problems.

Transfer of Inmates with HIV/AIDS

Slightly more than 10 percent of the informants from the interviewed jails indicated that their transfer policy may take into account an inmate's HIV serostatus. One informant mentioned that the jail doctor might recommend transfer so that an inmate could obtain more intensive medical care than could be provided at the jail. Informants from other jails reported that if an inmate from another county has HIV/AIDS, they might transfer the inmate back to their home county for care. Still others said they would not accept the transfer of an inmate they know had HIV/AIDS. As far as transfer procedures are concerned, one informant reported that transport deputies are told if an inmate has a "blood-borne disorder," though no more details are provided. In general, however, the transfer policies and procedures in Ohio's FSJs do not appear to be affected by inmates' HIV serostatus.

Disclosure of an Inmate's HIV Serostatus

Voinovich School staff asked interview informants about their jail's policies regarding the confidentiality of an inmate's HIV serostatus. Informants from more than one-half of the interviewed jails (58.2 percent) indicated that no one outside the jail medical staff is told that an inmate has HIV or AIDS.[13] Many of these informants stressed that medical and non-medical staff alike is urged to "treat everyone as if they have everything," so there is no need to disclose health information about inmates. However, it should be noted that in some of these jails, medical staff said they might tell non-medical staff members working with an inmate living with HIV/AIDS if the inmate has pronounced behavioral problems.

[13] In two of these cases, jail medical staff will tell a contact at the local health department so that HIV care can be coordinated for the inmate.

Over one-quarter of the interview informants reported that medical staff tell at least one member of the non-medical staff when one of the facility's inmates has HIV/AIDS. Five of these jails reported telling the head of the jail only. In the remaining jails, non-medical staff is either told directly or have access to medical records or other indicators of an inmate's HIV serostatus. No jail reported allowing other inmates to know if a fellow inmate has HIV/AIDS.

> "We utilize universal precautions and don't know the status of 95 percent of the population here. Officers don't usually like that and would like to know [inmates' HIV] status. But we tell them that someone you *do* know is HIV-positive is no more contagious than someone you *don't* know is HIV-positive. Always treat them the same and put your gloves on."
>
> -A medical staff member from one of Ohio's FSJs

Regardless of a jail's official policy, many interview informants stressed that it is extremely difficult to preserve the confidentiality of inmates' health information in the jail setting. To disclose their HIV serostatus when they are being admitted to the jail frequently requires telling the member of the non-medical staff who is conducting the intake screening. Moreover, these screenings are often conducted in settings that make it difficult to avoid being overheard by others. Many informants reported that at least one corrections officer is present during any interaction between medical staff and inmates. This means that even when inmates disclose their HIV serostatus to a member of the medical staff in the jail's medical area, at least one member of the non-medical staff is always privy to the information. The fact that corrections officers administer medications in many jails also creates an opportunity for non-medical staff to learn about an inmate's HIV serostatus. The frequency with which inmates living with HIV/AIDS have to take medications can also indicate an inmate's HIV serostatus to corrections officers as well as other inmates.

> "The Corrections Officers are well-taught. They know how to handle inmates with HIV and don't mistreat, stigmatize them, or overreact to their HIV status."
>
> -A medical staff member from one of Ohio's FSJs

In addition to unavoidable or inadvertent disclosure of an inmate's HIV serostatus, many interview informants said that inmates often willingly disclose their HIV serostatus, though these statements were balanced by anecdotes about inmates who were very hesitant to reveal their HIV serostatus.

HIV Awareness and Training of Non-Medical Staff

Informants from over 70 percent of the interviewed jails reported that their non-medical staff members had received some type of HIV training or, at minimum, training in universal precautions and blood borne pathogens. This education is typically provided to corrections officers during their initial training and is also often provided to new jail hires by the medical staff. Informants from 23 of the interviewed jails indicated that they would be interested in more training of this nature for their non-medical staff members.

Many of the interview informants commended their jails' non-medical staff on their professionalism and their attitude toward inmates with HIV/AIDS. However, some informants volunteered that they would welcome more training and education for their facility's non-medical staff to ensure that these employees are not alarmed by the presence of inmates with HIV/AIDS and do not purposefully or unwittingly stigmatize the inmates.

Release Care for Inmates with HIV/AIDS

Advocates of release planning stress that released inmates face a variety of obstacles they must overcome before being able to access medical HIV care. These may include finding transportation and housing, reapplying for insurance or other health benefits, and obtaining the necessary documentation to establish with a medical care provider (Fontana & Beckerman, 1997; Frank, 1997; Lanier & Paoline, 2005). The variety of needs that must be met upon release may be quite daunting, both for the inmate and for the providers trying to ensure that the inmate's medical care continues after release.

Survey responses strongly suggest that jails perceive release care to be an area of considerable weakness. When asked whether they agree with the statement, "Adequate release planning is provided to inmates with HIV/AIDS," the survey respondents provided a mean response of 3.02 (where 3 = *neutral*). This was the lowest mean score for any of the listed statements included in that item (see Table 8). When asked how well their facilities did at "ensuring that inmates' HIV care continues after they are released from the jail," the survey respondents provided a mean response of 2.75 (where 2 = *fair* and 3 = *average*), which was also one of the lowest mean scores for any item that was assessed (see Table 4). When asked about the degree of difficulty posed by various elements of HIV care, the survey respondents ranked "ensuring that inmate's medical HIV care continues after they are released from the jail" as the most challenging, on average, with a mean score of 3.83 (where 3 = *neutral* and 4 = *somewhat challenging*) (see Table 6). Table 13 provides an overview of the elements of release care provided by FSJs.

Table 13. *Elements of Release Care Provided by Jails*

Elements of Release Care	Percent of Interviewed Jails	Percent of Surveyed Jails
Case management services (provided by the jail)	1.8%	*
Case management services (provided by community organizations)	16.4%	*
Release planning (provided by community organizations)	10.9%	35.2%
Release medications	54.5%	48.2%

* The survey instrument did not solicit this information.

Release Medications

Roughly one-half of the informants from the interviewed jails reported that they provide release medications, making it the most frequently provided element of release care. The amount of release medications provided varied. Table 14 summarizes the interview data gathered on release medications.

Table 14. *Release Planning: Amount of Release Medications Provided to Inmates*

Amount of Release Medication	Number	Percent of Jails Providing Release Medications	Percent of All Interviewed Jails
3 days or less	6	20.0%	10.9%
4-5 days	4	13.3%	7.3%
14 days	2	6.7%	3.6%
Up to 30 days	1	3.3%	1.8%
Remaining supply	11	36.7%	20.0%
Varies	6	20.0%	10.9%
Total	**30**	**100.0%**	**54.5%**

Ryan White Program Funds

Less than one-half of the interview informants were aware of the potential to access Ryan White Program funds for inmate release care. When asked about the funding source, most informants responded by indicating that they would like to receive more information about the program. Table 15 provides specific information about the interview responses.

Table 15. *Release Planning: Ryan White Program Funds*

Have you accessed Ryan White Program funds for release care?	Number	Percent
Yes	1	2.0%
We have tried unsuccessfully to obtain Ryan White Program funds	1	2.0%
We are aware of the funding source but have not attempted to access it	22	43.1%
We are unaware of the funding source	27	52.9%
Total	**51**	**100.0%**

Follow-Up Care

Only a small number of jails provided formal case management services that assisted with making follow-up appointments with medical and non-medical care providers. When follow-up care was arranged for inmates, it was typically conducted informally. Almost one-third of informants from the interviewed jails reported that they will make appointments for inmates leaving their facilities. This is not necessarily done automatically; in many of these cases the inmate must request this assistance or the jail staff does this only if inmates do not have family to make appointments for them. Roughly 20 percent of the informants said they will advise departing inmates of any already scheduled appointments, though they will not necessarily make new appointments for inmates. In addition to these limited services, some jails provide wallet-sized cards with information on emergency housing, organizations that may provide a small supply of medications, and other community resources.

"It's all about self-care…it's [the inmate's] responsibility to follow up."

-A medical staff member from one of Ohio's FSJs

Almost one-third of informants from the interviewed jails stated explicitly that they provided no elements of release planning or care for their inmates. While jails reported that release care is a significant area of weakness, it should be noted that not all jails view it as their responsibility to provide extensive assistance to inmates departing their facilities. Some interview informants were adamant that inmates should be responsible for their own follow-up care; otherwise, they reported that there is little hope that they will remain adherent with their medications and other care after release. Some informants said that if inmates are not willing to make their own appointments, they are also unlikely to keep any appointments the jail staff make for them. Even several of the jails that do make follow-up appointments for inmates expressed concern that many released inmates do not keep these appointments.

Impediments to Release Planning

The elements of release care suggested in the academic and advocacy literature are far different from the elements of release care that most Ohio FSJs are able or willing to provide. Some potential reasons for this include:

- The short duration of stay for many FSJ inmates makes it difficult to identify those inmates who will be in the jail long enough to establish meaningful working relationships with social workers, case managers, and/or AIDS Task Forces.
- Jail inmates are often released with little or no notice, and it is difficult to schedule follow-up appointments in the community when the release date is unknown.
- Inmates are released at irregular hours. Medical staff may arrive at work in the morning to find that an inmate living with HIV/AIDS has been released overnight. This makes it difficult to provide inmates with release medications and with the documentation they will need to establish with medical care providers.
- Jails find it very difficult to afford HIV release medications.
- Some jails are located in areas with very few community resources, which complicates efforts to connect inmates to follow-up care.
- Some interview informants reported that the responsibility for follow-up care lies with exclusively with the inmate.
- Some interview informants suggested that the inmates they see are unlikely to adhere to HIV care regimens once they are released. Several medical staff members reported that they call their local clinics to advise them that inmates are being released and may not keep their appointments. This perception may make some jails less likely to pursue release care for their inmates.

> "I think it's very difficult for inmates to keep appointments with their outside providers."
>
> -A medical staff member from one of Ohio's FSJs

Jails' Linkages with their Communities

There is no single trend regarding FSJs and the degree to which they have established partnerships with community providers of HIV care. At one end of the spectrum, some interview informants that there are no organizations in their area that provide HIV care services. Nearly 15 percent of informants from the interviewed jails reported that they draw on no community resources to provide HIV care to their inmates and do not transport inmates with HIV/AIDS to specialists; almost 20 percent reported that they do not draw on community resources to provide HIV care, with the exception of transporting inmates to specialists. Some informants reported that there are local organizations that could provide HIV care services, but that they have not formed a partnership with them. A handful of jails appear to have established extensive community networks that increase the quality and array of services provided to their inmates with HIV/AIDS.

Some of this variation may simply be due to the relative availability of community providers of HIV care as well as differing levels of awareness on the part of jails regarding the resources available in their communities. In general, the jails that see the most cases of HIV/AIDS seem to have more incentive to seek out HIV-related assistance in the community. They also seem more likely to be situated in areas that have larger numbers of community HIV care providers.

While the degree to which jails draw on community organizations for assistance with HIV care varies greatly, on average, Ohio's FSJs would like to have more partnerships with local providers of HIV care.[14] The survey respondents gave the statement, "We would like local organizations to be involved in providing care for inmates with HIV" a mean score of 3.6 (where 3 = *neutral* and 4 = *agree*; see Table 8). While not expressing extreme agreement, this was nonetheless the highest mean score for any statement in that survey question.

Tables 16 and 17 summarize the information gathered via survey and interview about the community resources used by jails to provide HIV care to inmates.

[14] See Appendix E for a listing of the community organizations mentioned during the interviews.

Table 16. *Community Linkage: Community Organizations Providing HIV Care Services to Jails*

Note. Some jails receive services from more than one community organization and therefore percentages may sum to more than 100%.

Organization	Survey		Interview	
	Number	Percent	Number	Percent
Health Department	23	41.1	18	32.7
Mental Health Organization	*	*	17	30.9
AIDS Task Force	6	10.7	4	7.3
Other	17	30.4	9	16.4
No local organizations	15	26.8	8	14.5

* The survey did not ask specifically about mental health organizations.

Table 17. *Community Linkage: Specific HIV Care Services Provided by Community Organizations*

Note. Some jails receive services from more than one community organization and therefore percentages may sum to more than 100%.

HIV care service	Survey		Interview	
	Number	Percent	Number	Percent
HIV testing	16	29.6	14	25.5
Education	*	*	8	14.5
Mental health care	*	*	23	41.8
Non-medical care such as counseling or substance abuse treatment	23	42.6	**	**
Medications while in jail	8	14.8	10	18.2
Release medications	3	5.6	3	5.5
Case management	*	*	9	16.4
Release planning	19	35.2	6	10.9
No HIV care is provided by community organizations	16	29.6	8	14.5

* The survey did not ask about this component.

**The interview did not ask about this component.

Medical HIV Care

Over one-quarter of the participating jails reported using community organizations for HIV testing services. These services vary from the occasional HIV test to systematic testing of all willing inmates. Testing services are frequently provided by health departments, but also by medical clinics, AIDS task forces, and substance abuse treatment centers. A small number of informants from interviewed jails mentioned that community-based organizations provided the rapid HIV test, and several mentioned that organizations that provide testing also provide HIV education in tandem with that service.

Once an inmate has been identified as having HIV/AIDS, most jails reported that they use local specialists to design and monitor the inmate's course of treatment. Informants from thirty-four of the interviewed jails (61.8 percent) reported that community infectious disease specialists design and monitor inmates' treatment or collaborate with jail physicians in the designing and monitoring of inmates' treatment. Informants from over two-thirds of interviewed jails reported that they *can* or *do* transport inmates directly to the specialist. The survey had no directly comparable question, but 24 of the surveyed respondents (42.9 percent) reported using local hospitals for HIV care for their inmates.

A small number of jails also draw on community organizations to obtain HIV medications for their inmates while they are in jail. Respondents from eight of the surveyed jails (14.8 percent) and informants from 10 of the interviewed jails (18.2 percent) reported receiving HIV medications from community sources. However, it should be noted that these organizations may not provide inmates with a supply of medications for the duration of their incarceration. Some of the informants reported that community organizations may provide only a temporary supply or only provide medications for inmates who are already established clients. In one of the jails reporting this practice, the informant indicated that medications had actually only been provided by a community organization once and this was for an inmate who was a client of an out-of-area AIDS Task Force.

Non-Medical HIV Care

Respondents from 23 of the surveyed jails (42.6 percent) reported that they draw on community resources for non-medical aspects of HIV care such as counseling. The interviews yielded more detailed information on the types of non-medical care that jails access in their communities. Jails typically use community resources for mental health care and HIV education for inmates and sometimes for HIV education for jail staff. A small number of jails draw on community organizations to provide case management services to their inmates. Furthermore, many of the interviewed jails permit clergy and substance abuse counselors into their facilities to provide care to inmates. It should be stressed that most of the non-medical services available to

inmates with HIV/AIDS are not directly targeted at persons with HIV/AIDS, but rather are general services available to all inmates.

Release Care

According to the respondents from the surveyed jails, release planning is a significant area of weakness for most facilities (see the "Release Planning" section of this report for more information). This is reflected by the relatively small number of community organizations used by jails to help with inmates' release planning. When jails do utilize community resources for release planning, the most frequently used community organizations are local health departments and AIDS Task Forces.

Impediments to Community Linkages

Interviewed jails expressed varying degrees of willingness to allow outside organizations into their facilities to provide HIV care services. Some informants stressed that allowing outside organizations into jails is difficult because of the background checks and security screenings mandated by some jails for all persons coming into contact with inmates. Others remarked on the very temporary nature of many inmates' stays at their jails, saying that many inmates may be gone by the time the jail links the inmate with HIV care services. Still others thought that inmates who are living with HIV/AIDS are frequently already established in the community and so already know about the resources available to them. Informants also stressed that they simply see very few inmates living with HIV/AIDS, and so have not expended the effort to seek out community linkages.

Jails may also be situated in areas with few or no community providers of HIV care. Many interview informants said they would love to have assistance from the community but that none is available. Some also said that funding cuts to community organizations had caused several providers of HIV care to stop offering services to jails. In other cases, it seemed that jails were unaware of the community services available to them. In preparation for the interviews, Voinovich School staff contacted all of the Ryan White Consortia coordinators to ask about the HIV care services available to jails in their area. Given the information provided by consortia coordinators, it became apparent during the interviews that some jails simply did not know about all of their community's HIV care resources.

Finally, staff turnover (both in jails and in community organizations) may hinder community linkages. Interview information suggests that some relationships between jails and community organizations are informal and dependent upon personal contacts. If that personal

contact leaves the employment of the jail, the relationship with that community organization can be lost.

Incentives for Community Linkages

Despite these formidable barriers, most jails would like community organizations to be involved in HIV care for their inmates. Only two survey respondents (3.6 percent) disagreed with the statement "we would like community organizations to be more involved in providing care for inmates with HIV." Many interview informants remarked that community resources could help them provide services that they could not currently afford to provide. Other informants said that community organizations are more aware of local HIV programming and could link jails to a larger array of services. In particular, several interview informants reported that they would like to access community-provided HIV testing and HIV education services.

> "We'd love to have access to anything we can get."
>
> -A medical staff member from one of Ohio's FSJs

HIV Care in Managed Care and Non-Managed Care Jails

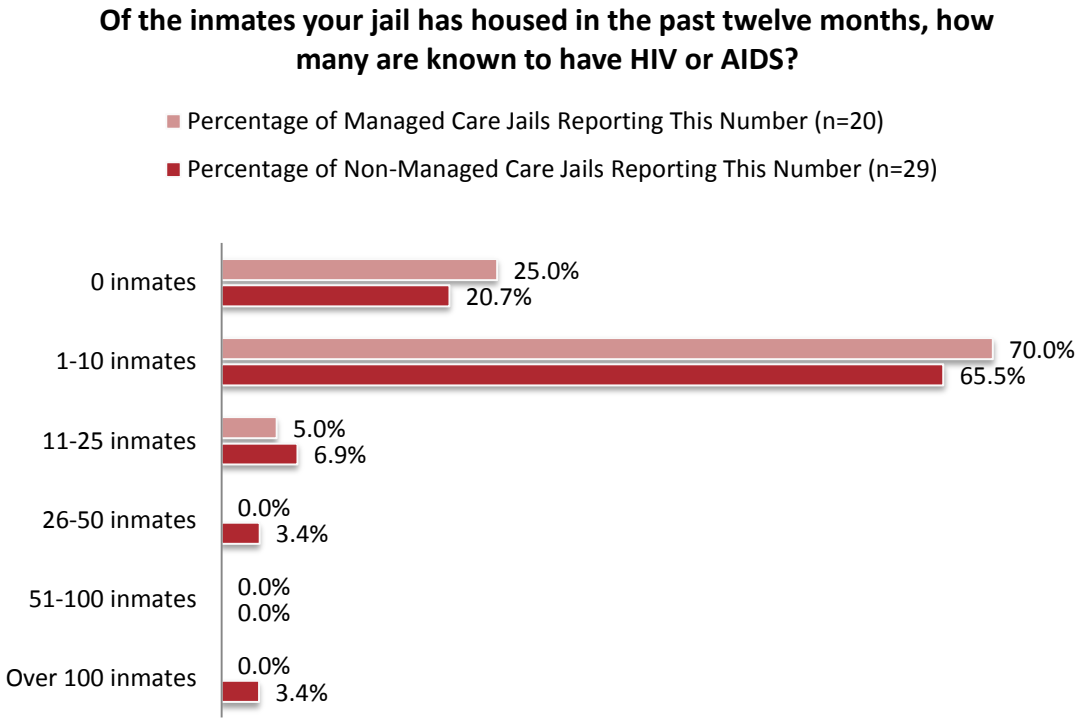
The following section offers a comparison between jails whose inmate health care is provided by managed care companies and jails that provide their own inmate health care. *Managed care jail* refers to any jail that hires a managed care organization to provide health care to its inmates. A total of 20 managed care and 32 non-managed care jails participated in the study. As no tests of statistical significance were performed, care should be taken when interpreting the figures provided in this section. The data should be seen as signaling *possible* similarities and differences between managed care and non-managed care jails as they care for inmates with HIV/AIDS.

HIV Statistics

Managed care jails, on average, housed a slightly higher number of inmates than non-managed care jails in the last year. The average number of inmates housed by managed care jails in the last year was 8,052 while the average for non-managed care jails was 7,357. Despite the higher number of inmates, managed care jails reported housing a slightly lower number of inmates known to be HIV-infected in the last year. For managed care jails, the average number of inmates known to be living with HIV/AIDS in the last year is estimated to range between 2-5 inmates.[15] For non-managed care jails the average number of inmates known to be living with HIV/AIDS in the last year is estimated to range between 9-11 inmates.[16,17] Figure 7 provides more specific data for the two categories of jails. The numbers and percentages represent combined data from the interview and survey.

[15] $N = 20$
[16] $N = 30$
[17] The average number of inmates known to have HIV/AIDS is given in the form of a range because the survey data were collected in the form of ranges. In the case of the non-managed care jail reporting *over 100* inmates with HIV/AIDS, the interview data from the jail were used to obtain the exact number in order to calculate the average.

Figure 7. *Comparison of Managed Care and Non-Managed Care Jails: Number of Inmates Known to Have HIV/AIDS Housed in the Last Year*

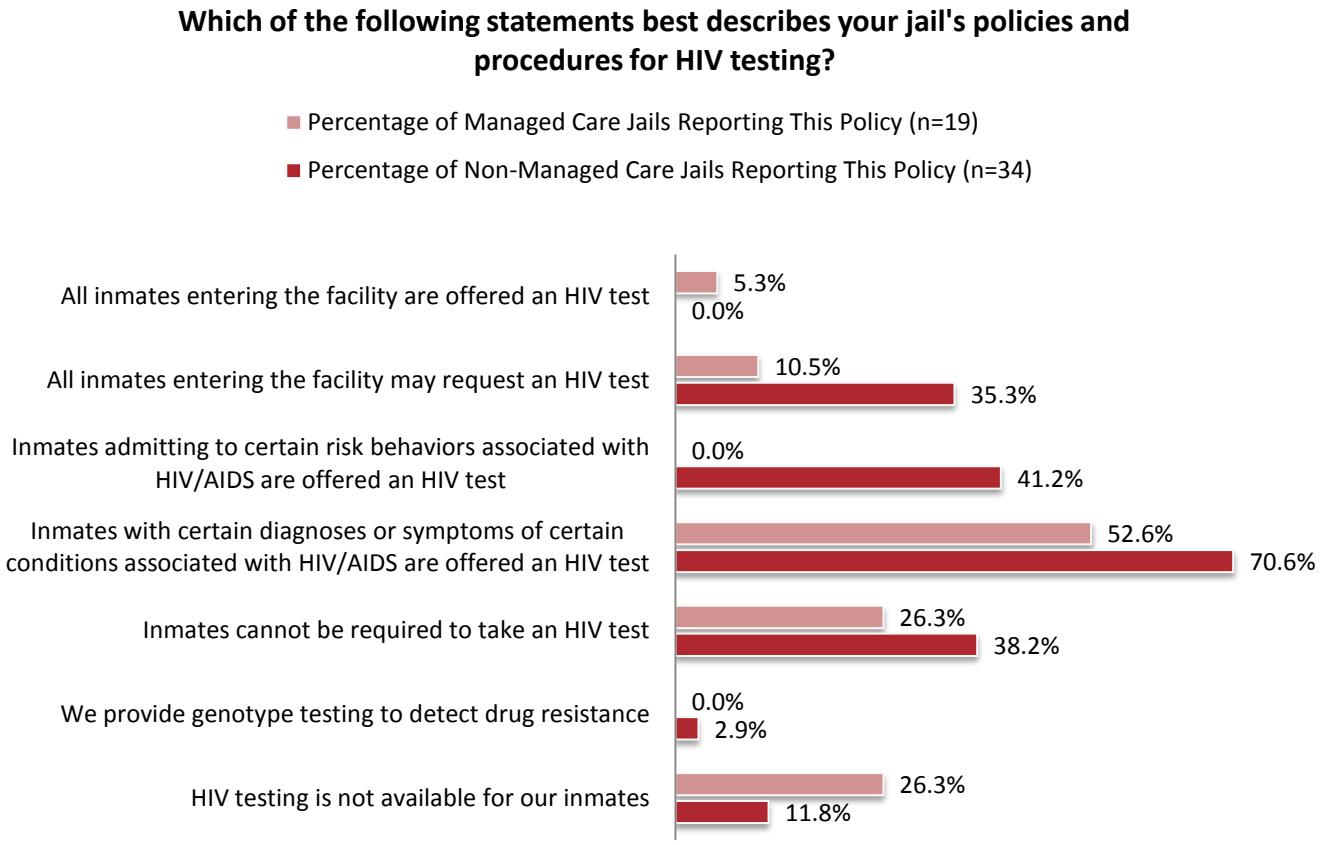


HIV Testing

> "The [managed care] company has a set contract price and lab work is rolled into that. [HIV testing] is going to up the lab costs."
>
> -An Ohio FSJ Medical Director

While caution should be used when interpreting these figures, it seems that non-managed care jails are somewhat more likely to offer HIV testing to their inmates. In particular, non-managed care jails seem more likely to offer testing when inmates are symptomatic, admit to risk behaviors, or simply request a test. Several interview informants from managed care jails reported that while they would like to offer more testing, they were certain that this would cause them to exceed the ceiling on laboratory costs established by their managed care company. A more restrictive testing policy may help explain why managed care jails report housing fewer inmates with HIV/AIDS than non-managed care jails, despite housing a similar number of inmates in the last year. Figure 8 provides details regarding policies and procedures for HIV testing.

Figure 8. *Comparison of Managed Care and Non-Managed Care Jails: HIV Testing Policies*



Medications

Both managed care and non-managed care jails almost always allow inmates to bring their medications with them to jail. All of the surveyed managed care jails and all but two of the surveyed non-managed care jails reported allowing this practice. Interview data suggest that it would be worth looking into whether formulary issues increase the time it takes for managed care jails to begin administering the medications inmates bring into the jail. Anecdotal evidence provided in the interviews suggests that this might be the case.

There is little difference between managed care and non-managed care jails regarding release medications. Forty-two percent of the surveyed managed care jails and fifty-two percent of the non-managed care jails reported providing release medications. When asked why they did not provide release medications, three of the managed care jails (a third of those answering the question) said that a lack of available prescribers prevents them from providing release medications. None of the non-managed care jails gave this answer.

Table 18 shows that managed care and non-managed care jails perceive that missed doses of HIV medications, when they occur, are generally the result of similar factors.

Table 18. *Comparison of Managed Care and Non-Managed Care Jails: Factors Contributing to Missed Doses of HIV-Related Medications*

Note. Higher rankings indicate higher perceived frequencies.

To the best of your knowledge, how often do the following situations cause an inmate to miss one or more doses of HIV-related medication?	Managed Care Ranking	Non-Managed Care Ranking
Inmate arrives at jail on weekend or after business hours	1 (tie)	3
Inmate's prescribed HIV-related medications are not on the jail's formulary	1 (tie)	8 (tie)
Inmate is transferred between jail and prison	3 (tie)	4
Inmate refuses medication	3 (tie)	1
Inmate is transferred between jails	5 (tie)	5
HIPAA prevents obtaining information on inmate's prescriptions in a timely manner	5 (tie)	2
No prescriber available to prescribe HIV-related medications	7	8 (tie)
Inmate is away from jail for court hearing or other approved activity	8	7
Inmate cannot be depended upon to take medications at correct times	9	6
Staff not able to monitor all doses of medications	10	10

- On average, managed care jails perceive that problems caused by an inmate's medications not being on the jail's formulary occur more often. Managed care jails gave this potential contributor to missed doses an average score of 2.5 (where 2 = *rarely* and 3 = *sometimes*) while non-managed care jails gave this factor an average score of 1.9 (where 1 = *never* and 2 = *rarely*).
- While the rankings for "HIPAA prevents obtaining information on inmate's prescriptions in a timely manner" suggest that managed care jails and non-managed care jails view this item differently, the average score given to this by managed care jails was 2.4 while the average score given by non-managed care jails was 2.8.

Jails' Perceptions of HIV Care

The following section summarizes the responses to the survey questions that probed jails' perceptions of the HIV care provided to inmates. In order to simplify comparisons between the two types of jails, the tables present the rank orderings of the average scores provided by each category of jail. Appendix J of this report provides the specific average scores given to each

listed item by each category of jail. At times, average scores are provided in this section of the report if they offer further clarification of the differences and similarities between the two categories of jail. Overall, the responses of managed care jails and non-managed care jails are quite similar.

Table 19. *Comparison of Managed Care and Non-Managed Care Jails: Strengths Related to Caring for Inmates with HIV/AIDS*

Note. Higher rankings indicate better perceived performance (1 = *highest ranking* and 9 = *lowest ranking*).

In your opinion, how well does your jail perform with the following aspects of HIV care? (If your jail has not housed inmates with HIV/AIDS, how well do you think they would perform with the following aspects of HIV care?)	**Managed Care Ranking**	**Non-Managed Care Ranking**
Ensuring inmates rarely or never miss doses of HIV-related medications while in jail	1	1
Identifying inmates with HIV/AIDS when entering jail	2	3
Providing access to HIV specialists	3	2
Developing courses of treatment appropriate to an inmate's specific condition	4	4
Keeping up-to-date with developments in the treatment of HIV/AIDS	5	6
Providing HIV-related medications immediately when an inmate arrives at the jail, regardless of whether the inmate enters on a weekend or after business hours	6	5
Providing social work, counseling, education, or other types of non-medical services to inmates with HIV/AIDS	7 (tie)	8
Finding undiagnosed cases of HIV/AIDS among inmates	7 (tie)	7
Ensuring that inmates' HIV care continues after they are released from the jail	9	9

- Managed care and non-managed care jails' overall perceptions of their ability to provide the various aspects of HIV care do not differ remarkably. All perceive that they do best at keeping an inmate on his or her medications while in jail and that they have the most trouble with ensuring continuity of care after release.

Table 20. *Comparison of Managed Care and Non-Managed Care Jails: Perceived Challenges Related to Caring for Inmates with HIV/AIDS*

Note. Higher rankings indicate greater perceived degrees of challenge (1 = *highest ranking* and 9 = *lowest ranking*).

How challenging is it for your jail to provide the following components of HIV care?	Managed Care Ranking	Non-Managed Care Ranking
Ensuring that inmates' medical HIV care continues after they are released from the jail	1	3
Finding undiagnosed cases of HIV/AIDS among inmates	2	1
Paying for HIV-related medications for inmates	3	2
Providing HIV-related medications within 24 hours after an inmate arrives at the jail, regardless of whether the inmate enters on a weekend or after business hours	4	10
Paying for HIV-testing for inmates	5	8
Identifying inmates entering jail with HIV/AIDS	6	5
Keeping up-to-date with developments in the treatment of HIV/AIDS	7	4
Providing counseling, education, or other types of non-medical treatment	8	6
Providing access to HIV specialists	9	7
Developing courses of treatment appropriate to an inmates' specific health condition	10	9
Ensuring that inmates rarely or never miss doses of HIV-related medications while in jail	11	11

- Managed care jails, on average, perceive that providing HIV-medications right away is a bit more difficult than many other components of HIV care. Managed care jails gave this component of HIV care an average score of 3.8 (where 3 = *neutral* and 4 = *somewhat challenging*); non-managed care jails gave this component an average score of 2.9 (where 2 = *not very challenging*). Interview data suggests that this may be because managed care jails sometimes need to obtain authorization for inmates to begin non-formulary medications.

Table 21. *Comparison of Managed Care and Non-Managed Care Jails: Factors Contributing to Challenges Related to Caring for Inmates with HIV*

Note. Higher rankings indicate greater perceived frequency (1 = *highest ranking* and 9 = *lowest ranking*).

When your jail encounters challenges with HIV care for inmates, how often are the following issues the source of the challenges?	Managed Care Ranking	Non-Managed Care Ranking
Insufficient finances	1	1 (tie)
Insufficient staffing	2 (tie)	3
Not enough time	2 (tie)	1 (tie)
Insufficient/inadequate health care space	4	4
Jail's relationship with community and elected officials	5	5

- There appears to be little difference between managed care and non-managed care jails when it comes to their perceptions of the factors that may make HIV care challenging.

Table 22. *Comparison of Managed Care and Non-Managed Care Jails: Overall Assessment of the Jails' Capacity to Care for Inmates with HIV/AIDS*

Note. Higher rankings indicate stronger expressed agreement.

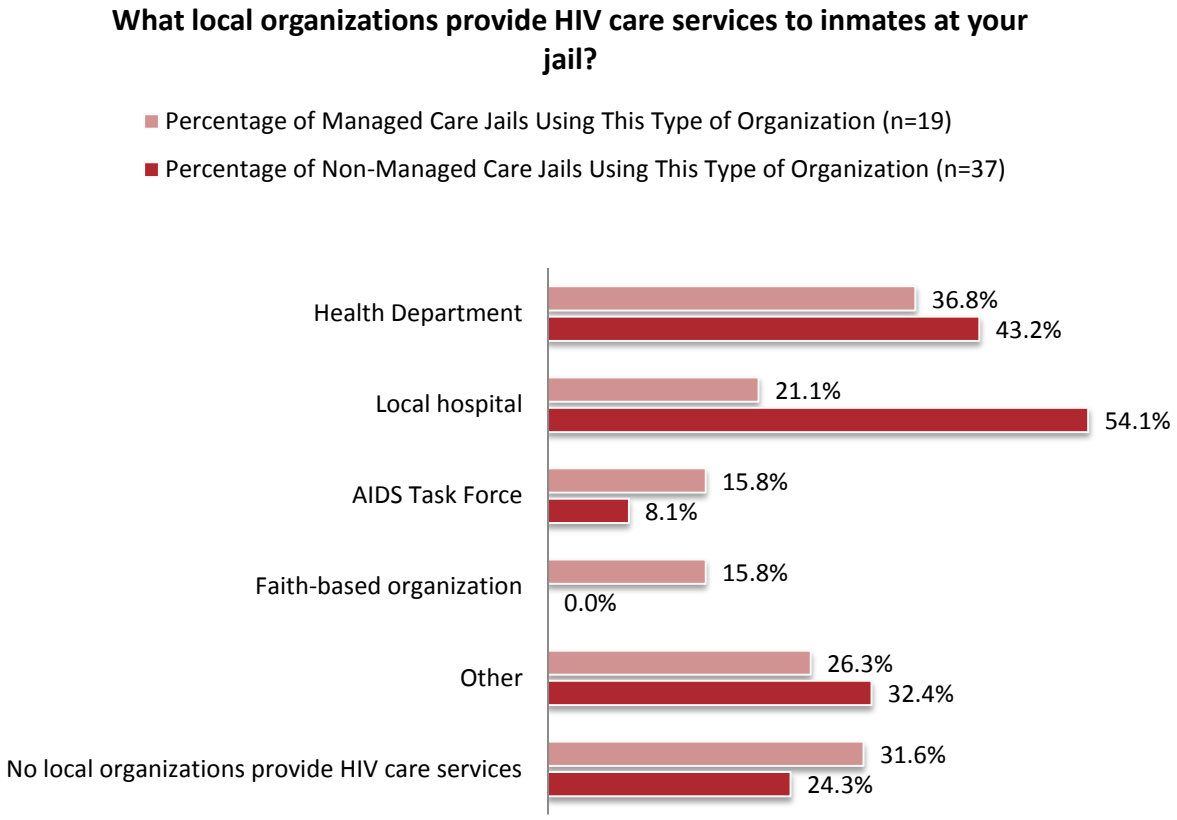
Please indicate how strongly you agree or disagree with the following statements.	Managed Care Ranking	Non-Managed Care Ranking
We would like local organizations to be more involved in providing care for inmates with HIV	1	2
Inmates at this jail have adequate access to HIV specialists	2	1
This jail is taking full advantage of local resources for HIV care for inmates	3	4
Jail personnel are able to provide a course of HIV treatment tailored to each inmate's particular health condition	4 (tie)	6
Adequate release planning is provided to inmates with HIV/AIDS	4 (tie)	7
Jail personnel are adequately trained to identify inmates who have HIV/AIDS	6	3
Jail personnel keep up-to-date on the latest medical treatment options for HIV/AIDS	7	5

- Respondents from managed- and non-managed care jails indicated that they would like local organizations to be more involved in providing care for inmates living with HIV.
- Respondents from managed- and non-managed care jails indicated that they believed that inmates had adequate access to HIV specialists.
- While the rankings assigned to the statement, "jail personnel are adequately trained to identify those inmates entering the facility who have HIV/AIDS," appear to indicate potential differences, the average scores assigned to the statement by both categories of jail are quite similar. Managed care jails gave this statement an average score of 3.0 (where 3 = *neutral*). Non-managed care jails gave this statement an average score of 3.4 (where 3 = *neutral* and 4 = *agree*).

Community Linkage

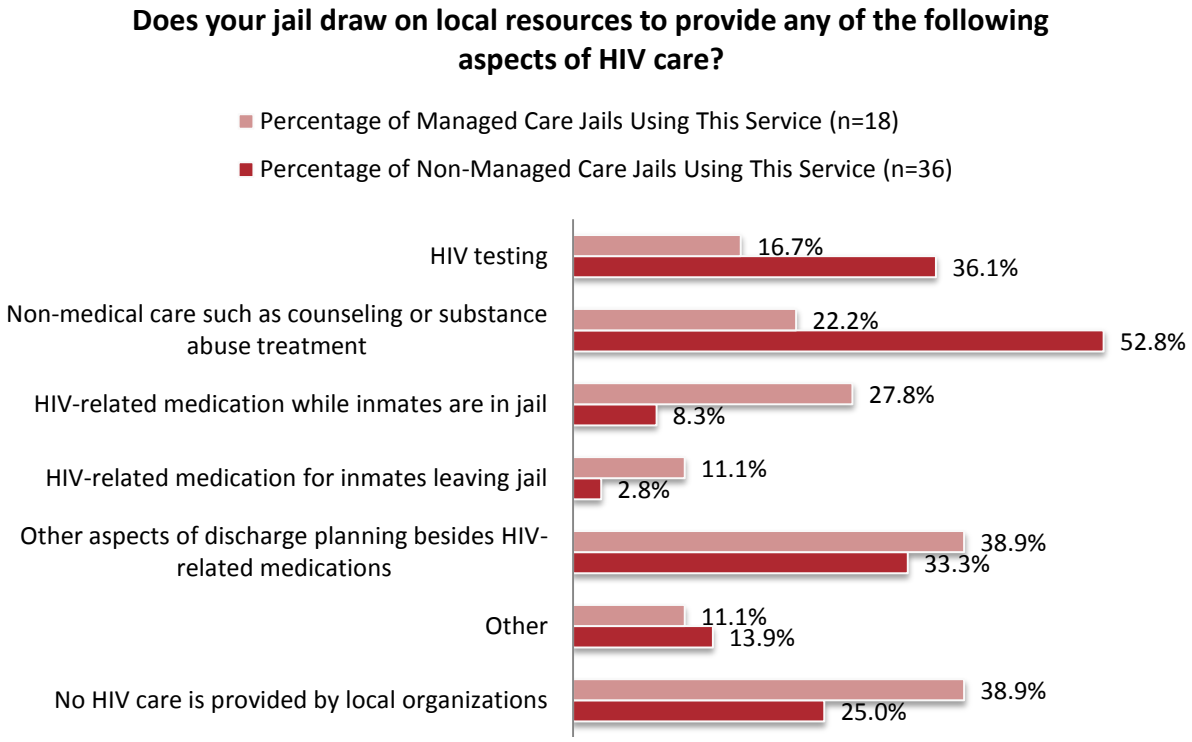
The types of local organizations that managed and non-managed care jails use for HIV care for their inmates are very similar. As for the services they use, it seems that non-managed care jails are more likely to draw on community organizations for non-medical HIV care and for HIV testing. The following figures present the survey data related to community linkage.

Figure 9. *Comparison of Managed Care and Non-Managed Care Jails: Community Providers of HIV Care Services (Survey Data)*



Interview data corroborate the trends seen in this figure, with the exception of jails' use of local hospitals. Roughly the same percentage of the interviewed jails reported using local hospitals (31.6 percent of managed care jails compared to 27.8% of non-managed care jails).

Figure 10. *Comparison of Managed Care and Non-Managed Care Jails: HIV Care Services Provided by Community Organizations (Survey Data)*



Interview data is at odds with survey data when it comes to release planning and release medications. Interview data show that managed care jails do not use community resources for release planning while 16.7 percent of non-managed care jails do. Interview data also indicate that managed care jails do not use community resources for release medications and that 8.3 percent of non-managed care jails do. Because of the contradictory data, no conclusions can be drawn about any differences between managed care jails and non-managed care jails regarding release planning and release medications.

Interview data also indicate that roughly equal percentages of managed care and non-managed care jails use community resources for HIV education for inmates (15.8 percent and 13.9 percent, respectively). They also suggest that managed care jails are more likely to access specialist care in the community. Almost two thirds of managed care jails reported drawing on specialists in the community while slightly more than one third of non-managed care jails reported this.

Conclusions

The data in this section suggest that managed care jails appear to be operating under somewhat more restrictive conditions than non-managed care jails. Potential evidence for this conclusion includes their more limited HIV testing and the suggestion of some difficulties or delays caused by non-formulary medications. Once medication is obtained and approved for an inmate, medication administration, potential causes of missed doses and policies regarding release medications are very similar to those of non-managed care jails.

HIV Care in Small and Large Jails

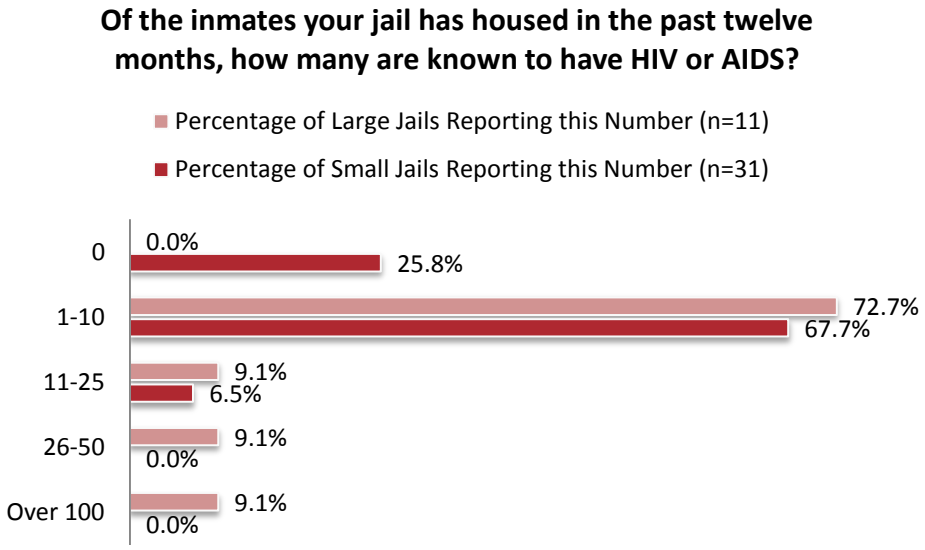
The following section offers a comparison of large (200 or more beds) and small (less than 200 beds) jails. Forty small jails and 25 large jails participated in the study. As no tests of statistical significance were performed, care should be taken when interpreting the numbers provided in this section. The data should be seen as signaling *possible* similarities and differences between large and small jails as they care for inmates living with HIV/AIDS.

HIV Statistics

In the last year, large jails housed an average of 11,963 inmates, while small jails housed an average of 4,792 inmates. Given the different size of the populations, it is not surprising that large jails reported housing more inmates known to be living with HIV/AIDS than small ones did. The average number of inmates known to be living with HIV/AIDS in large jails last year is estimated to range between 21-23 inmates.[18] The average for small jails is estimated to range between 2-4 inmates.[19] Figure 11, which is based on interview and survey data, provides greater detail on the number of inmates known to be living with HIV/AIDS housed by large and small jails in the last year.

[18] Averages are given in the form of ranges because survey data was gathered in the form of ranges.
[19] For large jails, $n = 11$; for small jails, $n = 31$. Data from 23 jails had to be omitted because it could not be disaggregated, it was based on a duplicative tracking system, or it was inconsistent between the survey and interview.

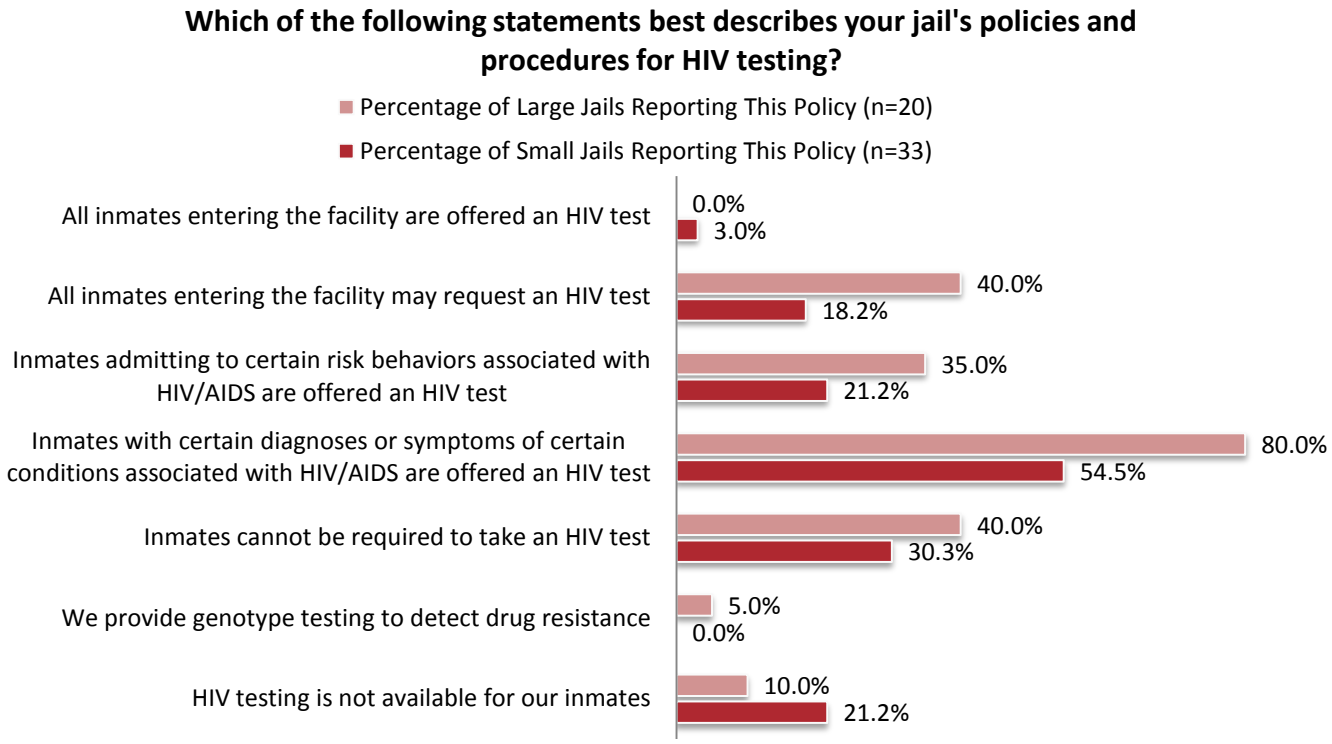
Figure 11. *Comparison of Large and Small Jails: Number of Inmates Known to Have HIV/AIDS Housed in the Last Year*



HIV Testing

Large jails seem slightly more likely to offer HIV testing to inmates than small jails, especially when it comes to inmates who are symptomatic or have medical diagnoses that might indicate HIV/AIDS. Figure 12 provides the details on the reported testing policies in large and small jails.

Figure 12. *Comparison of Large and Small Jails: HIV Testing Policies*



Medications

All of the surveyed small jails and 90.0 percent of the surveyed large jails reported allowing inmates to bring their own medications to jail with them. Policies regarding release medications are roughly the same. Fifty percent of large jails and 47.2 percent of small jails reported that they provide release medications to inmates with HIV/AIDS. Those jails that do not provide release medications offered the same reasons for this practice: insufficient notice of an inmate's pending release; budget constraints; potential liability; and a lack of prescribers willing to prescribe release medications.

Both large and small jails perceive that missed doses of HIV-medications are infrequent. For large jails, the most frequently identified contributor to missed doses was an inmate's transfer to prison. For small jails, the factor perceived to contribute most frequently to missed doses was a delay in prescription verification because of HIPAA regulations. Aside from these factors, large and small jails generally perceive that the factors behind missed doses occur with similar frequency.

Table 23. *Comparison of Large and Small Jails: Factors Contributing to Missed Doses of HIV-Related Medications*

Note. Higher rankings indicate greater perceived frequency (1 = *highest ranking* and 9 = *lowest ranking*).

To the best of your knowledge, how often do the following situations cause an inmate to miss one or more doses of HIV-related medications?	Large Jail Ranking	Small Jail Ranking
Inmate is transferred between jail and prison	1	5
Inmate refuses medication	2	2
Inmate arrives at jail on weekend or after business hours	3	3
Inmate is transferred between jails	4	4
HIPAA prevents obtaining information on inmate's prescriptions in a timely manner	5	1
Inmate is away from jail for court hearing or other approved activity	6	9
Inmate cannot be depended upon to take medications at correct times	7	7
Inmate's prescribed HIV-related medications are not on the jail's formulary	8	6
No prescriber available to prescribe HIV-related medications	9	8
Staff not able to monitor all doses of medications	10	10

- On average, both large and small jails perceive that these occurrences only infrequently lead to missed dosages. The highest average score given by large jails to any potential cause of missed doses was 2.9 and the highest average score given by small jails was 2.8. This means that, on average, no item was perceived to occur *sometimes, often,* or *very often* by either category of jail.

Jails' Perceptions of HIV Care

The following section summarizes the responses to the survey questions that probed jails' perceptions of the HIV care provided to inmates. In order to simplify comparisons between the two types of jails, the tables present the rank orderings of the average scores provided by each category of jail. Appendix I of this report provides the specific average scores given to each listed item by each category of jail. At times, average scores are provided in this section of the report if they offer further clarification of the differences and similarities between the two categories of jail. On the whole, large and small jails seem to perceive the challenges of HIV care and their ability to meet these challenges similarly. One potential difference between the two types of jails is their ability to access HIV specialty care.

Table 24. *Comparison of Large and Small Jails: Strengths Related to Caring for Inmates with HIV/AIDS*

Note. Higher rankings indicate better perceived performance (1 = *highest ranking* and 9 = *lowest ranking*).

In your opinion, how well does your jail perform with the following aspects of HIV care? (If your jail has not housed inmates with HIV/AIDS, how well do you think they would perform with the following aspects of HIV care?	Large Jail Ranking	Small Jail Ranking
Providing access to HIV specialists	1	3 (tie)
Ensuring that inmates rarely or never miss doses of HIV-related medications while in jail	2	1
Developing courses of treatment appropriate to an inmate's specific condition	3	3 (tie)
Identifying inmates with HIV/AIDS when entering jail	4	2
Keeping up-to-date with developments in the treatment of HIV/AIDS	5	6
Providing HIV-related medications immediately when an inmate arrives at the jail, regardless of whether the inmate enters on a weekend or after business hours	6	5
Providing social work, counseling, education, or other types of non-medical services to inmates with HIV/AIDS	7	7
Finding undiagnosed cases of HIV/AIDS among inmates	8	8
Ensuring that inmates' HIV care continues after they are released from the jail	9	9

- On average, large jails reported more confidence in their ability to provide inmates with access to HIV specialists. Large jails gave this item an average score of 4.6 (where 4 = *good* and 5 = *excellent*) while small jails gave this item an average score of 3.6 (where 3 = *average*).

Table 25. *Comparison of Large and Small Jails: Perceived Challenges Related to Caring for Inmates with HIV/AIDS*

Note. Higher rankings indicate greater perceived degree of challenge (1 = *highest ranking* and 9 = *lowest ranking*).

How challenging is it for your jail to provide the following components of HIV care?	Large Jail Ranking	Small Jail Ranking
Ensuring that inmates' medical HIV care continues after they are released from the jail	1	3
Finding undiagnosed cases of HIV/AIDS among inmates	2	1
Paying for HIV-related medications for inmates	3	2
Providing HIV-related medications within 24 hours after an inmate arrives at the jail, regardless of whether the inmate enters on a weekend or after business hours	4	9
Paying for HIV-testing for inmates	5	6
Identifying inmates entering jail with HIV/AIDS	6	8
Keeping up to date with developments in the treatment of HIV/AIDS	7	4
Providing counseling, education, or other types of non-medical treatment	8	7
Ensuring that inmates rarely or never miss doses of HIV-related medications while in jail	9	11
Developing courses of treatment appropriate to an inmate's specific health condition	10	10
Providing access to HIV specialists	11	5

- On average, small jails perceive providing inmates with access to HIV specialists to be more challenging. Large jails gave this component of HIV care an average score of 2.4 (where 2 = *not very challenging* and 3 = *neutral*) while small jails gave this an average score of 3.4 (where 4 = *somewhat challenging*).
- Despite differences in their rankings of the difficulty of providing HIV-related medications within 24 hours of an inmate's arrival at the jail, small and large jails gave this component of HIV care very similar average scores (3.4 in the case of large jails and 3.1 in the case of small jails).

Table 26. *Comparison of Large and Small Jails: Factors Contributing to Challenges Related to Caring for Inmates with HIV/AIDS*

Note. Higher rankings indicate greater perceived frequency (1 = *highest ranking* and 9 = *lowest ranking*).

When your jail encounters challenges with HIV care for inmates, how often are the following issues the source of the challenges?	Large Jail Ranking	Small Jail Ranking
Insufficient finances	1	1
Not enough time	2	2
Insufficient staffing	3	3
Insufficient/inadequate health care space	4	4
Jail's relationship with the community and elected officials	5	5

- On average, large and small jails gave identical rankings and very similar average scores to all of the potential sources of HIV care challenges.

Table 27. *Comparison of Large and Small Jails: Overall Assessment of the Jail's Capacity to Care for Inmates with HIV*

Note. Higher rankings indicate greater agreement (1 = *highest ranking* and 9 = *lowest ranking*).

Please indicate how strongly you agree or disagree with the following statements.	Large Jail Ranking	Small Jail Ranking
Inmates at this jail have adequate access to HIV specialists	1	2
We would like local organizations to be more involved in providing care for inmates with HIV	2	1
Jail personnel are adequately trained to identify inmates who have HIV/AIDS	3	4
This jail is taking full advantage of local resources for HIV care for inmates	4 (tie)	3
Jail personnel are able to provide a course of HIV treatment tailored to each inmate's particular health condition	4 (tie)	7
Jail personnel keep-up-to date on the latest medical and treatment options for HIV/AIDS	6	6
Adequate release planning is provided to inmates with HIV/AIDS	7	5

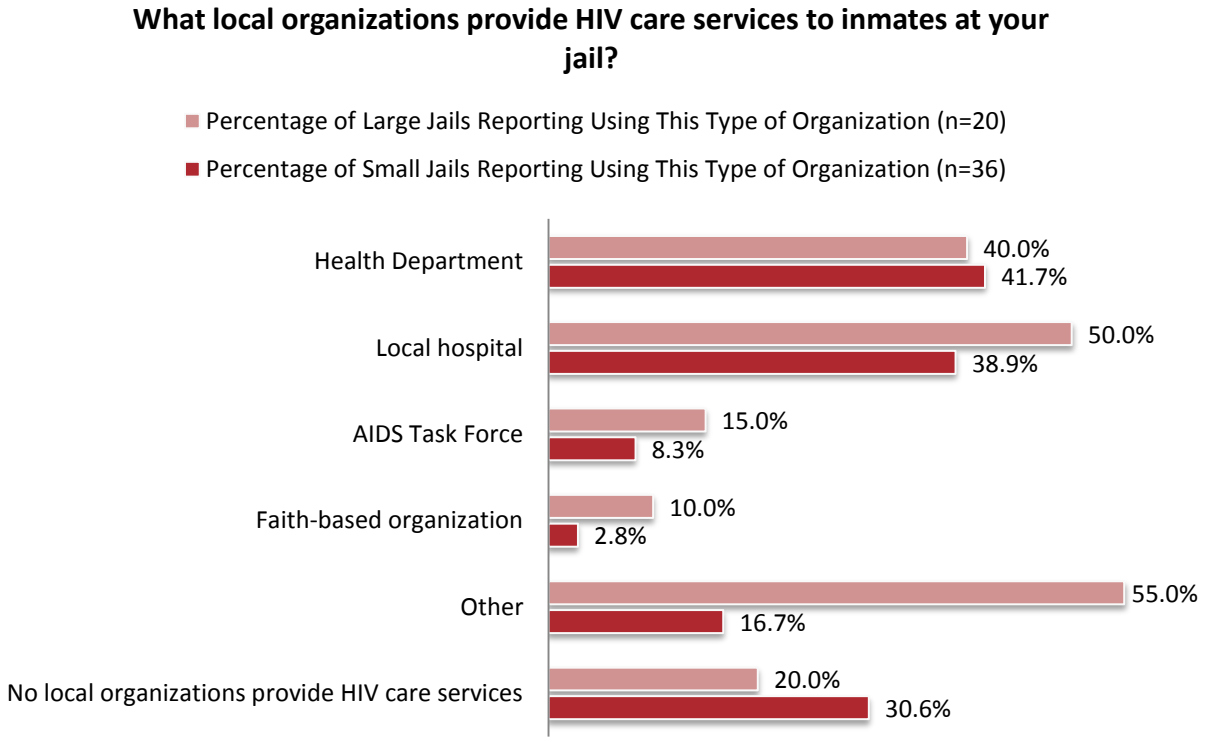
- Providing access to HIV specialists received the highest average level of agreement from large jails and the second highest level of agreement from small jails. This is somewhat surprising given the other survey data that suggests small jails perceive it to be more difficult to gain access to HIV specialists. For this survey question, the average score given to the statement "Inmates at this jail have adequate access to HIV specialists," by

large jails was 4.2 (where 4 = *agree* and 5 = *strongly agree*) while the average score from small jails was 3.3 (where 3 = *neutral*).

Community Linkage

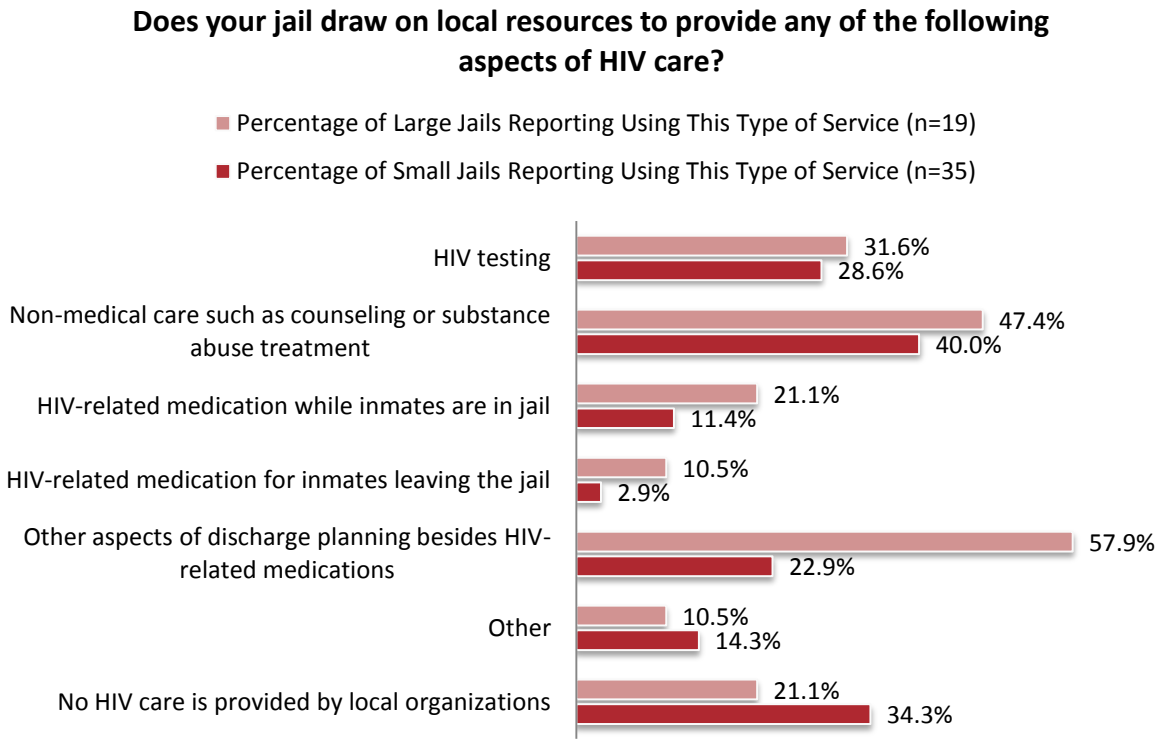
Survey and interview data do not provide a clear indication of differences between large and small jails when it comes to community provision of HIV care services. The following figures present the survey data related to community linkage.

Figure 13. *Comparison of Large and Small Jails: Community Providers of HIV Care Services (Survey Data)*



According to survey data, large jails may be slightly more linked in to community providers of HIV care (with the exception of health departments). Interview data suggest that this might be the case as well. Almost half of the large interviewed jails reported using their local health departments while roughly a quarter of the small jails did. The difference between large and small jails when it comes to use of local hospitals was larger in the interview data (over half of large jails report using local hospitals and slightly more than ten percent of small jails report this). This could be due to the fact that small jails are more frequently located in rural communities where there are fewer HIV care resources.

Figure 14. *Comparison of Large and Small Jails: HIV Care Services Provided by Community Organizations (Survey Data)*



The difference between large and small jails regarding reported use of community resources for HIV testing was more pronounced in the interview data. Forty-six percent of the large interviewed jails reported using community organizations to provide testing to inmates, while only 6.1 percent of the small interviewed jails reported this. In addition, almost half of the large interviewed jails reported using community organizations to provide HIV education to their inmates, compared to slightly more than ten percent of small jails. Over two thirds of the large interviewed jails reported using community HIV specialists, while slightly less than a third of small jails reported using community HIV specialists.

Conclusions

Large and small jails did not report differences regarding budget constraints or the ability to pay for HIV medications and other aspects of HIV care. Both perceive the financial aspects of HIV care to be challenging. They also have similar policies and practices regarding medication

for inmates while in jail and medications for inmates leaving jail. These categories of jails do potentially differ in regard to their ability to link inmates with community resources, especially HIV specialists. This difference may not be a result of the jail's size, per se, but rather a result of the fact that large jails tend to be located in more populated areas that have more HIV care resources.

HIV Care in Urban and Rural Jails

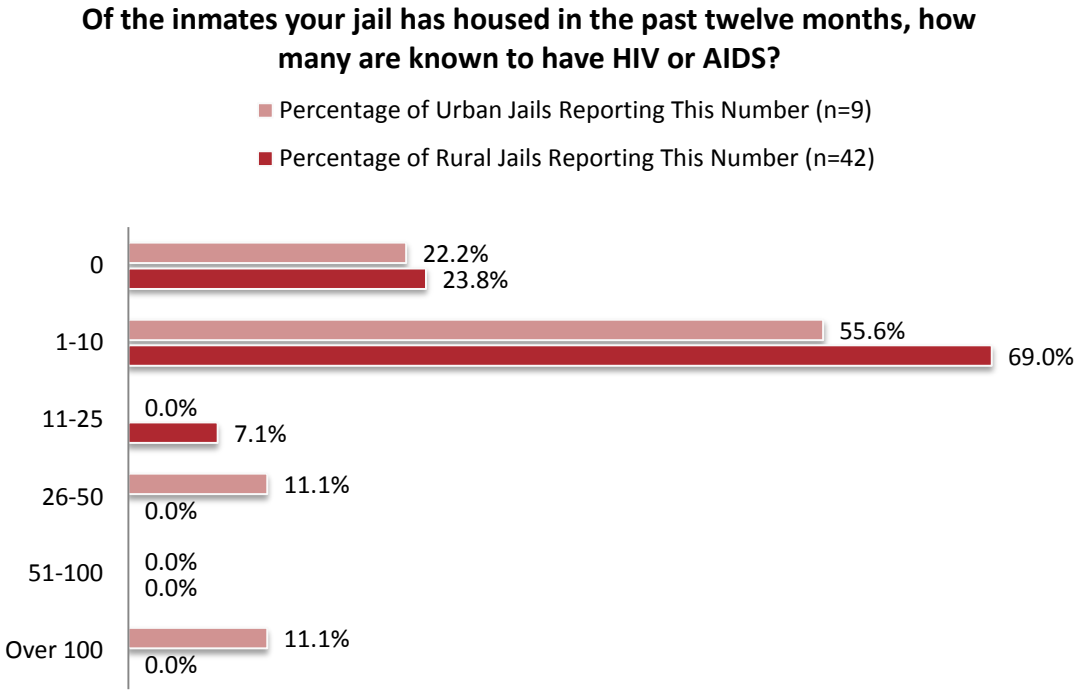
The following section offers a comparison of jails that are located in urban counties and jails that are located in rural counties. Jails are considered urban if they are located in a county that is home to one of the top eight most populous cities in Ohio. Specifically, jails are considered urban if they are in Cuyahoga, Franklin, Hamilton, Lucas, Mahoning, Montgomery, Stark, or Summit Counties (US Census Bureau, 2002). Fifteen urban jails and 50 rural jails participated in the study (10 of the urban jails and 41 of the rural jails completed a survey). As no tests of statistical significance were performed, care should be taken when interpreting the numbers provided in this section. The data should be seen as signaling *possible* similarities and differences between urban and rural jails as they care for inmates living with HIV/AIDS.

HIV Statistics

Not surprisingly, jails in urban areas housed more inmates than jails in rural areas. The average number of inmates housed by an urban jail in the last year was 15,292, while the average number housed by a rural jail was 5,575. As would be expected given the difference in the number of inmates, urban jails reported housing more inmates known to be living with HIV/AIDS in the last year than rural jails. The average number of inmates known to be living with HIV/AIDS housed by urban jails in the last year is estimated to range between 23-25[20], while the average for rural jails is estimated to range between 3-5.[21],[22] Figure 15 provides more specific data for the two categories of jails. The numbers and percentages represent combined data from the interview and survey.

[20] $N = 9$; data from four jails were omitted because the jails have potentially duplicative tracking systems and data from two jails were omitted because the jails provided contradictory data in their survey and interview responses.
[21] $N = 42$; one jail did not answer the question, data from three jails were omitted because of potentially duplicative tracking systems, and data from four jails were omitted because survey and interview responses for those jails conflicted.
[22] The averages are presented in the form of ranges because survey data was gathered in the form of ranges.

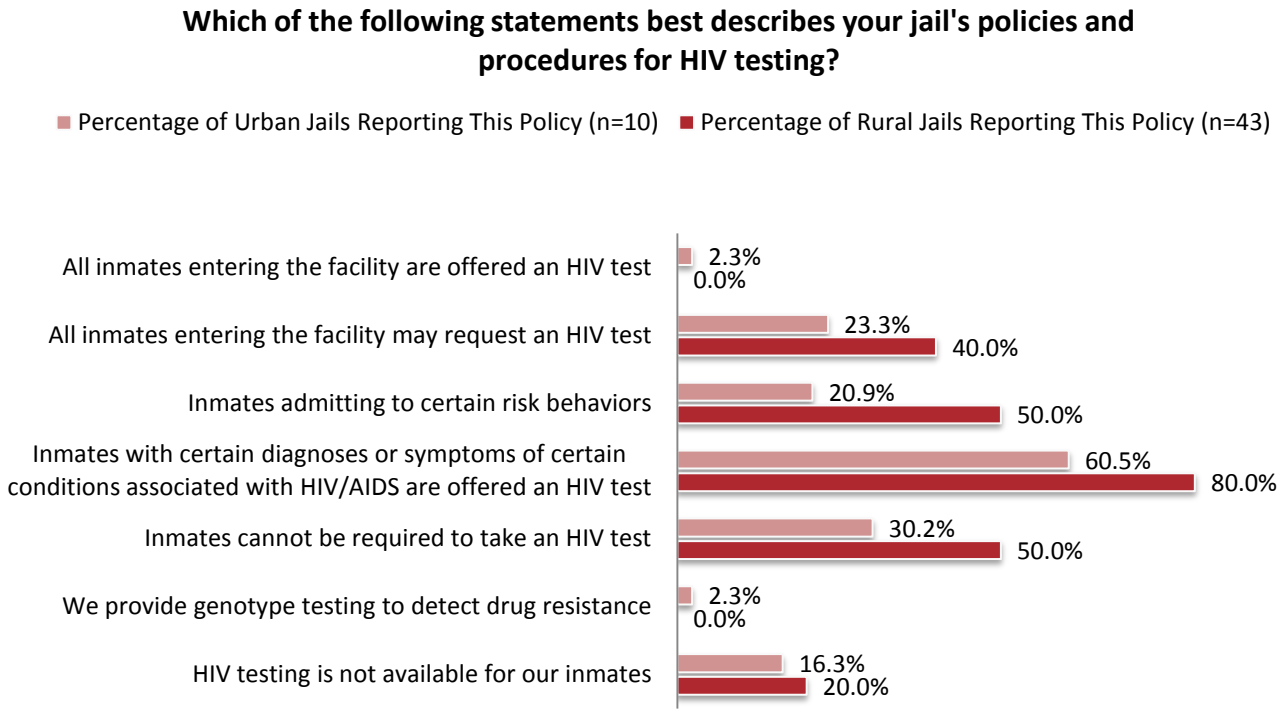
Figure 15. *Comparison of Urban and Rural Jails: Number of Inmates Known to Have HIV/AIDS Housed in the Last Year*



HIV Testing

Jails in urban counties appear somewhat more likely to offer HIV testing to their inmates, though roughly the same percent of the surveyed urban and rural jails said that no HIV testing is available to their inmates. Of those jails that do make HIV testing available, slightly more urban than rural jails reported offering HIV tests to inmates if they are symptomatic or admit to risk behaviors. Figure 16 provides more detailed information on HIV testing policies in urban and rural jails.

Figure 16. *Comparison of Urban and Rural Jails: HIV Testing Policies*



Medications

All of the surveyed rural jails and almost all of the surveyed urban jails (81.8 percent) allow inmates to bring their own medications to jail with them. When inmates leave the jail, over one-third of the surveyed urban jails reported that they provide release medications; while over one-half of the surveyed rural jails reported that they provide release medications. Of those jails that do not provide release medications, roughly equal percentages of both categories said that they do not provide release medications because of budget constraints and because medical staff do not have enough notice of an inmate's release. More urban jails than rural jails reported that potential liability for the jail prevented them from providing release medications (71.4 percent and 36.8 percent, respectively). Sixteen percent of rural jails reported that the no release medication policy was due to a lack of prescribers willing to prescribe release medications. No urban jails gave this reason.

Urban and rural jails both perceive that missed doses of HIV medication do not happen frequently. When asked about factors that might contribute to missed doses of HIV-related medications, neither category of jail gave an average score of 3.0 or higher to any of the listed items (i.e., none of the potential factors was perceived to occur *sometimes*, *often*, or *very often*). Table 28 provides the survey data related to missed doses of HIV medication.

Table 28. *Comparison of Urban and Rural Jails: Factors Contributing to Missed Doses of HIV-Related Medications*

Note. Higher rankings indicate greater perceived frequency (1 = *highest ranking* and 9 = *lowest ranking*).

To the best of your knowledge, how often do the following situations cause an inmate to miss one or more doses of HIV-related medications?	Urban Ranking	Rural Ranking
Inmate refuses medication	1	2
Inmate is transferred between jail and prison	2 (tie)	4
Inmate arrives at jail on weekend or after business hours	2 (tie)	3
Inmate is transferred between jails	4	5
HIPAA prevents obtaining information on inmate's prescriptions in a timely manner	5	1
Inmate is away from jail for court hearing or other approved activity	6	9
Inmate cannot be depended upon to take medications at correct times	7 (tie)	7
No prescriber available to prescribe HIV-related medications	7 (tie)	8
Inmate's prescribed HIV-related medications are not on the jail's formulary	9	6
Staff not able to monitor all doses of medications	10	10

- According to the survey results, rural jails appear to perceive HIPAA regulations as slightly more frequent contributors to missed doses. Rural jails also perceive formulary issues to occur more often. The average score given to the statement "Inmate's prescribed HIV-related medications are not on the jail's formulary" by rural jails was 2.4 (where 2 = *rarely* and 3 = *sometimes*), while the average score given by urban jails was 1.3 (where 1 = *never*).

Jails' Perceptions of HIV Care

The following section summarizes the responses to the survey questions that probed jails' perceptions of the HIV care provided to inmates. In order to simplify comparisons between the two types of jails, the tables present the rank orderings of the average scores provided by each category of jail. Appendix K of this report provides the specific average scores given to each listed item by each category of jail. At times, average scores are provided in this section of the report if they offer further clarification of the differences and similarities between the two categories of jail.

Table 29. *Comparison of Urban and Rural Jails: Strengths Related to Caring for Inmates with HIV/AIDS*

Note. Higher rankings indicate better perceived performance (1 = *highest ranking* and 9 = *lowest ranking*).

In your opinion, how well does your jail perform with the following aspects of HIV care? (If your jail has not housed inmates with HIV/AIDS, how well do you think they would perform with the following aspects of HIV care?)	Urban Ranking	Rural Ranking
Providing access to HIV specialists	1	3
Identifying inmates with HIV/AIDS when entering jail	2 (tie)	2
Developing courses of treatment appropriate to an inmate's specific condition	2 (tie)	4
Ensuring that inmates rarely or never miss doses of HIV-related medications while in jail	4	1
Keeping up-to-date with developments in the treatment of HIV/AIDS	5	6
Providing HIV-related medications immediately when an inmate arrives at the jail, regardless of whether the inmate enters on a weekend or after business hours	6	5
Providing social work, counseling, education, or other types of non-medical services to inmates with HIV/AIDS	7	7
Ensuring that inmates' HIV care continues after they are released from the jail	8	9
Finding undiagnosed cases of HIV/AIDS among inmates	9	8

- On average, rural jails perceive that they do best at ensuring that inmates do not miss doses of HIV-related medications; urban jails perceive that they do best at providing inmates with access to HIV specialists.

Table 30. *Comparison of Urban and Rural Jails: Perceived Challenges Related to Caring for Inmates with HIV/AIDS*

Note. Higher rankings indicate a greater perceived degree of challenge (1 = *highest ranking* and 9 = *lowest ranking*).

How challenging is it for your jail to provide the following components of HIV care?	Urban Ranking	Rural Ranking
Finding undiagnosed cases of HIV/AIDS among inmates	1	3
Ensuring that inmates' medical HIV care continues after they are released from the jail	2	2
Paying for HIV-testing for inmates	3	6
Identifying inmates entering jail with HIV/AIDS	4	9
Paying for HIV-related medications for inmates	5	1
Providing social work, counseling, education, or other types of non-medical treatment	6	8
Keeping up to date with developments in the treatment of HIV/AIDS	7	5
Developing courses of treatment appropriate to an inmate's specific health condition	8	10
Providing HIV-related medications within 24 hours after an inmate arrives at the jail, regardless of whether the inmate enters on a weekend or after business hours	9	4
Providing access to HIV specialists	10	7
Ensuring that inmates rarely or never miss doses of HIV-related medications while in jail	11	11

- On average, rural jails perceive that paying for HIV related medications, providing these medications immediately upon an inmate's arrival, and providing access to HIV specialists are a bit more challenging (compared to other aspects of HIV care) than urban jails perceive them to be.
- On average, urban jails perceive that identifying inmates entering their facilities with HIV/AIDS is more challenging (compared to other aspects of HIV care) than rural jails perceive them to be.

Table 31. *Comparison of Urban and Rural Jails: Factors Contributing to Challenges Related to Caring for Inmates with HIV/AIDS*

Note. Higher rankings indicate greater perceived frequency (1 = *highest ranking* and 9 = *lowest ranking*).

When your jail encounters challenges with HIV care for inmates, how often are the following issues the source of the challenges?	Urban Ranking	Rural Ranking
Not enough time	1	2
Insufficient finances	2	1
Insufficient/inadequate health care space	3	4
Insufficient staffing	4	3
Jails' relationship with the community and elected officials	5	5

- On average, urban and rural jails appear to have very similar perceptions of the frequency with which the listed potential contributors to HIV care challenges occur.

Table 32. *Comparison of Urban and Rural Jails: Overall Assessment of the Jails' Capacity to Care for Inmates with HIV/AIDS*

Note. Higher rankings indicate stronger agreement (1 = *highest ranking* and 9 = *lowest ranking*).

Please indicate how strongly you agree or disagree with the following statements.	Urban Ranking	Rural Ranking
Inmates at this jail have adequate access to HIV specialists	1	2
We would like local organizations to be more involved in providing care for inmates with HIV	2	1
Jail personnel are adequately trained to identify inmates who have HIV/AIDS	3	4
This jail is taking full advantage of local resources for HIV care for inmates	4	3
Jail personnel keep-up-to date on the latest medical and treatment options for HIV/AIDS	5	7
Jail personnel are able to provide a course of treatment for inmates with HIV/AIDS that is tailored to each inmate's particular health condition	6	5
Adequate release planning is provided to inmates with HIV/AIDS	7	6

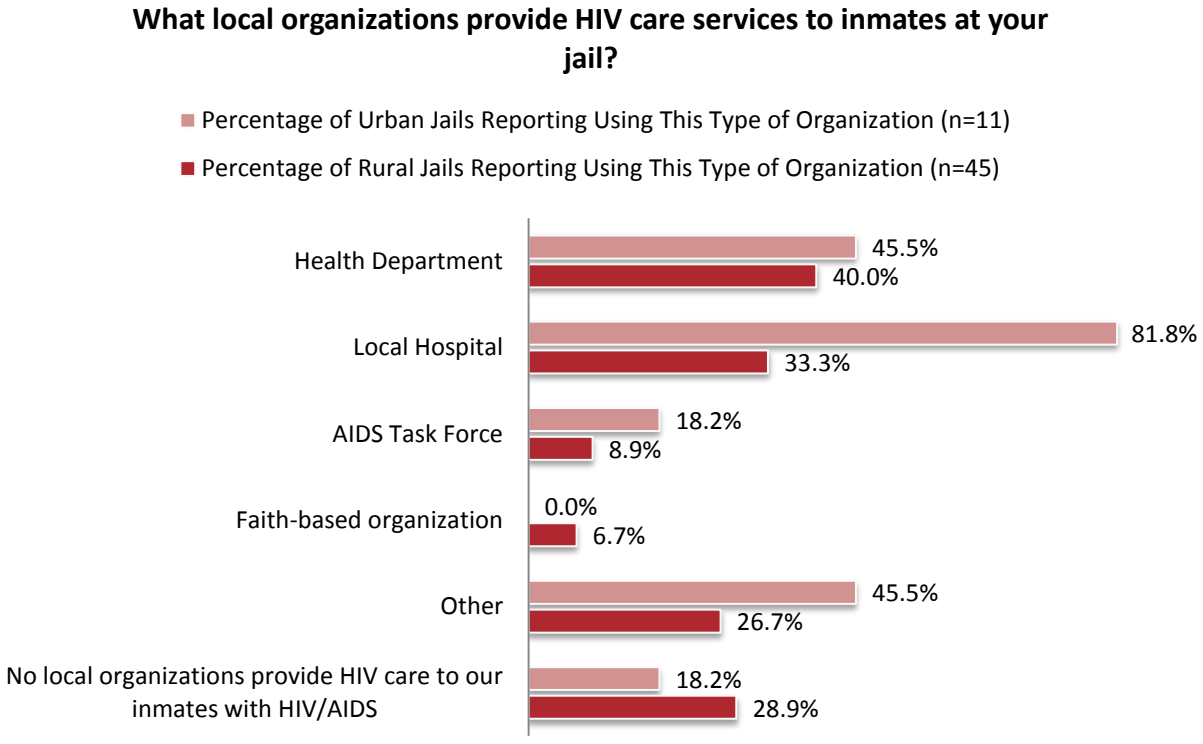
- Despite giving similar rankings to the statement "Inmates at this jail have adequate access to HIV specialists," urban jails, on average, appear to be more in agreement with this statement. Urban jails gave access to specialists an average score of 4.5 (where 4 = *agree* and 5 = *strongly agree*) while rural jails gave this item an average score of 3.4 (where 3 = *neutral*).

- Despite giving similar rankings to the statement "Jail personnel are adequately trained to identify inmates who have HIV/AIDS," urban jails, on average, appear to be more in agreement with this statement. Urban jails gave this statement an average score of 4.0 while rural jails gave this item an average score of 3.1.

Community Linkage

Jails in urban areas are generally more linked in to community-provided HIV care services. The most likely reason for this is that urban areas are far more likely to have such community organizations. Figure 17, which is based on survey data, provides more detailed information on the types of organizations on which urban and rural jails draw for HIV care. Figure 18 provides details on the services these organizations provide, and is based on survey data.

Figure 17. *Comparison of Urban and Rural Jails: Community Providers of HIV Care Services*



Survey data indicate that urban jails are more likely to use all services provided by local organizations, with the exception of organizations that are faith-based. The largest difference between urban and rural jails in their community outreach to provide HIV care services is found

in the use of local hospitals. Nearly eighty-two percent of urban jails report utilizing local hospitals, compared to only a third of rural jails that report using local hospital services.

Figure 18. *Comparison of Urban and Rural Jails: HIV Care Services Provided by Community Organizations*

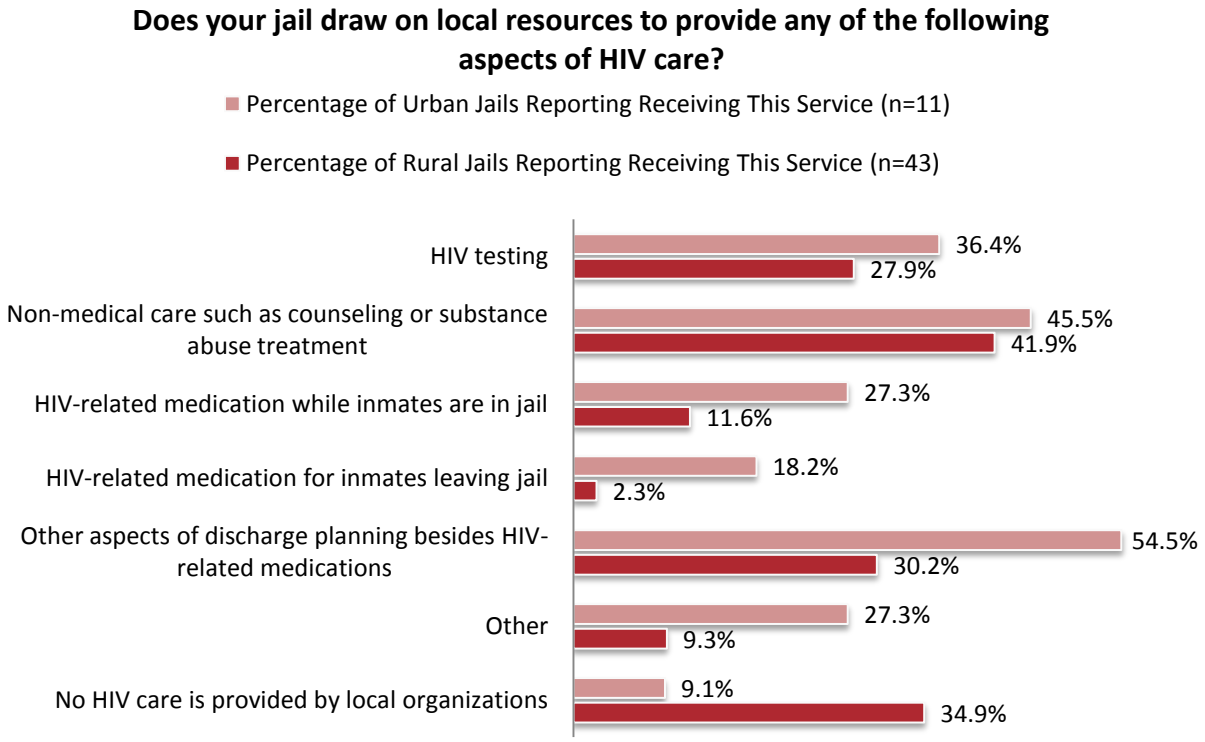


Figure 18 also shows that urban jails are more likely to use the resources available in the community compared to their rural counterparts. Urban jails are especially more likely to use community resources as a source of inmate medication, while inmates are in jail and when they are leaving. Using a community organization to provide inmates with medication during discharge from jail occurred in less than 2.5 percent of rural jails compared to over 18 percent of urban jails. More than 50 percent of urban jails use community organizations for aspects related to inmate discharge, while only 30 percent of rural jails report using these services. The only resource that rural jails use with nearly the same frequency as urban jails is counseling and substance abuse treatment. This is due, in part, to the relatively small number of community organizations available in rural areas.

Conclusions

Jails in urban counties typically have far more inmates living with HIV/AIDS than rural jails and appear to be somewhat better linked to community-based HIV care resources, especially HIV specialists and local hospitals. The increased connection to community providers may be

due to a combination of a greater incentive to seek out community providers of HIV care (because of the higher numbers of inmates with HIV/AIDS in urban jails) and the simple fact that there tend to be more resources available in urban areas. Many interview informants from rural jails expressed frustration with a lack of accessible HIV care services in their area.

While urban and rural jails, on average, give their provision of HIV care generally similar ratings, rural jails seem slightly less confident in the ability to obtain HIV medications and identify inmates with HIV/AIDS. Rural jails also have somewhat more restrictive HIV testing policies. It is possible that urban jails reported providing more HIV testing and having less difficulty obtaining HIV medications because more community organizations provide these services in their areas.

HIV Care in Regional, County, and Municipal Jails

FSJs in Ohio are either county jails, municipal jails or regional jails. County and municipal jails are run by the county or city in which they are located, while regional jails are run by several jurisdictions. There are currently five jails in Ohio that were officially created to be regional jails (one of these facilities is a privately-run organization). One of the ideas behind the regional jail concept is that multiple jurisdictions can pool their resources and deploy them in a cost-effective way, taking advantage of the economies of scale afforded by serving a larger population. This is said to allow counties or municipalities with limited resources to provide more modern facilities and more specialized services to inmates than they could afford to offer on their own (National Institute of Corrections Information Center, 1992; Paquette, 1987).

The possibility that HIV care is impacted by the different organizing principals and the potentially different resource bases of regional, county, and municipal jails merits consideration. Unfortunately, the number of regional and municipal jails in the state make any systematic comparison problematic. Three regional jails, five municipal jails, and 48 county jails completed surveys. Four regional jails, four municipal jails, and 47 county jails completed interviews. Because of the extremely small number of regional and municipal jails, statistical analysis is not the most effective way to discern any differences between these types of facilities. Instead, qualitative analysis of the interview data was used to identify possible themes that might merit future investigation. What follows is a brief overview of some of the facets of HIV care in regional and municipal jails.

HIV Statistics

Neither regional nor municipal jails appear to house a significantly higher number of inmates known to have HIV/AIDS than other jails in the state. After omitting data from one jail because of a duplicative tracking system, the remaining three regional jails all reported housing no more than ten inmates known to have HIV/AIDS in the last year.[23] One municipal jail reported housing over ten inmates with HIV/AIDS in the last year and the remaining three reported housing no more than ten inmates known to have HIV/AIDS in that time period.[24]

[23] $N = 3$; data from one jail were not included because of a potentially duplicative tracking system.
[24] $N = 4$; data from one jail were not included because number provided in the interview and survey were inconsistent.

HIV Testing

All of the regional jails reported that HIV testing is available upon request or that they explicitly offer testing to all inmates. These appear to be broader testing policies than those found on average across Ohio FSJs. Testing policies in municipal jails appear more restrictive: municipal jails reported that court orders, exchanges of bodily fluids, and doctor's orders are the primary reasons testing would be made available to inmates. One of the municipal jails indicated that tests are available on request.

Medications

All of the interviewed regional jails allow inmates to provide their own medications. In two of these cases, the facilities will use these medications only temporarily until they obtain medications for the inmates. It is notable that out of all the FSJs participating in the study, less than ten jails reported obtaining medications for inmates when inmates are able to provide their own. All of the interviewed municipal jails reported allowing medications in; none reported that they will obtain medications for inmates who can provide them on their own.

Half of the interviewed regional jails provide release medications. One of the municipal jails reported providing release medications; the others either do not have a set policy or do not provide release medications.

Community Linkage

All of the regional jails reported that they link inmates with a variety of community-provided services. These are typically not HIV-specific and non-medical in nature. Two of the regional jails reported that their medical staff is primarily responsible for the course of treatment for inmates with HIV/AIDS, though all regional jails reported being willing to transport inmates to community HIV specialists when needed.

One of the municipal jails reported being well connected to community providers of care for inmates. The remaining municipal jails reported that no community organizations provided care to their inmates and that non-medical HIV care is limited. Three of the municipal jails reported that they do not transport their inmates to specialists.

Observations

An examination of the interview data for regional jails provides a limited amount of anecdotal evidence for the argument that these facilities may provide more specialized services for their inmates. A study of the interview data for municipal jails provides a small amount of anecdotal evidence that these jails are not as well situated to provide a broad spectrum of HIV care services to inmates.

Suggestions for Best Practices

Any efforts to increase the depth and variety of HIV care services provided by FSJs should appreciate the often hectic and resource-scarce environments in which jail medical staff operate. Such efforts should also recognize that HIV/AIDS is not the medical condition most often confronted by jails. Indeed, the vast majority of jails see fewer than ten inmates known to be living with HIV/AIDS per year. Nonetheless, there are some jails that successfully provide a wide array of HIV care services. In particular, HIV care in FSJs seems to be more contemporary and more comprehensive in those jails that enjoy the following conditions:

- *Funding sources* that relieve the financial strain of HIV care.
- *Partnerships with community providers of HIV care*.
- *Supportive sheriffs and jail administrators* who encourage efforts to link with community care providers and to provide as broad a spectrum of HIV care as possible, given institutional constraints.
- *Medical staff with a high degree of HIV awareness and knowledge* (e.g., an appreciation of the ramifications of medication interruptions and of the relationship between non-medical care and medication adherence).

Funding

Jails need more information about funding sources, such as Ryan White Program funds, that they can access to provide HIV testing, medications, release care, and other aspects of HIV care. They also need more information about free or reduced cost services available to them such as free testing at community sites, pharmaceutical company programs that benefit the indigent, and legislation like Ohio Revised Code §341.192, which requires that medical providers charge jails no more than the Medicaid reimbursement rate for necessary care for their inmates. Jails that had secured funding or free provision of HIV testing and HIV medications in particular tended to offer broad selections of HIV care services to inmates. In order to heighten jails' awareness of the funds and free or reduced-cost services for which they are potentially eligible:

- ODH can provide information sheets explaining the conditions under which jails are eligible for Ryan White Program funds. Many interview respondents expressed confusion about whether their facility qualified to apply for monies from this funding source.
- Jails can establish networks (through listservs, for example) to discuss sources of funding. This may help jails within the same region become aware of resources that they are not accessing, such as clinics that provide free testing. It may help jails across the state learn about state or federal programs, programs run by pharmaceutical companies, or other means of obtaining financial support for HIV care.

Community Linkage

By far the most effective way Ohio FSJs have found to offer expansive HIV care despite scarce resources is to establish partnerships with organizations that are willing to provide these services for free. While there are jails that are relatively isolated from community providers of HIV care, interview information suggests that there are many other jails that are unaware of local resources available to them. It seems most likely that jails will establish these community partnerships if the community organizations do the work of making themselves known to jails. To do this:

- Ryan White Consortia coordinators could provide concise lists of the specific services that community organizations are willing to provide to jails. These lists should be updated regularly, both to keep information current and to maintain jails' awareness of the resources. It is important that these lists be tailored specifically to jails, so that jail personnel do not feel they have to do additional research to determine which programs they might be able to access.
- In addition to resource lists for jails, Ryan White Consortia coordinators can provide jails with release literature that list the resources available to *inmates* living with HIV/AIDS as they return to the community. This may help with the problematic area of release planning.

> "It doesn't make sense to put a lot of time and money into researching and having provisions on things that I never see…I know that HIV is a big concern, but we just don't see it and so for me to spend a lot of time, money, and resources to try to have a big program set up just doesn't make sense."
>
> -A medical staff member from one of Ohio's FSJs

Jails must also be open to these community linkages, despite the difficulties of screening individuals who come into contact with inmates and the other measures they would need to take in order to allow community HIV care providers into their facilities. Interview information suggests that it is particularly helpful if:

- Sheriffs and jail administrators are open to the provision of HIV care services by community providers and communicate this openness to their employees. This creates an atmosphere in which medical staff members feel freer to pursue community linkages. Endorsement by jail administration can also encourage cooperation on the part of the non-medical staff who may help or hinder HIV care efforts through their control of inmates' movements (releasing inmates to attend HIV education sessions, for example). During the interviews, many respondents specifically cited the attitude of their jail administration as an influence on HIV care policies and procedures.

HIV Awareness/Education

Many medical staff members expressed the desire to update their training in HIV care. Several specifically requested a resource book on HIV care for inmates to which they could refer when an inmate with HIV/AIDS arrives at the jail. In addition to information on medical protocols, some respondents asked for information on the correct policies for housing inmates with HIV/AIDS and for handling the inmate's medical information. To address these needs:

- Many jails, especially those who do not see many inmates with HIV/AIDS and who do not have a physician with infectious disease experience on staff, would benefit from a resource book to which they could refer when they identify an inmate with HIV/AIDS. Some jails appeared to not have set policies regarding certain aspects of HIV care, so such a resource could fill this gap with valuable guidance. Some of the jails that appear to provide a broad array of medical services to inmates with HIV/AIDS mentioned using similar resources.
- Members of jail medical staff who might not have the time or funds to travel to seek continuing education in HIV/AIDS could seek out online training in the subject. One potential source of this training is the Health Resources and Services Administration-funded AIDS Education and Training Centers, which provide online webcasts for continuing education.[25]
- Jails may also benefit from a listserv or social media site dedicated to HIV care in FSJs that deals with care issues as well as the funding issues mentioned previously.

A Policies and Procedures "Toolkit"

One of the most important findings from this study is that no two FSJs are alike and developing policies and procedures at the state-level related to HIV care could prove to be difficult. A possible focus could be to encourage jails to develop policies and procedures locally. A *toolkit* and technical assistance could be provided to jail staff to support them as they write policies and procedures that are responsive to the current local environment. Some suggestions for policies and procedures include:

(1) Jails should create an environment in which inmates are encouraged to disclose their HIV-seropositive status to jail medical staff. This would enable inmates to receive more relevant medical care. Perhaps something as simple as placing posters throughout the facility that encourage inmates to self-disclose their HIV-serostatus or

[25] For more on the AIDS Education and Training Centers, see http://www.aidsetc.org/; for the Pennsylvania/MidAtlantic AIDS Education and Training Center web site, see http://www.pamaaetc.org/.

Hepatitis C status would improve medical care and jail staff would get the candid self-disclosure that many of them would apparently like to get.

(2) It would seem critically important for jails to ensure that inmates living with HIV are connected with a local AIDS service organization (ASO) when released back into the community. ASOs can help with issues such as housing, medications and adherence, legal assistance, and mental health care. During the release period, it seems important for jail staff to have current information about community resources available to inmates being released.

(3) More confidential/private intake environments may be needed to facilitate a fuller disclosure of an inmate's health issues (e.g., HIV-serostatus disclosure). Regardless of a jail's official policy, many interview respondents stressed that it is extremely difficult to preserve the confidentiality of inmates' health information in the jail setting. To disclose their HIV status when they are being admitted to the jail frequently requires inmates telling a member of the non-medical staff who is conducting the intake screening. Moreover, these screenings are often conducted in settings that make it difficult to avoid being overheard by others. Many respondents reported that at least one corrections officer is present during any interaction between medical staff and inmates. This means that even when inmates disclose their HIV serostatus to a member of the medical staff in the jail's medical area, at least one member of the non-medical staff is always privy to the information.

(4) All jails should permit HIV-infected inmates to bring their HIV-related medications into jail with them.

(5) Policies are needed so that non-adherence does not occur when a person moves from a jail to prison.

Some suggestions for resources include:

(1) Mental health care seems inadequate. The two or three weeks that many inmates spend in jail can provide the opportunity to initiate some form of mental health treatment/intervention. The same could be said for alcohol and substance abuse interventions/treatment. Perhaps the use of telepsychiatry should be considered or the use of other innovative technologies (e.g., the Internet) should be considered as ways to bring cost-effective forms of treatment to inmates. Perhaps jails could partner with nearby universities and graduate students who can offer counseling or psychotherapy to inmates.

(2) Given that approximately one-half of the jails were unaware of Ryan White funds, jails should be provided greater information about the potential use of Ryan White funds to provide services for their inmates living with HIV/AIDS.

Concluding Remarks

Limitation of the Study

A key limitation of this study was the inability to determine prevalence rates for HIV/AIDS in FSJs. In order to appropriately assess the impact of HIV/AIDS on the inmate population in FSJs, it is essential to establish a state-wide reporting system. This reporting system could include a voluntary testing system which would result in more empirical prevalence rates than self-reported data. In any case, a reporting system (based on either self-reported HIV diagnoses or laboratory diagnoses) would identify FSJs with high prevalence rates that could be used in piloting programs such as the *Policies and Procedures Toolkit* as described previously. Policies and procedures crafted by FSJs who are experienced in housing inmates living with HIV/AIDS could potentially serve as templates for those FSJs with little or no experience.

Directions for Future

As the focus of this project was assessing needs, it could prove helpful to bring together jail administrators from across the state to discuss the findings of this study. One of the benefits of using participatory research methods such as interviewing is to bring the information back to the informants for review. The jail administrators and jail medical staff members could be very helpful in prioritizing the agenda for HIV/AIDS care in Ohio's FSJs.

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Interview Script for HIV Care Services Jail Needs Assessment
Prepared by the Voinovich School of Leadership and Public Affairs at Ohio University

Thank you for taking the time to speak with us today.

The HIV Care Services Section of the Ohio Department of Health is interested in the way Ohio's Full Service Jails provide care for inmates with HIV or AIDS. ODH is aware that housing inmates with HIV/AIDS is a difficult task that requires a great deal of resources, so it would like to learn how it can be of assistance to your jail and other Full Service Jails.

ODH has asked Ohio University's Voinovich School to meet with personnel from all of Ohio's Full Service Jails to gather information about HIV care in these facilities. Our goal is to learn how jails meet the challenges of providing HIV care and to gather information for ODH about how it can assist FSJs with HIV care. Our discussion today will be absolutely confidential. No names of people or facilities will be used in our reports. Nothing you say can be traced back to you.

As we meet with people from the Full Service Jails throughout Ohio, we sometimes speak with members of the jail medical staff, and at other times we speak with wardens or other jail staff members. Because of this, the questions we have today are designed for both audiences. This means that there might be some questions that are outside of your area of expertise. If this happens, please feel free to tell us and we'll move one.

Because your input is important we'd like to make sure that I can remember all that you tell us today. Recording this conversation will help make sure that we don't miss any details. The recording would be used for reference only as the Voinovich School prepares its report for ODH and will be erased once the report is complete. Do you have any questions or concerns before I turn on the recorder and begin?

Background

(1) To start with, please tell me a little bit about your facility.

(a) How many inmates do you house? (# beds)

(b) How many employees are at this facility?

(c) Does your jail have any features that make it unique among Ohio's Full Service Jails?

(2) How long you have worked at the jail? What is your position at the jail?

(3) Has your jail housed inmates known to have HIV/AIDS?

Follow up:

(a) If so, roughly how many? In the past year?

Can you tell me how many inmates you've had in the last year? This will help me determine the frequency of HIV cases in your jail.

(b) We understand that it can be difficult for correctional facilities to avoid duplicates in their counts of inmates with HIV/AIDS. If an inmate with HIV/AIDS is committed to your facility multiple times, are they counted only once in your total number of inmates with HIV/AIDS, or are they counted each time they are committed to the jail?

(c) ODH is very interested in tracking the cases of HIV and AIDS in Ohio's Full Service Jails. Has your jail collected any data on the number of cases of HIV/AIDS in the jails, the number of cases newly identified in jail, the number of inmates refusing treatment for HIV/AIDS, or issues like that?

(d) Can you tell us how many inmates with Hepatitis C and how many inmates with TB have passed through your jail in the last twelve months?

(4) Our records indicate that health care in this jail is provided by (a managed care provider)/(your jail, not a managed care provider). Is that correct?

(5) Since we will be discussing the care provided to inmates with HIV or AIDS, I'd first like to know about the people who provide that care. How many people are on the medical staff at your jail?

Follow up:

(a) What are their positions?

(b) How often are they at the jail?

Identifying Inmates with HIV/AIDS

The next few questions are designed to help me learn how your jail identifies those inmates with HIV or AIDS.

(6) Let's talk about the initial health screening of inmates. Would you please walk me through the screening? If I were in the room for an intake screening, what would I see?

Follow up:

(a) When does this screening take place?

(b) Are any medical staff available to provide this screening after hours or on weekends?

(c) What particular health conditions are you looking for when you do the screening? (What medical conditions raise a red flag for you?)

(7) At what point during their entry into the jail do inmates have the opportunity to self-identify as HIV-positive?

Follow up: Once an inmate self-identifies, what steps, if any, do you take to verify their HIV status?

(8) We've talked about existing conditions, what about conditions inmates might not know about? Do you view it as your role to uncover these conditions, in particular HIV/AIDS?

(9) Under what circumstances is an inmate tested for HIV?

Follow up:

(a) Is testing explicitly offered or is it available upon the inmate's request?

(b) Under what circumstances is the inmate charged for the test and what is the cost?

(10) Tell me about what changes, if any, you'd like to see in the way this facility identifies inmates with HIV or AIDS.

Follow up:

(a) What would allow you to make these changes?

(b) [If not currently offering testing] If you were to offer HIV testing to inmates and if this subsequently increased the number of your inmates know to have HIV/AIDS, what types of assistance would your jail need in order to be able to provide care for this larger number of inmates with HIV/AIDS?

(11) Now let's talk about what happens after an inmate's HIV status has been identified. Once the jail learns that an inmate has HIV or AIDS, what members of the jail staff are told about the inmate's health status?

(12) Would you describe your jail's housing policy for inmates with HIV/AIDS?

Care While in Jail

Now I would like to learn about the care provided for inmates with HIV/AIDS.

(13) I'd like to ask several questions about prescription medications for inmates with HIV/AIDS. To start, does your jail allow inmates or their families to bring medications to the jail?

Follow up, if medication is allowed:

(a) Is this practice to fill in the gap between the time the inmate arrives and the time the jail obtains medications for the inmate? Or do families bring in medication for the duration of the inmate's stay?

(b) How do you go about verifying that the inmate has a prescription for the medication they bring in, and that the pills in the bottle are actually the prescribed pills?

(c) Can a non-formulary medication be brought into the facility?

(14) If an inmate is not providing his or her own medication, how does the jail go about getting medication for the inmate?

Follow up:

(a) Does the pharmacy keep a supply of drugs in stock for HIV/AIDS patients?

(b) How much time does it normally take for medications to be obtained for the inmate? Does this change if the inmate arrives after hours or on a weekend?

(c) Are there any limitations on the types of HIV medications you can dispense?

(d) If the jail is paying for medications, does that play a role in the length of time the inmate ends up staying in jail?

(15) We've been told that sometimes jails have to transfer inmates identified as having HIV or AIDS to other jails, perhaps to return them to their home county or for some other reason. Are there any differences in the way your jail handles the transfer of inmates with HIV/AIDS, as opposed to the way it handles transfers of inmates from the general jail population?

(16) Who is responsible for designing and monitoring the course of medical treatment for inmates with HIV or AIDS?

Follow up: Would you describe for me the process by which an inmate's course of treatment is determined?

(17) Describe for me the way HIV/AIDS medications are administered to inmates.

Follow up:

(a) Do you use pill lines or a keep-on-person policy?

(b) Are inmates required to be directly observed while taking their medications?

(c) Are you able to dispense medications more than one time a day?

(18) It is our understanding that the medical regimens for patients with HIV/AIDS are difficult to adhere to, even under the best of circumstances. In your jail, what are the most common causes of missed doses?

Follow up: How frequently do such cases occur?

(19) Now I'd like to know about specialist care for inmates with HIV/AIDS. Please tell me how your jail goes about providing inmates with access to HIV specialists.

Clarification, if needed: Do you transport inmates to HIV specialists as a part of their HIV care?

Follow up: What would make it easier for you to get your inmates to specialists, or to get specialists to your inmates?

(20) Please tell me about the non-medical services, for example social workers, counseling, that your jail provides for inmates with HIV/AIDS.

(21) What role do community social agencies play in the provision of medical and non-medical care for inmates with HIV/AIDS? When I say social agencies I'm thinking of groups like health departments that provide HIV testing, religious groups that provide counseling, social services that provide case management, and other groups like that.

Follow up: Tell me more about these agencies that provide services to inmates with HIV/AIDS.

(a) What specific services do they provide?

(b) At what point during an inmate's incarceration are they linked up with these services?

(22) Have any jail employees, including members of the non-medical jail staff, participated in HIV/AIDS training?

Follow up, if yes:

(a) Who provided the training?

(b) When and where did the training take place?

(c) Is there more training planned for the future?

(d) Would your jail be interested in this type of training, if it were made available?

Discharge/Transfer

We've just discussed care for inmates while in jail, now I'd like to discuss care for inmates as they leave the jail.

(23) First I'd like to ask about inmates who are transferred to prisons after sentencing.

Has your jail ever transferred an inmate with HIV or AIDS to a prison?

(a) If no: Would you tell me about any policies or protocols your jail might have to help ensure continuity of medical care for inmates as they are transferred to prison?

If yes: Would you describe what steps, if any, the jail was able to take to ensure continuity of medical care for the inmate?

Follow up:

(b) Were any pharmaceuticals, including HIV-related medicines, sent with the inmate?

(c) How much of a supply?

(d) How were the inmate's medical records transferred to the prison (with the inmate or later on, by mail, fax, etc.)?

(24) Next I'd like to hear about inmates who are released into the community. I understand that inmates can have very short stays in jail and that they may be released with little notice. Both of these conditions must make discharge planning quite difficult. I'd like to hear about what your jail is able to do in the face of these challenges.

The first aspect of an inmate's discharge I'd like to hear about has to do with medications. Specifically, what is your jail's practice when it comes to providing pharmaceuticals, including HIV medications, to inmates reentering the community?

Follow up, if applicable:

(a) How many days' worth of HIV-related medicines are provided?

(b) Do you ever have inmates refuse discharge medications?

(25) Now I want to discuss doctor's appointments. How can an inmate go about scheduling medical appointments for HIV care in the community as they approach release?

(26) In addition to doctor's appointments, what other types of HIV care, if any, are arranged for an inmate nearing release?

(27) As you may know, the Ryan White HIV/AIDS Treatment Modernization Act provides funds under certain conditions for medical services for incarcerated persons exiting the correctional system. These services can include HIV testing, counseling, medical referrals, and prescription drugs. Has your jail been able to draw on resources funded by the Ryan White to help you as you arrange follow-up care for inmates?

Follow up: How would these types of services be helpful to your jail in the re-entry process?

Concluding Questions

I have just a few more questions before we are done.

(28) Overall, where do you see the biggest gaps or needs in care for inmates with HIV/AIDS?

(29) What are your jail's biggest strengths when it comes to providing care for inmates with HIV/AIDS?

(30) What else you would like ODH to know about HIV care for jail inmates?

Request formulary and medical protocols

ODH is interested in the pharmaceuticals that are available to inmates with HIV/AIDS. The best way to get this information is to see the formularies of each jail. Would you be willing to provide us a copy of your formulary? Absolutely no documents will be identified with the jail that provides them to us.

We are also interested in the medical policies of each jail, including protocols for the treatment of inmates with HIV or AIDS. Would you be willing to give us a copy of your jail's medical policies and protocols? Again, we will take great care to ensure that no documents can be linked to the jails providing them to us.

Thank you again for taking the time to be interviewed today. We appreciate your willingness to help and will send your facility a copy of our report once it is complete.

I.

[redacted]

Incident Number

Booking System Inmates Property -

Last Name: First Name: MI: Social: Booking #: Ano: Date:

Number: Name: Apt: City: St: Zip: Phone: Time:

Wallet: Watch:
Keys: Rings:
Credit:
Clothing:
Other:

	MONEY:	TOTAL:	ITEMS ISSUED:	
Ones:	0	0.00	Matress:	NO
Fives:	0	0.00	Blanket:	NO
Tens:	0	0.00	Towel:	NO
Twenties:	0	0.00	Wash Cloth:	NO
Fifties:	0	0.00	Hygiene Kit:	NO
Hundreds:	0	0.00	Shoes:	NO
Change:	0.00	0.00	Sheet:	NO
Total:		0.00	Uniform:	NO

Booking Officer: 704 Property Bag:

Acknowledgement of Inventory Collected

Inmate: _____ Date: _____ Time: _____

Officer: _____ Date: _____ Time: _____

Acknowledgement of Inventory Returned

Inmate: _____ Date: _____ Time: _____

Officer: _____ Date: _____ Time: _____

DO YOU HAVE ANY MEDICAL PROBLEMS THAT WE SHOULD KNOW ABOUT? _____

If yes what type _____ Action Taken _____

Do you use alcohol? _____ If so how often? _____

Release Information:

Reason Released _____

Agency / Person Released To: _____ Date: _____ Time: _____

Officer Released To: _____

Prisoner's Signature: _____ Releasing Officer: _____

Inmate's Medications Returned? _____

I HAVE BEEN FURNISHED A COPY OF THE [redacted]JAIL FACILITIES RULES AND REGULATIONS FOR INMATES. I AM ABLE TO READ AND UNDERSTAND THE RULES AND REGULATIONS WHICH I ACKNOWLEDGE WITH MY SIGNATURE.

Inmate's Signature Date Witness

[redacted]

Incident Number

-

Booking System Medical Evaluation

Last Name: First Name: Mi: Title: Social: Book #:

Number: Name: Apt: City: St: Zip: Phone: Date: Time:

1. Is the inmate conscious? NO
2. Does inmate have obvious pain, bleeding or other symptoms that suggest need for Emergency Service? NO
3. Are their any signs of trauma or illness requiring immediate care? NO
4. Are their any signs of infections that might spread through jail? NO
5. Does inmate appear to be under the influence of alcohol or drugs? NO
6. Is the inmate carrying medication? NO
7. Does inmate's behavior suggest risk of assault to staff or inmates? NO
8. Are you contemplating suicide at this time? NO
9. Are you presently taking medication for diabetes, heart disease, arthritis, asthma, ulcers, high blood pressure or psychiatric disorder? NO
   Medication Type:
   Doctor Name:
10. Do you have a special diet perscribed by a physician? NO
    Diet Type:
11. Do you have a history of venereal disease or abnormal discharge? NO
    Disease Type:
12. Have you recently been hospitalized or recently seen a medical doctor or psychiatric doctor? NO
13. Are you allergic to any medication? NO
14. Have you fainted recently or had a recent head injury? NO
15. Do you have Epilepsy? NO Hiv? NO
    Tuberculoses? NO Hepatitus? NO
    Diabetes? NO Dental? NO
16. Have you ever attempted suicide? NO
17. Has a member of your immediate family committed suicide? NO
18. Are you pregnant? NO
19. Are you on birth control pills? NO
20. Have you recently delivered? NO

Remarks:

20. Do you have health Insurance? Is so attach copy! NO

Booking Officer:

I hereby Authorize the release of the above information regarding my Medical / Mental health and condition.

Inmate: Date:

Apr. 14. 2009 8:16AM [redacted] No. 1635 P. 1

ALCOHOL USE

1. DO YOU USE ALCOHOL? YES NO
2. HOW MUCH ALCOHOL DO YOU USE? _____
3. WHEN DID YOU LAST DRINK ALCOHOL? _____

STREET DRUG USE

5. DO YOU USE DRUGS? YES NO
6. WHAT TYPE OF DRUGS DO YOU USE? _____
7. HOW OFTEN DO YOU USE DRUGS? _____
8. HOW MUCH DO YOU USE? _____
9. WHEN DID YOU LAST TAKE DRUGS? _____

DOES THE PRISONER USE

10. ARTIFICAL LIMBS? LIST _____
11. BRACES YES NO
12. DENTURES YES NO
13. GLASSES YES NO
14. HEARING AID YES NO
15. PACEMAKER YES NO
16. WHEEL CHAIR YES NO
17. CRUTCHES YES NO

DOES THE PRISONERS HAVE

18. INJURIES OR ID MARKS (BIRTHMARKS)? _____
19. DEFORMITIES _____
20. ALLERGIES _____
21. RASHES/INFESTATIONS _____
22. MEDICAL INSURANCE YES / NO & WITH WHO _____
23. POLICY NUMBER _____
24. DO YOU HAVE YOUR MEDICAL CARD? YES NO (IF YES PHOTOCOPY)
25. PERSONAL PHYSICIAN _____
26. PHONE NUMBER AND ADRESS _____
27. SPECIAL MEDICAL NEEDS

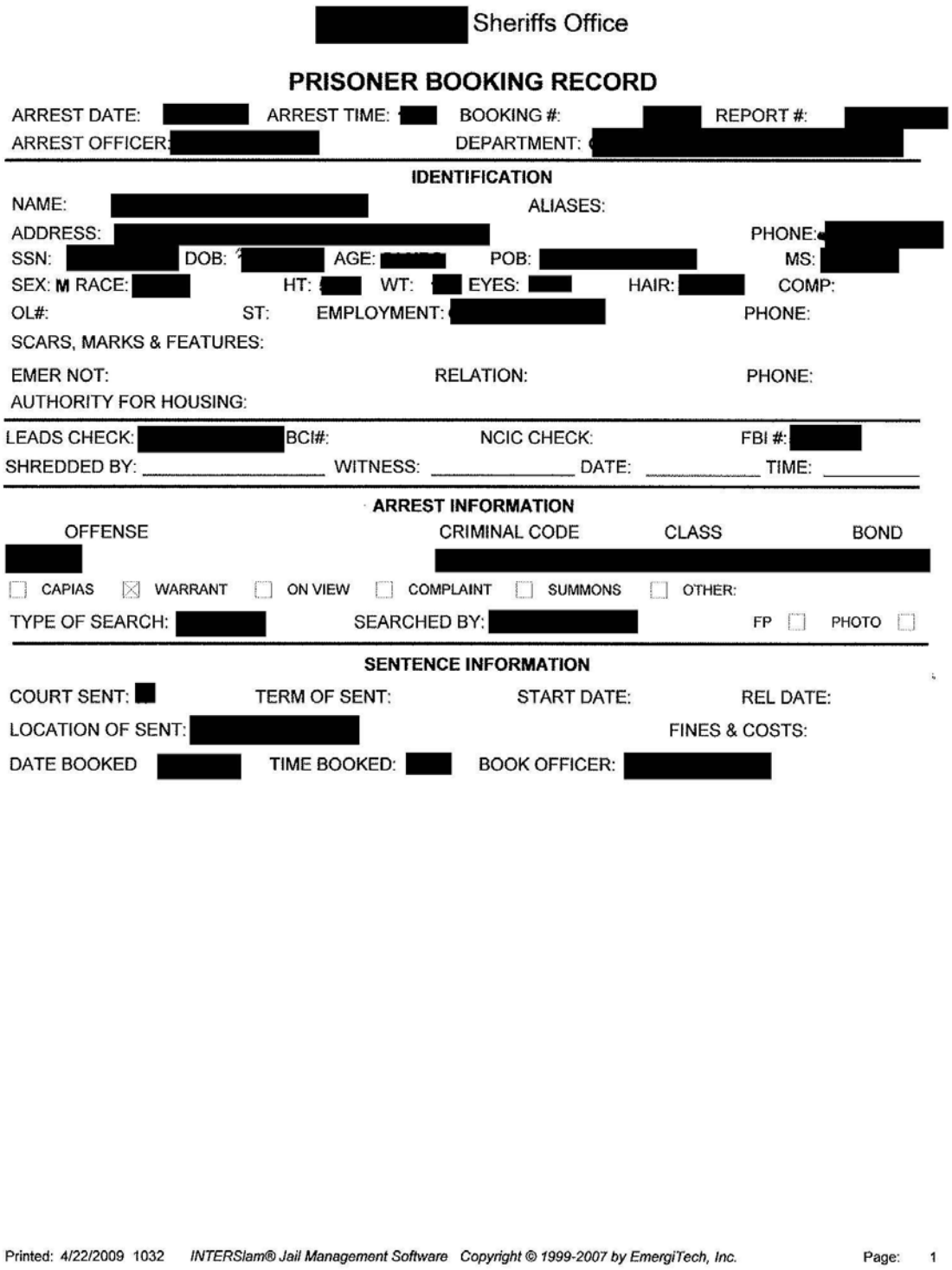
_____
_____
_____

I HAVE ANSWERED ALL MEDICAL QUESTOINS TRUTHFULLY AND TO THE BEST OF MY KNOWLEDGE AND I HAVE REVIEWED A COPY OF THE RULES AND REGULATIONS OF THE JAIL AND I AM AWARE THEY ARE POSTED IN THE INCARCERATION AREA?

_____
(PRISONERS SIGNATURE) DATE/TIME

_____
(CORRECTION OFFICER) DATE/TIME

II.



[redacted] Sheriffs Office

PRISONER BOOKING RECORD

ARREST DATE: [redacted] ARREST TIME: [redacted] BOOKING #: [redacted] REPORT #: [redacted]
ARREST OFFICER: [redacted] DEPARTMENT: [redacted]

IDENTIFICATION

NAME: [redacted] ALIASES:
ADDRESS: [redacted] PHONE: [redacted]
SSN: [redacted] DOB: [redacted] AGE: [redacted] POB: [redacted] MS: [redacted]
SEX: M RACE: [redacted] HT: [redacted] WT: [redacted] EYES: [redacted] HAIR: [redacted] COMP:
OL#: ST: EMPLOYMENT: [redacted] PHONE:
SCARS, MARKS & FEATURES:
EMER NOT: RELATION: PHONE:
AUTHORITY FOR HOUSING:

LEADS CHECK: [redacted] BCI#: NCIC CHECK: FBI #: [redacted]
SHREDDED BY: _____ WITNESS: _____ DATE: _____ TIME: _____

ARREST INFORMATION

OFFENSE [redacted] CRIMINAL CODE [redacted] CLASS BOND

☐ CAPIAS ☒ WARRANT ☐ ON VIEW ☐ COMPLAINT ☐ SUMMONS ☐ OTHER:

TYPE OF SEARCH: [redacted] SEARCHED BY: [redacted] FP ☐ PHOTO ☐

SENTENCE INFORMATION

COURT SENT: [redacted] TERM OF SENT: START DATE: REL DATE:
LOCATION OF SENT: [redacted] FINES & COSTS:
DATE BOOKED [redacted] TIME BOOKED: [redacted] BOOK OFFICER: [redacted]

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[redacted] Sheriffs Office

PRISONER BOOKING RECORD

NAME: [redacted] BOOKING #: [redacted] REPORT #: [redacted]

HOLD INFORMATION

HOLD FOR: REASON:

DATE CONFIRMED: TIME CONFIRMED: CONFIRMED BY:

RELEASE INFORMATION

AUTHORITY TO RELEASE:

BOND POSTED: **$0.00** TYPE BOND: TIME HELD-HOURS: **0**

RELEASE DATE: RELEASE TIME: RELEASED BY:

RELEASED TO CUSTODY OF:

OFFICIAL REC. PRISONER:

COMMENTS: [redacted]

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Printed: 4/22/2009
At: 1032

[redacted] Sheriffs Office

Page: 1

Inmate Medical Screening

Inmate Info
Name: [redacted] Book#: [redacted]
DOB: [redacted] SSN: [redacted] Sex: [redacted]

Questionnaire Info
Created: [redacted] By: [redacted]
Edited: [redacted] By:

VISUAL ASSESSMENT

1.	Is inmate unconscious?	Yes **No**
2.	Does inmate have any visible signs of trauma, illness, obvious pain or bleeding, requiring immediate emergency or doctor's care?	Yes **No**
3.	Is there obvious fever, swollen lymph nodes, jaundice, or other evidence of infection that might spread throughout the facility?	Yes **No**
4.	Any signs of poor skin condition, vermin, rashes, or needle marks?	Yes **No**
5.	Does inmate appear to be under the influence of drugs or alcohol?	Yes **No**
6.	Any visible signs of alcohol or drug withdrawal?	Yes **No**
7.	Does inmate's behavior suggest the risk of suicide or assault?	Yes **No**
8.	Is inmate carrying medication?	Yes **No**
9.	Does inmate agree to allow Jail Doctor to check this medication and approve it for inmates use while incarcerated?	**Yes** No
10.	Does the inmate have any physical deformities?	Yes **No**
11.	Does inmate appear to have psychiatric problems?	Yes **No**

INMATE QUESTIONNAIRE

Do you have or have you ever had any of the following:

12.	allergies to food or medication	Yes **No**
13.	seasonal allergies	Yes **No**
14.	arthritis	Yes **No**
15.	asthma	Yes **No**
16.	diabetes	Yes **No**
17.	epilepsy-seizures-date of last seizure	Yes **No**
18.	fainting spells	Yes **No**
19.	heart condition	Yes **No**
20.	hepatitis	Yes **No**
21.	high blood pressure	Yes **No**
22.	psychiatric disorder	Yes **No**
23.	seizures	Yes **No**
24.	tuberculosis	Yes **No**
25.	ulcers	Yes **No**
26.	venereal disease	Yes **No**
27.	other (specify)	Yes **No**
27.	Have you recently been hospitalized or treated by a doctor?	Yes **No**
28.	Do you currently take any medication prescribed by a doctor?	Yes **No**
29.	Are you allergic to any medication?	Yes **No**
30.	Do you have any handicaps or conditions that limit activity?	Yes **No**
31.	Have you ever attempted suicide or are you thinking about it now?	Yes **No**
32.	Do you regularly use alcohol or street drugs?	Yes **No**
33.	Do you have any problems when you stop drinking/using drugs?	Yes **No**
34.	Do you have a special diet prescribed by a physician?	Yes **No**
35.	Do you have any other medical problems?	Yes **No**
36.	Do you have Health Insurance?	Yes **No**
37.	Are you covered under Veterans Hospital Rights?	Yes **No**

Form 01-INM-022
Revised: 1/27/2005

Printed: 4/22/2009
At: 1032

[redacted] Sheriffs Office

Page: 2

Inmate Medical Screening

Inmate Info
Name: [redacted]
DOB: [redacted] SSN: [redacted] Book#: [redacted] Sex: [redacted]

Questionnaire Info
Created: [redacted] By: [redacted]
Edited: [redacted] By:

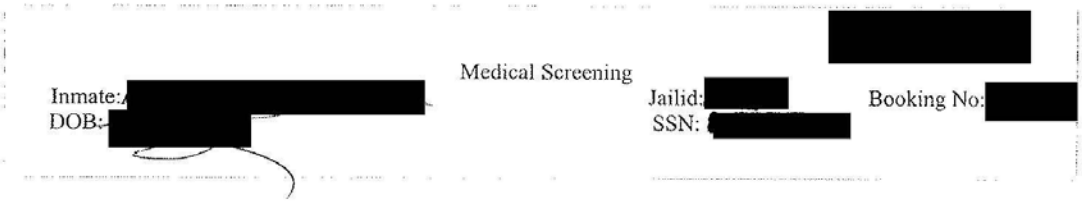
I CERTIFY THAT I HAVE TRUTHFULLY ANSWERED THESE QUESTIONS ABOUT MY HEALTH.

Inmate's Signature X_____ Witness X_____

Medical Officer X_____ Date _____ Time _____

Form 01-INM-022
Revised: 1/27/2005

III.



Medical Screening

Inmate: [redacted]
DOB: [redacted]
Jailid: [redacted]
SSN: [redacted]
Booking No: [redacted]

Booking Officer Observations		
No	Question	Answer
1	VISIBLE SIGNS OF TRAUMA OR ILLNESS REQUIRING IMMEDIATE EMERGENCY OR DOCTOR'S CARE?	No
2	OBVIOUS FEVER, SWOLLEN LYMPH NODES, JAUNDICE OR OTHER SIGNS OF INFECTION?	No
3	POOR SKIN CONDITION, VERMIN, RASHES, OR NEEDLE MARKS?	No
4	APPEARS TO BE UNDER THE INFLUENCE OF ALCOHOL OR DRUGS OR HAS VISIBLE SIGNS OF WITHDRAWAL? (EXTREME PERSPIRATION, PINPOINT PUPILS, SHAKES, NAUSEA, CRAMPING, VOMITTING)	Yes
5	BEHAVIOR OR STATEMENTS THAT SUGGEST RISK OF SUICIDE OR ASSAULT?	No
6	APPEARS CONFUSED OR DISORIENTED	No
7	PHYSICAL INJURIES, DEFORMITIES, PROSTHETIC DEVICES (LIST):	No

Officer Detainee Questionaire		
No	Question	Answer
1	ALLERGIES	No
2	ARTHRITIS	No
3	ASTHMA	No
4	DENTAL PROBLEMS	No
5	DT'S (DELRIUM TREMENS)	No
6	DIABETES	No
7	EPILEPSY	No
8	FAINTING	No
9	PHYSICIAN PRESCRIBED DIET	No
10	URINARY TRACT PROBLEMS	No
11	ULCERS	No
12	VENEREAL DISEASE (VD)	No
13	EVER TESTED POSITIVE FOR AIDS, TB, OR HEPATITIS	No
14	ANY TYPE OF HEART OR HIGH BLOOD PRESSURE PROBLEMS	No
15	ARE YOU BEING TREATED FOR MENTAL HEALTH PROBLEMS	No
16	HAVE YOU EVER TRIED TO KILL OR HARM YOURSELF	No
17	DO YOU FEEL DEPRESSED OR SUICIDAL NOW	No
18	ARE YOU TAKING ANY MEDICATION? IF YES, WHAT?	No
19	WHO PRESCRIBED THE MEDICATION	
20	DO YOU HAVE THE MEDICATION WITH YOU	No
21	FEMALE: ARE YOU ON BIRTH CONTROL PILLS	No
22	ARE YOU PREGNANT? IF SO, HOW MANY MONTHS?	No
23	DO YOU HAVE ANY OTHER MEDICAL PROBLEMS	No
24	ADDITIONAL INFORMATION:	No

Alcohol/Drugs		
No	Question	Answer
1	DO YOU USE ALCOHOL?	Yes
2	IF YES, HOW OFTEN?	WEEKENDS
3	HOW MUCH?	COUPLE BEERS
4	ADDITIONAL INFORMATION:	No
5	WHEN DID YOU DRINK LAST	01/03/2009 2030HRS
6	DO YOU USE STREET DRUGS	No
7	HOW OFTEN?	
8	HOW MUCH?	
9	WHEN DID YOU TAKE DRUGS LAST	

Medical Screening

Inmate: [redacted] Jailid[redacted] Booking No: [redacted]
DOB: [redacted] SSN: [redacted]

Disposition/Referral		
No	Question	Answer
1	GENERAL POPULATION	Yes
2	SICK CALL	No
3	MENTAL HEALTH	No
4	MENTAL ISOLATION	No
5	PLACE UNDER CLOSE OBSERVATION, PERSONAL CHECKS EVERY___ MINUTES.	No
6	REFUSE TO ADMIT UNTIL EXAMINED BY A PHYSICIAN	No
7	OTHER	No
8	COMMENT	No
9	DETAINEE REFUSED ANSWER QUESTIONS	No
10	DETAINEE WAS UNABLE TO ANSWER MEDICAL QUESTIONS	No
11	REASON	No
12	DO YOU HAVE MEDICAL INSURANCE OR COVERAGE. IF YES, WHO IS THE CARRIER? WHAT IS THE CARD NUMBER?	No
13	EMERGENCY CONTACT INFORMATION? NAME AND PHONE NO.	Yes Yes

Inmate Signature _____ Date _____

Officer's Signature _____ Date _____

Witness _____ Date _____

IV.

[redacted] SHERIFF'S OFFICE

Booking System Medical Evaluation

Last Name: First Name: MI: Title: Social: Book #:

Number: Name: Apt: City: St: Zip: Phone: Date: 03/31/2009 Time:

1. Is the inmate conscious? NO
2. Does inmate have obvious pain, bleeding or other symptoms that suggest need for Emergency Service? NO
3. Are their any signs of trauma or illness requiring immediate care? NO
4. Are their any signs of infections that might spread through jail? NO
5. Does inmate appear to be under the influence of alcohol or drugs? NO
6. Is the inmate carrying medication? NO
7. Does inmate's behavior suggest risk of assault to staff or inmates? NO
8. Are you contemplating suicide at this time? NO
9. Are you presently taking medication for diabetes, heart disease, arthritis, asthma, ulcers, high blood pressure or psychiatric disorder? NO
   Medication Type:
   Doctor Name:
10. Do you have a special diet perscribed by a physician? NO
    Diet Type:
11. Do you have a history of venereal disease or abnormal discharge? NO
    Disease Type:
12. Have you recently been hospitalized or recently seen a medical doctor or psychiatric doctor? NO
13. Are you allergic to any medication? NO
14. Have you fainted recently or had a recent head injury? NO
15. Do you have Epilepsy? NO Hiv? NO
    Tuberculoses? NO Hepatitus? NO
    Diabetes? NO Dental? NO
16. Have you ever attempted suicide? NO
17. Has a member of your immediate family committed suicide? NO
18. Are you pregnant? NO
19. Are you on birth control pills? NO
20. Have you recently delivered? NO

Remarks:

Booking Officer:

I hereby Authorize the release of the above information regarding my Medical / Mental health and condition.

Inmate: Date:

V.

[redacted] SHERIFF'S OFFICE

JAIL DIVISION

JAIL BOOKING: [redacted] FAX: [redacted]

MEDICAL OFFICE: [redacted]

MEDICAL RECORD/TRANSFER SHEET

INMATE NAME: _____

DATE OF BIRTH: _____ SSN#: _____

BOOK IN DATE: _____ BOOKING #: _____

MEDICAL PROBLEMS

ALLERGIES: _____

_____

_____

_____

MEDICAL DIAGNOSIS: _____

_____

_____

_____

CURRENT MEDICATONS: (MEDICATON/DOSAGE/ROUTE/EXP) _____

_____

_____

_____

_____

SPECIAL DIET: (YES) (NO)

REASON: _____

PPD: (YES) (NO)

DATE: _____ RESULT: (+) (-) _____mm

CHEST X-RAY: (Y) (N) RESULT: _____

MEDICATION STARTED: _____ COMPLETE DATE: _____

PHYSICAL DISABLITIES: ( ) NONE

( ) GLASSES ( ) DENTURES: TOP / BOTTOM ( ) CONTACTS

( ) CANES ( ) BRACE: type: _____

FOLLOW/UP CARE NEEDED (Y) (N): _____

_____

_____ _____ _____

NAME (RN / MEDICAL OFFICER) TITLE DATE

Medical Screening

Inmat[redacted] Jailid:[redacted] Booking No:[redacted]
DOB[redacted] SSN[redacted]
Run Date:[redacted]

Booking Officer Observations		
No	Question	Answer
1	DOES THE PRISONER HAVE VISIBLE SIGNS OF TRAUMA OR ILLNESS REQUIRING IMMEDIATE EMERGENCY OR DOCTOR'S CARE?	Yes BURN TO WRIST HAS NOT BEEN CHECK OUT HAPPENED APPROX 30 HOURS AGO
2	OBVIOUS FEVER, SWOLLEN LYMPH NODES, JAUNDICE OR OTHER SIGNS OF INFECTION?	No
3	POOR SKIN CONDITION, VERMIN, RASHES, OR NEEDLE MARKS?	Yes HAS BURNES TO LEFT WRIST
4	APPEARS TO BE UNDER THE INFLUENCE OF ALCOHOL OR DRUGS OR HAS VISIBLE SIGNS OF WITHDRAWAL? (EXTREME PERSPIRATION, PINPOINT PUPILS, SHAKES, NAUSEA, CRAMPING, VOMITTING)	No
5	BEHAVIOR OR STATEMENTS THAT SUGGEST RISK OF SUICIDE OR ASSAULT?	No
6	APPEARS CONFUSED OR DISORIENTED	No
7	PHYSICAL INJURIES, DEFORMITIES, PROSTHETIC DEVICES (LIST):	Yes BURN TO WRIST
8	DO YOU CURRENTLY HAVE ANY INJURIES?	Yes BURNES TO WRIST
9	DO YOU HAVE ANY OPEN SORES OR LESIONS?	Yes BURNES TO WRIST

Officer Detainee Questionaire		
No	Question	Answer
1	ALLERGIES	No
2	ASTHMA	Yes NO MEDICATION
3	DT'S (DELERIUM TREMORS)	No
4	DIABETES	No
5	EPILEPSY	No
6	HX BIPOLOR/MANIC DEPRESSIVE	No
7	ULCERS	No
8	VENEREAL DISEASE (VD)	No
9	EVER TESTED POSITIVE FOR AIDS, TB, OR HEPATITIS	No
10	ANY TYPE OF HEART OR HIGH BLOOD PRESSURE PROBLEMS	No
11	ARE YOU BEING TREATED FOR MENTAL HEALTH PROBLEMS	No
12	HAVE YOU EVER TRIED TO KILL OR HARM YOURSELF	No
13	DO YOU FEEL DEPRESSED OR SUICIDAL NOW	No
14	ARE YOU TAKING ANY MEDICATION? IF YES, WHAT?	No
15	DO YOU HAVE THE MEDICATION WITH YOU	No
16	FEMALE: ARE YOU ON BIRTH CONTROL PILLS	No
17	ARE YOU PREGNANT? IF SO, HOW MANY MONTHS?	No
18	ADDITIONAL INFORMATION:	No

Alcohol/Drugs		
No	Question	Answer
1	DO YOU DRINK ALCOHOL EVERY DAY?	No
2	DO YOU USE STREET DRUGS? IF SO, WHAT TYPE?	No

Disposition/Referral		
No	Question	Answer
1	GENERAL POPULATION	No
2	SICK CALL (PROCESS COVERED?)	Yes
3	MENTAL HEALTH	No
4	MENTAL ISOLATION	No
5	PLACE UNDER CLOSE OBSERVATION, PERSONAL CHECKS EVERY___ MINUTES.	No
6	DETAINEE REFUSED ANSWER QUESTIONS	No

Medical Screening

Inmat[redacted] Jaili[redacted] Booking No:[redacted]
DOB[redacted] SSN:[redacted]
Run Date: [redacted]

7	DO YOU HAVE MEDICAL INSURANCE OR COVERAGE. IF YES, WHO IS THE CARRIER? WHAT IS THE CARD NUMBER?	Yes MAYBE ON MEDICADE
8	EMERGENCY CONTACT INFORMATION? NAME AND PHONE NO.	Yes 740-969-3674 JANET MOTHER

Inmate Signature _____ Date _____

Officer's Signature _____ Date _____

Witness _____ Date _____

[redacted] Jail Form

NAME_____ DATE_____

ALLERGIES_____

Withdrawal: Alcohol_____ Heroin_____ Opiate pills_____ Benzodiazapines _____

CURRENT MEDICATIONS/DRUGS AND DOSES_____

_____

_____

ALCOHOL HX Abuse Beers a day Vodka /Whiskey Pregnant Y N

History_____

_____

_____

_____

_____ (over)

BP_____ P_____ R_____ T if indicated_____

Weight _____ Height _____ LMP_____

History of: Smoker Seizures TB Cancer Heart Attack Stroke Hypertension Ulcers GERD Abuse DT's Depression Suicide Attempt Suicide thoughts Mind racing Voices Visions Jaundice, Hepatitis B Hepatitis C HIV

Klonopin Xanax Valium Heroin Oxycontin Percocet Vicodin Cocaine C Meth

Psych Hospitalization_____ Bipolar Schizophrenia Incarceration last_____

HEENT _____

Normal Thyroid enlarged Caries Periodontal Disease Tooth Abscess

_____

Heart RR&R Irregular A fib Murmur S3 S4_____

Chest/Lungs Normal /clear Pectus Old CABS scar Wheezing Rales COPD

_____

Abdomen Normal Liver: Enlarged Tender Other:_____

_____

Extremities Abscesses__ Vein Scars_____ Needle tracks Y N

Diagnosis:_____

Bipolar Disorder Mood Disorder NOS Hypertension Diabetes Insulin Dependent Diabetes Abscesses PTSD Childhood Abuse GERD Peptic Ulcer Disease

Depression Anxiety Disorder Poly Substance Abuse Alcohol Withdrawal Heroin/opiate W/D Sleep Disorder

Meds_____

Standing orders:

Rev 2008 Thomas R Vujea MD

VI.

JAIL ASSESSMENT TOOL

NAME: _____

D.O.B.: _____ SOCIAL SECURITY #: _____

ALLERGIES: _____

_____

HAVE YOU BEEN HERE BEFORE: _____

CURRENT MEDICAL ISSUES: CURRENT MEDICATIONS:

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____

DOCTORS: _____

PHARMACY: _____

VITAL SIGNS: B/P:_____ P:_____ R:_____ T:_____

PULSE OX: _____% BREATH SOUND: _____

PREGNANCY

HOW FAR ALONG: _____

URINE PREGNANCY TEST: _____

URINE DIP STICK: _____

OB/GYN MD: _____

COMENTS: _____

_____

NURSE'S SIG.: DATE:

[redacted]

INTAKE SCREENING FORM

Booking Date _____ Booking Number _____

Name _____ DOB _____

Officer Completing Form _____ Nurse Reviewer _____

PBT _____ Under the Influence of Drugs _____

Allergies (Any type) _____

Pertinent Medical Information _____

_____

Medical Clearance Done Y N NA

Does Patient have Medication with them? Y N Verified by RN _____

MEDICAL HISTORY

Contact Lenses/Glasses	Y	With Patient	Not With Patient	N
Body Piercings	Y	Location _____		N
		_____		
Body Deformities	Y	Location _____		N
Any Bleeding Presently	Y	Location _____		N
Emergency Care Needed	Y			N

CHRONIC DISEASE PROCESSES

Diabetes Y N Type _____ Medication Form: Pill _____ Insulin NPH REG

Accu-Check _____ times daily Last accu-check and shot? Day _____ Time _____

Asthma Y N Mild Moderate Severe Do you use an inhaler? Y N Type _____

Last asthma attack? _____ Have you ever been hospitalized for asthma? Y N

High Blood Pressure: Y N Do you take medicine: Y N Type _____

Do you have any history of Heart Disease? N Y Specify _____

Seizure: Y N Last Seizure _____ Mediation, if any _____

PSYCHIATRIC HISTORY

Are you on Psychiatric Medication? Y N Type _____

Have you been hospitalized recently for psychiatric problems? Y N Date _____

Who is your psychiatric Dr. or contact? _____

Have you ever been or are you now suicidal? Y N Are precautions needed? Y N

Is inmate a threat to staff or self? Y N Precautions Needed _____

RECENT MEDICAL PROBLEMS

Last Dr. Visit _____ Who is your Dr? _____ None

Any recent head injuries? Y N How did it occur? _____

Any skin conditions or rashes? Y N Please specify _____

Is inmate presently complaining of any of the following:

Headache Y N Stomach Pain Y N Generalized Pain Y N Specify _____

Fever Y N Lice/Itching Y N Other _____

GENERAL CONSENT FORM
CONSENT FOR TREATMENT

I, _____, hereby authorize attending physician, or the physician designated by him, and other facility employees, to examine and treat me. I also authorize such treatment and procedures, as deemed necessary by the physician, including but not limited to, the taking of such x-rays, medications, blood samples, urine samples and other therapies as deemed necessary. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantee or assurance has been made or implied to me as to the results that may be obtained by examination and treatment.

I hereby certify that I understand the above authorization.

WITNESS: _____

INMATE SIGNATURE: _____

DATE & TIME: _____

INMATE OR PERSON AUTHORIZED TO CONSENT: _____

RELATIONSHIP TO PATIENT: _____

[redacted]

Authorization for Release of Offender Medical Health Information

This Authorization may not be used for mental health or substance abuse treatment information

[redacted] will not condition treatment on this authorization. If authorizing disclosure to persons or organizations that are not health plans, covered health plans, covered health care providers or health care clearinghouses subject to federal health information privacy laws, they may further disclose the protected health information. However, genetic testing or HIV/AIDS information disclosed pursuant to this authorization may not be further disclosed except pursuant to authorization.

I hereby authorize _____ to release
Facility

_____
State specific Medical Health information to be disclosed including date(s) or date range

_____

_____

At Request of Offender and/or: _____
Purpose of disclosure

From the records of D.O.B. _____ _____
ID# Print Offender's Name

to: ☐ Self ☐ Authorized Attorney ☐ Health Care Facility ☐ Other: _____

Name: _____ – FAX [redacted] – PHONE [redacted]
Print Name

Address: _____ _____ _____ _____
Street Address City State Zip Code

I hereby release and hold harmless [redacted] and its employees from any liability which may occur as a result of the disclosure or dissemination of the records or information contained therein resulting from the access permitted to the authorized attorney, health care facility, other as specified, or self. Records disclosed may contain confidential medical information including HIV disease information. I understand that I have the right to revoke this authorization at any time prior to disclosure by giving written notice (witnessed by someone who knows my identity) to the Facility Privacy Officer.

Expiration: This authorization will expire (complete one):

☐ 45 days from date of signature

☐ Upon the occurrence of the following event (must relate to the individual or purpose of the authorization):

_____

Signature:

_____ _____ _____
Signature of Offender or Person Authorized to Consent Relationship Date

RUN DATE: [redacted]
RUN TIME:

[redacted] SHERIFF'S OFFICE

MEDICAL SCREENING FORM

SELECTED FILTER: BOOKING NUMBER(S): [redacted]

INMATE NAME: [redacted] BOOKING #: [redacted]

SEX: MALE RACE: [redacted] D.O.B.: [redacted] SSN: [redacted] JAIL ID: [redacted]

OFFICER OBSERVATION

1	N	IS THE INMATE UNCONCIOUS?	N
2	N	DOES THE INMATE HAVE VISIBLE SIGNS OF TRAUMA, OR IN OBVIOUS PAIN?	N
3	N	IS THERE EVIDENCE OF INFECTION THAT MIGHT SPEED THROUGH THE JAIL?	N
4	N	IS THERE A SKIN CONDITION SUCH AS RASHES, BRUISES, LESIONS, OR INFECTIONS?	N
5	N	DOES THE INMATE APPEAR TO BE UNDER THE INFLUENCE OF ALCOHOL AND/OR DRUGS?	N
6	N	IS THERE NEEDLE MARKS OR OTHER INDICATIONS OF DRUG ABUSE?	N
7	N	IS THERE ANY BLEEDING, JAUNDICE, TREMORS, SWEATING, OR PERSITANT COUGH?	N
8	N	DOES THE INMATE HAVE EASE OF MOVEMENT, AND/OR VISIBLE BODY DEFORMITIES?	N
9	N	DOES THE INMATE APPEAR TO HAVE A MENTAL CONDITION OR MENTAL RETARDATION?	N
10	N	DOES THE INMATE'S BEHAVIOR SUGGEST THE RISK OF SUICIDE OR ASSUALT ON OTHERS?	N
11	N	IS THE INMATE EXHIBITING ASSUALTIVE, VIOLENT, LOUD, OR OBNOXIOUS BEHAVIOR?	N

INMATE QUESTIONNAIRE

12	N	COMMUNICABLE DISEASE?	N
13	N	SEXUALLY TRANSMITTED DISEASE (STD)?	N
14	N	AIDS, HIV?	N
15	N	ALCOHOL ADDICTION?	N
16	N	DRUG ADDICTION?	N
17	N	ALLERGIES?	N
18	N	ASTHMA	N
19	N	ARTHRITIS?	N
20	N	TUBERCULOSIS?	N
21	N	BACK PROBLEM?	N
22	N	DIABETES?	N
23	N	EMPHYSEMA OR SHORTNESS OF BREATH?	N
24	N	EPILEPSY OR SEIZURES?	N
25	N	HEART DISEASE?	N
26	N	HIGH BLOOD PRESSURE?	N
27	N	HEPATITIS?	N
28	N	HERNIA?	N
29	N	ULCERS OR STOMACH PROBLEMS?	N
30	N	DENTAL PROBLEMS?	N
31	N	VISION OR HEARING DIFFICULTIES?	N
32	N	PHYSICAL HANDICAP?	N
33	N	OTHER MEDICAL PROBLEMS?	N

FEMALE ONLY

34	ARE YOU PREGNANT?
35	IF YES, WHAT IS YOUR DUE DATE?
36	DO YOU HAVE ANY GYNELOGICAL PROBLEMS?
37	ARE YOU ON BIRTH CONTROL PILLS?
38	WHAT IS THE DATE OF YOUR LAST MENSTRUAL PERIOD?
39	DO YOU HAVE ANY OTHER FEMALE RELATED PROBLEMS?

RUN DATE: [redacted]
RUN TIME:

[redacted] SHERIFF'S OFFICE

MEDICAL SCREENING FORM

SELECTED FILTER: BOOKING NUMBER(S): 20091495

SUICIDE

1.	N	HAVE YOU EVER ATTEMPTED SUICIDE? WHEN? WHY? HOW?	N
2.	N	HAVE YOU EVER CONSIDERED SUICIDE? WHEN? WHY?	N
3.	N	ARE YOU NOW, OR HAVE YOU EVER BEEN TREATED FOR MENTAL HEALTH OR EMOTIONAL PROBLEMS?	N
4.	N	HAVE YOU RECENTLY EXPECIENCED A SIGNIFCANT LOSS?	N
5.	N	HAS A FAMILY MEMBER OR CLOSE FRIEND EVER ATTEMPTED OR COMMITTED SUICIDE?	N
6.	N	DO YOU FEEL LIKE THERE IS NOTHING TO LOOK FORWARD TO IN THE IMMEDIATE FUTURE?	N
7.	N	ARE YOU THINKING OF KILLING YOURSELF?	N
8.	Y	GENERAL POPULATION?	Y
9.	N	OBSERVATION?	N
10.	N	RELEASE?	N
11.	N	TRANSFER?	N
12.	N	REFERRAL?	N

COMMENTS

SUICIDE COMMENT
8.

MEDICAL INSURANCE: UNKNOWN PERSONAL DOCTOR: STATES NONE
EMERGENCY CONTACT:
ADDRESS: NONE
CITY: STATE: ZIP: PHONE:

I CERTIFY THAT I HAVE TRUTHFULLY ANSWERED THESE QUESTIONS ABOUT MY HEALTH.

INMATE SIGNATURE: [redacted] DATE: [redacted] TIME: 1206

OFFICER SIGNATURE: [redacted] DATE: [redacted] TIME: 1206

MEDICAL STAFF: [redacted] DATE: [redacted] TIME: 1320

VII.

F-121

[redacted]

Preliminary Health Screening

Name _____ Sex ___ DOB _____ SSN _____

Date ___ / ___ / ___ Time _____ hours CELL # _____

Officer's Visual Observations

1. Is the inmate unconscious?..... Yes No
2. Does the inmate have obvious pain, bleeding restrictive mobility or other symptoms suggesting need for an emergency service?..... Yes No
3. Are there visible signs of trauma, bruises, lesions, or illness requiring immediate emergency care or doctor's care?..... Yes No
4. Is there obvious fever, swollen lymph nodes, jaundice or other evidence of infection which might spread through the jail?..... Yes No
5. Is the skin in good condition and free of vermin and rashes?..... Yes No
6. Does the inmate appear to be under the influence of alcohol?..... Yes No
7. Does the inmate appear to be under the influence of drugs?..... Yes No
8. Are there any signs of alcohol/drug withdrawal symptoms?..... Yes No
9. Does the inmate's behavior suggest the risk of suicide?..... Yes No
10. Does the inmate's behavior suggest the risk of assault to staff/inmates?..... Yes No
11. Is the inmate carrying medication, or does the inmate report being on medication which should be continuously administered or available? ..... Yes No

Officer-Inmate Questionnaire

12. Are you presently taking medication for diabetes, heart disease, seizure, arthritis asthma, ulcers, high blood pressure or psychiatric disorder?..... Yes No
13. Do you have a special diet or health care need prescribed by a physician?..... Yes No
14. Do you have a history of venereal diseases or abnormal discharge?..... Yes No
15. Have you recently been hospitalized, or have you recently seen a medical or psychiatric doctor for any illness? (use reverse side)..... Yes No
16. Are you allergic to any medications or food? (use reverse side)..... Yes No
17. Have you fainted recently, or experienced a recent head injury?..... Yes No
18. Do you have epilepsy, diabetes, or a history of tuberculosis?..... Yes No
19. Do you now have or ever have been exposed to hepatitis, AIDS, or HIV virus? Have you ever used IV drugs?..... Yes No
20. Do you have a painful dental condition or do you wear dentures?..... Yes No
21. Do you wear glasses or contact lenses?..... Yes No
22. If female, are you pregnant, or have you delivered recently?..... Yes No
23. Have you ever attempted suicide? If yes, how and when? (use reverse side)..... Yes No
24. Are you thinking of committing suicide now?..... Yes No
25. Do you have medical insurance?..... Yes No
26. Do you have any other medical problems that we should know about?..... Yes No

Refused admission to jail? Yes No **Referred to jail physician?** Yes No

Reason:_____ **Reason:**_____

Prisoner Signature_____ **C.O.Signature**_____

Rev. 09/01

VIII. [redacted] [redacted]

Page 1

Inmate Name: TEST, TEST (# 0000000) DOB: 01/01/1900 SSN: 123456789
Sex: MALE Race: W Status: NOT ACTIVE Housing: NONE
Booking Date: 1/1/1900 12:00:00 AM Completed On: 11/3/2008 12:02:56 PM by NAPHCARE\roxanne.walters

Vital Signs
BP: 0/0 Pulse: 0 Temp: 0 Resp: 0 Sa02: BS: Ht: 0' 0 " Wt: 0 lbs

Medication/Allergies
Current meds receiving (name, dosage, frequency): None
Medication allergies: None
Food allergies: None

Past Medical History
☒ No ☐ Yes Heart Disease ☒ No ☐ Yes Diabetes ☒ No ☐ Yes Immune Deficiency
☒ No ☐ Yes Asthma ☒ No ☐ Yes Hepatitis ☒ No ☐ Yes Thyroid
☒ No ☐ Yes Cancer ☒ No ☐ Yes Seizures ☒ No ☐ Yes Surgery ( )
☒ No ☐ Yes High Blood Pressure ☒ No ☐ Yes Sexually Transmitted Diseases

Tuberculosis Risk Factors
☒ No ☐ Yes Known exposure to anyone with active TB
☒ No ☐ Yes HIV/AIDS

Tuberculosis Symptoms
☒ No ☐ Yes Chronic Cough Longer than 4 weeks
☒ No ☐ Yes Blood in Sputum
☒ No ☐ Yes Night Sweats
☒ No ☐ Yes Unintentional weight loss > 15lbs in last 6 months

☒ **Yes** ☐ **No TB Current**
Given: 01/01/1900
Read: 11/03/2008
Results:

Substance Abuse
Alcohol Usage
☒ None ☐ One to 5 drinks per week ☐ More than 5 drinks per week ☐ Drinks everyday
Withdrawal History
☒ N/A ☐ No History of W/D ☐ Hallucinations ☐ Seizures ☐ Tremors ☐ See Withdrawal Protocol
Other Drugs of Abuse
☒ None ☐ Benzodiazepines ☐ Cocaine ☐ Marijuana ☐ Methamphetamine ☐ Other drugs:

Clinician's Observations:
Oriented to Person: Yes ☒ No ☐ Place: Yes ☒ No ☐ Time: Yes ☒ No ☐ Situation: Yes ☒ No ☐
Appearance: appropriate ☒ bizarre ☐ disheveled ☐ sweating ☐ tremors ☐ other ( )
Behavior: appropriate ☒ disorderly ☐ insensible ☐ other ( )
Perception: appropriate ☒ delusional ☐ hallucinating ☐ paranoid ☐ other( )
State of consciousness: alert ☒ lethargic ☐ responsive ☐ other( )
Affect: appropriate ☒ afraid ☐ angry ☐ depressed ☐ flat ☐ happy ☐ other ( )
Overall Demeanor: cooperative ☒ agitated ☐ guarded ☐ uncooperative ☐ other ( )

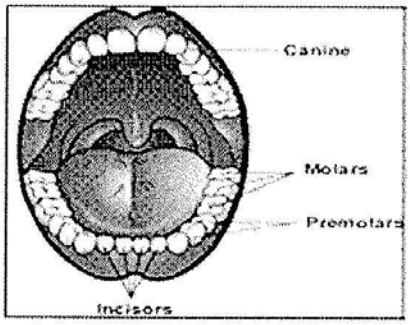
Physical Exam
New Injuries: None ☐ Abrasions ☐ Abscess ☐ Burn Wounds ☐ Contusions ☐ Lacerations ☐ Puncture Wounds ☐ Sutures/Staples ☐ other (specify): ( )

HEENT
☒ PERRLA
☒ No trauma to head, face , or neck
☒ Pharynx normal
☐ Abnormal findings:

☒ TMs with no fluid or erythema
☒ External canals normal
☒ Neck supple, normal range of motion

Dental
☒ No ☐ Yes Mouth Pain
☒ No ☐ Yes Infection/Abscess
Describe:
☒ No ☐ Yes Taste Bad
☒ No ☐ Yes Fever

Refer abnormal exams to Dentist
Educational material provided to inmate



[redacted]

Medical Assessment

Inmate Name: TEST, TEST (# 0000000) DOB: 01/01/1900 SSN: 123456789
Sex: MALE Race: W Status: NOT ACTIVE Housing: NONE
Booking Date: 1/1/1900 12:00:00 AM Completed On: 11/3/2008 12:02:56 PM by [redacted]

Cardiovascular
☒ Regular rate, normal
☐ Abnormal findings:

Respiratory
☒ Respirations even, unlabored, and normal rate
☒ Lung sounds clear and equal in all lung fields
☐ Abnormal findings:

Abdominal
☒ Abdomen soft, nontender, nondistended
☒ No hernia or masses palpated
☒ Bowel sounds active and normally pitched
☐ Abnormal findings:

Musculoskeletal/Skin
☒ Grossly normal strength and function of all extremities
☒ Gait normal with no limitations for ADL's
☒ No injuries or infections on extremities
☐ Abnormal findings:

Pregnancy
☒ No ☐ Yes Are you or could you be pregnant? Last menstrual cycle? N/A
☒ No ☐ Yes Do you use birth control? ☒ No ☐ Yes Have you recently delivered, miscarried or aborted?

Request Laboratory Test:
☐RPR ☐ HIV ☐Other:

Clearances issued:
☒ None ☐Bottom Bunk ☐Lower Tier ☐Wheelchair/crutches ☐medical diet

Treatment Plan Refer to:

☐ Medical Doctor (acute)	☐ Dental
☐ Medical	☐ Dentist (acute need)
☐ Medical Chronic Care	☐ Mental Health
☐ Detoxification Protocol	☐ Mental Health Chronic Care Clinic
☐ Authorization for Release of Inmate	☐ Psychiatrist (acute need)
☐ Off-site treatment	☐ Enact Suicide Precautions
☐ Continue Standard Booking and Housing procedure	☐ Auth. for Release of Mental Health/Substance Abuse Info

Continue standard Booking and Housing procedure
☐ Immediate Medical Housing
☐ Isolation
☐ General Population
☐ Immediate Mental Health Housing
☐ Suicidal precautions:

Consent
I have answered all questions on the Comprehensive Nurse Exam forms truthfully to the best of my knowledge and ability. I have been told and shown how to obtain medical and mental health services. I hereby give consent for professional services to be provided to me by and through [redacted]

_____
Inmate's Signature

[redacted]
Interviewer's Signature

[redacted] [redacted] test

Receiving Screening Page 1

Inmate Name: TEST, TEST (# 0000000) DOB: 01/01/1900 SSN: 123456789
Sex: MALE Race: W Status: NOT ACTIVE Housing: NONE
Booking Date: 1/1/1900 12:00:00 AM Completed On: 10/12/2008 9:52:09 AM by [redacted]

Allergies:
Vital Signs
BP: 0/0 Pulse: 0 Temp: 0 Resp: 0 Ht: 0' 0 " Wt: 0 lbs

1. Is the inmate unconscious or showing signs of illness, injury, bleeding, pain or other symptoms implying need for emergency medical referral?	☒No	☐Yes
2. Obvious signs of abrasions, abscesses, bruises, cuts, infection, needle marks, rash,skin lesions, trauma, or head lice?	☒No	☐Yes
3. Have you fainted or had a head injury (eg., coma, concussion) in the past 72 hours?	☒No	☐Yes
4. Do you have a history of: No Medical Problems,		
5. Have you ever been diagnosed with any medical problems?	☒No	☐Yes
6. Are you currently taking or have you been prescribed any medications?	☒No	☐Yes
7. Persistent cough, fever, tremors, sweating or lethargy?	☒No	☐Yes
8. Mobility restricted in any way due to bandages, cast, deformity, splints or injury?	☒No	☐Yes
9. Appears to be unsteady, confused, lethargic, slurred speech, stupor, and/or tremors?	☒No	☐Yes
10. Are you using alcohol or drugs?	☒No	☐Yes
11. Are you or could you be pregnant?	☒No	☐Yes
12. Do you use birth control?	☒No	☐Yes
13. Have you recently delivered, miscarried or aborted?	☒No	☐Yes

14. Last menstrual cycle?

Additional Brief Pertinent Comments:

[redacted]
Interviewer's Signature

[redacted]

Mental Health Evaluation Page 1

Inmate Name: TEST, TEST (# 0000000) DOB: 01/01/1900 SSN: 123456789
Sex: MALE Race: W Status: NOT ACTIVE Housing: NONE
Booking Date: 1/1/1900 12:00:00 AM Completed On: 10/12/2008 9:51:28 AM by [redacted]

1. Does the supervising correctional officer have any information that indicates the inmate is a medical, mental health or suicide risk now?	☐No	☒Yes
2. On a scale of 1 to 5, with 1 being mentally unstable and psychotic and 5 being mentally stable and functioning well, how would you rate yourself at this time? 4		
3. Are you thinking about hurting or killing yourself?	☒No	☐Yes
4. Are you thinking about hurting or killing anyone else?	☒No	☐Yes
5. Has anyone in your family been incarcerated? Who? When? 1-3 years At what age? 41 or older	☐No	☒Yes
6. At what age did you commit your first crime? 16 to 19		
7. At what age were you first arrested? 11 to 15		
8. How many prior charges have you had? 1 or 2 What type of prior charges have you had?		
9. Have you ever been violent toward another person? Worst victim injury? injury not requiring medical attention	☐No	☒Yes
10. Have you ever had treatment for drugs or alcohol, including detoxification?	☒No	☐Yes
11. Have you ever been in the military? When? 1-3 years ago What Branch? Army How Long? less than one year Were you engaged in combat? no Were you honorably discharged? yes	☐No	☒Yes
12. Do you usually attend religious services? How often? several times per week What religion do you practice? Christian other:		
13. Have you ever been married?	☒No	☐Yes
14. Do you have any children outside of marriage?	☒No	☐Yes
15. What is your occupation?		

[redacted]

Mental Health Evaluation Page 2

Inmate Name: TEST, TEST (# 0000000) DOB: 01/01/1900 SSN: 123456789
Sex: MALE Race: W Status: NOT ACTIVE Housing: NONE
Booking Date: 1/1/1900 12:00:00 AM Completed On: 10/12/2008 9:51:28 AM by [redacted]

trade
other:

16. How do you feel right now about your current situation?

Clinician's Observations:

Appearance:

Behavior:

Perception:

State of consciousness:

Affect:

Speech:

Overall Demeanor:

Additional information pertaining to question(s) number:

Inmate's Signature

[redacted]
Interviewer's Signature

[redacted] Mental Health Evaluation Page 2

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[redacted]
Interviewer's Signature

I.

POLICY AND PROCEDURE STANDARD FORM **Page 1 of 2**

TITLE:	HIV Case Management	**NUMBER:**	IC-11
DEPARTMENT:	Health Care Services Infection Control	**DATE ISSUED:**	August 1996
		Reviewed:	December 2000, December 2003

POLICY ☒ **ORIG** ☒ **REVISED** ☒
PROCEDURE ☒ **ORIG** ☒ **REVISED** ☒

POLICY:

Upon entry to the [redacted] facility, ALL inmates identified with an HIV+ status will have HIV case management by the designated primary infection control (IC) nurse and external primary care physician to promote a continuum of quality health care.

DEFINITIONS:

HIV+ Inmate: HIV+ inmates are those who should be identified through health screening at the time of booking by the intake personnel. Internal HIV testing for various reasons may identify others.

External Primary Care Physician: Shall be the inmate's primary HIV physician outside of the Corrections Center.

Primary Infection Control Nurse: HIV case manager as designed by [redacted]

PROCEDURE:

A. INTAKE PERSONNEL:

1. Identifies/assesses an HIV+ inmate at time of initial health screening with cooperation of inmate sharing this information.
2. Documents HIV+ information on daily PPD summary sheets using a "+" sign in correct column and onto inmate health screening form.
3. Should obtain initial list of HIV medications and/or current treatment plan; name and phone number of primary external HIV care physician; and have inmate sign Consent for Release of Information.
4. Classifies/places inmate in general population unless physical and/or psychological condition warrants otherwise.
5. Must notify the primary infection control nurse or designee as soon as possible.

PRIMARY I.C. NURSE (HIV CASE MANAGER):

1. Assesses inmate within 24 hours.
2. Obtains faxed or phoned current medical treatment record on all HIV+ cases.
3. Contacts inmate's primary external HIV physician and/or treatment center to verify medications and care plan.

DEPARTMENT – Health Care Services Infection Control
TITLE – HIV Case Management
NUMBER – IC-11

4. Inmate will be referred to primary external HIV physician. If none available one will be chosen with inmate's approval.
5. Inmate will be seen by [redacted] physician and/or infection control nurse PRN.

Note:

- HIV+ CASES TO BE PLACED IN MEDICAL SEPARATION ONLY FOR COMMUNICABLE DISEASE REASONS, NOT FOR HIV+ STATUS ONLY!!
- IF CONDITION DETERIORATES, INFECTION CONTROL TO ARRANGE FOR ADVANCED CARE AS NEEDED, BY TRANSFER TO PRIMARY EXTERNAL HIV PHYSICIAN OR ECC DEPARTMENTS.

II.

[redacted]

CLINICAL PROTOCOLS

Page	1 of 2
Effective Date	September 1, 2007
Reviewed Date	September 1, 2007

Subject: **O03 HIV Positive**

1. At the time of book-in current medication regimen should be confirmed and started.

2. All individuals who book in on anti-retrovirals should be continued on these medications. Every 3-4 months follow-up labs should be drawn according to the following recommendations:

Drug	2 weeks	1 month	2 months	3-4 months
Nevirapine	AST	AST, Viral Load	AST, Viral Load, T-cells	H & H, LFTs, Chem 7, T-cells, Viral Load, lipids
Efavirenz		Viral Load	Viral Load, T-cells	H & H, LFTs, Chem 7, T-cells, Viral Load, lipids
AZT	H & H	H & H, Viral Load	H & H, Viral Load, T-cells	H & H, LFTs, Chem 7, T-cells, Viral Load, lipids
3TC, D4T, ddI, Abacaviir, Tenovir		Viral Load	Viral Load, T-cells	H & H, LFTs, Chem 7, T-cells, Viral Load, lipids
Indinivir		Viral Load	Viral Load, T-cells	H & H, LFTs, Chem 7, T-cells, Viral Load, lipids
Nelfinavir, Ritonavir, Saquinivir, Kaletra		Viral Load	Viral Load, T-cells	H & H, LFTs, Chem 7, T-cells, Viral Load, lipids

3. If the patients claims to be positive, but there is no confirmation, draw an HIV test. Place on the physician line only if this is positive.

4. The HIV intake form should be completed at the time of the Health Assessment and reviewed by the physician.

5. Patients who book into the jail and are confirmed HIV positive with no acute needs should be placed on the physician line approximately 2 weeks from the date of book-in. If there is more than one physician at the facility, attempts should be made to appoint the patient to the physician that he/she has previously seen.

6. The physician who sees the patient determines the needed laboratory testing and future follow-up appointments.

7. Newly diagnosed HIV positive patients should be placed on the physician line for evaluation and counseling. If the patient is released before he/she has been informed of the test results, contact appropriate health department so that they may notify the patient.

8. The initial interview will ascertain previous care, if any, and if the patient wishes us to initiate and/or continue routine follow-up.

9. If they desire work-up and evaluation, patients with no previous evaluation or no testing within the last 3 months should have the following studies:

   a. CD4 cell count
   b. Plasma HIV RNA

[redacted]	CLINICAL PROTOCOLS	Page 2 of 2
		Effective Date September 1, 2007
		Reviewed Date September 1, 2007
Subject: O03 HIV Positive		

c. Complete blood count, chemistry profile, transaminase levels, BUN and creatinine, urinalysis, RPR or VDRL, tuberculin skin test (unless a history of prior tuberculosis or positive skin test), *Toxoplasma gondii* IgG, Hepatitis A, B, and C serologies, and PAP smear in women.

d. Fasting blood glucose and serum lipids if considered at risk for cardiovascular disease and for baseline evaluation prior to initiation of combination antiretroviral therapy

10. For individuals who have an initial evaluation elsewhere, the physician seeing the patient will determine what repeat laboratory evaluation is necessary.

11. Individuals who are not on anti-retrovirals will have this treatment discussed with them as per currently recommended standards. It is currently recommended that resistance testing is obtained prior to initiation of treatment.

12. Individuals who are newly diagnosed, who have no community care source should be referred to the discharge planning team as soon as possible in the course of their incarceration.

13. If a Public Health Department contacts the facility for information about newly diagnosed HIV positive individuals, the call should be referred to the HSA who will obtain the name of the patient, pull the chart and refer it to the Medical Director.

14. Any patient on DDI complaining of abdominal pain must be seen and evaluated immediately to rule out possibility of pancreatitis. This can be a medical emergency. Place on that day's physician list or call physician for possible Emergency Room referral.

15. HIV positive patients will be followed in accordance with the NCCHC Guidelines for care of the HIV patient in conjunction with the NIH treatment recommendations. Since recommendations in the treatment of this disease change rapidly, it is recommended that providers caring for these patients frequently check the recommendations at: http://aidsinfo.nih.gov/guidelines/ .

NOTE: Physician (M.D.) approval MUST be obtained prior to any prescription medication being administered.

[redacted]

Date

III.

4.8

13. All medical treatment performed by [redacted] shall be performed under the direction of the jail physician.

VI. Communicable Diseases:

A. Inmates who are suspected of having communicable diseases or body vermin will be separated from each other and the general inmate population until they are no longer contagious or convalescent or until they are transferred.

1. During such isolation, inmates will receive necessary medical treatment.
2. The jail physician will develop a program to address the specific needs of inmates in these categories and will periodically update that program to reflect contemporary community practice.
3. Inmates who are HIV-positive may be housed in the general population.
4. An employee or inmate suspected of having contracted a communicable disease will be examined, if so ordered by the jail physician.
5. Employees will receive ongoing care for such a condition from their personal physician or employer's health source.

VII. Elective Procedures:

A. Elective medical procedures are not performed at jail expense.

1. [redacted] inmates who seek to be treated by outside physicians or facilities for conditions that are not within the scope of services provided by the jail must make a request for such care to the doctor. These requests ordinarily will not be approved.
2. If approved, the inmate will be responsible for the entire bill and the cost of security supervision while in the community. For such cases, financial

Page 8 of 14

arrangements must be made by the inmate or family members prior to any such medical appointment. The inmate will be required to sign a Release of Financial Responsibility Form.

VIII. Medication:

A. Medications will be issued as approved or prescribed by the jail physician or other approved physician. The [redacted] exercises proper management of pharmaceuticals and addresses:

1. Physician orders, and administration of medication by qualified health-trained personnel and under the supervision of the health authority and jail administrator, or designee. All security staff administering medications are trained to do so. Training is provided by or approved by medical staff. A log system developed by the Jail Administrator/jail physician will be maintained regarding the administration of all dispensed medications; these records will be filed in the inmate's medical record.
2. All medications issued will be clearly labeled with the inmate's name and booking number, type of medication and dosage, date due and any special instructions for taking the medicine.
3. Medications may include over-the-counter medications as well as those prescribed by a physician.
4. When medically appropriate, self-care will be encouraged by the health care staff through daily availability of nonprescription medication (e.g., aspirin and cough medicine).

5. No inmate may share, loan, give or otherwise provide medications of any type to another inmate.
6. Medications prescribed by a licensed physician and filled by a licensed pharmacist or nurse will be dispensed to inmates as instructed by medical staff.
7. Separate records will be kept on all medication dispensed so it will be possible to reconstruct the entire course of medication for each inmate. These records will be a part of the inmate's medical file.
8. Medication will be distributed at a scheduled time each morning, afternoon, evening, and night by the medical staff or a corrections officer. During the morning, afternoon, and evening medication call, inmates will be given an opportunity to ask for nonprescription medications such as aspirin, antacids, sinus medications, and laxatives.
9. All inmates are required to take their pills with water; after swallowing the medication, the inmate will open his or her mouth for inspection. Stockpiling medication or exchanging medication may result in discontinuance of medication for the inmates involved, on the doctor's review. Disciplinary action will be initiated.
10. Inmates entering the jail bringing with them their own medication will be inventoried by the jail staff and verified by jail staff by calling the pharmacy verifying the medication. The jail physician will be contacted by jail staff advising him of medication needing ordered. If jail staff has any question regarding its use, the jail physician should be contacted. Otherwise an order

shall be written to continue such medication and the jail physician shall be made aware of and sign the order during the next scheduled doctor's visit. The medication brought in by the inmate will be stored with his property.

11. Medication for seizure, hypertension, cardiac, diabetic, or psychiatric disorders, infection, or other medication that may be designated by the jail physician, will not be discontinued during the verification process.
12. Non-addicting substitutes may be made for narcotic pain relievers at the discretion of the jail physician. Minor tranquilizers may be discontinued until personal examination by the jail physician at the doctor's next regularly scheduled visit.
13. Refusals to take medication will be documented in the inmate's file and on the medication log.
14. All medication for daily issue and immediate emergency use will be kept in a secure area or medical storage room, accessible only to the medical staff and officers on duty.
15. A separate, maximum-security storage area will be used for bulk storage; the keys to these areas will be restricted keys. No inmates will have access to the drug storage areas.
16. Medication stored in the daily use area will be under a daily inventory maintained by staff as they assume their post. Inventory of bulk supplies will be performed jointly by members of the medical and security staff not less than monthly, and a record of that inventory will be maintained.

IV.

[redacted] *Sheriff's Office Jail Division*
Policies and Procedures Manual

MEDICAL AND HEALTH CARE SERVICES

COMMUNICABLE DISEASE PRECAUTIONS

OHIO MINIMUM STANDARDS: 5120: 1-8-03 (GG)(11) **EFFECTIVE DATE:** _____

Page _____ **to** _____

Sheriff's Signature:_____ **Date:**_____

Jail Administrator's Signature:_____ **Date:**_____

Medical Authority Signature:_____ **Date:**_____

I. POLICY

Prisoners admitted with an infectious disease will require special care, instruction, and precautions in order to prevent the spread of disease to other prisoners or staff members in the jail.

II. DEFINITION

Communicable disease: an illness that may be transmitted to others.

III. PROCEDURE

A. **Supplies.** A supply of disposable masks, gowns, gloves, and plastic bags for disposal of wastes will be kept in Medical for medical isolation.

B. **Handwashing.** Staff members should wash their hands thoroughly with soap and hot water both before and after caring for patients. Prisoners should be encouraged to wash their hands frequently.

1. Remove all jewelry, including watch.
2. Adjust water temperature and leave water running.
3. Wet hands and lower forearms and apply soap to obtain a good lather. Get under nails and between fingers.
4. Hold hands and forearms upright while washing.
5. Rub lather into hands and arms briskly (all sides) with special attention to spaces between fingers and around nail beds. Wash for one minute with rotating frictional motion. Wash at least two or

MEDICAL AND HEALTH CARE SERVICES

DETECTING AND AVOIDING THE SPREAD OF AIDS

OHIO STANDARDS: 5120: 1-8-03(GG)(11) EFFECTIVE DATE: _____

Sheriff's Signature:_____
Date:_____

Jail Administrator's Signature:_____
Date:_____

Medical Authority Signature:_____
Date:_____

I. POLICY

To provide proper medical care for prisoners infected with AIDS and to prevent the spread of AIDS to other prisoners and staff, prisoners will be screened closely to identify high-risk individuals and precautions will be taken to decrease the risk of spreading undiagnosed AIDS. To accommodate the safety needs of the AIDS prisoner, he/she will not be housed in the general population.

II. DEFINITIONS:

HIV: Human Immunodeficiency Virus - the AIDS virus.

AIDS: Acquired Immunodeficiency Syndrome.

III. PROCEDURE

A. The following will be instituted to decrease the risk of spreading undiagnosed AIDS to staff or other prisoners:

1. All jail staff will wear protective gloves any time they may come in contact with a prisoner's body fluids (e.g., during pat searches, when handling inmate clothing/bedding, when providing first aid/medical care).

2. Any cell that has blood in it will be scrubbed with a household bleach solution (1:10 dilution). Persons scrubbing the cells will wear rubber gloves.

3. Any blood sample drawn specifically for the detection of AIDS will be labeled with precautionary warning labels and be double-bagged. All needles used to draw HTLV-III should be placed in a puncture-resistant container.

4. All prisoners will be issued individual disposable razors. No sharing of razors will be allowed.

5. Current educational material will be available to prisoners and staff.

B. During the medical receiving screening, the following persons will be brought to the attention of medical personnel by the jail staff:

1. Prisoners who express homosexual preference.

2. I.V. drug users.

3. History of Hepatitis B or C

4. Hemophiliac.

5. Haitian immigrant.

6. The spouse or child of someone who has diagnosed AIDS.

7. Prisoners who indicate they have or may have AIDS.

C. These high-risk groups will be further assessed by medical personnel. This in-depth screen will include the prisoner's history of:

1. Sexual contacts

2. Drug usage

3. Recent weight loss

4. Night sweats

5. Chronic diarrhea

6. Swollen lymph nodes

7. Extreme fatigue

8. Persistent fever

9. Oral candiasis

10. Recurrent pneumonia

11. Purple skin lesions

D. The responsible medical authority physician may request further medical tests to confirm AIDS.

E. Prisoners who have HTLV-III positive antibodies and Western Blot positive, but do not have the disease, will be treated as follows:

1. Body fluid precautions will be employed.

2. Linens will be bagged and washed separately with household bleach solution (1:10 Clorox).

3. Good handwashing techniques will be used.

4. [redacted] Health Department will be notified.

5. Educational material and counseling will be provided in order to prevent the spread of the disease.

F. Prisoners found to have AIDS shall be housed in special custody. The following precautions will be employed.

1. Prisoner will be isolated in a one-man cell.

2. Body fluid precautions will be employed.

3. Enteric precautions will be employed.

4. Disposable utensils will be used.

5. Linens will be bagged and washed separately with household bleach solution (1:10 Clorox).

6. Good handwashing techniques will be used.

7. [redacted] Health Department will be notified.

G. The Center for Disease Control has promulgated the following general guidelines for the prevention of HIV transmission in the workplace:

1. General.

a. Avoid needle sticks and other sharp instrument injuries.

b. Wear gloves when contact with blood or body fluids is likely.

c. Use disposable shoe coverings if considerable blood contamination is encountered.

d. Keep all cuts and open wounds covered with clean bandages.

e. Avoid smoking, eating, drinking, nailbiting, and all hand-to-mouth, hand-to-nose, and hand-to-eye actions while working in areas contaminated with blood or body fluids.

f. Wash hands thoroughly with soap and water after removing gloves and after any contact with blood or body fluids.

g. Clean up any spills of blood or body fluids thoroughly and promptly, using a 1:10 household bleach dilution.

h. Clean all possibly contaminated surfaces and areas with a 1:10 household bleach dilution.

i. Place all possibly contaminated clothing and other items in clearly identified impervious plastic bags.

2. Human bites.

a. Encourage "backbleeding" by applying pressure and "milking the wound," as with a snakebite.

b. Wash the area thoroughly with soap and hot water.

c. Seek medical attention as soon as possible.

d. HIV antibody testing of the victim and perpetrator of the bite may be appropriate. However, several factors must be considered. First, laws in some states prohibit testing without informed consent of the subject. Second, anyone considering being tested should be thoroughly counseled on the meaning of the results and the possible negative effects on individual's lives in terms of access to insurance, employment, and housing, if a positive result were to be divulged. Third, knowledge of antibody status of either or both of the individuals involved in the incident would not change the medical response to the victim's case: the same patient surveillance and care of the wound in all cases. This is because there is always the possibility of a false negative test or a negative result based on blood drawn during the lag time between infection and the appearance of antibodies (usually within 6 to 12 weeks, but sometimes longer.)

3. Searches and evidence handling.

Although the risk of HIV infection from being cut or punctured by contaminated needles or other sharp instruments appears to be very low, many criminal justice personnel are concerned about such incidents. Cuts, needle sticks, and puncture wounds might be sustained by officers while searching suspects, motor vehicles, or cells, or while handling evidence in a variety of settings. There is particular concern regarding searches of areas where sharp objects may be hidden from view -- such as pockets and spaces beneath car seats. The following precautionary measures will help to minimize the risk of infection:

a. Whenever possible, ask suspects to empty their own pockets.

b. Whenever possible, use long-handled mirrors to search hidden areas.

c. If it is necessary to search manually, always wear protective gloves and feel very slowly and carefully.

d. Use puncture-proof containers to store sharp instruments and clearly marked plastic bags to store other possibly contaminated items.

e. Use tape -- never metal staples -- when packaging evidence.

4. Laboratory analysis of evidence.

Many of the general infection control procedures and the precautionary measures for evidence handling summarized above are applicable to the laboratory setting. However, the following procedures should also be followed:

a. All cuts and needle sticks involving possibly contaminated instruments should be promptly reported to a designated safety officer so that proper records are maintained and appropriate medical consultation can be provided.

b. Hands should be washed frequently, but especially before eating, drinking or smoking and after completing analytical work (liquid or granular soap is preferable to bar soap.)

c. All personnel who have direct or indirect contact with blood or body fluids should wear gloves.

d. Gloved hands should not contact other items which may be touched by ungloved personnel.

e. Gowns, laboratory coats, or plastic aprons should be worn in all laboratory areas.

f. Face shields or protective eyeglasses and masks should be worn if there is potential for spattering of blood or body fluids.

g. Smoking, eating and drinking should be prohibited.

h. Fingers, pencils and other objects should be kept out of mouths.

i. Mouth pipetting should be prohibited.

j. Specimens should be properly packaged and labeled at all times.

k. Special receptacles should be maintained for contaminated wastes.

5. Cardiopulmonary resuscitation (CPR).

Criminal justice personnel are also concerned about infection with HIV through administration of CPR. Agencies should respond to these concerns by stressing the research showing the extreme unlikelihood of HIV transmission through saliva.

At the same time, agencies should make disposable protective masks or airways available to officers and provide training in their proper use. Devices with valves to prevent the patient's saliva from entering the caregiver's mouth are preferable.

H. This policy will be subject to change as updated data on AIDS becomes available.

three inches above the wrist. Interlace the fingers and rub up an down.

6. Clean nails as needed.

7. Rinse well holding fingers up.

8. Dry thoroughly on a paper towel.

9. Take a clean, dry paper towel and use it to turn off faucets.

10. Hand sanitizer may be used until you are able to wash your hands correctly.

NOTE: If you are using hand lotion, use the small sample size as lotion is a great culture medium if left to stand. To safeguard the prisoners, employees, and yourself, it is important to develop the habit of frequent handwashing -- practice this habit religiously.

C. **Delivery of food to isolated prisoners.** The kitchen will be notified that the prisoner is in isolation, and which cell he is in. The kitchen will use disposable dishes/utensils.

D. **Medical watch**. The prisoner will be checked by medical staff at least during each sick call and more often if necessary.

1. Vital signs
2. Physical needs
3. General condition of inmate

E. **Respiratory isolation.** Prisoners housed in isolation to rule out active tuberculosis should have respiratory precautions observed.

1. Private room with a door. If no private room is available, the prisoner must be sent to the appropriate medical facility.

2. Hepa Masks must be worn by all persons entering the room and by the prisoner if leaving the room.

3. Tissues should be discarded in a plastic bag.

4. Sputum specimens should be labeled "r/o T.B." and handled with care.

5. The health department should be notified by medical staff.

6. Disposal of garbage as indicated in J. of this procedure.

F. **Wound and skin precautions.** For prisoners with infected wounds or ulcers, precautions should be taken to avoid cross-infection of staff or other patients.

1. Handwashing before and after dressing change.
2. Disposable gloves should be worn when changing dressings; a second set of sterile gloves should be used for application of new dressing.
3. Sterile equipment should be used.
4. Soiled dressings should be discarded in a sealed plastic bag (for active disease)
5. If the wound area is soaked, the basin used should be sterilized or discarded.
6. Disposal of garbage as indicated in #J of this procedure.

G. **Enteric precautions.** For prisoners that have hepatitis, precautions should be observed to avoid the spread through direct or indirect contact with infected feces, blood, or sputum:

1. Handwashing by prisoners before and after using the bathroom. Handwashing by staff before and after caring for prisoner.
2. Gloves should be worn if handling potentially contaminated objects (i.e., bedpan or urinal).
3. Disposable needles and syringes should be used and disposed of in a needle container marked "contaminated."
4. Disposable utensils and dishes should be used and discarded in a plastic bag.
5. Lab specimens should be labeled "hepatitis" and placed in a plastic bag. Gloves should be worn when Lab Techs are drawing blood.
6. Toilet should be scrubbed well with liquid antimicrobial soap.

H. Prisoner with chicken pox, herpes zoster, measles, or mumps should be confined to his/her own room. Pregnant women should not be permitted contact with these prisoners. If there is an outbreak of influenza or any of the above communicable airborne diseases, the affected prisoners should be confined to one housing area, avoiding exposure to the rest of the population.

I. **Strict Isolation.** Prisoners requiring strict isolation for extensive burns, diphtheria, rubella in women, extensive staphylococcal or streptococcal skin infections must be sent to an appropriate medical facility.

J. **Disposal of garbage.**

1. Disposal of garbage will be done every shift.
2. All garbage will be double-bagged.
3. Garbage will be marked "contaminated" and will be disposed of according to EPA requirements.

V.

[redacted] SHERIFF'S OFFICE
MEDICAL SERVICES

OCCUPATIONAL EXPOSURE TO POTENTIAL BLOODBORNE PATHOGENS

INMATE-TO-INMATE EXPOSURE

POLICY: The [redacted] Medical Services Department will provide confidential first aid care, evaluation and follow-up when exposure to blood and/or body fluids that may transmit bloodborne (BBP's) is reported.

1. Follow-up care, counseling, testing and treatment for exposure will be done by an [redacted] health provider
2. [redacted] Medical Services staff will provide the inmate with information to assist the inmate in making informed decisions regarding post exposure care.
3. ***An occupational exposure to blood and other body fluids is considered an URGENT MEDICAL CONDITION.***
4. All information is treated as CONFIDENTIAL. All files and communication regarding exposure will be handled in a manner that protects both the exposed inmate and the source inmate.

PROCEDURE:

1. Assess the exposed inmate(s) ASAP (to stay within the 3 hour window) after the reported incident.
2. Perform immediate first aid in the event of any exposure to blood and/or body fluids
   a. Wash exposed skin promptly with soap and water.
   b. Needlesticks and/or puncture wounds should be washed thoroughly with soap and water
   c. Flush mucous membranes with clean water, saline or sterile irrigants.
3. Determine the **Exposure Code** and the **HIV Status Code** (see worksheet).
4. Notify the [redacted] Doctor ASAP (within the 3-hour window) so that he can determine the **Post Exposure Prophylaxis (PEP)** recommendation.
5. With a Doctor's order, arrange to have the exposed inmate and source Inmate's bloods drawn for:
   1. HIV
   2. Hepatitis B Surface Antigen (HBsAg). If the source has had the HB vaccine series, draw a Hepatitis B Surface Antibody instead.
   3. Hepatitis C Antibody.
   a. Obtain prior written consent
   b. Give the inmates pre and post counseling information.
6. Begin PEP (see table 3 on the worksheet) if ordered by the Center Doctor.
7. Schedule to see the Doctor for follow up.

48

[redacted] - POLICIES AND PROCEDURES

SUBJECT: INFECTION CONTROL PROGRAM
~~J12~~ J-C-01

PAGE 2 OF 7

II. MANAGEMENT IN CORRECTIONS

A. Education:

1. Inmates will be provided with important and concise information on AIDS during their Booking Department stay. This information will be in the form of printed material issued to inmates by the Intake Counselor during the preclassification interview. The counselor will explain the provided information to inmates who are unable to read.
2. During the nursing physical, the inmate will be informed of the risks of sharing others' blood and body fluids when engaging in needle sharing with IV drug abusers and having sexual intercourse with homosexual/bisexual males and IV drug abusers.
3. Inmates will receive more detailed information on AIDS in the form of a pamphlet to be passed out at the time of their doctor's physical. Inmates are then give the opportunity to ask a corrections center nurse or doctor any questions they may have at that time.
4. Up-to-date information on AIDS will be available to inmates at anytime through the nursing staff.
5. [redacted] Sheriff's Office staff, particularly medical and nursing staff, will be updated on the current status of the management of AIDS through conferences and printed materials.

B. RECOGNITION:

1. All [redacted] medical and nursing staff will be familiar with the basic clinical presentation of AIDS as listed below:
   a. Signs and symptoms (of at least one month duration).
      a. Fever, chills and night sweats
      b. Cough
      c. Shortness of breath
      d. Fatigue – extreme and constant
      e. Diarrhea
      f. White patches in mouth
      g. Enlarged lymph nodes
      h. Purple skin blotches/lumps that do not spontaneously disappear.
      i. Weight loss for an unknown reason.

   The signs and symptoms of AIDS do vary greatly. Clinical manifestations depend on the degree of immunosuppression and the opportunistic infections and neoplasms that develop secondarily. (See Mosby's Clinical Nursing Third Edition pp 1145-1146).

   b. Presence of a risk factor
      a. Homosexual/bisexual male
      b. IV drug abuser
      c. Hemophiliac
      d. Sexual contact with a person in a high-risk group/multiple sex partners.
      e. Hepatitis; STD
      f. Frequent viral illnesses

[redacted] - POLICIES AND PROCEDURES

SUBJECT: INFECTION CONTROL PROGRAM
~~J-12~~ J-B-01

PAGE 3 OF 7

Once the inmate presents as noted in A1 or A2, he/she will be referred to the corrections center doctor for the following:

a. To establish the diagnosis of AIDS a physical exam will include but not be limited to assessment of the following:
   1. Weight
   2. Temperature
   3. Pertinent finds of oral cavity, integument heart, lungs, lymph nodes and skin.

b. Laboratory studies may include:
   1. CBC with differential
   2. SMAC – 12
   3. Hepatitis screen
   4. AFB stain
   5. Chest x-ray
   6. ELISA and Western blot (obtain signed informed consent)
   7. Others as indicated: Stool (for ova and parasites; viral titers (e.g. herpes, EB virus, CMV); tissue biopsy, cultures, bronchoscopy).

c. Referral for specialized care or hospitalization if condition warrants.

C. MANAGEMENT OF SUSPECTED CASES:

1. Inmates presenting with a risk factor, signs and symptoms but testing negative on the HIV antibody will be managed in the following manner:
   a. No isolation or restrictions will be imposed
   b. Nursing and social worker counseling on the disease and the risk factors
   c. Follow up (if inmate remains at [redacted]) in two months for repeat HIV antibody testing (ELISHA)

D. MANAGEMENT OF CONFIRMED CASES:

1 Inmates with AIDS (presence of HIV antibody and a severe or life threatening opportunistic infection) will be placed in immediate isolation for blood and body fluids precaution only until the following can be arranged:
   a. The degree of infectiousness is determined (e.g. productive cough, open lesions, and other pertinent conditions).
   b. The probability of releasing the inmate for specialized medical management of his/her condition based on the extent of the immunosuppression; and disease progression.
   c. If the inmate is stable physically and is determined not to be infectious (e.g., productive cough, open lesion) he/she will be placed in general population.
   d. If the inmate is determined to be infectious, he/she will be placed on blood and body fluids isolation.

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e. Inmates who demonstrate irresponsibility in personal hygiene, who use their condition for manipulative purposes, or lack the mental capacity to understand preventative care, will be placed on administrative restriction.
f. Nurse and social worker counseling on the disease and preventative care.
g. The nurse is to report confirmed AIDS cases tot he Public Health Department.

E. MANAGEMENT OF SEROPOSITIVE CASES:

1. Inmates testing positive for HIV antibody who are not exhibiting signs of infection will be managed in the following manner:
   a. To remain at [redacted] in general population.
   b. No isolation (in the form of a medical floor placement), segregation or trusteeship restrictions shall be imposed unless the inmate has any of the symptoms as listed under "RECOGNITION A1".
   c. Inmates coming into the Center with confirmed positive HIV antibody testing shall not be isolated from other inmates if clinical symptoms are absent.
   d. Inmates who demonstrate irresponsibility in personal hygiene, who use their condition for manipulative purposes, or who lack the mental capacity to understand preventative care, will be placed on administrative restriction.
   e. Nurse and social worker counseling on the disease with emphasis on preventative care.
   f. The nurse is to report confirmed HIV(+) cases to the Public Health Department

F. ASSESSMENT OF PERSONS COMING INTO THE CENTER WHO CLAIM TO HAVE AIDS:

1. Interview the inmate and collect the following information:
   a. Were you tested for AIDS? When?
   b. The name of your doctor or the hospital you were tested at.
   c. Are you under any special treatment?
   d. Do you have any special problems we should know about?
   e. Assess the inmate's knowledge of AIDS.
2. Perform an assessment:
   a. Does the inmate look ill? Sickly? Pale? Weak?
   b. Check for signs of Karposi's sarcoma i.e., skin lesions.
   c. Check for signs of pneumonia, i.e., and productive cough, wheezing.
   d. Other obvious secondary infections (herpes, thrush, etc.)?
3. Isolate the inmate (as the assessment warrants) in the designated isolation area:
   a. Set up for blood and body fluids by:
      1. Posting the "Blood and Body Fluids Precautions" notice on the inmate's cell door or designated door.
      2. Have gloves, gowns, masks, goggles, caps, plastic bags, and ambu bag made available to ALL Center staff who will come into contact with the inmate.

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3. Make certain non-nursing staff have been properly instructed on isolation technique.
4. Explain to the inmate the isolation procedure and necessary precautions he/she must take:
   a. Perform good hand washing technique often.
   b. DO NOT expose one's own body fluids to others.
5. All cell furniture, fixtures, floors, and walls will be washed down with a 1:10 bleach/water solution after the inmate's release from the cell.

G. MEDICAL MANAGEMENT OF CONFIRMED HIV+ CASES

1. If the HIV+ patient is under the care of an infectious disease physician, the [redacted] doctor will follow the treatment plan as prescribed.
2. If the HIV+ patient has not been to see their infectious disease doctor in three months or is newly diagnosed, an appointment will be made to have the patient seen by the infectious disease doctor.
3. HIV+ patients who are having complications will be seen monthly by their infectious disease doctor. Stable HIV patients who have been seeing their infectious disease doctor regularly (confirm with doctor's office and if patient is stable, will see the [redacted] doctor every three months.
4. The [redacted] doctor will manage the HIV+ patient following the treatment plan of the infectious disease doctor that should include:
   a. Being aware of the rapid evolution of new information regarding treatment of HIV+ patients.
   b. Laboratory monitoring including plasma HIV RNA, CD4 cell counts, and HIV drug resistance testing.
   c. Antiretroviral therapy-when to start treatment, what drugs to initiate, when to change therapy and therapeutic options when changing therapy.
   d. Special consideration for pregnant women and adolescents.
   e. Patient understanding of the risks and benefits of treatment.
   f. Meeting the goal of maximal suppression of the HIV virus and suppression of opportunistic infections and cancers (for which there is primary and secondary prophylaxis) which includes:
      1. Candidiasis
      2. Cytomegalovirus
      3. Cryptococcus
      4. Histoplasmosis
      5. Herpes Virus
      6. Mycobacterium Avium Complex
      7. Mycobacterium Tuberculosis
      8. Pneumocystis Carinii Pneumonia
      9. Toxoplasmosis

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6. All linen, towels, clothing, and other cloth used by the inmate are to be disposed of in the designated hamper.
7. All contamminated articles, clothing, and refuse are to be double-bagged before they are removed from the inmate area. They are to be labeled "Contaminated-Use gloves when touching contents".

J UNIVERSAL PRECAUTIONS

Since inmates cannot be reliably identified as persons infected with the HIV or other blood-borne pathogens, blood and body fluids precautions must be consistently used for ALL inmates. This is referred to as "universal precautions". It must be used in all cases where the risk of blood exposure is increased or when there is potential for contact with blood. It is NOT necessary to use precautionary gear if there is no risk of exposure to inmate's blood.

A. All inmate-resident floors will be equipped with five sets of precautionary gear. Each set will include gloves, cap, mask, goggles, gown, ambu bag, and plastic bags. This gear is to be used incase any physical conflict could result in exposure to large amounts of blood or blood contaminated body fluids.
B. Center staff will be trained in the proper use of precautionary gear including the proper disposal.

VI.

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Infection Control Policy

[redacted]

MARCH 2005

I. Purpose

This directive has been developed so this department may manage those things we can reasonably predict will occur in the performance of our duties and protect department personnel from unnecessary exposure to infectious disease, including but not limited to human immunodeficiency virus (HIV).

II. Background and Definition

Human immunodeficiency virus (HIV) is the cause of an immunosuppressive disease. The virus depresses the body's ability to fight off otherwise harmless infections, eventually leading to death.

The virus enters the body through sexual activity or direct exposure into the bloodstream. The virus enters a group of white blood cells known as the T-4 lymphocytes, where it multiplies and subsequently destroys these lymphocytes. The T-4 lymphocytes are the "helper cells" for the human immune system; thus, their destruction leads to profound immune deficiency. The virus may directly infect the brain and has been known to cause dementia independent of immune deficiency in some individuals.

HIV infection can progress rapidly to complete immune deficiency and death, but more commonly, a long period of relative health follows initial exposure. As the population of lymphocytes in the individual is destroyed, symptoms such as weight loss, lymphadenopathy (swelling of the lymph glands), night sweats, weakness, lassitude, diarrhea and chronic cough begin to develop. Transient improvement in symptoms occurs at any point in an individual case, but statistically a patient who has attained profound symptomatic immune deficiency by Center for Disease Control (hereinafter referred to as CDC) standards will probably die of the disease.

III. Discussion

Law enforcement and other public safety personnel routinely come into contact with members of the public. At some point in time, it is predictable that they will come into contact with a person who has an infectious disease, such as HIV, hepatitis B, or other infectious diseases. Documented cases of transmission of these diseases have been the result of handling blood samples with ungloved hands (particularly where skin disorders or cuts have left broken skin), splashing of contaminated blood into a mucous membrane, or a needle stick.

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As a result, extreme caution should be exercised when dealing with blood or body fluids.

For the purposes of this policy, "body fluids" is defined as semen, vaginal fluids, urine and feces. Extreme caution should also be exercised in handling items stained with blood or body fluids and persons who engage in high risk behaviors.

IV. General Infection Control Procedures

The CDC has promulgated guidelines, known as universal precautions, for prevention of HIV and other infectious disease transmission in the workplace. These guidelines should be followed with all people, regardless of whether or not you suspect they have an infectious disease.

1. Wear disposable latex gloves when contact with blood or body fluids is likely to occur.

2. Wash hands thoroughly with soap and water after removing gloves and after any contact with blood or body fluids.

3. Avoid needle sticks and other sharp instrument injuries.

4. Keep all cuts and wounds covered with clean bandages.

5. Use impervious protective gowns and disposable shoe coverings if considerable blood contamination is encountered.

6. Avoid all hand to mouth, hand to nose and hand to eye actions when working in areas contaminated with blood and body fluids.

7. Clean all spills of blood or body fluids thoroughly and promptly, using a 1:10 household bleach solution.

8. Clean all surfaces possibly contaminated with blood or body fluids, with a 1:10 household bleach solution.

9. Place all clothing or other items possibly contaminated with blood or body fluids in a clearly identified impervious plastic bag.

Two key implementation issues regarding these general infection control principles must be emphasized: Judgment and consistency--precautionary measures should always be commensurate with the risk involved.

Law enforcement and public safety personnel should exercise their professional judgment as to when they believe there is a reasonable likelihood of contact with blood or body fluids. They should

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exercise reasonable care in those situations just as they do in addressing other types or risks common in their work.

They should be used when there is a reasonable likelihood of contact with the blood or body fluids of anyone, regardless of whether or not they are known or suspected to be infected with HIV.

These procedures will be effective in avoiding other infectious diseases that are not airborne, including hepatitis B. As a general rule, all unprotected contact with blood or body fluids should be avoided.

V. Policy

1. Infection Disease Precautions

1.1. Discretion should be used by members of the department in accordance with the material contained above, to limit their exposure to contagious diseases.

1.2. Protective disposable latex gloves and other infectious disease control materials should be used by members of the department whenever it is likely that they are to come in contact with blood or body fluids. Direct contact with blood and body fluids should be avoided whenever possible. Members of the department are required to carry issued protective disposable latex gloves while on their tours of duty.

1.3. Members of the department shall not eat, drink or smoke at crime scenes where blood or body fluids are present or other contagious factors exist.

1.4. Members of the department should be advised to report to their physician any direct contact with blood or body fluids in the line of duty.

2. Infectious Disease Training

2.1. The department's training bureau and medical department will have the responsibility for disseminating updated material as it becomes available, and coordinating additional roll call and/or in-service training.

2.2. Until a definitive treatment for AIDS is developed, education is a key strategy for preventing transmission of the human immunodeficiency virus. It is absolutely essential that the HIV education program remain a high priority. Therefore, it will be the responsibility of the medical department to implement, monitor and update the HIV education program on a yearly basis. Attendance at this program will be mandatory for all department personnel.

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2.2.1. Educating staff and inmates about AIDS is a continually evolving process. The rate of spread of HIV within the correctional system, as in the general public, is tied closely to education and the population's awareness of high risk behavior and virus transmission. It is therefore vital that an aggressive, high-quality HIV education program be initiated and maintained for the inmates.

2.3. The health status of any individual in the custody of the department is strictly confidential and may not be released as public information without the consent of the individual. When the health status must be revealed to another officer or health care provider, it must be done in a manner that does not risk a breach of confidentiality by being overheard by any unauthorized person. Purposeful violation of this policy will result in disciplinary action. Repeated violations could result in suspension.

VI. Procedures

1. The medical department shall ensure that adequate supplies are available for infectious disease control within their respective bureaus.

2. The medical department will be responsible for the inventory and dissemination of supplies for infectious disease control.

2.1. They will initiate reordering procedures before supplies become depleted.

3. Members of the department using such supplies are responsible for replacing them.

3.1. Protective disposable latex gloves and other infectious disease control materials and disinfecting materials will be made readily available at all times.

4. The medical department will designate appropriate receptacles as a "contaminated item receptacle."

4.1. After the completion of a task or search where protective disposable latex gloves or other infectious disease control materials were used, they should be removed and placed in a plastic bag and securely sealed.

4.2. All items should be separated into disposable and nondisposable items. Nondisposable items include any item that can be effectively disinfected.

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4.3. The separated items should then be placed into the appropriate "contaminated item receptacle, disposable" or "contaminated item receptacle, nondisposable" container.

5. Subjects with blood or body fluids present on their persons should be transported separated from other persons whenever possible.

6. Members of the department have an obligation to inform other law enforcement and public safety personnel whenever a transfer or change of custody occurs and the subject has blood or body fluids present on his/her person, or if the subject has made a voluntary statement that he/she has an infectious disease. However, it is important not to violate the subject's right of confidentiality of health status.

6.1. Whenever possible the blood and/or body fluid precaution form is to utilized.

7. Upon entry to the booking/slating areas of the correctional facilities, the transporting officer is to notify the corrections staff if the subject taken into custody has blood or body fluids on his/her person so that appropriate precautionary measures can be taken. Once again it is important to remember not to violate the subject's right to have his/her health status remain confidential.

8. Arresting or transporting officers should indicate on the arrest form when a subject taken into custody makes a voluntary statement that he/she has an infectious disease.

8.1. Additionally, a notation should be made when the subject has blood or body fluids present on his person or clothing.

9. Once the subject is in custody at the correction center, proper disinfection procedures, as outlined in this regulation, are to be strictly followed.

VII. Disinfection procedures

1. Disinfection procedures shall be effected when a department vehicle requires cleanup after being contaminated by blood or other body fluids.

2. Recommended disinfection procedures are as follows:

2.1. Protective disposable latex gloves will be worn during all phases of disinfection.

2.1.1. Personnel should be made aware that rings, jewelry, or long fingernails may compromise the structural integrity of the gloves. They should make

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certain the gloves are not torn before they attempt to begin any phase of the maintenance process.

2.2. Any excess blood or body fluids should be first wiped up with approved absorbent materials. Afterwards, the absorbent materials should be immediately placed in a plastic bag and placed in the designated "contaminated item receptacle, disposable."

2.3. The affected area shall be cleanses with a broad-spectrum virucidal-germicidal solution or a 1:10 household bleach solution and allowed to air dry for at least ten (10) minutes.

2.4. All disposable contaminated cleaning items shall be placed in a plastic bag and placed in the designated "contaminated item receptacle, disposable."

2.5. Personnel shall be careful not to contaminate themselves during this cleaning regimen, or when taking off their protective disposable latex gloves.

2.6. All vehicles taken for routine service will be cleaned in the interior with the approved disinfecting materials.

3. Cell Contamination

3.1. The supervisor will be responsible for ensuring that any cell contaminated by blood or body fluids will be properly disinfected. All cells will be disinfected between prisoners.

3.2. Recommended disinfection procedures to be followed are the same as for vehicle disinfection procedures above.

3.3 Each work and housing area in the correctional facilities shall maintain a sufficient quantity of disposable gloves and other infectious disease control materials.

3.3.1. The disposable gloves shall be used only when indicated, i.e., to clean up blood/body fluid spills.

3.3.2. Indiscriminate use of disposable gloves is unnecessary and is viewed as contradictory to HIV education. Indiscriminate use could lead to disciplinary action.

3.4. Linen soiled with blood/body fluids should be placed into and transported in melt-away bags. The linen should be placed in the washer still in the melt-away bags and should be washed in hot water with detergent at a temperature no less than 160 degrees for 25 minutes.

VIII. Testing of Inmates/Staff

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1. Inmates--After consultation with the facility physician or medical staff, an inmate may request an HIV antibody test.

2. Consistent with sound clinical judgment, medical staff may order an HIV antibody test if an inmate presents with chronic illnesses or symptoms suggestive of an HIV infection.

2.1. Inmates demonstrating promiscuous, assaultive or predatory behavior may be tested within this category.

3. Staff--Staff who feel that they have been exposed to hazardous blood and/or body fluids while on duty shall report this exposure to their supervisor, at which time an exposure form will be completed.

3.1. Examples of line-of-duty high risk exposure are:

3.1.1. The handling of bloody or wet items, where scratches, cuts, or open sores are noticed on the area of contact.

3.1.2. Direct contact with body fluids from a subject on an area where there is an open sore or cut.

3.1.3. The receiving of a cut or puncture wound as a result of searching or arresting a subject when either the sharp object or the skin has been exposed to blood or body fluids.

3.2. Members of the department will be evaluated clinically and serologically by a hospital or their family physician for evidence of infection, immediately after the alleged exposure.

4. Positive Test Results

4.1. Only a positive result that has been confirmed by a Western Blot will be entered in the inmate's medical file.

6. Communal Implements

6.1. Toothbrushes, razors, or other personal implements that could become contaminated with blood or body fluids shall not be used by more than one inmate.

6.2. Multiple use items such as bandage scissors, barber equipment, etc., shall be washed in warm soapy water, agitated in disinfectant for not less than 15 seconds, then dried with a clean cloth following each use.

7. Syringe and Needle Precautions

In accordance with CDC recommendations: "All health care workers should take precautions to prevent injuries caused by needles,

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scalpels, and other sharp instruments or devices during procedures; when cleaning used instruments; during disposal of used needles; and when handling sharp instruments after procedures. To prevent needle stick injuries, needles should not be recapped, purposely bent or broken by hand, removed from disposable syringes, or otherwise manipulated by hand. After they are used, disposable syringes and needles, scalpel blades, and other sharp items should be placed in puncture-resistant containers for disposal; the puncture-resistant containers should be located as close as practical to the use area. Large-bore reusable needles should be placed in a puncture-resistant container for transport to the reprocessing area."

8. Counseling

8.1. Inmates receiving the HIV antibody test shall receive pre- and post-test counseling from someone who has been trained by the Ohio Health Department's AIDS Training Unit or by a physician, regardless of the test results.

8.2. Pre- and post-test counseling should address the limitations of the test, false positive,s false negatives, and the possible need for additional testing, as well as the complications and consequences or a negative and a positive test result.

8.3. Inmates who test positive should also be counseled about the disease process, how to maintain their health, and how to avoid transmission to others by a medical professional with experience with HIV.

8.4. Pregnant women who test positive shall also be advised of the probability that the virus will be transmitted to the fetus, and what their medical alternatives are.

IX. Housing

1. There shall be no special housing established for inmates with an infectious disease until and/or unless their medical condition warrants such housing.

2. Inmates determined at intake to have a communicable, contagious, or infectious disease shall be initially placed in single cell housing and an IOC sent to the classification supervisor.

2.1. The classification supervisor in consultation with the medical administrator shall thereafter make the proper housing assignment.

3. An inmates may be placed in controlled housing status when there is reliable evidence causing staff to believe that the inmate may engage in conduct posing a health risk to others. This evidence

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may be the inmate's behavior, statements by the inmate, or other reliable evidence.

3.1. The classification supervisor shall consider an inmate for controlled housing status when the inmate has been confirmed having a communicable, contagious, or infectious disease and there is reliable evidence indicating that the inmate may engage in conduct posing a health risk to others.

3.2. This evidence may come from the statements by the individual, repeated misconduct (including disciplinary actions), or other behavior suggesting that the inmate may engage in predatory or promiscuous sexual behavior, assaultive behavior where blood or body fluids may be transmitted to another, or the sharing of needles.

3.3. The procedures contained in the policies and procedures manual regarding isolation shall apply.

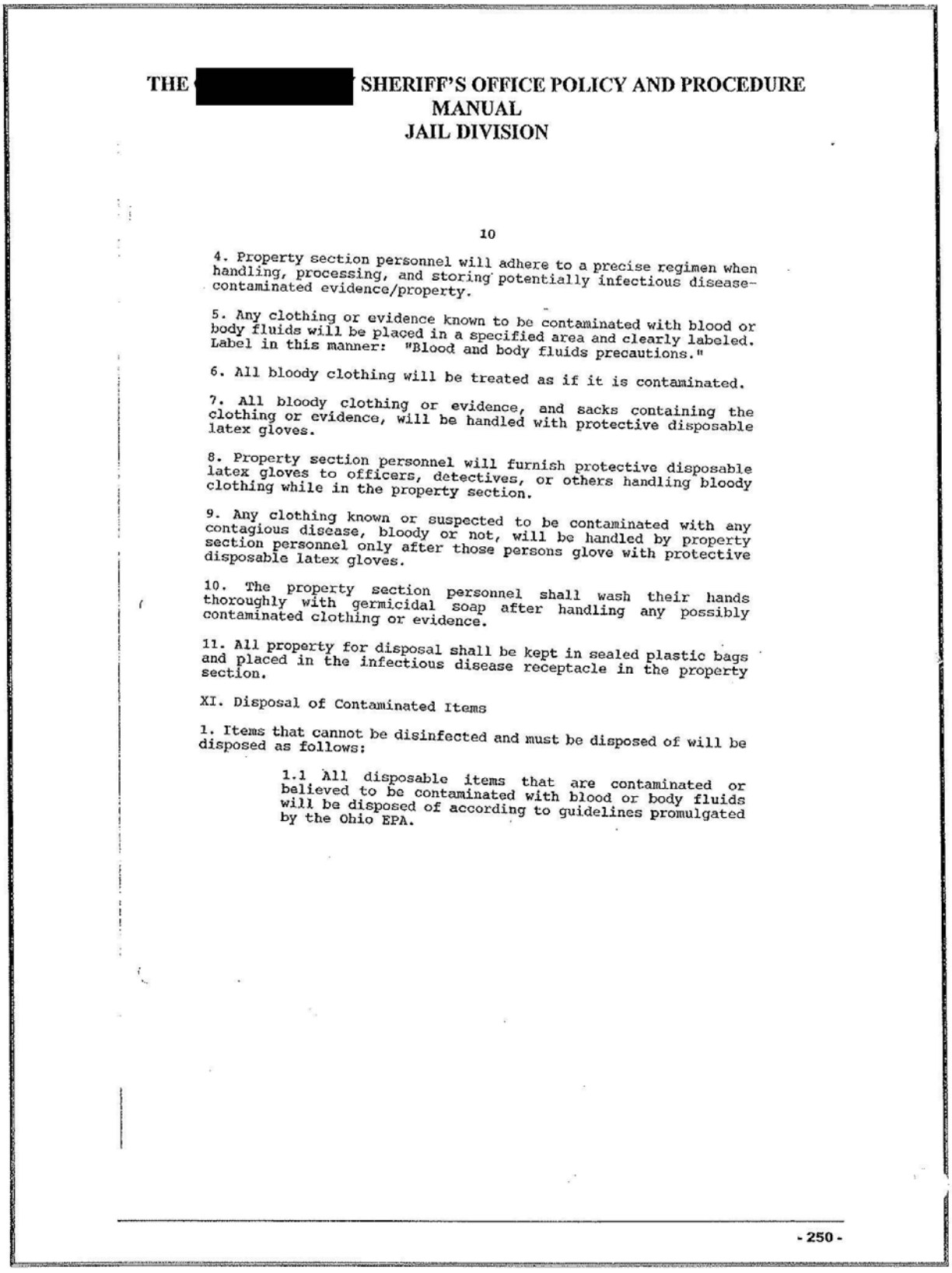
4. An inmate may be placed in controlled housing status when clinically indicated by the medical staff for the inmate's protection and treatment.

X. Handling and Storage of Property and Evidence

1. Evidence containing suspected blood or other bodily fluids should be handled with gloves. If the stain or sample is dry, it should be placed in a paper bag. A proper evidence tag, an evidence processing request, and a special label should be affixed to the outside of the package. If the evidence consists of a syringe and needle, the needle portion should be made safe by wrapping with tape so that the sharp point is covered and is blunt. The needle/syringe should be placed in a plastic bag so that it can abe seen by persons handling the evidence. The bag should be tagged with an evidence tag, an processing request and a special label. It should be noted that if the needle/syringe is to be processed for latent fingerprints, the plastic bag may hinder the obtaining of latents. Remember, the safety of police personnel is of utmost importance. Liquid samples either should be collected as a liquid and stored in a bottle or, if located on clothing or similar materials, should be air-dried and packaged as described above.

2. Always wash thoroughly with soap and water after handling any item suspected of being contaminated with blood or other bodily fluids. Wash even if you have worn gloves.

3. Persons working in areas for extended periods of time where blood or other bodily fluids have been shed (for example, crime scene personnel working for protracted periods of time at homicide scenes) should wear anti-contamination clothing, such as suits, masks, boot covers, and gloves.



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4. Property section personnel will adhere to a precise regimen when handling, processing, and storing potentially infectious disease-contaminated evidence/property.

5. Any clothing or evidence known to be contaminated with blood or body fluids will be placed in a specified area and clearly labeled. Label in this manner: "Blood and body fluids precautions."

6. All bloody clothing will be treated as if it is contaminated.

7. All bloody clothing or evidence, and sacks containing the clothing or evidence, will be handled with protective disposable latex gloves.

8. Property section personnel will furnish protective disposable latex gloves to officers, detectives, or others handling bloody clothing while in the property section.

9. Any clothing known or suspected to be contaminated with any contagious disease, bloody or not, will be handled by property section personnel only after those persons glove with protective disposable latex gloves.

10. The property section personnel shall wash their hands thoroughly with germicidal soap after handling any possibly contaminated clothing or evidence.

11. All property for disposal shall be kept in sealed plastic bags and placed in the infectious disease receptacle in the property section.

XI. Disposal of Contaminated Items

1. Items that cannot be disinfected and must be disposed of will be disposed as follows:

1.1 All disposable items that are contaminated or believed to be contaminated with blood or body fluids will be disposed of according to guidelines promulgated by the Ohio EPA.

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DETENTION FACILITY

POLICY AND PROCEDURE

TITLE: HIV AND AIDS

CODE: J-802

EFFECTIVE DATE: January 1, 1997

REVISED: November 10, 2003

REFERENCE TO STANDARDS: OMJS 5120 1-8-09

APPROVED BY: [redacted]

I. POLICY:

It is the policy of the [redacted] to be responsible for the health and safety of both, the inmates under its protection and employees under its supervision. It is also policy to protect the privacy of individuals that have any disease or disorder that is not airborne, or casual contact transmitted. OMJS 5120: 1-8-09 (R)

II. PURPOSE:

To be alert to health conditions, and to take action to protect all concerned.

III. DEFINITION:

The letters A-I-D-S stand for Acquired Immune Deficiency Syndrome. **When a person is sick with AIDS, he/she is in the final stages of a series of health problems caused by a virus (HIV)** that can be passed from one person to another chiefly during sexual contact, or through the sharing of intravenous drug needles and syringes.

The letters H-I-V stand for Human Immunodeficiency Virus. **The virus attacks a person's immune system and damages his/her ability to fight another disease**. Without a functioning immune system to ward off other germs, he/she becomes vulnerable to becoming infected by bacteria, protozoa, fungi and other viruses and malignancies which may cause life-threatening illnesses, such as pneumonia, meningitis and cancer.

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POLICY AND PROCEDURE

TITLE: HIV and AIDS CODE: J-802

How A Healthy Immune System Works: Human blood contains different types of white blood cells that play different roles in protecting against disease. Among a type of white blood cells, called Lymphocytes, are the B and T cells. Some T cells (also called Helper Cells) help the B cells produce antibodies that fight disease-causing organisms. Other T cells (known as Suppressor Cells) work to stop or suppress the fight against invading germs once the infection has been overcome. In a healthy person, Helper cells outnumber Suppressor cells by a 2 to 1 ratio. In a person that is HIV positive, the Suppressor cells outnumber the Helper cells, leaving the immune system weak, or ineffective in the fight against disease.

There is presently no cure for A.I.D.S. There is presently no vaccine to prevent A.I.D.S.

Awareness and education about A.I.D.S will help you separate the facts from the fiction about A.I.D.S, and dispel the myths and fears.

Symptoms: Although many illnesses share the same symptoms, the following list is provided for your understanding of the A.I.D.S virus.

1. Extreme tiredness combined with headache, dizziness, or light-headedness.
2. Continued fever or night sweats.
3. Weight loss of more than 10 pounds, not due to dieting or increased physical activity.
4. Swollen glands in the neck, armpit or groin.
5. Purple or discolored growths on the skin or mucous membrane (inside the mouth, anus or nasal passages).
6. Heavy continual dry cough. Too persistent to be a cold or flu.
7. Continual bouts with diarrhea.
8. Thrush (a thick whitish coating on the tongue, or in the throat, which may be accompanied by a sore throat).

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9. Unexplained bleeding from any body opening, or from growths on the skin or mucous membranes.

10. Bruising more easily than usual.

11. Progressive shortness of breath.

III. PROCEDURE:

A. The Jail Administrator shall make available protective gloves, masks and clothing for the Correction Officers to use when they suspect they are dealing with an infectious disease.

B. Correction Officers will take the following precautions when working with inmates, in order to protect themselves from infectious disease.

1. Wear disposal plastic or rubber gloves.

2. Take precautions against punctures and cuts when doing pat-down searches.

3. Take strict precautions to avoid any exchange of blood or body fluid with inmates.

4. Make sure any open wounds and/or sores are covered with clean bandages to prevent possible exchange of blood.

5. Wear protective gloves if there is a chance of contact with blood or other body fluid.

6. Avoid needle sticks, or punctures with any sharp object.

7. Never blindly place hands in an area where there may be sharp objects that could cut or puncture the skin, and be particularly alert for such objects during cell searches.

8. Wash hands with soap and warm water after the skin becomes contaminated with any questionable material, and after every search.

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9. Dispose of masks, gloves, gowns, etc. in the BioHazard container, or in a sealed plastic bag.

10. Wash officer's clothing as soon as possible, using hot water and detergent. Wipe shoes with disinfectant.

11. Avoid being bitten or scratched by inmates.

12. The safest method of protection against infectious disease is to follow the above listed precautions when working with all inmates.

C. Cleaning of Blood and Other Body Fluid Spills

1. Wear protective gloves and use disinfectant solution, such as household bleach, diluted 1 part bleach to 10 parts water.

2. Contaminated clothing shall be placed in a plastic bag and laundered as soon as possible.

3. During laundering, any of the following solutions will kill the AIDS virus:

   a. Hot water and detergent
   b. Bleach
   c. Heat from an automatic dryer

D. Contaminated Equipment

1. Disinfect with any of the following:

   a. Hot water and detergent
   b. A 40% to 70% alcohol/water solution

E. Inmate Isolation

1. The fact that someone is HIV positive is privileged medical information. Officers will not discuss the fact, or possibility with inmates, that someone is HIV positive.

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2. Inmates, who are HIV positive, will be housed in general population unless isolation is needed for medical reasons or, for protective custody. These inmates will be treated the same as any other inmate.

F. Protection Of Inmates From Opportunistic Infections

1. Due to their greatly suppressed immune system, HIV infected persons are highly susceptible to infectious disease. Mild viruses, carried by other inmates or staff members, can, if transmitted to a HIV-infected inmate, result in a life-threatening illness to that inmate. Correction Officers shall be alert to signs of illness in and around known HIV positive inmates, and shall report the condition to the Jail Physician and the Jail Administrator.

2. Inmates will not be permitted to share razors or toothbrushes with other inmates.

G. Personnel Testing

1. In the event that blood or body fluids of a HIV positive person directly enters an employee's bloodstream, the employee shall be tested for the A.I.D.S. antibody, four (4) to six (6) weeks after the suspected contamination.

2. If the test results are negative, the test shall be repeated six (6) months later, and again one (1) year later.

3. Since there is no known risk of transmitting the A.I.D.S. virus through casual contact, personnel shall not be excused, at their own request, from working with AIDS infected persons.

4. Employees, who believe they are at high-risk for infection because of their own immune status (due to previous illness or pregnancy), shall discuss their work responsibilities with their personal physician. If the physician determines that there are certain assignments the employee should not accept, this shall be communicated by the physician, in writing, to the Jail Administrator for appropriate action.

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VII.

New		[redacted] County Sheriff's Office Medical Services Division	Memorandum	
Amendment			Directive	
Permanent	X		P&P	1-13
Temporary			Protocol	
Written By	[redacted] Administrator		Effective Date	01/01/03
Authorized By	[redacted] Medical Director		Date Amended	9/11/03
Topic	PRISONERS WITH AIDS OR HIV POSITIVE		Date Purged	

INMATES WITH AIDS OR HIV POSITIVE

Inmates that claim to be "HIV" positive, or are medically diagnosed "HIV" positive, or "AIDS," shall be medically evaluated immediately upon incarceration. This is to assure that the continuity of prescribed medical care already being administered to the patient is not disrupted, or to confirm and initiate medical care and counseling for the inmate.

The HIV positive / AIDS confirmed inmate is to be placed in general population unless there is a risk of the transmission of blood or other certain bodily fluids to other inmates or staff. Examples of this would be open sores, ulcerations, and bleeding. If you feel the inmate needs to be isolated for medical reasons, the Jail Physician shall be contacted for advice.

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VIII.

[redacted]

Health Care Policy & Procedure

INFECTIOUS DISEASE MANAGEMENT

HC
PS: 6190.03

1. Purpose and Scope § 549.10. The Bureau will manage infectious diseases in the confined environment of a correctional setting through a comprehensive approach which includes testing, appropriate treatment, prevention, education, and infection control measures.

2. Summary of Changes. Bureau policy is updated to reflect the following:

- Compliance with the revision of 29 CFR 1910.1030, the Bloodborne Pathogen standard in conformance with the Needlestick Safety and Prevention Act. This will expand the requirements of the elements of Section 11, Exposure Control Plan to:
  - include new examples in the definition of engineering controls;
  - reflect how employers implement new developments in control technology; and
  - require employers to solicit input from employees in the selections of engineering and work practice controls.
- Compliance with 18 U.S.C. §4014, Testing for Human Immunodeficiency Virus (HIV) (Correction Officers Health and Safety Act of 1998), Pub. L. 105-370, Nov.12, 1998, 112Stat. 3374. This addresses testing for HIV among persons sentenced to a term of imprisonment for a Federal offense, or ordered detained before trial under Section 3142(e), who may have intentionally or unintentionally transmitted HIV to any officer, employee of the United States, or any person lawfully present in a correctional facility who is not incarcerated.
- To incorporate guidelines from the Centers for Disease Control and Prevention (CDC) into the BOP management of occupational exposures to Hepatitis B virus (HBV), Hepatitis C virus (HCV), and HIV; HIV counseling and testing and tuberculosis contact investigations.

3. Program Objectives. The expected results of this program are:

a. The incidence and associated health risks of infectious diseases will be reduced.

b. Inmates will receive appropriate training, education, and counseling on contagious disease prevention.

c. Risks of infection will be reduced by universal precautions, engineering and work practice controls, appropriate treatment, use of vaccinations, use of personal protection equipment, and other infection control measures.

d. Occupational Safety and Health Administration (OSHA) standards relevant to infectious disease management will be met.

e. Compliance with the "Correction Officers Health and Safety Act of 1998 will be attained.

4. Directives Affected

a. Directive Rescinded

P6190.02 Infectious Disease Management (10/3/95)

b. Directives Referenced

P1351.05	Release of Information (9/19/02)
P1600.08	Occupational Safety and Environmental Health Manual (8/16/99)
P5050.46	Compassionate Release, Procedures for Implementation of 18 U.S.C. 3582(c)(1)(A) and 4205(g) (5/19/98)
P5214.04	HIV, Handling of Inmates Testing Positive (2/4/98)
P5270.07	Inmate Discipline and Special Housing Units (12/29/87)
P5290.14	Admission and Orientation Program (4/3/03)
P5500.12	Correctional Services Procedures Manual (10/10/03)
P5538.04	Escorted Trips (12/23/96)
P5566.05	Use of Force and Applications of Restraints On Inmates (12/31/96)
P6031.01	Patient Care (1/15/05)
P6090.01	Health Information Management (1/15/05)

c. Rules cited in this Program Statement are contained in 28 CFR 549.10 through 549.15.

d. Rules referenced in this Program Statement are contained in 5 CFR 339.102 and 339.301 through 339.305 and 29 CFR § 1910.1030 (Bloodborne Pathogens).

e. "Correction Officers Health and Safety Act of 1998", Pub. L. 105-370, November 12, 1998, 112 Stat. 3374, Sec. 2. Testing for Human Immunodeficiency Virus.

5. Standards Referenced

a. American Correctional Association (ACA) 4th Edition Standards for Adult Correctional Institutions: 4-4281, 4-4354, 4-4355, 4-4356, 4-4357, and 4-4358

b. American Correctional Association 3rd Edition Standards for Adult Local Detention Facilities: 3-ALDF-4E-08, 3-ALDF-4E-35, and 3-ALDF-4E-36

c. American Correctional Association 2nd Edition Standards for the Administration of Correctional Agencies: 2-CO-4E-01

6. Program Responsibility § 549.11. Each institution's Health Services Administrator (HSA) and Clinical Director (CD) are responsible for the operation of the institution's infectious disease program in accordance with applicable laws and regulations.

a. The HSA will provide:

- Infectious disease procedures written in accordance with this Program Statement and other Bureau policy.
- Infectious disease procedures that incorporate and reference, as applicable, standards, guidelines, and recommendations from other Federal agencies including the Department of Health and Human Services (HHS), the Centers for Disease Control and Prevention (CDC), the Occupational Safety and Health Administration (OSHA), and the National Institutes for Occupational Health(NIOSH). Applicable standards and guidelines will be provided to the Infection Control Officer (ICO).
- An institution occupational exposure control plan for bloodborne pathogens and tuberculosis (TB) in accordance with applicable OSHA Standards.
- The CDC Morbidity and Mortality Weekly Report (MMWR) is available to institution clinical staff for review either as hard copy or on-line.
- A Registered Nurse (RN) or Mid-Level Practitioner (MLP) will be designated, through attrition, as the institution ICO. He/She is responsible for implementing the institution infection control program. The responsibilities of the designated person will be defined in writing (refer to the Quality Improvement/Infection Control Officer position description available on BOPDOCS).
- Infectious disease procedures will be reviewed annually by the HSA and CD to ensure clinical accuracy.
- The CD, HSA, ICO, and other appropriate institution staff will meet at least quarterly to review the implementation of the institution's infection control and surveillance program.
- Evidence of, at a minimum, quarterly Infection Control meetings (minutes) and review of surveillance activities that are documented and included as part of the institution's Quality Improvement Program (QIP).

7. Testing § 549.12. All HIV testing will be conducted using a Food and Drug Administration (FDA) approved method. All HIV testing requires pre- and post-test counseling. Classification of HIV testing includes:

- Voluntary. Voluntary testing is done when the inmate requests testing via an Inmate Request to Staff Member (BP-S148) form, which will be turned into Health Services.
- Mandatory. Mandatory testing is performed when there are risk factors and the test is clinically indicated and/or surveillance testing is required. Inmates must participate in mandatory HIV testing programs. If an inmate refuses

[redacted]

mandatory testing, staff will initiate an incident report for failure to follow an order. Inmate written consent is not required.

- Involuntary Testing. Involuntary testing is performed following an exposure incident. Written consent of the inmate is not required. If an inmate refuses testing, testing will be conducted in accordance with the Program Statement on Use of Force.

a. Human Immunodeficiency Virus (HIV)

(1) Clinically Indicated. The Bureau tests inmates who have sentences of six months or more if health services staff determine, taking into consideration the risk as defined by the Centers for Disease Control guidelines, that the inmate is at risk for HIV infection. If the inmate refuses testing, staff may initiate an incident report for refusing to obey an order.

Inmates housed in BOP institutions, regardless of commitment status, who have risk factors for HIV infection or clinical evidence of HIV infection, will be tested in accordance with clinical guidance from the Medical Director.

(2) Exposure Incidents. The Bureau tests an inmate, regardless of the length of sentence or pretrial status, when there is a well-founded reason to believe that the inmate may have transmitted the HIV infection, whether intentionally or unintentionally, to Bureau employees or other non-inmates who are lawfully present in a Bureau institution. Exposure incident testing does not require the inmate's consent.

An exposure incident means a specific eye, mouth, other mucous membrane, non-intact skin, or parenteral contact with blood or other potentially infectious body fluids.

Inmates involved in an exposure incident will be tested for HIV infection. If an inmate refuses, institution medical staff will test the inmate involuntarily with authorization from the Warden. A court order is not required.

- The Warden, or designee, will determine whether inmates who are subject to an incident report for failure to obey an order are placed in administrative detention/segregation.
- After the inmate is involuntarily tested for HIV, the CD will send a message to the Bureau Medical Director with a copy to the Regional Director. The message must contain:

(a) the inmate's name and register number;
(b) the specific diagnosis;
(c) a description of the exposure incident; and
(d) an indication that education and counseling have been provided to the inmate prior to testing.

(3) Surveillance Testing. The Bureau conducts HIV testing for surveillance purposes as needed. If the inmate refuses testing, staff may initiate an incident report for refusing to obey an order.

Surveillance testing may include but is not limited to testing of newly incarcerated inmates with serial retesting or a random sampling of institutional populations. This testing is conducted based upon guidance from the Medical Director.

(4) Inmate Request. An inmate may request to be tested. The Bureau limits such testing to no more than one per 12-month period unless the Bureau determines that additional testing is warranted.

HIV testing that is requested by an inmate is considered voluntary testing.

(5) Counseling. Inmates being tested for HIV will receive pre- and post-test counseling, regardless of the test results.

Medical staff will provide HIV counseling to inmates in accordance with guidance from the Medical Director and CDC recommendations. Counseling will be provided in a language that is easily understood by the inmate.

- Individual and confidential pre-test (unless random) and post-test counseling will be the institution physician's responsibility; however, any appropriately trained health care provider may conduct the actual counseling. The physician or the ICO will counsel all post-test inconclusive inmates. The physician will counsel all post-test positive inmates.
- Pre- and post-test counseling will address the limitations of the test, i.e., the inability to detect early infections, false positives, false negatives, and the possible need for additional testing as well as the complications and consequences of a negative or positive test result.
- Pregnant inmates who test positive will be advised the virus may be transmitted to the fetus and of current treatment options to prevent perinatal transmission.
- All inmates testing positive will be referred to the Psychology Department for follow-up counseling.
- HIV testing information will be discussed during A&O. The HIV Information Sheet (BP-S490) may be used.
- The actual pre-counseling session will be documented on the HIV Counseling Documentation (BP-S489) form. The BP-S489 form will be placed in the inmate's health record or maintained in a suspense file until test results are obtained.
- The HIV Counseling Documentation form (BP-S489) will be used for negative, inconclusive, or positive test results. The BP-S489 form will be signed by the inmate and retained in the medical record. All forms are available on BOPDOCS.

b. Tuberculosis (TB)

(1) The Bureau screens each inmate for TB within two calendar days of initial incarceration. Contagious pulmonary TB disease must be eliminated as a potential diagnosis prior to placing an inmate into general population. Screening for active TB disease for newly incarcerated inmates includes the following:

- All inmates will be assessed by a health care professional for clinical signs and symptoms (i.e., weight loss, chronic cough, hemoptysis) of active pulmonary TB during intake screening. The clinical assessment must be documented in the health record. All inmates with symptoms of pulmonary TB will be further evaluated with a chest radiograph.
- Tuberculin skin test screening with the PPD (purified protein derivative) skin test, must be initiated within two calendar days of initial incarceration to screen for both latent TB infection and TB disease unless a previously positive tuberculin skin test has been adequately documented. It is recommended that the TB skin test be placed during intake screening. Inmates with a documented previously positive tuberculin skin test, should not be retested, but should be screened for active TB disease by chest radiograph.
- A self-reported, undocumented previous positive tuberculin skin test is not a contraindication to receiving a tuberculin skin test unless a severe previous reaction (e.g. whole arm swelling or severe blistering) has been documented or described by the inmate.
- Asymptomatic inmates with a positive tuberculin skin test at intake, or a previously positive tuberculin skin test, will have a chest radiograph completed within 14 calendar days to screen for TB disease unless the inmate has a documented negative chest x-ray subsequent to the positive skin test.
- An inmate may not request to substitute a chest radiograph for a screening tuberculin skin test. The only exception is when there is a medical contraindication to tuberculin skin testing or in instances where involuntary testing may cause significant injury to the staff or inmate. The CD or designee is the approving authority for ordering a screening chest radiograph in lieu of an otherwise indicated tuberculin skin test.
- Refer to Subsection (4) below, for information on inmates who refuse PPD skin testing.
- Inmates will be evaluated and treated for latent TB infection or TB disease in accordance with guidance from the Medical Director.

(2) The Bureau conducts screening for each inmate annually as medically indicated.

All inmates without prior TB infection must be screened annually for newly acquired TB infection, including the following:

- An evaluation by a health care professional for signs and symptoms of TB disease.
- An annual tuberculin skin test for all inmates with a prior negative tuberculin skin test who have no medical contraindications for testing.
- A chest x-ray for all inmates with a newly positive annual tuberculin skin test will be completed within 14 calendar days of the annual tuberculin skin test, or sooner if the inmate has symptoms of TB disease. If the inmate is symptomatic, immediately obtain a chest radiograph and place the inmate in a negative pressure isolation room (NPIR) or make arrangements to transport the inmate to the community hospital.

- Follow-up periodic chest x-rays for inmates with previously positive tuberculin skin tests will be conducted based upon guidance from the Medical Director.
- An inmate may not request to substitute a chest radiograph for an annual tuberculin skin test. The only exception is when there is a medical contraindication to tuberculin testing or in instances where involuntary testing may cause significant injury to the staff or inmate. The CD or designee is the approving authority for ordering a screening chest radiograph in lieu of an otherwise indicated tuberculin skin test.

(3) The Bureau will screen an inmate for TB when health services staff determine that the inmate may be at risk for infection.

Inmates who have clinical evidence of active TB or a recent exposure to TB will be evaluated in accordance with guidance from the Medical Director.

(4) An inmate who refuses TB screening may be subject to an incident report for refusing to obey an order. If an inmate refuses skin testing, and there is no contraindication to tuberculin skin testing, then, institution medical staff will test the inmate involuntarily.

- The physician will document the education and counseling as well as the specific diagnostic evaluation or procedure in the inmate's health record.
- Inmates who refuse TB screening will not be placed in medical isolation unless there is a clinical indication for such isolation.
- For tracking purposes, after involuntary tuberculin testing for TB infection, the CD will send a message to the Bureau Medical Director with a copy to the respective Regional Director. The message must contain:
  - the inmate's name and register number;
  - the specific diagnosis;
  - a description of the exposure incident; and
  - some indication that education and counseling have been provided to the inmate.

(5) The Bureau conducts TB contact investigations following any incident in which inmates or staff may have been exposed to tuberculosis. Inmates will be tested according to paragraph (b)(4) of this section. (For WITSEC inmates refer to Section 10.)

All active pulmonary TB cases will be investigated when indicated according to CDC guidelines. The investigation and evaluation will be conducted in consultation with the local health department and Regional and Central Office administrative staff (See Section 8. for surveillance reporting).

(6) Refusal of Treatment. Refer to the Program Statement on Patient Care, Involuntary Medical Treatment/Refusal of Treatment when an inmate refuses treatment for active tuberculosis disease and the inmate poses a risk to others by refusing treatment.

[redacted]

(7) Medical Clearance for Transporting Inmates. BOP inmates (including all holdover status inmates, i.e., DEA, U.S. Marshals Service, Bureau of Immigration and Customs Enforcement (ICE), FBI, etc.) who have not been screened for TB are prohibited from transfer between Bureau institutions. Transporting officials will only accept any inmate who has one of the following screening criteria prior to transport:

(a) a valid negative tuberculin skin test documented in millimeters;
(b) a negative chest x-ray result if the tuberculin skin test is positive or the tuberculin skin test is medically contraindicated; or
(c) a health record review documenting no evidence of medical complaints/symptoms associated with TB within the past 30 days.

- Inmates who have been evaluated for symptoms such as a cough or chills within the past 30 days will be evaluated prior to transport, as clinically indicated.
- Findings of the evaluation/examination should be documented in the "Additional Information" section of the BP-S659, if symptoms are present.

One of the above criteria must be documented on the Medical Summary of Federal Prisoner/Alien in Transit (BP-S659).

For security reasons, the CD may recommend the requirement for a tuberculin skin test or chest x-ray be waived prior to the immediate transport of an inmate, (e.g., an uncooperative inmate where the risk of injury to the inmate or staff precludes involuntary forced testing). An institution physician will examine and clear such inmates for transfer and document this recommendation. If the tuberculin skin test or chest x-ray is waived, the inmate will be tested upon arrival at the receiving institution.

c. Diagnostics. The Bureau tests an inmate for an infectious or communicable disease when the test is necessary to verify transmission following exposure to bloodborne pathogens or to infectious body fluid. An inmate who refuses diagnostic testing is subject to an incident report for refusing to obey an order.

Testing for viral hepatitis, sexually transmitted infections (STI) and other infectious diseases will be performed based upon clinical indications. The following are of clinical significance. Additional guidance will be at the discretion of the Medical Director.

- Ectoparasites: Pediculosis and Scabies – Inmates entering any institution in which NaphCare provides health care will be examined and treated, if indicated, for ectoparasites in order to prevent possible institutional infestation.

  a. Transmission of both occurs by close, personal contact and/or contact with objects, such as clothing, bedding, and in the case of head lice by combs, brushes, hats.
  b. Any person with whom the infested inmate has had recent personal contact or shared clothing or other items will be evaluated and treated regardless of the presence or absence of symptoms.

- Sexually Transmitted Diseases: Gonorrhea/Chlamydia/Syphilis.

  a. Tests will be done in accordance with Infection Control Manuals.
  b. Reporting to the local health department will follow state and local guidelines.
  c. Treatment will be determined by the Advanced Clinical Provider.

- Food Poisoning: The treatment of individuals with suspected food poisoning will vary with the causative agent and is prescribed by the attending advanced clinical provider. Enteric isolation precautions will be instituted with outbreaks.

- Rabies:

  a. Victims of animal bites should immediately report the incident to health care staff, who, in turn, will notify the institution authority/designee.

  b. The animal should be immediately quarantined or turned over to the county animal control officer.

  c. Sacrificed animals such as bats, mice, rats, etc., should be sent in a sealed plastic bag as soon as possible to the appropriate laboratory for processing.

  d. Telephone notification of the results pertaining to the transported animal should be made. Treatment will be consistent with the CDC recommendations.

d. Disease Prevention. Influenza, Pneumococcal, Tetanus/Diphtheria, and Measles/ Mumps/Rubella Immunizations will be provided routinely to inmates in accordance with CDC guidelines and guidance from the Medical Director.

All inmates who receive vaccinations will be provided information, based on the Center for Disease Control and Prevention (CDC) Vaccine Information Statements (VIS), about the risks and benefits of the vaccine including specific side effects that may occur.

- Informed consents are recommended in accordance with State laws.
- Health Services staff will maintain the immunization record (available in BOPDOCS) in each inmate's health record.

8. Monitoring, Bureau Reporting, and Surveillance. All Bureau reportable infectious diseases are identified on the Sensitive Medical Data (SMD) Outpatient Morbidity and Procedures Classification Reporting. Each institution will ensure that all cases of infectious diseases are entered into the SENTRY SMD system consistent with current policy. The ICO will monitor prevalence and incidence data by retrieving data from the SENTRY SMD system or other tracking mechanism.

[redacted]

The ICO will ensure that infectious disease outbreaks or infectious diseases with outbreak potential are reported to the Health Services Division, Central Office, on the Infectious Disease Outbreak Record form (BP-S664).

The ICO will ensure all active TB cases are reported to the Health Services Division, Central Office, on the TB Case/Suspect Record form (BP-S665), if a state reporting form is not available for submission.

- Consultation on specific TB control, evaluation measures, and treatment will be provided to the institution CD.

The Central Office will be notified of all investigation outcomes, i.e.:

- number of inmates and number of staff screened;
- the number of exposures (or conversions) for each group (inmates and staff), and
- the number(s) treated.

9. Programming, Duty, and Housing Restrictions § 549.13

a. The CD will assess any inmate with an infectious disease for appropriateness for programming, duty, and housing. Inmates with infectious diseases that are transmitted through casual contact will be prohibited from work assignments in any area, until fully evaluated by a health care provider.

b. Inmates may be limited in programming, duty, and housing when their infectious disease is transmitted through casual contact. The Warden, in consultation with the CD, may exclude inmates, on a case-by-case basis, from work assignments based upon the security and good order of the institution.

Inmates with infectious diseases that are not foodborne or transmitted by casual contact; i.e., HBV, HCV, HIV, are not prohibited from assignment to Food Service based solely upon the diagnosis of the infectious disease. The primary care provider will determine the inmate's suitability for Food Service.

c. If an inmate tests positive for an infectious disease, that test alone does not constitute sole grounds for disciplinary action. Disciplinary action may be considered when coupled with a secondary action that could lead to transmission of an infectious agent. Inmates testing positive for infectious disease are subject to the same disciplinary policy that applies to all inmates (see 28 CFR 541, subpart B). Except as provided for in our disciplinary policy, no special or separate housing units may be established for HIV-positive inmates.

In addition to standard precautions, all institutions will utilize appropriate transmission-based precautions, such as:

- airborne precautions for small particle organisms;
- droplet precautions for large particle organisms; and

- contact precautions for direct skin-to-skin touching or when indirect spread may occur.

Necessary containment measures will be used to transport, isolate, restrict contact of inmates with potentially communicable disease, until no longer contagious.

- Only those institutions equipped with the proper engineering controls to house inmates in a negative pressure isolation room (NPIR) that comply with the current CDC recommendations, have the option to isolate and treat inmates with suspected TB or other airborne disease (requiring airborne precautions) that may remain suspended in the air and be spread by casual contact.
- Refer to Section 11, for NPIR controls under engineering controls and personal protective equipment(PPE). Otherwise, arrangements will be made to transport the inmate to the local hospital with the necessary facilities to isolate and treat until the inmate is no longer contagious.

(1) Containment will include the following:

- Until the inmate is transported to a local hospital, he or she will be immediately removed from the institution's general population.
- The inmate will be placed in a low traffic flow area until transported to a local hospital.
- When transporting the inmate in a vehicle or when interacting with the inmate in a negative pressure room, special respirator precautions will be taken.
- Escort personnel will wear an appropriately fitted NIOSH-certified Respirator (N95 efficiency or better) whenever interacting with the inmate in a room or closed environment.
- The inmate is to be moved from the holding area to R&D in a manner to eliminate or minimize contact with other staff or inmates. The inmate will be issued and wear a standard "surgical-type" mask.
- No other inmates will be transported with an inmate suspected of or diagnosed with a contagious communicable disease.

(2) Appearances at Court, ICE, or U.S. Parole Commission (USPC) Hearings. If for any reason an inmate with suspected TB or other communicable contagious disease is scheduled to appear in Court, before an Executive Office of Immigration Review (EOIR) judge or Cuban Review Panel, an ICE or USPC hearing, the Warden will ensure the appropriate hearing authority is notified that the inmate is undergoing treatment for a communicable contagious disease and cannot be moved until the treating physician determines that the inmate is considered no longer contagious.

- If possible, a tentative treatment timetable and date of inmate availability should be given to the hearing authority.

(3) Staff Escorting Inmates with TB, Suspected TB or Other Communicable Contagious Diseases. Special respiratory protection measures will be taken when transporting the inmate in a vehicle or when interacting with the inmate in a negative pressure room.

[redacted]

Escort personnel, including contract guard services, clinical staff, and others in close contact with the inmate will wear a NIOSH approved respirator (N-95 or better).

Prior to use of a respirator, staff will be medically cleared, fit-tested and trained in accordance with the current OSHA standard on respiratory protection.

10. Confidentiality of Information § 549.14. Any disclosure of test results or medical information is made in accordance with:

a. The Privacy Act of 1974, under which the Bureau publishes routine uses of such information in the Department of Justice Privacy Act System of Records Notice entitled "Inmate Physical and Mental Health Record System, JUSTICE/BOP-007"; and

b. The Correction Officers Health and Safety Act of 1998 (codified at 18 U.S.C. § 4014), which provides that test results must be communicated to a person requesting the test, the person tested, and, if the results of the test indicate the presence of HIV, to correctional facility personnel consistent with Bureau policy.

Relevant infectious disease data will be disclosed as follows:

(1) To State Health Departments and/or the Center for Disease Control, pursuant to state and/or federal laws requiring notice of cases of reportable infectious diseases.

- If the inmate is a WITSEC, and circumstances mandate that an infectious disease be reported to the Public Health Department (county or state), Inmate Monitoring, Central Office, must be notified prior to any release of the inmate's name and/or any communication (telephone, face-to-face, etc.) between the inmate and public health officials.

The HSA or designee will ensure that the respective State Health Department is informed of all cases of reportable infectious disease.

(2) Findings of all contact investigations will be reported, as required, to the State Health Department.

(3) The Community Corrections Manager will receive a copy of the Medical/ Psychological Pre-Release Evaluation form (BP-S351), included in the request for CCC placement. This form will identify inmates known to be HIV positive, or under treatment for exposure to, or active TB.

(4) To the physician/provider of a Bureau or non-Bureau staff, or other person exposed to a bloodborne pathogen while lawfully present in a Bureau facility, for the purpose of providing prophylaxis or other treatment and counseling.

(5) To Department of Justice employees who have a need to know in the performance of their duties including, but not limited to, Health Care Personnel, Social Workers, Unit Management staff, and Psychologists.

[redacted]

(6) All parties, with whom confidential medical information regarding another individual is communicated, will be advised not to share this information, by any means, with any other person. Medical information may be communicated among medical staff directly concerned with an inmate's case in the course of their professional duties.

11. Exposure Control Plan. Each institution will have a written Exposure Control Plan (ECP) that will comply with and contain the elements as defined in 29 CFR 1910.1030, Bloodborne Pathogens. Staff will be trained on compliance with 29 CFR 1910.1030 on employment and during annual training.

a. Exposure Determination. All Bureau employees assigned to correctional facilities are required to perform tasks which potentially could expose them to blood and body substances. All Bureau employees are covered by, and must comply with, all aspects of the ECP.

- Each institution will identify in the ECP the classification of work assignments for inmates based upon risk of occupational exposure.

b. Methods of Compliance.

(1) Universal Precautions (Standard Precautions). This method of infection control requires all employees and inmates to assume that all human blood and specified human body fluids are infectious for HIV, HBV, and other bloodborne pathogens.

(2) Engineering and Work Practice Controls. The institution ECP will define the position or department responsible for examining, maintaining, and/or replacing engineering and work practice controls on a regular schedule to ensure their effectiveness.

(3) Personal Protective Equipment (PPE). The institution ECP will identify the person or department responsible for:

- requiring the use of personal protective equipment;
- providing personal protective equipment;
- ensuring that personal protective equipment is properly used, stored, cleaned, laundered, repaired, replaced, or discarded as needed; and
- investigating and documenting circumstances in which PPE was not used in order to determine whether changes can be instituted to prevent such occurrences in the future.

Inmates may never refuse to wear personal protective equipment.

(4) Housekeeping. Each institution will develop a housekeeping plan to assign responsibilities in keeping a clean and sanitary environment. The plan will include a written cleaning schedule.

- The Warden will assign a person to be responsible for developing and maintaining the plan. The HSA will review the plan to ensure it complies with the requirements of 29 CFR 1910.1030.

(5) Regulated Medical Waste. Each institution will have local policies and procedures for the handling, collecting, transporting, and storing regulated medical waste. Regulated waste management must meet OSHA standards and comply with respective state and local requirements, and local security procedures.

The HSA and Safety Manager have joint responsibility for written procedures for the management of regulated medical waste.

- Disposal of all regulated medical waste must be in accordance with applicable regulations of the United States, States and Territories, and political subdivisions of States and Territories.

Regulated waste will be stored in a manner and location that maintains the integrity of the packaging and provides protection from outside elements, rodents, and vermin. Regulated waste will be stored in the following manner:

(a) out of sight of inmates and visitors in a non-congested area;
(b) in a locked storage area with a biological hazard symbol posted on the door; and
(c) the storage area must have an exhaust system to the outside and a smooth, impervious floor.

(6) Laundry. Each institution will include in the Health Services Policy and Procedure Manual procedures for the handling and bagging, laundering (on-site), storage, and transport of linens contaminated with blood or body fluids in accordance with the 29 CFR 1910.1030, Bloodborne Pathogen Standard, state and local sanitation requirements.

c. Bloodborne Pathogen Post-Exposure Evaluation and Follow-Up.

(1) Inmates at risk of work exposures who believe that they have been exposed to an infectious disease, blood, or body fluids while on duty will report the exposure to their supervisor and the Health Services Unit where an Inmate Injury Report (BP-A362) will be completed.

(2) Inmates in non-work related situations who believe they have been exposed to an infectious disease will report to the Health Services Unit for clinical evaluation.

(3) The CD/staff physician will determine the occurrence of a bloodborne exposure.

(4) The CD will promptly order mandatory testing on any inmate sentenced to a term of imprisonment for a Federal offense, or ordered detained before trial, when there is well-founded reason to believe the inmate may have intentionally or unintentionally transmitted HIV to any officer or employee of the United States, or to any non-inmate who is lawfully present in a correctional facility.

(a) Consistent with this Program Statement, when there is a determination of an exposure to HIV, medical staff will inform any person who may have been exposed to HIV (in, as appropriate, confidential consultation with the

person's physician), of the potential risk involved and, if warranted by the circumstances, that prophylactic or other treatment should be considered.

(b) The inmate who may have transmitted HIV will be tested promptly for the presence of HIV, and the test results will be communicated to the inmate tested.

(c) Employees will be told if an exposure incident was negative for HIV.

(d) If the results of a test indicate a source positive for the presence of HIV, the BOP will:

- Advise the tested inmate that the test was positive for the presence of HIV, and provide the inmate with appropriate counseling, health care, and support services.
- Provide the affected officer or employee of the United States access to medically necessary healthcare.
- Provide all other non-inmate individuals who are lawfully present in the correctional facility with information about national hotlines, health care referral centers, and other resources of information concerning treatment for HIV and AIDS. The local procedure for providing and documenting the information provided to these individuals will be defined in the ECP.

(5) If there has been a determination of a bloodborne exposure to an infectious disease other than HIV, the source inmate will be tested according to 28 CFR 549.12. Refer to Section 7.c., Diagnostics, of this Program Statement.

(6) Once a determination is made that a bloodborne exposure has occurred, the exposed inmate will be offered emergency care, evaluation, and prophylaxis in accordance with the U.S. Public Health Service recommendations, 18 U.S.C. § 4014, and guidance from the Medical Director.

(7) If the inmate is due for release from custody and will require continuation of recommended treatment, the inmate must sign a Consent for the Release of Medical Information form (BP-S621) to allow release of the information to a community provider. Preparation for transitional medical needs should be initiated in advance for continuity of prescribed treatments.

(8) The CD will ensure that all post-exposure medical evaluation and follow-up is documented in the medical record. At a minimum, this documentation will include:

- the routes of exposure and a detailed account of how the exposure occurred (work related or non-work related);
- all medical and prophylactic treatments received and counseling;
- completion of the Inmate Consent/Declination for HIV Post Exposure Prophylaxis (PEP) form (BP-S361), when indicated;
- assurance that the exposed inmate has been informed of potential risks of infection, precautions to prevent potential transmission of infection, and the

[redacted]

results of the evaluation, including any medical conditions resulting from the exposure incident, that may require further evaluation or treatment;
- protection of the privacy of the exposed/injured person according to the Privacy Act; and
- exclusion of specific names of source individuals on the medical record for inmate exposures.

d. Communication of Hazards: Use of Labels and Signs. Each institution will include in the Health Services Policy and Procedure Manual procedures for the use of labels and signs that are in compliance with 29 CFR 1910.1030, federal, state, and local regulations.

12. Infectious Disease Training and Preventative Measures §549.15.

a. The HSA will ensure that a qualified health care professional provides training, incorporating a question-and-answer session, about infectious diseases to all newly committed inmates, during Admission and Orientation.

b. Inmates in work assignments which staff determine to present the potential for occupational exposure to blood or infectious body fluids will receive annual training on prevention of work-related exposures and will be offered vaccination for Hepatitis B.

(1) Inmate Orientation. All inmates entering Bureau facilities will receive education on the following infectious disease topics:

- HIV infection including general review of current information on HIV transmission, prevention, disease course, and treatment options;
- Tuberculosis including general review of current information on tuberculosis transmission, prevention, surveillance (skin-testing), latent TB infection, disease course, and treatment; and
- Viral Hepatitis and sexually transmitted diseases, including general review of current information on transmission, treatment, and prevention.

(2) Bloodborne pathogen and TB control training will be provided to all inmate workers consistent with the requirements stipulated in 29 CFR 1910.1030 and will contain the following elements:

- Obtaining copies of applicable regulatory texts with an explanation of their contents;
- Information on the epidemiology and symptoms of bloodborne diseases and TB;
- Ways in which bloodborne pathogens and TB are transmitted;
- Explanation of the ECP and how to obtain a copy;
- Information on recognizing tasks that might result in occupational exposure;
- Explanation of standard precautions, the use and limitations of work practice, engineering controls, and personal protective equipment;
- Information on the types, selection, proper use, location, removal, handling, decontamination, an disposal of personal protective equipment;

- Information on hepatitis B vaccination such as safety, benefits, efficacy, methods of administration, and availability;
- Information on who to contact and what to do in an emergency;
- Information on reporting an exposure incident and on the post-exposure evaluation and follow-up;
- Information on warning labels, signs (where applicable), and color-coding; and
- Question and answer session on any aspect of the training.

(3) Preventive Measures (Hepatitis B Vaccination). Each institution will include in the ECP which inmate work assignments have the potential for exposure to blood and body fluids and includes, but is not limited to:

- inmates who are assigned to a blood/body fluid spill team;
- inmate workers who handle laundry contaminated with blood or body fluids; and
- inmates assigned to Health Services.

Inmates will be offered the Hepatitis B vaccine in compliance with 29 CFR 1910.1030.

- If vaccine administration is deemed appropriate and the individual consents, the health care provider will review the Information on the Vaccine-Hepatitis B form (BP-S552) with the inmate and complete the Consent for Hepatitis B Vaccine form (BP-S552) available on BOPDOCS.

The hepatitis B vaccine and vaccination series will be initiated within 10 working days of initial assignment to inmates who have occupational risk for exposure to blood or other potentially infectious materials and according to the institution's ECP unless:

(a) the individual declines the vaccination; or
(b) the individual has previously received the complete hepatitis B vaccination series; or
(c) medical contraindications exist.

Inmates who decline the vaccination will sign a Declination for Hepatitis B Vaccine form (BP-S552) available on BOPDOCS. An inmate may request and obtain the vaccination at a later date if he or she continues to be in an exposure prone job.

(4) Training Records. Each institution's ECP will identify the person or department responsible for maintaining the training records as required by 29 CFR 1910.1030.

13. Sharps Safety Program. Each institution will establish a Sharps Safety Program as a component of the institution ECP. The ECP will define the person or department responsible for the program. The program will consist of the following:

Disposal of Sharps:

- All sharp objects such as needles and razors will be considered contaminated after use and disposed of in approved sharps disposal units and removed from the institution as biohazard waste.
- Contaminated needles and other contaminated sharps will not be bent, recapped, or removed. Shearing or breaking of contaminated needles is prohibited.
- Sharps disposal containers will not be emptied. Sharps disposal containers and other biohazard materials will be stored in a secure area and in a secondary container that will be provided by the contracted biohazard waste disposal company.
- Sharps disposal containers will be functional, accessible, and visible to ease the use by health care staff.

a. Sharps Injury Log

(1) The Safety Manager is responsible for establishing and maintaining a Sharps Injury Log for the recording of percutaneous injuries from contaminated sharps. All sharps injuries must be reported to the Safety Manager.

(2) The Infection Control Officer in conjunction with the Safety Manager will ensure that sharp injuries are tracked on an ongoing basis to include information that will identify high risk areas and assist in the selection and review of safety devices.

b. Evaluation of injuries and medical devices will be documented and reported to Infection Control, Safety, and Quality Improvement Program committees.

c. The annual review and update of the ECP will reflect the process for documentation of the evaluation and implementation of appropriate commercially available and effective safer medical devices.

The annual review and update of the ECP will reflect the process for solicitation of input from non-managerial employees responsible for direct patient care. This will include employees who have the potential for exposure injuries from contaminated sharps in the identification, evaluation, and selection of effective engineering and work practice controls and documentation of this solicitation in the ECP.

d. The Sharps Safety Program will account for the actions necessary to reduce exposure to bloodborne pathogens by incorporating technologic innovations.

14. Exposure to Airborne Diseases. Respiratory protection devices help prevent exposure by inhalation of infectious airborne nuclei. Such equipment must be NIOSH certified and provide a filter efficiency of 95% or better (i.e., N95 or a high efficiency particulate air filter).

- Each institution will purchase NIOSH certified particulate respirators (N95 or HEPA) of appropriate sizes necessary for all staff designated for fit-testing and store them in the Health Services storage area. Particulate respirator

should be available in work areas where clinical assessment and identification of a TB suspect may occur.

a. The cost of purchasing NIOSH respirators and training and fit-testing will be incurred locally.

- The Safety Manager is to provide the Business Office a list of recommended vendors for purchase.

b. The Safety Manager or designee at each institution is to be trained in the necessary functions to provide fit testing of TB respirators for inmates that require training. Subsequently, the Safety Manager or designee, will provide each inmate at risk of work-related exposure who is fitted with a NIOSH respirator, the training necessary in its wear and use.

- All training for the inmate worker at risk on TB respirator use is to be documented and placed on inmate's training record. The HSA will ensure inmate training records are placed in the Inmate's Central File.

c. Tuberculosis Exposures. Following an incident in which an inmate(s) may have been exposed to tuberculosis, the inmate(s) will be tested according to 28 CFR 549.12(b). 20 CFR 549.12(b) refers to Section 7.b.(3),(4), and (5) of this Program Statement.

- Once an institution physician determines a TB exposure has occurred, the exposed individuals will be offered evaluation and treatment for latent TB in accordance with the U.S. Public Health Service recommendations and guidance from the Medical Director.

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d. Ensuring that that current *MAR* or copy is placed in the health record prior to the clinic visit

e. Obtaining complete vital signs and weight on the day of the clinic visit.

f. Monitoring medication adherence and counseling inmates noted to be non-adherent. This counseling will be documented in the progress notes.

g. Reinforcing, and in some cases, initiating inmate education related to specific disease processes, medication(s), health promotion and disease prevention strategies and the importance of keeping scheduled medical follow-up appointments. All areas discussed will be documented in the progress notes.

h. Maintaining an accurate CCC *Tracking Log* (electronic or traditional) with all inmates listed by specific clinic.

E. Advanced Clinical Provider Responsibilities

a. Obtaining history information and performing an inmate exam, as needed, with focused attention on the organ system(s) affected by the chronic illness(es) being evaluated.

b. Recording and/or updating the *Problem List*, if applicable.

c. Monitoring changes in the inmate's condition.

d. Developing and updating the *Special Needs Treatment Plan*, based on the inmate's disease control and status.

e. Writing physician orders for:

i. Medication(s) – a thirty (30) day supply with up to two (2) refills. The practitioner must ensure that the medication quantity ordered is sufficient to get the inmate through the next scheduled clinic visit. Medication(s) should be ordered as part of the clinic visit to avoid medication(s) from running out before the next clinic visit is held.

ii. Laboratory and/or diagnostic tests – those needed prior to the next scheduled clinic visit. Results should be available between seven (7) to ten (10) days before the next visit.

iii. Therapeutic diets – if clinically indicated, specify the type and duration the diet should be in effect. Specify nutritional supplements, if medically indicated.

iv. Immunizations (i.e., influenza, etc.) according to disease-specific clinical guidelines.

v. Follow-up visits – indicate when the inmate is to be seen for the next clinic appointment.

vi. Consultations – complete the *Consultation Request* form, if applicable

f. Monitoring medication adherence by reviewing the current *MAR* or copy during the clinic visit.

g. Documenting inmate education related to the specific disease process, immunizations, health promotion / maintenance, disease prevention, medication(s), etc. in the progress note.

h. In general, inmates in chronic care clinics will be evaluated in accordance with their disease control and status.

   i. Inmates whose chronic disease is poorly controlled will be monitored as often as clinically indicated until disease control stabilizes. There is no absolute time frame and each case will be handled on an individual basis. However, inmates will be seen no less frequently than every six (6) weeks.

   ii. Inmates with a chronic illness that is consistently well controlled, and whom are adherent to prescribed medication(s), if applicable, follow up appointments may be scheduled less frequently. The advanced clinical provider must document the clinical rationale for recommending less frequent monitoring. These inmates may be scheduled for follow-up appointments every six (6) months.

j. There are exceptions to monitoring well-controlled inmates every six (6) months. These exceptions are HIV and HCV inmates prescribed antiviral therapy, diabetics and inmates with multiple diseases in the General Medicine clinic.

k. For inmates found to be in fair or poor disease control and/or worsening status, the advanced clinical provider is responsible for making changes to the *Special Needs Treatment Plan* in an effort to improve disease control and/or status.

l. The advanced clinical provider is responsible for overseeing the Chronic Care Clinics for all inmates in the CCC program. A nurse may assist in obtaining information during the clinic visit (i.e., listing demographic information, listing current medication(s), obtaining vital signs, writing in lab results, etc.); however, the advanced clinical provider is ultimately responsible to ensure that the clinical information documented by the nurse is accurate.

m. CCC test results and follow-up procedures/forms require documentation of advanced clinical provider's review prior to filing in the health record.

G. Inmates Refusing CCC Care

a. For inmates who refuse CCC monitoring, the nurse will document complete and detailed inmate counseling progress notes, which address the potential health risks and dangers the inmate could experience as a result of refusing medical follow-up.

b. The inmate will sign a *Release of Responsibility - Specific Procedure*, if applicable.

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DRUG FORMULARY

ANTI-INFECTIVES

Penicillins
Penicillin VK (V-Cillin K)
250 mg, 500 mg (P)
Amoxicillin (Amoxil) 500 mg (P)
Amoxil 875 mg (P)

Penicillinase Resistant Penicillins
Dicloxacillin (Dynapen) 500 mg(NP)

Penicillins – Extended Spectrum
Augmentin (250, 500mg) (P)

Cephalosporins – 1st Generation
Cephalexin (Keflex) 500 mg(P)
" " 250 mg (P)
Duricef 500mg (NP)

Cephalosporins – 2nd and 3rd Generation
Cefaclor (Ceclor) 250 mg(NP)
Ceftiaxone (Recephin) Injection 250 mg, 1gm(P)
Cefazolin (Ancef) Injection 1 Gm (P)
Fortaz 1 Gm, (P)
Unasyn 1.5 Gm, 3 Gm (R)

Tetracyclines
Tetracycline HCl (Sumycin) 250 mg, 500 mg(P)
Doxycycline Hyclate (Vibramycin) 100 mg (P)

Fluoroquinolone
Ciprofloxacin (Cipro) 250 mg, 500 mg (P)

Macrolide Antibiotics
Erythromycin Stearate (Erythrocin) 250 mg, 500 mg (P)
Azithromycin (Zithromax) 250mg (R), 600mg (R)
Clarithromycn (Biaxin) 500 mg Tab (P)
Zithromax (Z-pack) (NP)

For MAC Prophylaxis Only!

Miscellaneous Anti-infectives
Clindamycin Phosphate (Cleocin) 150mg, 300 mg (P)
Quinine Sulfate 325 mg (P)
SMX/TMP DS (Bactrim DS)(P)
Sulfasalazine 500 mg(P)
Metronidazole (Flagyl) 250 mg, 500 mg(P)
Dapsone 100 mg(P)
Phenazopyridine HCl 100 mg, 200 mg(P)
Macrobid (Nitrofurontoin) 100mg cap (P)

Anti-fungals
Nystatin oral susp 100,00u/ml (P)
Nystatin cream

(P) Preferred
(NP) non-Preferred
(R) Restricted, Need Approval

Ketoconazole (Nizoral) 200 mg(P)
Fluconazole (Difulcan) 100, 150,200mg (P)

Vaginal Anti-fungals
Miconazole Suppository (Monistat)(P)
Miconazole Vaginal Cream (Monistat)(P)

Anti-Tubercular's
Isoniazid 300 mg(P)
Ethambutol (Myambutol)(NP)
Pyrazinamide(NP)
Rifabutin (Mycobutin)(NP)
Rifampin (Rimactane)(NP)

Antiviral Agents-RTI's
Didanosine "ddI" (Videx) 250,500 mg(P)
Zalcitabine "ddC" (Hivid)(NP)
Lamivudine "3TC" (Epivir) 150 mg (P)
Stavudine "d4T" (Zerit) 30, 40 mg (P)
Zidovudine "AZT" (Retrovir) 100, 300 mg(P)
Lamivudine/Zidovudine (Combivir)(P)
Abacavir (Ziagen) 300 mg (P)

Antiviral Agents-Protease Inhibitors
Indinavie (Crixivan) 400mg (P)
Nelfinavir (Viracept) 250mg (P)
Saquinavir (Fortovase) (P)
Ritonavir (Norvir) (P)
Amprenavir (Agenerase) (P)
Atazanavir (Reyataz) 150, 200 mg
Fosamprenavir (Lexiva) 700mg

Antiviral Agents – NNRTI'S
Delavridine (Rescriptor) (P)
Nevirapine (Viramune) (P)
Efavirenz (Sustiva) 300, 600 mg (P)
Emtricitabine (Emtriva) 200 mg
Tenorfovir (Viread) 300 mg

Miscellaneous Antiviral Agents
Acyclovir (Zovirax) 200 mg, 400 mg (P)
And 800 mg (P)

ENDOCRINE DRUGS

Insulins
Recombinant Human Insulin
Humulin N.R. 70/30 (P)
Novolin N.R and 70/30 (P)
Lantus (NP)
Humalog (NP)

Oral Sulfonylureas
Glyburide (Micronase) 2.5mg,5 mg (P)
Glipizide (Glucotrol) 5mg,10 mg (P)
Amaryl 2mg, 4mg tab (P)

Biguanides
Metformin (Glucophage) 500 mg, 850mg (P)
" " 1000 mg (P)

Glucose Elevating Agents
Dextrose 50% injection 50cc (P)
Insta-Glucose 40% 31Gm (P)

Thyroid Hormone Replacement
Levothyroxine (Synthroid) all strengths 25,50,75,100,125, 150, 200 mcg (P)

Glucocorticoids
Methylprednisolone (oral) 4 mg (P)
Prednisone 5 mg, 10 mg, 20 mg (P)
Hydrocortisone Sod Phos Inj.(NP)
Methylprednisolone Sod Phos Inj.(NP)
Decadron 4 mg (P)
Medrol Dose Pack (P)

Estrogen Replacement Therapy
Conjugated Estrogens (Premarin) 0.625 mg, 0.9 mg, 1.25 mg (P)

Progestins
Medroxyprogesterone (Provera) 5 mg 10 mg (P)

CARDIOVASCULAR

Sublingual Nitrates
Nitroglycerine Sublingual 0.4 mg(P)
Oral Nitrates
Isosorbide Dinitrate 10, 20,40 mg (P)
Imdur (Mononitrate) 30 mg, 60 mg (P)

Transdermal Nitrates
Nitroglycerine Ointment 2% (P)
Tranderm Nitro patches 0.2 mg, 0.4 mg(P)

Calcium Channel Blockers-
Verapamil 80 mg (P)
Verapamil SR 120 mg, 180 mg, 240 mg(P)
Diltiazem 30 mg (P)
Diltiazem SR 120 mg, 180 mg, 240 mg 300 mg(NP)
Nifedipine 10 mg(P)
Nifedipine SR (Adalat cc) 30 mg, 60mg,90mg (NP)
Norvasc (Amlodipine) 2.5, 5, 10mg (P)

Vasodilator
Hydralazine 25, 50 mg (P)

Beta-Blocker – Non-Selective
Propranolol (Inderal) 10, 20,40 mg (P)
Atenolol (Tenormin)25 mg, 50 mg, 100 mg (P)

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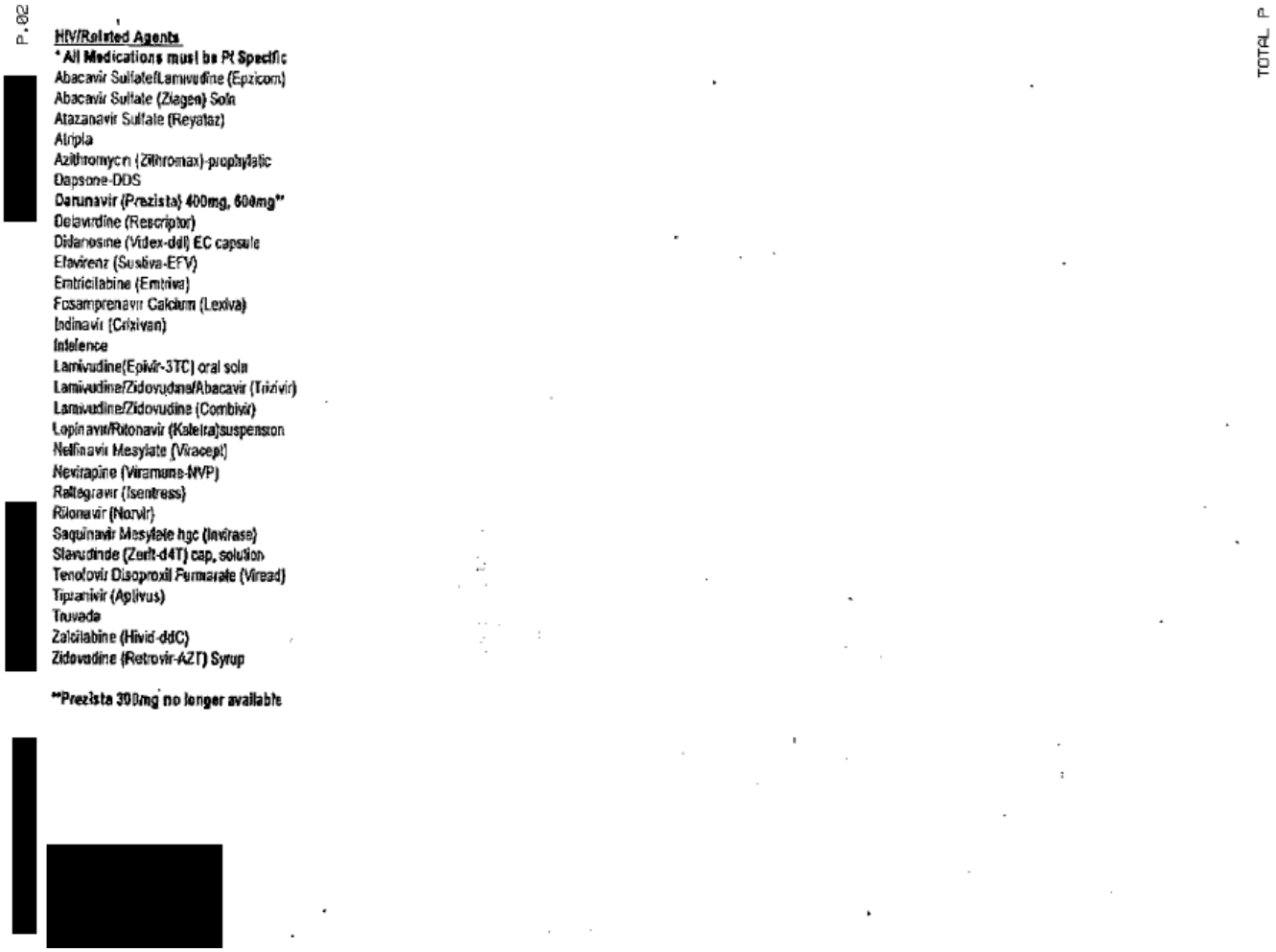
II.



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HIV/Related Agents

* All Medications must be Pt Specific

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Abacavir Sulfate/Lamivudine (Epzicom)
Abacavir Sulfate (Ziagen) Soln
Atazanavir Sulfate (Reyataz)
Atripla
Azithromycin (Zithromax)-prophylatic
Dapsone-DDS
Darunavir (Prezista) 400mg, 600mg**
Delavirdine (Rescriptor)
Didanosine (Videx-ddI) EC capsule
Efavirenz (Sustiva-EFV)
Emtricitabine (Emtriva)
Fosamprenavir Calcium (Lexiva)
Indinavir (Crixivan)
Intelence
Lamivudine(Epivir-3TC) oral soln
Lamivudine/Zidovudine/Abacavir (Trizivir)
Lamivudine/Zidovudine (Combivir)
Lopinavir/Ritonavir (Kaletra)suspension
Nelfinavir Mesylate (Viracept)
Nevirapine (Viramune-NVP)
Raltegravir (Isentress)
Ritonavir (Norvir)
Saquinavir Mesylate hgc (Invirase)
Stavudine (Zerit-d4T) cap, solution
Tenofovir Disoproxil Fumarate (Viread)
Tipranivir (Aptivus)
Truvada
Zalcitabine (Hivid-ddC)
Zidovudine (Retrovir-AZT) Syrup

**Prezista 300mg no longer available

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CONFIDENTIAL 3

3. ANTI-TUBERCULARS
- $ Isoniazid (INH) 300mg Tablet (Not 100mg)
- $$$$ Pyrazinamide (PZA) 500mg Tablet
- $$$$ Rifampin (Rimactane) 150, 300mg Capsule
- $$$$$ Ethambutol (Myambutol) 100,400mg Tablet

G. ANTIVIRALS

1. ANTIVIRALS
Acyclovir (Zovirax) 200,400,800mg Tablet, Capsule (Not Ointment or Suspension)

3. HIV AND RELATED ANTIVIRALS

NON-NUCLEOSID E REVERSE TRANSCRIPTASE INHIBITORS
Delavirdine (Rescriptor) 100, 200mg Tablet
Efavirenz (Sustiva-EFV) 50,100,200mg Capsule, 600mg Tablet
* ***Empty Stomach*** *

VIRAMUNE BLACK BOX WARNING:

Severe, life -threatening, and in some cases fatal hepatotoxicity, particularly in the first 18 weeks, has been reported in patients treated with VIRAMUNE®. In some cases, patients presented with non-specific prodromal signs or symptoms of hepatitis and progressed to hepatic failure. These events are often associated with rash. Female gender and higher CD4 counts at initiation of therapy place patients at increased risk; women with CD4 counts >250 cells/mm3, including pregnant women receiving VIRAMUNE in combination with other antiretrovirals for the treatment of HIV infection, are at the greatest risk. However, hepatotoxicity associated with VIRAMUNE use can occur in both genders, all CD4 counts and at any time during treatment. Patients with signs or symptoms of hepatitis, or with increased transaminases combined with rash or other systemic symptoms, must discontinue VIRAMUNE and seek medical evaluation immediately.

Severe, life -threatening skin reactions, including fatal cases, have occurred in patients treated with VIRAMUNE. These have included cases of Stevens-Johns on syndrome, toxic epidermal necrolysis, and hypersensitivity reactions character ized by rash, constitutional findings, and organ dysfunction. Patients developing signs or symptoms of severe skin reactions or hypersensitiv ity reactions must discontinue VIRAMUNE and seek medical evaluation immediately.

It is essential that patients be monitored intensively during the first 18 weeks of therapy with VIRAMUNE to detect potentially life-threatening hepatotoxicity or skin reactions. Extra vigilance is warranted during the first 6 weeks of therapy, which is the period of greatest risk of these events. Do not restart VIRAMUNE following severe hepatic, skin or hypersensitiv ity reactions. In some cases, hepatic injury has progressed despite discontinuation of treatment. In addition, the 14-day lead-in period with VIRAMUNE 200 mg daily dosing must be strictly followed (see WARNINGS).

OTHER CLINICAL NOTES*: As a group, watch for skin rash. EFV may cause sleep disturbances. Patient* ***may*** *need psych referral. NVP & EFV are potent p450 enzyme inducers. Thus, when giving* ***EFV or NVP*** *with PIs, the PI dose should either be increased or boosted with ritonavir depending on the PI.*

NUCLEOSIDE ANALOG REVERSE TRANSCRIPTASE INHIBITORS
Didanosine (Videx - **ddI**) 125, 200, 250, 400mg EC Capsule * ***Take 1/2 hour before or 2 hours after a meal*** *
Stavudine (Zerit - **d4T**) 15, 20, 30,40mg Capsule, 1mg/ml Solution
Zalcitabine (Hivid - **ddC**) 0.750mg Tablet

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*D-Drugs: Combining 2 or more of the D-Drugs (ddI, d4T, ddc) may increase the incidence of mitochondrial side effects (peripheral neuropathy, pancreatitis, lactic acidosis), and is not recommended.

Emtricitabine (Emtriva) 200mg Capsule
Lamivudine (Epivir - 3TC) 100,150, 300mg Tablet, 10mg/ml Oral Solution
Lamivudine/**Zidovudine** (*Combivir*) 150/300mg Tablet
Lamivudine/**Zidovudine**/Abacavir (*Trizivir*) 150/300/300mg Tablet

NOTE :Writing prescriptons for the individual components in the above medications: Combivir and Trizivir will allow our pharmacy to save your facility on average 50% per patient, per month. Each individual componentof Comivir and Trizivir must be written as a separate prescription. We will not automatically convert patients who are on Combivir or Trizivir over to thesemedication'sindividualcomponents. For yourassistance, we have attachedat the endof thisdocumenta conversionchart in order to properlyconvert Combivir and Trizivir over to their individual components..

Zidovudine (Retrovir - AZT) 100,300mg Capsule, 10mg/ml Syrup

Abacavir Sulfate (Ziagen) 300mg Tablet, 20mg/ml Sol.***Avoid alcohol****
Abacavir Sulfate/Lamivudi ne (Epzicom) 600/300mg Tab****Avoid alcohol****

CLINICAL NOTES:

In HIV/ HEP B co-infectionpatients: Treating HBV in an HIV co-infected patient with lamivudine monotherapy will result in HIV resistance to lamivudi ne. In patients currently taking Epivir, Epivir HBV or Combivir, and are co infected with HBV, closely monitor the patient's hepatic function clinically and via labs for several months after these medications are discontinued.

In HIV/HEP C co-infection patients: If the patient is taking both **ribavirin** and **zidovudine**, close monitoring of their hemoglobin is warranted. Both of these medications can cause anemia.

Patients starting on Abacavir (contained in Ziagen, Trizivir, and Epzicom) must be counseled in regards to the potential hypersensitivity reaction and rash that may occur.**"see black box warning"**

Dose adjustments (with the exception of Abacavir) may be needed in patients with renal insufficiency.

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CONFIDENTIAL 5

WARNING

FATAL HYPERSENSITIVITY REACTIONS HAVE BEEN ASSOCIATED WITH THERAPY WITH ZIAGEN. PATIENTS DEVELOPING SIGNS OR SYMPTOMS OF HYPERSENSITIVITY (WHICH INCLUDE FEVER; SKIN RASH; FATIGUE; GASTROINTESTINAL SYMPTOMS SUCH AS NAUSEA, VOMITING, DIARRHEA, OR ABDOMINAL PAIN; AND RESPIRATORY SYMPTOMS SUCH AS PHARYNGITIS, DYSPNEA, OR COUGH) SHOULD DISCONTINUE ZIAGEN AS SOON AS A HYPERSENSITIVITY REACTION IS SUSPECTED. TO AVOID A DELAY IN DIAGNOSIS AND MINIMIZE THE RISK OF A LIFE-THREATENING HYPERSENSITIVITY REACTION, ZIAGEN SHOULD BE PERMANENTLY DISCONTINUED IF HYPERSENSITIVITY CANNOT BE RULED OUT, EVEN WHEN OTHER DIAGNOSES ARE POSSIBLE (E.G., ACUTE ONSET RESPIRATORY DISEASES, GASTROENTERITIS, OR REACTIONS TO OTHER MEDICATIONS).

ZIAGEN SHOULD NOT BE RESTARTED FOLLOWING A HYPERSENSITIVITY REACTION BECAUSE MORE SEVERE SYMPTOMS WILL RECUR WITHIN HOURS AND MAY INCLUDE LIFE-THREATENING HYPOTENSION AND DEATH.

SEVERE OR FATAL HYPERSENSITIVITY REACTIONS CAN OCCUR WITHIN HOURS AFTER REINTRODUCTION OF ZIAGEN IN PATIENTS WHO HAVE NO IDENTIFIED HISTORY OR UNRECOGNIZED SYMPTOMS OF HYPERSENSITIVITY TO ABACAVIR THERAPY (SEE WARNINGS, PRECAUTIONS: INFORMATION FOR PATIENTS, AND ADVERSE REACTIONS).

LACTIC ACIDOSIS AND SEVERE HEPATOMEGALY WITH STEATOSIS, INCLUDING FATAL CASES, HAVE BEEN REPORTED WITH THE USE OF NUCLEOSIDE ANALOGUES ALONE OR IN COMBINATION; INCLUDING ZIAGEN AND OTHER ANTIRETROVIRALS (SEE WARNINGS).

NUCLEOTIDE ANALOG REVERSE TRANSCRIPTASE INHIBITOR

Tenofovir Disoproxil Fumarate (Viread) 300mg Tablet

CLINICAL NOTES: Use caution in patients with renal insufficiency (Dose adjustment may be necessary). When given with ddI, the dose of ddI should be reduced to 250mg for patients weighing 60 kgs and 200mg or 125 mg for patients <60 kg. When given with Reyataz, the boosted Reyataz regimen (Reyataz 300mg QD with ritonavir 100mg QD) should be used. TNF decreases Reyataz's AUC by 26%.

NUCLEOTIDE/NUCLEOSIDE ANALOG REVERSE TRANSCRIPTASE INHIBITOR COMBINATION

Tenofovir Disoproxil Fumarate/Emtricitabine (Truvada) 300/200mg Tablet

NUCLEOTIDE/NUCLEOSIDE/NON NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITOR COMBINATION

Tenofovir Disoproxil Fumarate/Emtricitabine/Efavirenz (Atripla) 300/200/600mg Tablet

PROTEASE INHIBITORS

Atazanavir Sulfate (Reyataz) 100, 150, 200mg Capsule * ***Take with food*** *
Avoid PPI's and space H2 antagonists 12 hours from atazanavir.
Fosamprenavir Calcium (Lexiva) 700mg Tablet
Darunavir (Prezista) 300mg Tablet
Indinavir (Crixivan) 200,333,400mg Capsule * ***Take 1 hour before, 2 hours after meals with plenty of water.*** *
Lopinavir/Ritonavir (Kaletra) 200/50mg Tab, 400mg-100mg/5ml Oral Susp.
Nelfinavir Mesylate (Viracept) 250mg, 625mg Tab/Powder * ***Take with food*** *
Ritonavir (Norvir) 100mg Capsule, 80mg/ml Oral Sol * ***Food may increase tolerability*** * **Cost of ritonavir has increased 5 times, thus, when a boosted regimen is utilized; if possible, give the lowest dose of ritonavir recommended by the DHHS guidelines needed to boost the other PI.**
Saquinavir Mesylate hgc (Invirase) 200mg Capsule, 500mg Tablet * ***No food effect when taken with ritonavir*** *
Tipranivir (Aptivus) 250mg Capsule

[redacted] Drug Formulary July 2008

CLINICAL NOTES: * Many drug interactions and therefore, dosing adjustments may be necessary. Other special dosing requirements may be necessary for PI experienced patients (Lexiva, Reyataz).*

As a class, hepatotoxicity is a concern, although, NFV is more liver friendly than the other PI's. Although diarrhea is a common side effect of NFV, it can be resolved with Imodium. ATZ has less of an adverse effect on lipids than other PI's. It is not recommended to use ATZ with IND due to both PI's potential to cause hyperbilirubinem ia. Saquinavir hgc and Indinavir are not recommended to be used as a single protease inhibitor (Boosted regimens are recommended). Indinavir is no longer recommended to be used for women who are pregnant.

MISC HIV AGENTS
Atovaquone (Mepron) 750mg/5ml Suspension
Azithromycin (Zithromax) 600mg Tablet, 600mg/15ml Suspension
Fluconazole (Diflucan) 50,100,150,200mg Tablet
Ganciclovir (Cytovene) 250mg Capsule, 500mg Injection
Pentamidine (Nebupent) 300mg Aerosol
Pentamidine (Pentam) 300mg Injection
Rifabutin (Mycobutin) 150mg Capsule
Dapsone - DDS 25mg, 100mg Tablet

H. ANTIMALARIAL
Quinine Sulfate (Quinamm) 200,260mg Tablet, 200,325mg Capsule

I. ANTIPARKINSON AGENTS
$ Benztropine Mesylate (Cogentin) 0.5, 1,2mg Tablet, 1mg/ml Injection
$$$ Trihexyphenidyl (Artane) 2,5mg Tablet
$$$$$ Carbidopa/Levodo pa (Sinemet) 10/100, 25/100, 25/250mg Tablet (Not SR)

J. CARDIOVASCULAR AGENTS

1. ANTI-ANGINALS
$ Isosorbide Dinitrate (Isordil) 5, 10, 20, 30,40mg Tablet
$$ Nitroglycerin SR (Nitro-Bid) 2.5, 6.5, 9mg Capsule
$$ Verapamil (Calan, Isoptin) 40, 80,120mg Tablet
$$ Nifedipine (Procardia) 10,20mg Capsule
$$ Nitroglycerin SL (Nitrostat SL) 0.3, 0.4, 0.6mg Tablet
$$$ Verapamil (Calan, Isoptin) 180,240mg SR Tablet
$$$ Diltiazem (Cardizem) 30, 60, 90,120mg Tablet
$$$$ Diltiazem (Cardizem) SR 60, 90,120mg Capsule
$$$$ Diltiazem (Cardizem) XR 120, 180, 240mg Capsule
$$$$ Diltiazem (Cardizem) CD 120, 180, 240, 300mg Capsule
$$$$$ Nitroglycerin (Transderm-Nitro, Deponit) 0.1, 0.2, 0.3, 0.4, 0.6mg (not 0.8mg) Patch
$$$$$ Nifedipine CC (Adalat CC) 30, 60, 90mg Tablet
$$$$$ Nifedipine XL (Procardia XL) 30, 60, 90mg Tablet

2. ANTIARRHYTHMICS
GROUP I
$ Quinidine Sulfate 200,300mg Tablet
$$ Disopyramide (Norpace) 100,150mg Capsule

IV.

Formulary Build 3/17/2009

ID	Primary Category	Secondary Category	Sub Category	Brand Name
1	Anti-infectives	Antihelmintic	1A	Vermox
2	Anti-infectives	Antibacterial	1B	Amoxil
3	Anti-infectives	Antibacterial	1B	Augmentin
4	Anti-infectives	Antibacterial	1B	Bactrim DS
5	Anti-infectives	Antibacterial	1B	Dynapen
6	Anti-infectives	Antibacterial	1B	E-Mycin
7	Anti-infectives	Antibacterial	1B	Flagyl
8	Anti-infectives	Antibacterial	1B	Keflex
9	Anti-infectives	Antibacterial	1B	Macrodantin
10	Anti-infectives	Antibacterial	1B	Pen V K
11	Anti-infectives	Antibacterial	1B	Rifadin
12	Anti-infectives	Antibacterial	1B	Tetracycline
13	Anti-infectives	Antibacterial	1B	Vibramycin
14	Anti-infectives	Antibacterial	1B	Cleocin
15	Anti-infectives	Antibacterial	1B	Cipro
16	Anti-infectives	Antifungal	1C	Diflucan
17	Anti-infectives	Antifungal	1C	Grifulvin V
18	Anti-infectives	Antitubercular	1D	INH
19	Anti-infectives	Antitubercular	1D	Myambutol
20	Anti-infectives	Antitubercular	1D	PZA
21	Anti-infectives	Antitubercular	1D	Rifadin
22	Anti-infectives	Antiviral	1E	Symmetrel
23	Anti-infectives	Antiretroviral	1F	Agenerase
24	Anti-infectives	Antiretroviral	1F	Combivir
25	Anti-infectives	Antiretroviral	1F	Crixivan
26	Anti-infectives	Antiretroviral	1F	Epivir
27	Anti-infectives	Antiretroviral	1F	Fortovase
28	Anti-infectives	Antiretroviral	1F	Hivid
29	Anti-infectives	Antiretroviral	1F	Kaletra
30	Anti-infectives	Antiretroviral	1F	Norvir
31	Anti-infectives	Antiretroviral	1F	Rescriptor
32	Anti-infectives	Antiretroviral	1F	Retrovir
33	Anti-infectives	Antiretroviral	1F	Sustiva
34	Anti-infectives	Antiretroviral	1F	Videx
35	Anti-infectives	Antiretroviral	1F	Viracept
36	Anti-infectives	Antiretroviral	1F	Viramune
37	Anti-infectives	Antiretroviral	1F	Zerit
38	Anti-infectives	Antiretroviral	1F	Ziagen
39	Blood Modifier	Antiplatelet, Anticoagula	2A	Asprin
40	Blood Modifier	Antiplatelet, Anticoagula	2A	Coumadin
41	Blood Modifier	Antiplatelet, Anticoagula	2A	Plavix
42	Blood Modifier	Antiplatelet, Anticoagula	2B	Trental
43	Cardiovascular	Antianginal	3A	Imdur
44	Cardiovascular	Antianginal	3A	Isordil
45	Cardiovascular	Antianginal	3A	NitroDur
46	Cardiovascular	Antianginal	3A	Nitrostat

[redacted] Page 1

Formulary Build 3/17/2009

Generic Name	Form
Mebendazole	Tablet
Amoxicillin	Capsule
Amox/Clav Pot	Tablet
SMX/TMP DS	Tablet
Dicloxacillin	Capsule
Erythromycin	Tablet
Metronidazole	Tablet
Cephalexin	Capsule
Nitrofurantoin	Capsule
Penicillin	Tablet
Rifampin	Capsule
Tetracycline	Capsule
Doxycycline	Tablet
Clindamycin	Capsule
Ciprofloxin	Tablet
Fluconazole	Tablet
Griseofulvin	Tablet
Isoniazid	Tablet
Ethambutol	Tablet
Pyrazinamide	Tablet
Rifampin	Capsule
Amantadine	Capsule
Amprenavir	Capsule
Lamivudine/Zidovudine	Tablet
Indinavir	Capule
Lamivudine	Tablet
Saquinavir	Capsule
Zalcitabine	Tablet
Lopinavir/Ritonavir	Capsule
Ritonavir	Capsule
Delviridine	Tablet
Zidovudine	Capsule
Efavirenz	Capsule
Didanosine	Tablet
Nelfinavir	Tablet
Nevirapine	Tablet
Stavudine	Capsule
Abacavir	Tablet
Asprin	Tablet
Warfarin	Tablet
Clopidogrel	Tablet
Pentoxifylline	Tablet
Isosorbide mon	Tablet
Isosorbide din	Tablet
Nitroglycerin Patch	Patch
Nitroglycerin SL	Tablet

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V.
[1]

[redacted] FORMULARY

Client Name: _____ SSN: _____

Please check the appropriate box next to any of the following medications you are prescribing for the above-referenced patient.
This list is the current [redacted] Formulary through ***June 2008***.

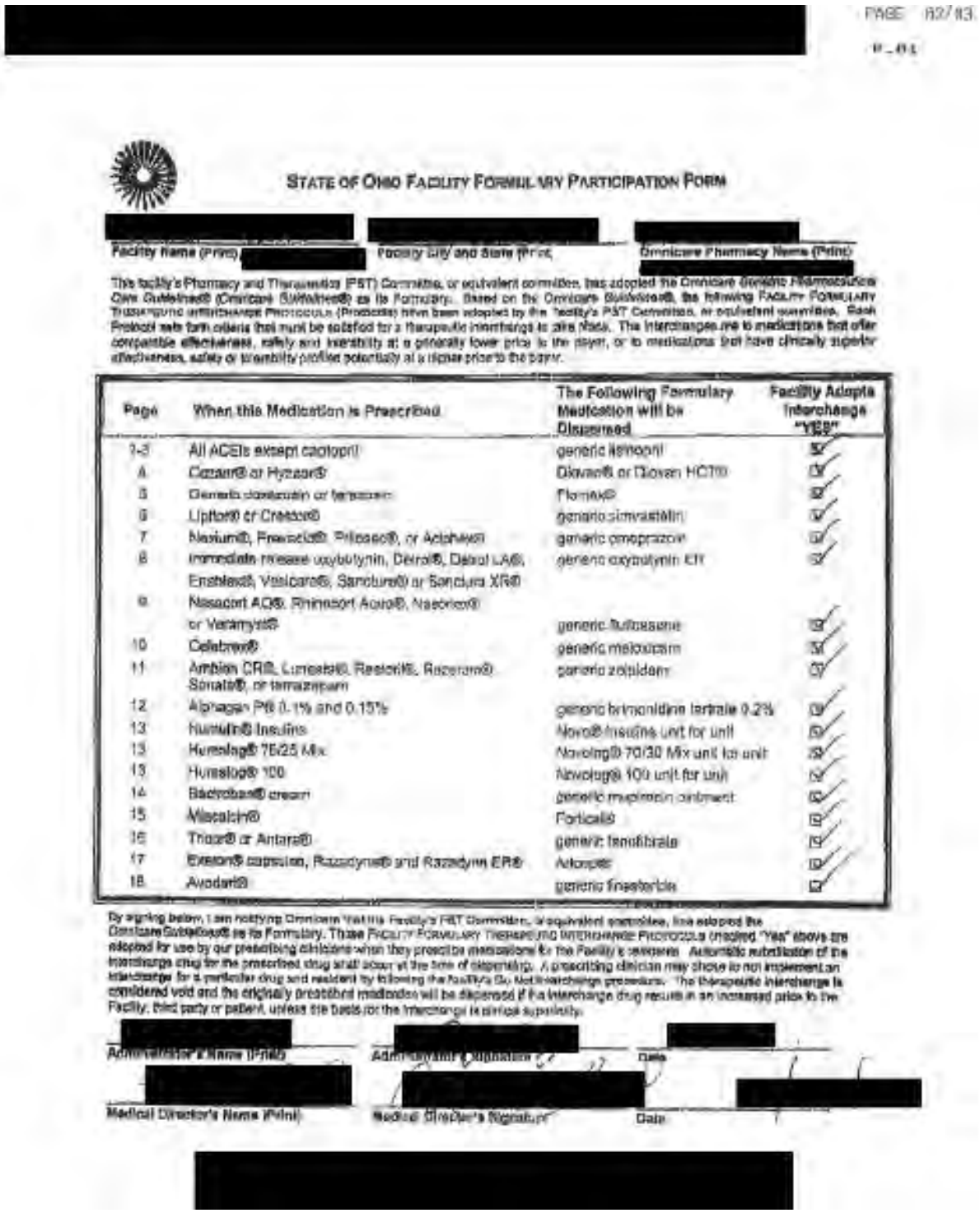
	NNRTIs		**Anti Acids**		**Mental Health**
	Delavirdine, DLV (**Rescriptor®**)		Nizatidine (**Axid®**)		Amitriptyline (**Elavil®**)
	Efavirenz, EFV (**Sustiva®**)		Omeprazole (**Prilosec®**)		Aripiprazole (**Abilify®**)
	Etravirine (**Intelence®**)		Ranitidine (**Zantac®**)		Buproprion (**Wellbutrin®**)
	Nevirapine (**Viramune®**)		**Anti Diarrheals**		Citalopram HBr (**Celexa®**)
	NRTIs		Atropine diphenoxylate (**Lomotil®**)		Desipramine (**Norpramin®**)
	Abacavir (**Ziagen®**)		Loperamide (**Immodium®**)		Divalproex sodium (**Depakote®**)
	Didanosine, ddI (**Videx EC®**)		**Anti Fungals**		Duloxetine HCl (**Cymbalta®**)
	Emtricitabine, FTC (**Emtriva®**)		Clotrimazole (**Mycelex®** Troche)		Fluoxetine (**Prozac®**)
	Lamivudine, 3TC (**Epivir®**)		Clotrimazole & betamethazone dipropionate (**Lotrazone®**)		Lamotragine (**Lamictal®**)
	Stavudine, d4T (**Zerit®**)		Fluconazole (**Diflucan®**)		Mirtazapine (**Remeron®**)
	Zidovudine, AZT (**Retrovir®**)		Nystatin (**Nilstat®**)		Nefazodone (**Serzone®**)
	AZT + 3TC (**Combivir®**)		Itraconazole (**Sporanox®**)		Paroxetine (**Paxil®**)
	AZT + 3TC + Abacavir (**Trizivir®**)		Ketoconazole (**Nizoral®**)		Pregabalin (**Lyrica®**)
	Abacavir + Lamivudine (**Epzicom®**)		**Anti Nausea**		Quetiapine fumerate (**Seroquel®**)
			Prochloroperazine (**Compazine®**)		Risperidone (**Risperdal®**)
			Promethazine (**Phenergan®**)		Sertraline (**Zoloft®**)
	Nucleotide Analogues		**Diabetes Treatment**		Trazodone (**Desyrel®, Trialodine®**)
	Tenafovir (**Viread®**)		Acarbose (**Precose®**)		Venlafaxine (**Effexor®**)
	Emtricitabine + Tenofovir (**Truvada®**)		Glipizide (**Glucotrol®**)		Ziprasidone Hcl (**Geodon®**)
			Insulin and supplies (need rx for syringes)		**PCP Prophylaxis & Tx**
	Protease Inhibitors		Metformin (**Glucophage®**)		Atovaquone (**Mepron®**)
	Amprenavir (**Agenerase®**)		Plaglitizone (**Actos®**)		Dapsone (**Dapsone®**)
	Atazanavir (**Reyataz®**)		Rosiglitazone maleate (**Avandia®**)		Pentamidine (**Pentam®**)
	Darunavir (**Prezista®**)		**Herpes Treatment**		TMP/SMZ (**Bactrim®/Septra®**)
	Fosamprenavir (**Lexiva®**)		Acyclovir (**Zovirax®**)		
	Indinivavir sulfate (**Crixivan®**)		Famciclovir (**Famvir®**)		**Toxo Prophylaxis & Tx**
	Nelfinavir (**Viracept®**)		Valacyclovir (**Valtrex®**)		Leucovorin
	Ritonavir (**Norvir®**)		**Cardiac-Related Treatment**		Pyrimethamine (**Daraprim®**)
	Ritonavir + Lopinavir (**Kaletra®**)		Atorvastatin (**Lipitor®**)		Sulfadiazine
	Saquinavir (**Invirase®**)		Clopodogrel bisulfate (**Plavix®**)		**TB Treatment**
	Tipranavir (**Aptivus®**)		Ezetimibe (**Zetia®**)		Ethambutol (**Myambutol®**)
			Fenofibrate (**Tricor®**)		Isoniazid (**INH**)
	Cross-Class Combos		Gemfibrozil (**Lopid®**)		**Other Formulary Medications**
	Efavirenz + Emtricitabine + Tenofovir (**Atripla®**)		Lisinopril (generic only)		albuterol sulfate inhaler (generic only)
			Pravastatin (**Pravachol®**)		gabapentin (generic only)
			Rosuvastatin calcium (**Crestor®**)		Medroxyprogesterone (**Depo-Provera®**) No prefilled syringes
	Integrase Inhibitors		**MAI Prophylaxis & Tx**		
	Raltegravir (Isentress®)		Azithromycin (**Zithromax®**)		Penicillin G benzathine (**Bicillin LA®**)
	CCR5 Antagonists		Clarithromycin (**Biaxin®**)		Valganciclovir (**Valcyte®**)
	Maraviroc (**Selzentry®**)**		Rifabutin (**Mycobutin®**)		Varenicline (**Chantix®**) 6 months/lifetime
	Fusion Inhibitors		**Vaccines**		Imiquimod (**Aldara®** Cream)
	Enfuvirtide (**Fuzeon®**)**		Hep A vaccine (**Havrix®**)		Podofilox (**Condylox®**)
			Hep B vaccine (**Engerix®/Recombivax®**)		
	**Requires prior authorization		Hep A/Hep B vaccine (**Twinrix®**)		**Wasting Syndrome**
			Pneumococcal Pneumonia Vaccine		Testosterone (all non-injectible forms)
			Tetanus Vaccine		

**For instructions on obtaining authorization for Fuzeon or Selzentry, please contact the [redacted] rse at [redacted]

[redacted]

[1] Three jails submitted this sheet as their formulary.

VI.



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STATE OF OHIO FACILITY FORMULARY PARTICIPATION FORM

[redacted]

Facility Name (Print) [redacted] Facility City and State (Print) [redacted] Omnicare Pharmacy Name (Print) [redacted]

This facility's Pharmacy and Therapeutics (P&T) Committee, or equivalent committee, has adopted the Omnicare Geriatric Pharmaceutical Care Guidelines® (Omnicare Guidelines®) as its Formulary. Based on the Omnicare Guidelines®, the following FACILITY FORMULARY THERAPEUTIC INTERCHANGE PROTOCOLS (Protocols) have been adopted by the facility's P&T Committee, or equivalent committee. Each Protocol sets forth criteria that must be satisfied for a therapeutic interchange to take place. The interchanges are to medications that offer comparable effectiveness, safety and tolerability at a generally lower price to the payer, or to medications that have clinically superior effectiveness, safety or tolerability profiles potentially at a higher price to the payer.

Page	When this Medication is Prescribed	The Following Formulary Medication will be Dispensed	Facility Adopts Interchange "YES"
1-3	All ACEIs except captopril	generic lisinopril	☑
4	Cozaar® or Hyzaar®	Diovan® or Diovan HCT®	☑
5	Generic clopidogrel or ticlopidine	Plavix®	☑
6	Lipitor® or Crestor®	generic simvastatin	☑
7	Nexium®, Prevacid®, Prilosec®, or Aciphex®	generic omeprazole	☑
8	Immediate release oxybutynin, Detrol®, Detrol LA®, Enablex®, Vesicare®, Sanctura® or Sanctura XR®	generic oxybutynin ER	☑
9	Nasacort AQ®, Rhinocort Aqua®, Nasarel® or Veramyst®	generic fluticasone	☑
10	Celebrex®	generic meloxicam	☑
11	Ambien CR®, Lunesta®, Restoril®, Razadone® Sonata®, or temazepam	generic zolpidem	☑
12	Alphagan P® 0.1% and 0.15%	generic brimonidine tartrate 0.2%	☑
13	Humulin® Insulins	Novo® insulins unit for unit	☑
14	Humalog® 75/25 Mix	Novolog® 70/30 Mix unit for unit	☑
15	Humalog® 100	Novolog® 100 unit for unit	☑
16	Bactroban® cream	generic mupirocin ointment	☑
17	Miacalcin®	Fortical®	☑
18	Trizo® or Antara®	generic fenofibrate	☑
19	Exelon® capsules, Razadyne® and Razadyne ER®	Aricept®	☑
20	Avodart®	generic finasteride	☑

By signing below, I am notifying Omnicare that this Facility's P&T Committee, or equivalent committee, has adopted the Omnicare Guidelines® as its Formulary. Those FACILITY FORMULARY THERAPEUTIC INTERCHANGE PROTOCOLS checked "Yes" above are adopted for use by our prescribing clinicians when they prescribe medications for this Facility's residents. Automatic substitution of the interchange drug for the prescribed drug shall occur at the time of dispensing. A prescribing clinician may choose to not implement an interchange for a particular drug and resident by following the Facility's Do Not Interchange procedure. The therapeutic interchange is considered void and the originally prescribed medication will be dispensed if the interchange drug results in an increased price to the Facility, third party or patient, unless the basis for the interchange is clinical superiority.

[redacted]

Administrator's Name (Print) Administrator's Signature Date

[redacted]

Medical Director's Name (Print) Medical Director's Signature Date

[redacted]

PREFERED DRUG LIST

[redacted] MAINTENANCE MEDICATION FORMULARY

	DRUG NAME	STRENGTH		BRAND NAME	
ANALGESICS					
Rheumatoid	METHOTREXATE		TAB		
Muscle	BACLOFEN		TAB	LIORESAL 222-5985	
	CYCLOBENZAPRINE		TAB	FLEXERIL 226-4471	
	METHOCARBAMOL		TAB	ROBAXIN 130-5035	
NSAID's	MELOXICAM		CAP		
	ASPIRIN		TAB		OTC
	ASPIRIN EC		TAB		OTC
	NAPROXEN		TAB	NAPROSYN 277-6243	
	IBUPROFEN		TAB	ADVIL	OTC
Narcotic					
	OXYCODONE/APAP CII		TAB	PERCOCET 5/325MG	
	HYDROCODONE/APAP		TAB	VICODIN 5/500	
Analgesic OTHER					
	ACETAMINOPHEN		TAB	TYLENOL	OTC
	ACETAMINOPHEN		TAB	TYLENOL	OTC
	TRAMADOL		TAB	ULTRAM	
ANTIMICROBIALS					
	NYSTATIN	100,000U/ML	SUSP	MYCOSTATIN	
	DOXYCYCLINE		CAP	VIBRAMYCIN*	
	CEPHALEXIN		CAP	KEFLEX	
	CEFUROXIME		TAB	CEFTIN	
	OMICEF		CAP	*	
	CEFTRIAXONE		INJ	ROCEPHIN	
	AZITHROMYCIN		TAB	ZITHROMAX	
	AMOXICILLIN		CAP	AMOXIL	
	AMOXICILLIN/CLAV	500/125MG	TAB	AUGMENTIN	
	AMOXICILLIN/CLAV	875/125MG	TAB	AUGMENTIN	

OTC = STORE IN NURSE MEDICATION CART

[redacted] MAINTENANCE MEDICATION FORMULARY

	CIPROFLOXACIN		TAB	CIPRO	
	LEVAQUIN		TAB		
	AVELOX		TAB		
	SULFAMETH/TMP DS		TAB	BACTRIM DS	
	METRONIDAZOLE		TAB	FLAGYL	
	TRIMETHOPRIM		TAB	PRIMSOL *	
	VANCOMYCIN		CAP	VANCOCIN	
CARDIOVASCULAR					
ACE inhibitors	CAPTOPRIL		TAB	CAPOTEN	
	LISINOPRIL		TAB	PRINIVIL/ZESTRIL	
	ALTACE		CAP		
Aldosterone antagonist	SPIRONOLACTONE		TAB	ALDACTONE	
ARB's	COZAAR		TAB		
	DIOVAN		TAB		
ntiadrenergic agents	CLONIDINE		TAB	CATAPRES	
	DOXAZOSIN		TAB	CARDURA	
nti-dysrhythmics	AMIODARONE			CORDARONE/PACERONE	
	DIGOXIN		TAB	LANOXIN	
	SOTALOL		TAB	BETAPACE*	
	SOTALOL		TAB	BETAPACE*	
nti-hyperlipidemic	COLESTID		TAB		

OTC = STORE IN NURSE MEDICATION CART

[redacted] MAINTENANCE MEDICATION FORMULARY

	LOVASTATIN		TAB	MEVACOR
			TAB	*
	SIMVASTATIN		TAB	ZOCOR
	NIACIN		CAP	
	FINOFIBRATE		TAB	
Antihypertensive combo's	DIOVAN		TAB	*
	DIOVAN HCT		TAB	
	TRIAMTERENE/HCTZ		CAP	DYAZIDE
				*
	LOTREL		CAP	*
	BISOPROLOL/HCTZ		TAB	ZIAC
Anti-HTN miscellaneous	HYDRALAZINE		TAB	APRESOLINE
Anti-platelet	PLAVIX		TAB	
	ASA		TAB	
Beta-blockers	ATENOLOL		TAB	
				*
	METOPROLOL		TAB	LOPRESSOR
	METOPROLOL SUCCINATE XL		TAB	TOPROL XL
CCB's				
	AMLODIPINE		TAB	NORVASC
	NIFEDIPINE ER/SA		TAB	ADALAT CC,PROCARDIA xl
	NIFEDIPINE CC		TAB*	ADALAT CC,PROCARDIA XL
	DILTIAZEM ER/SA		CAP	CARDIZEM SR
	DILTIAZEM CD/ER		CAP	CARDIZEM CD*

OTC = STORE IN NURSE MEDICATION CART

[redacted] MAINTENANCE MEDICATION FORMULARY

	VERAPAMIL		TAB	CALAN, ISOPTIN	
	VERAPAMIL ER		TAB	CALAN, ISOPTIN	
Diuretics					
	FUROSEMIDE		TAB	LASIX	
	HCTZ			*	
	METOLAZONE		TAB	ZAROXOLYN	
Nitrates					
	ISOSORBIDE MONO		TAB	IMDUR	
	NITROGLYCERIN SL		TAB		
	NITROGLYCERIN		PATCH		
Other					
	CILOSTAZOL		TAB	PLETAL	
	PENTOXIFYLLINE		TAB	TRENTAL	
ENDOCRINE & METABOLIC					
Corticosteroids					
	DEXAMETHASONE		TAB	DECADRON	
	PREDNISONE		TAB	DELTASONE	
Diabetes					
	METFORMIN		TAB	GLUCOPHAGE	
	METFORMIN ER		TAB	GLUCOPHAGE*	
	ACTOS		TAB	*	
	AVANDIA		TAB	*	
	GLIMEPIRIDE		TAB	AMARYL	
	GLIPIZIDE		TAB	GLUCOTROL	
	GLIPIZIDE XL		TAB	GLUCOTROL*	
	GLYBURIDE		TAB	DIABETA/MICRONASE	
	GLUTOSE GEL		GEL		
REFRIGERATE)	NOVOLOG		VIAL		
REFRIGERATE)	NOVOLIN R		VIAL		
REFRIGERATE)	NOVOLIN N		VIAL		
REFRIGERATE)	LANTUS		VIAL		
	NOVOLIN MIX		VIAL		
Gout-related					

OTC = STORE IN NURSE MEDICATION CART

[redacted] MAINTENANCE MEDICATION FORMULARY

	ALLOPURINOL		TAB	ZYLOPRIM	
	COLCHICINE	0.6MG	TAB		
Minerals					
	OYSTER SHEL CAL +D	500MG	TAB	OS-CAL+D	OTC
	FERROUS SULF EC	325MG	TAB	FEOSOL	
	NIFEREX FORTE	150	TAB	"	
	MAGDELAY	64MG	TAB	SLO-MAG "	
	MAGNESIUM OXIDE		TAB	MAG-OX	
Potassium					
	KLOR CON M 10meq		TAB	K-DUR 10MEQ	
Thyroid Agents					
	LEVOTHYROXINE		TAB	SNYTHROID	
Vitamin K					
	MEPHYTON	5MG	TAB	"	
Other					
	MIACALCIN	200U	SPRAY		
	SODIUM POLYSTYRENE	15GM/60ML		KAYEXALATE	
ANTIHISTAMINE					
	DIPHENHYDRAMINE	12.5MG/5ML	BTL	BENADRYL LIQ	OTC
	FEXOFENADINE		TAB	ALLEGRA	
	LORATADINE		TAB	CLARITIN	
	ZYRTEC		TAB	"	
ANTITUSSIVE/ EXPECT.					
	BENZONATATE	100MG	TAB	TESSALON"	
	MUCINEX ER	600MG	CAP	"	
GASTROENTEROLOGY					
Diarrhea	DIPHENOXYLATE/ATROPINE	2.5MG	TAB	LOMOTIL	
	ANTIDIARREAL TAB		TAB	IMMODIUM AD	OTC
Gastritis					
	METOCLOPRAMIDE	10MG	TAB	REGLAN	
	PROMETHAZINE	25MG	TAB	PHENERGAN	

OTC = STORE IN NURSE MEDICATION CART

[redacted] MAINTENANCE MEDICATION FORMULARY

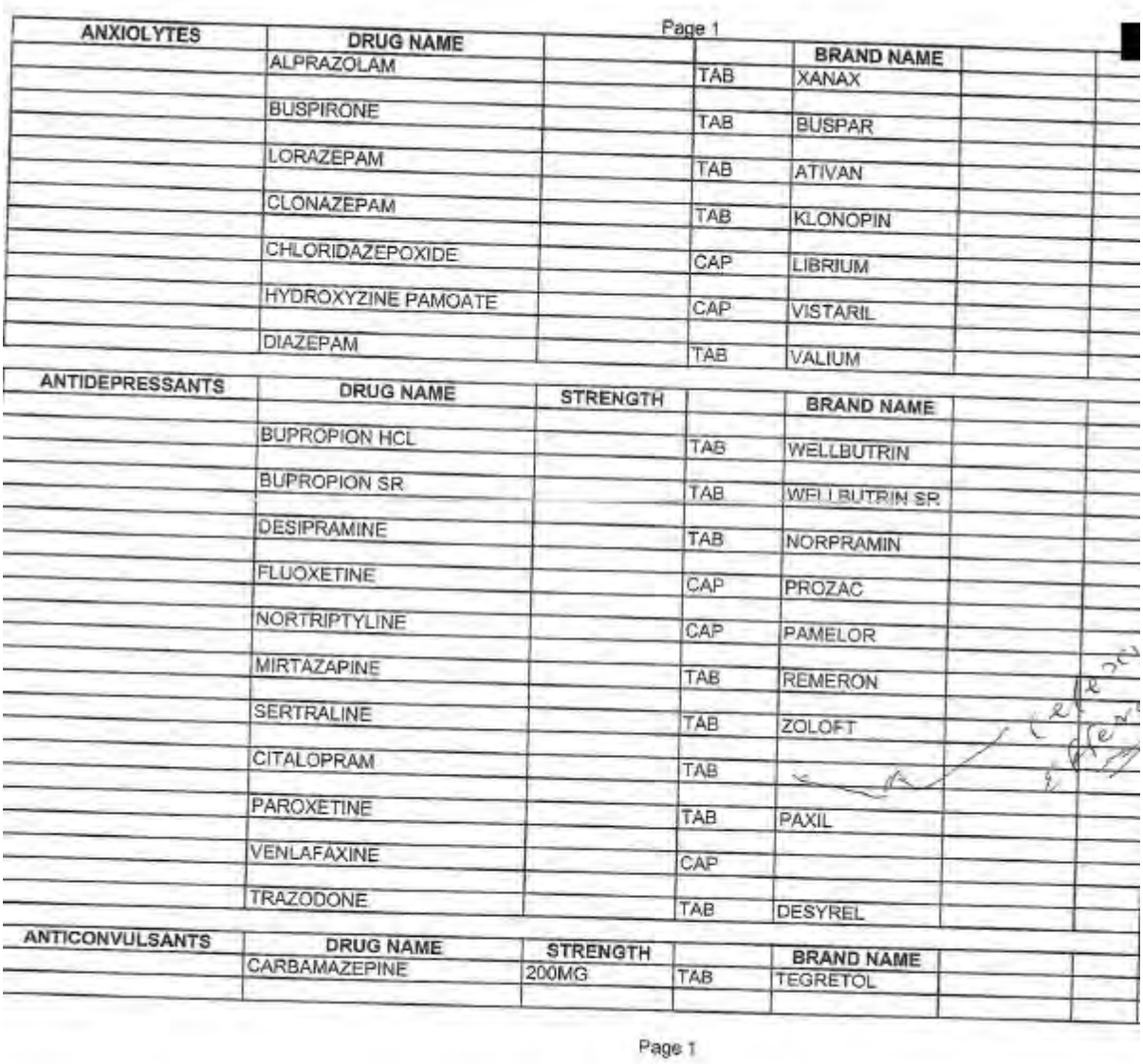
	FAMOTIDINE			PEPCID	
	RANITIDINE		TAB	ZANTAC	
	NEXIUM		TAB		
	OMEPRAZOLE		CAP	PRILOSEC*	
Constipation					
	BISACODYL		TAB	DULCOLAX	OTC
	BISACODYL		SUPP	DULCOLAX	OTC
	DOCUSATE SODIUM		CAP	COLACE	
	SENNA-S		TAB		OTC
Acid Indigestion					OTC
	CALCIUM CARBONATE		TAB	TUMS	OTC
	ANTACID/SIMETHICONE		TAB		OTC
	MAALOX		BT		OTC
Nausea (REFRIG)					
	PROMETHAZINE SUPP	25MG	SUPP	PHENERGAN	
	PROMETHAZINE INJ	25MG/ML	AMP	PHENERGAN	
HEMATOLOGY					
	WARFARIN		TAB	COUMADIN*	
NEUROLOGY					
	KEPPRA		TAB	*	
	PHENYTOIN ER		CAP	DILANTIN*	
	CARBIDOPA/LEVADOPA		TAB	SINEMET	
	CARBIDOPA/LEVADOPA ER		TAB	SINEMET CR	
	REQUIP		TAB	*	
	MECLIZINE		TAB	ANTIVERT	
	AMANTADINE		CAP	SYMMETREL*	
PULMONARY					
	ALBUTEROL	0.083%	UD	PROVENTIL/VENTOLIN	
	IPRATROPIUM	0.5MG/2.5ML	UD	ATROVENT	
IROLOGY					

OTC = STORE IN NURSE MEDICATION CART

[redacted] MAINTENANCE MEDICATION FORMULARY

	OXYBUTYNIN XL		TAB	DITROPAN	
DVT PROPH					
	HEPARIN	5000U/ML	VIAL		

OTC = STORE IN NURSE MEDICATION CART



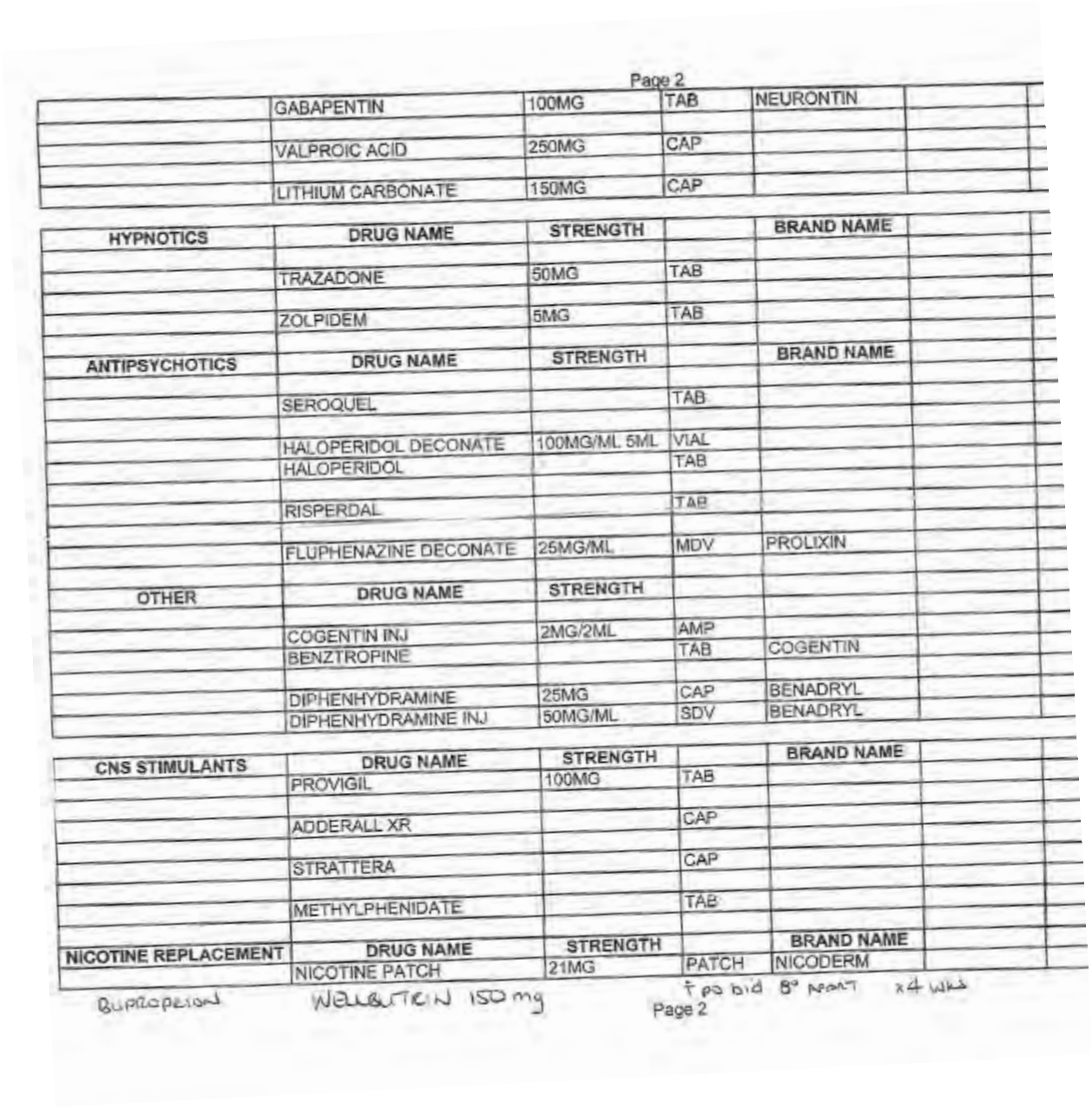
Page 1

ANXIOLYTES	DRUG NAME			BRAND NAME
	ALPRAZOLAM		TAB	XANAX
	BUSPIRONE		TAB	BUSPAR
	LORAZEPAM		TAB	ATIVAN
	CLONAZEPAM		TAB	KLONOPIN
	CHLORIDAZEPOXIDE		CAP	LIBRIUM
	HYDROXYZINE PAMOATE		CAP	VISTARIL
	DIAZEPAM		TAB	VALIUM

ANTIDEPRESSANTS	DRUG NAME	STRENGTH		BRAND NAME
	BUPROPION HCL		TAB	WELLBUTRIN
	BUPROPION SR		TAB	WELLBUTRIN SR
	DESIPRAMINE		TAB	NORPRAMIN
	FLUOXETINE		CAP	PROZAC
	NORTRIPTYLINE		CAP	PAMELOR
	MIRTAZAPINE		TAB	REMERON
	SERTRALINE		TAB	ZOLOFT
	CITALOPRAM		TAB	
	PAROXETINE		TAB	PAXIL
	VENLAFAXINE		CAP	
	TRAZODONE		TAB	DESYREL

ANTICONVULSANTS	DRUG NAME	STRENGTH		BRAND NAME
	CARBAMAZEPINE	200MG	TAB	TEGRETOL

Page 1



Page 2

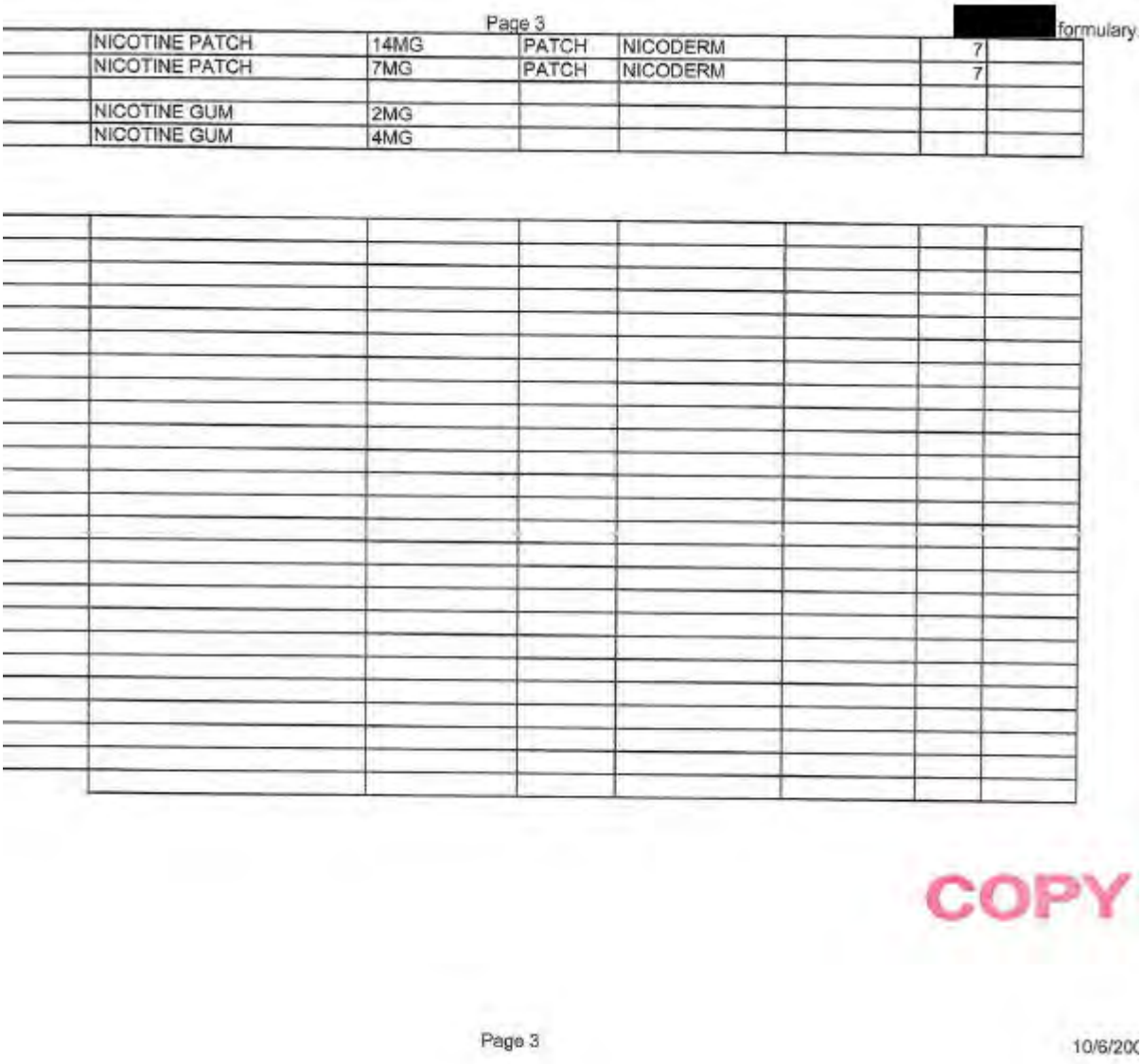
	GABAPENTIN	100MG	TAB	NEURONTIN	
	VALPROIC ACID	250MG	CAP		
	LITHIUM CARBONATE	150MG	CAP		

HYPNOTICS	DRUG NAME	STRENGTH		BRAND NAME	
	TRAZADONE	50MG	TAB		
	ZOLPIDEM	5MG	TAB		
ANTIPSYCHOTICS	**DRUG NAME**	**STRENGTH**		**BRAND NAME**	
	SEROQUEL		TAB		
	HALOPERIDOL DECONATE	100MG/ML 5ML	VIAL		
	HALOPERIDOL		TAB		
	RISPERDAL		TAB		
	FLUPHENAZINE DECONATE	25MG/ML	MDV	PROLIXIN	
OTHER	**DRUG NAME**	**STRENGTH**			
	COGENTIN INJ	2MG/2ML	AMP		
	BENZTROPINE		TAB	COGENTIN	
	DIPHENHYDRAMINE	25MG	CAP	BENADRYL	
	DIPHENHYDRAMINE INJ	50MG/ML	SDV	BENADRYL	

CNS STIMULANTS	DRUG NAME	STRENGTH		BRAND NAME	
	PROVIGIL	100MG	TAB		
	ADDERALL XR		CAP		
	STRATTERA		CAP		
	METHYLPHENIDATE		TAB		
NICOTINE REPLACEMENT	**DRUG NAME**	**STRENGTH**		**BRAND NAME**	
	NICOTINE PATCH	21MG	PATCH	NICODERM	

Bupropion Wellbutrin 150 mg ↑ po bid 8° apart x4 wks

Page 2



Page 3 [redacted] formulary

	NICOTINE PATCH	14MG	PATCH	NICODERM		7	
	NICOTINE PATCH	7MG	PATCH	NICODERM		7	
	NICOTINE GUM	2MG					
	NICOTINE GUM	4MG					

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Appendix E: Community Providers of HIV Care Named in Interviews

During the course of the interviews, some respondents gave the names of community organizations that provide HIV care services to their inmates. The following is a list of those providers named during the interviews. **This is not a comprehensive list of organizations that provide HIV care services to Ohio FSJs.**

Health Departments

Akron City Health Department (Akron)

Auglaize County Health Department (Wapakoneta)

Canton City Health Department (Canton)

Champaign Health District (Urbana)

Clark County Combined Health District (Springfield)

Clermont County Health District (Batavia)

Columbus Public Health (Columbus)

Cuyahoga County Health District (Parma)

Erie County General Health District (Sandusky)

Greene County Combined Health District (Xenia)

Hamilton County General Health District (Cincinnati)

Hancock County Health Department (Findlay)

Holmes County General Health District (Millersburg)

Lake County General Health District (Painesville)

Licking County Health Department (Newark)

Infectious Disease Specialists

Akron General Medical Center (Akron)

Grady Memorial Hospital (Delaware)

University Hospital (University of Cincinnati), Holmes Clinic (Cincinnati)

Miami Valley Hospital (Dayton)

Ohio State University Medical Center, Infectious Diseases Clinic (Columbus)

Summa Health System, including St. Thomas Hospital (Akron)

University Hospitals (Cleveland)

University of Toledo Medical Center, Division of Infectious Diseases (Toledo)

Other Medical Care Providers

Care Alliance Health Center (Cleveland)

Comprehensive Care Center (Youngstown)

AIDS Task Forces, Case Management, Support Groups, and Mental Health Care Providers

AIDS Resource Center (Toledo)

Columbus AIDS Task Force (Columbus)

Community Connection (Lima)

Consolidated Care, Inc. (Bellefontaine)

Marion AIDS Task Force (Marion)

Maumee Valley Guidance Center (Defiance)

Mental Health and Recovery Services of Warren and Clinton Counties (Lebanon)

Neighboring Mental Health Services (Mentor)

New Horizons Youth and Family Center (Lancaster)

Pathways Counseling Center (Ottawa)

Recovery Services of Northwest Ohio (formerly Five County Alcohol/Drug Program) (Defiance)

STOP AIDS (formerly AIDS Volunteers of Cincinnati) (Cincinnati)

Substance Abuse Services, Inc. (Toledo)

Trillium Family Solutions (Canton)

Unison Behavioral Health Group (Toledo)

Zepf Center (Toledo)

OHIO UNIVERSITY

Voinovich Center for
Leadership and Public Affairs

Voinovich Center for
Leadership and Public Affairs

Institute for Local Government
Administration and Rural Development
Building 22, The Ridges
Athens, OH 45701

«First» «Last»
«Jail_Name_»
«Street»
«City», «State» «Zip»

Dear «First» «Last»,

Enclosed please find a survey about your jail's policies and procedures for inmates with HIV/AIDS. This survey is part of a study that Ohio University is conducting on behalf of the Ohio Department of Health. We would very much appreciate it if you would fill out the survey and return it in the included postage-paid envelope.

A comment on our survey procedures -- an identification number is printed on each page of the questionnaire so that we can check your facility off the mailing list when it is returned. Protecting the confidentiality of your answers is very important to us. When we submit our report to ODH, none of the information you provide to us will be identified with your facility. Thank you for your help with this study.

Sincerely,

Sara L Boyd

Project Manager

HIV/AIDS in Full Service Jails: Needs Assessment Survey

Ohio University's Voinovich School of Leadership and Public Affairs is conducting a study of HIV care in Ohio's Full Service Jails on behalf of the Ohio Department of Health (ODH). ODH would like to know how it can be of assistance to you as you care for inmates with HIV/AIDS. Please answer the following questions as candidly as possible. Information from your jail will be combined with information from all other participating jails in the report of findings. No information you provide will be identified with you or your facility.

If your jail has not housed inmates with HIV, we are still interested in learning about your policies on HIV care. If possible, please answer all questions based on the policies you have in place for HIV care for inmates.

If you have any questions or concerns about this survey please contact Kelli Schoen at (877) 593-2311 or schoenk@ohio.edu. Jails that participate in this survey will receive a copy of the report.

DIRECTIONS: Fill in the bubble next to the response that best represents your opinions.

Please mark answers like this: ● **Not like this:** ⊘ ✓

1. What is your position at the jail? _____

2. In the last twelve months, how many total inmates has your jail housed? ☐☐☐☐☐

3. Of the inmates your jail has housed in the past twelve months, how many are known to have HIV or AIDS?

O 0 O 1-10 O 11-25 O 26-50 O 51-100 O Over 100 O I do not know

4. In your opinion, how well does your jail perform with the following aspects of HIV care? (If your jail has not housed inmates with HIV/AIDS, how well do you think they would perform with the following aspects of HIV care?)

	Excellent	Good	Average	Fair	Poor
a. Identifying inmates with HIV/AIDS when entering jail	O	O	O	O	O
b. Finding undiagnosed cases of HIV/AIDs among inmates	O	O	O	O	O
c. Keeping up to date with developments in the treatment of HIV/AIDS	O	O	O	O	O
d. Providing access to HIV specialists	O	O	O	O	O
e. Developing courses of treatment appropriate to an inmate's specific condition	O	O	O	O	O
f. Providing counseling, education, or other types of non-medical services to inmates with HIV/AIDS	O	O	O	O	O
g. Providing HIV-related medications immediately when an inmate arrives at the jail, regardless of whether the inmate enters on a weekend or after business hours	O	O	O	O	O
h. Ensuring that inmates rarely or never miss doses of HIV-related medications while in jail	O	O	O	O	O
i. Ensuring that inmates' HIV care continues after they are discharged from the jail	O	O	O	O	O

---PLEASE TURN PAGE OVER---

5. Which of the following statements best describes your jail's policies and procedures for HIV testing? Select all that apply.

- O All inmates entering the facility are offered an HIV test
- O All inmates entering the facility may request an HIV test
- O Inmates admitting to certain risk behaviors associated with HIV/AIDS are offered an HIV test
- O Inmates with certain medical diagnoses or inmates who are exhibiting symptoms of certain medical conditions associated with HIV/AIDS are offered an HIV test
- O Inmates cannot be required to take an HIV test
- O We provide genotype testing to detect drug resistance
- O HIV testing is not available for our inmates

6. To the best of your knowledge, how often do the following situations cause an inmate to miss one or more doses of HIV-related medication?

	Very often	Often	Some-times	Rarely	Never
a. Inmate arrives at jail on weekend or after business hours	O	O	O	O	O
b. Inmate is transferred between jails	O	O	O	O	O
c. Inmate is transferred between jail and prison	O	O	O	O	O
d. HIPAA prevents obtaining information on inmate's prescriptions in a timely manner	O	O	O	O	O
e. Inmate's prescribed HIV-related medications are not on the jail's formulary	O	O	O	O	O
f. No prescriber available to prescribe HIV-related medications	O	O	O	O	O
g. Inmate is away from jail for court hearing or other approved activity	O	O	O	O	O
h. Inmate refuses medication	O	O	O	O	O
i. Inmate cannot be depended upon to take medications at correct times	O	O	O	O	O
j. Staff not able to monitor all doses of medications	O	O	O	O	O
k. Other (Please describe below.)	O	O	O	O	O

_____

7. Do your jail's policies allow anyone (such as an inmate, their family, or their case manager) to bring an inmate's HIV-related medications to the jail?

O Yes (skip to question 9) O No

8. If you answered No to the previous question, please tell us the reasons your jail does not allow anyone to bring an inmate's HIV-related medications to the jail. Select all that apply.

- O We are not able to confirm that medications brought in are actually those prescribed for the inmate
- O Confirming the medications are those prescribed for the inmate places too great a strain on our resources
- O HIPPA regulations prevent us from verifying prescription medications brought in to the jail
- O Other (please specify)

_____

9. When inmates with HIV or AIDS are released from jail, are they given a temporary supply of HIV-related medications?

O No

O Yes If Yes, who pays for the medications? _____

(If Yes, skip to Question 11)

---PLEASE CONTINUE ON NEXT PAGE---

10. If you answered No to question 9, please tell us the reasons the jail does not provide HIV-related discharge medications. Select all that apply.

- O Medical staff are not given enough notice to prepare discharge prescriptions
- O Our budget does not allow us to provide discharge medications
- O Potential liability for the jail prevents us from providing discharge medications
- O No prescribers are willing to prescribe discharge medications
- O Other (please specify) _____

11. What local organizations provide HIV care services to inmates at your jail? Select all that apply.

O Health department O Local hospital O AIDS task force O Faith-based organization

O Other (please specify) _____

O No local organizations provide HIV care services to our inmates with HIV/AIDS

12. Does your jail draw on local resources (such as the local health department or AIDS task force) to provide any of the following aspects of HIV care? Select all that apply.

- O HIV testing
- O Non-medical care such as counseling or substance abuse treatment
- O HIV-related medication while inmates are in jail
- O HIV-related medication for inmates leaving the jail
- O Other aspects of discharge planning besides HIV-related medications (medical referrals, counseling, case management, etc.)
- O Other (please specify) _____
- O No HIV care is provided by local organizations

13. How challenging is it for your jail to provide the following components of HIV care?

	Very challenging	Somewhat challenging	Neutral	Not very challenging	Not at all challenging
a. Identifying inmates entering jail with HIV/AIDS	O	O	O	O	O
b. Finding undiagnosed cases of HIV/AIDs among inmates	O	O	O	O	O
c. Paying for HIV-related medications for inmates	O	O	O	O	O
d. Paying for HIV-testing for inmates	O	O	O	O	O
e. Providing access to HIV specialists	O	O	O	O	O
f. Keeping up to date with developments in the treatment of HIV/AIDS	O	O	O	O	O
g. Developing courses of treatment appropriate to an inmate's specific health condition	O	O	O	O	O
h. Providing counseling, education, or other types of non-medical treatment	O	O	O	O	O
i. Providing HIV-related medications within 24 hours after an inmate enters the jail, regardless of whether the inmate enters on a weekend or after business hours	O	O	O	O	O
j. Ensuring that inmates rarely or never miss doses of HIV-related medications while in jail	O	O	O	O	O
k. Ensuring that inmates' medical HIV care continues after they are discharged from the jail	O	O	O	O	O
l. Other (please specify below)	O	O	O	O	O

_____

---PLEASE TURN PAGE OVER---

14. When your jail encounters challenges with HIV care for inmates, how often are the following issues the source of the challenges?

	Very often	Often	Some-times	Rarely	Never
a. Not enough time	O	O	O	O	O
b. Insufficient finances	O	O	O	O	O
c. Insufficient staffing	O	O	O	O	O
d. Insufficient/inadequate health care space	O	O	O	O	O
e. Jail's relationship with the community and elected officials	O	O	O	O	O
f. Other _____	O	O	O	O	O

15. Please indicate how strongly you agree or disagree with the following statements.

	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
a. Jail personnel are adequately trained to identify those inmates entering the facility who have HIV/AIDS	O	O	O	O	O
b. Jail personnel are able to provide a course of treatment for inmates with HIV/AIDS that is tailored to each inmate's particular health condition	O	O	O	O	O
c. Jail personnel keep up-to-date on the latest medical and treatment options for HIV/AIDS	O	O	O	O	O
d. Inmates at this jail have adequate access to HIV specialists	O	O	O	O	O
e. This jail is taking full advantage of the local resources for HIV care for inmates	O	O	O	O	O
f. We would like local organizations to be more involved in providing care for inmates with HIV	O	O	O	O	O
g. Adequate discharge planning is provided to inmates with HIV/AIDS	O	O	O	O	O

16. Is there any other information that you think should be part of this study?

_____

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS SURVEY

What is your position at the jail?

	Number of Respondents	Percentage
Health Services Director	8	15.7%
Medical Staff	26	51.0%
Corrections Officer	1	2.0%
Jail Administrator/Warden	13	25.5%
Other	3	5.9%
Total	51	100.0%

Note. Some respondents answered for more than one jail in their county.

In the last 12 months, how many total inmates has your jail housed?

	Number of Respondents
420	1
600	1
683	1
950	1
1,021	1
1,050	1
1,171	1
1,350	1
1,445	1
1,466	1
1,614	1
1,693	1
1,884	1
2,192	1
2,207	1
2,462	1
2,577	1
2,591	1
2,771	1
3,058	1
3,275	1
3,483	1
3,500	1
4,473	1
4,500	1
4,648	1
4,968	1
5,424	1
5,430	1
5,802	1
6,019	1
7,000	1
7,170	1
7,500	1
9,500	1
10,000	1
11,480	1
12,311	1
16,000	1
20,000	1
24,771	1
27,881	1
36,000	1
58,400	1
Total	44

Note. 7 jails did not respond to this question.

Of the inmates your jail has housed in the past twelve months, how many are known to have HIV or AIDS?

	Number of Respondents	Percentage
0	6	12.8%
1-10	30	63.8%
11-25	4	8.5%
26-50	3	6.4%
51-100	2	4.3%
Over 100	1	2.1%
I do not know	1	2.1%
Total	47	100.0%

Note. Some respondents answered for more than one jail in their county.

Note. 4 jails did not respond to this question.

In your opinion, how well does your jail perform with the following aspects of HIV care? (If your jail has not housed inmates with HIV/AIDS, how well do you think they would perform with the following aspects of HIV care?)

Identifying inmates with HIV/AIDS when entering jail

	Number of Respondents	Percentage
Poor	2	3.6%
Fair	1	1.8%
Average	13	23.6%
Good	22	40.0%
Excellent	17	30.9%
Total	55	100.0%

Note. 1 jail did not respond to this question.

Finding undiagnosed cases of HIV/AIDS among inmates

	Number of Respondents	Percentage
Poor	7	13.5%
Fair	7	13.5%
Average	17	32.7%
Good	19	36.5%
Excellent	2	3.8%
Total	52	100.0%

Note. 4 jails did not respond to this question.

Keeping up-to-date with developments in the treatment of HIV/AIDS

	Number of Respondents	Percentage
Poor	2	3.6%
Fair	9	16.1%
Average	19	33.9%
Good	16	28.6%
Excellent	10	17.9%
Total	56	100.0%

Providing access to HIV specialists

	Number of Respondents	Percentage
Poor	4	7.1%
Fair	5	8.9%
Average	10	17.9%
Good	10	17.9%
Excellent	27	48.2%
Total	56	100.0%

Developing courses of treatment appropriate to an inmate's specific condition

	Number of Respondents	Percentage
Poor	2	3.6%
Fair	7	12.5%
Average	11	19.6%
Good	17	30.4%
Excellent	19	33.9%
Total	56	100.0%

Providing social work, counseling, education, or other types of non-medical services to inmates with HIV/AIDS

	Number of Respondents	Percentage
Poor	5	8.9%
Fair	13	23.2%
Average	14	25.0%
Good	15	26.8%
Excellent	9	16.1%
Total	56	100.0%

Providing HIV-related medications immediately when an inmate arrives at the jail, regardless of whether the inmate enters on a weekend or after business hours

	Number of Respondents	Percentage
Poor	4	7.1%
Fair	8	14.3%
Average	12	21.4%
Good	17	30.4%
Excellent	15	26.8%
Total	56	100.0%

Ensuring that inmates rarely or never miss doses of HIV-related medications while in jail

	Number of Respondents	Percentage
Poor	1	1.8%
Fair	1	1.8%
Average	7	12.5%
Good	22	39.3%
Excellent	25	44.6%
Total	56	100.0%

Ensuring that inmates' HIV care continues after they are discharged from the jail

	Number of Respondents	Percentage
Poor	11	20.0%
Fair	7	12.7%
Average	26	47.3%
Good	7	12.7%
Excellent	4	7.3%
Total	55	100.0%

Note. 1 jail did not respond to this question.

Which of the following statements best describes your jail's policies and procedures for HIV testing?

	Number of Respondents	Percentage
All inmates entering the facility are offered an HIV test	1	1.9%
All inmates entering the facility may request an HIV test	14	26.4%
Inmates admitting to certain risk behaviors associated with HIV/AIDS are offered an HIV test	14	26.4%
Inmates with certain medical diagnoses or inmates who are exhibiting symptoms of certain medical conditions associated with HIV/AIDS are offered an HIV test	34	64.2%
Inmates cannot be required to take an HIV test	18	34.0%
We provide genotype testing to detect drug resistance	1	1.9%
HIV testing is not available for our inmates	9	17.0%

Note. Respondents could choose multiple responses.

To the best of your knowledge, how often do the following situations cause an inmate to miss one or more doses of HIV-related medication?

Inmate arrives at jail on weekend or after business hours

	Number of Respondents	Percentage
Never	4	7.1%
Rarely	24	42.9%
Sometimes	22	39.3%
Often	2	3.6%
Very often	4	7.1%
Total	56	100.0%

Inmate is transferred between jails

	Number of Respondents	Percentage
Never	6	10.9%
Rarely	21	38.2%
Sometimes	24	43.6%
Often	2	3.6%
Very often	2	3.6%
Total	55	100.0%

Note. 1 jail did not respond to this question.

Inmate is transferred between jail and prison

	Number of Respondents	Percentage
Never	6	10.9%
Rarely	19	34.5%
Sometimes	24	43.6%
Often	4	7.3%
Very often	2	3.6%
Total	55	100.0%

Note. 1 jail did not respond to this question.

HIPPA prevents obtaining information on inmate's prescriptions in a timely manner

	Number of Respondents	Percentage
Never	12	21.8%
Rarely	10	18.2%
Sometimes	19	34.5%
Often	12	21.8%
Very often	2	3.6%
Total	55	100.0%

Note. 1 jail did not respond to this question.

Inmate's prescribed HIV-related medications are not on the jail's formulary

	Number of Respondents	Percentage
Never	26	47.3%
Rarely	12	21.8%
Sometimes	6	10.9%
Often	5	9.1%
Very often	6	10.9%
Total	55	100.0%

Note. 1 jail did not respond to this question.

No prescriber available to prescribe HIV-related medications

	Number of Respondents	Percentage
Never	23	41.8%
Rarely	15	27.3%
Sometimes	12	21.8%
Often	5	9.1%
Very often	0	0.0%
Total	55	100.0%

Note. 1 jail did not respond to this question.

Inmate is away from jail for court hearing or other approved activity

	Number of Respondents	Percentage
Never	17	30.9%
Rarely	20	36.4%
Sometimes	17	30.9%
Often	0	0.0%
Very often	1	1.8%
Total	55	100.0%

Note. 1 jail did not respond to this question.

Inmate refuses medication

	Number of Respondents	Percentage
Never	4	7.3%
Rarely	15	27.3%
Sometimes	27	49.1%
Often	8	14.5%
Very often	1	1.8%
Total	55	100.0%

Note. 1 jail did not respond to this question.

Inmate cannot be depended upon to take medications at correct times

	Number of Respondents	Percentage
Never	18	32.7%
Rarely	18	32.7%
Sometimes	13	23.6%
Often	4	7.3%
Very often	2	3.6%
Total	55	100.0%

Note. 1 jail did not respond to this question.

Staff not able to monitor all doses of medications

	Number of Respondents	Percentage
Never	38	69.1%
Rarely	13	23.6%
Sometimes	1	1.8%
Often	1	1.8%
Very often	2	3.6%
Total	55	100.0%

Note. 1 jail did not respond to this question.

Other

	Number of Respondents	Percentage
Never	5	71.4%
Rarely	0	0.0%
Sometimes	0	0.0%
Often	1	14.3%
Very often	1	14.3%
Total	7	100.0%

Note. 49 jails did not respond to this question.

Do your jail's policies allow anyone (such as an inmate, their family, or their case manager) to bring an inmate's HIV-related medications to the jail?

	Number of Respondents	Percentage
Yes	54	96.4%
No	2	3.6%
Total	56	100.0%

If you answered No to the previous question, please tell us the reasons your jail does not allow anyone to bring an inmate's HIV-related medications to the jail.

	Number of Respondents	Percentage
We are not able to confirm that medications brought in are actually those prescribed for the inmate	2	100.0%
Confirming the medications are those prescribed for the inmate places too great a strain on our resources	0	0.0%
HIPPA regulations prevent us from verifying prescription medications brought in to the jail	2	100.0%
Other	0	0.0%

Note. Respondents could choose multiple responses.

When inmates with HIV or AIDS are released from jail, are they given a temporary supply of HIV-related medications?

	Number of Respondents	Percentage
Yes	27	48.2%
No	29	51.8%
Total	56	100.0%

If yes, who pays for the medications?

	Number of Respondents	Percentage
Jail	12	50.0%
Health Department	5	20.8%
Inmate, Family, or Personal Insurance	5	20.8%
Other	2	8.3%
Total	24	100.0%

Note. 3 jails did not respond to this question.

If you answered No to the previous question, please tell us the reasons the jail does not provide HIV-related discharge medications.

	Number of Respondents	Percentage
Medical staff are not given enough notice to prepare discharge prescriptions	8	30.8%
Our budget does not allow us to provide discharge medications	17	65.4%
Potential liability for the jail prevents us from providing discharge medications	12	46.2%
No prescribers are willing to prescribe discharge medications	3	11.5%
Other	9	34.6%

Note. Respondents could choose multiple responses.

What local organizations provide HIV care services to inmates at your jail?

	Number of Respondents	Percentage
Health Department	23	41.1%
Local hospital	24	42.9%
AIDS task force	6	10.7%
Faith-based organization	3	5.4%
Other	17	30.4%
No local organizations provide HIV care services to our inmates with HIV/AIDS	15	26.8%

Note. Respondents could choose multiple responses.

Does your jail draw on local resources (such as the local health department or AIDS task force) to provide any of the following aspects of HIV care?

	Number of Respondents	Percentage
HIV testing	16	29.6%
Non-medical care such as counseling or substance abuse treatment	23	42.6%
HIV-related medication while inmates are in jail	8	14.8%
HIV-related medication for inmates leaving the jail	3	5.6%
Other aspects of discharge planning besides HIV-related medications (medical referrals, counseling, case management, etc.)	19	35.2%
Other	7	13.0%
No HIV care is provided by local organizations	16	29.6%

Note. Respondents could choose multiple responses.

How challenging is it for your jail to provide the following components of HIV care?

Identifying inmates entering jail with HIV/AIDS

	Number of Respondents	Percentage
Not at all challenging	2	3.6%
Not very challenging	11	19.6%
Neutral	23	41.1%
Somewhat challenging	17	30.4%
Very challenging	3	5.4%
Total	56	100.0%

Finding undiagnosed cases of HIV/AIDS among inmates

	Number of Respondents	Percentage
Not at all challenging	0	0.0%
Not very challenging	4	7.1%
Neutral	20	35.7%
Somewhat challenging	14	25.0%
Very challenging	18	32.1%
Total	56	100.0%

Paying for HIV-related medications for inmates

	Number of Respondents	Percentage
Not at all challenging	5	9.4%
Not very challenging	5	9.4%
Neutral	9	17.0%
Somewhat challenging	12	22.6%
Very challenging	22	41.5%
Total	53	100.0%

Note. 3 jails did not respond to this question.

Paying for HIV testing for inmates

	Number of Respondents	Percentage
Not at all challenging	7	12.5%
Not very challenging	11	19.6%
Neutral	16	28.6%
Somewhat challenging	6	10.7%
Very challenging	16	28.6%
Total	56	100.0%

Providing access to HIV specialists

	Number of Respondents	Percentage
Not at all challenging	8	16.3%
Not very challenging	11	22.4%
Neutral	11	22.4%
Somewhat challenging	10	20.4%
Very challenging	9	18.4%
Total	49	100.0%

Note. 7 jails did not respond to this question.

Keeping up-to-date with developments in the treatment of HIV/AIDS

	Number of Respondents	Percentage
Not at all challenging	4	7.1%
Not very challenging	9	16.1%
Neutral	21	37.5%
Somewhat challenging	14	25.0%
Very challenging	8	14.3%
Total	56	100.0%

Developing courses of treatment appropriate to an inmate's specific health condition

	Number of Respondents	Percentage
Not at all challenging	4	7.5%
Not very challenging	16	30.2%
Neutral	18	34.0%
Somewhat challenging	13	24.5%
Very challenging	2	3.8%
Total	53	100.0%

Note. 3 jails did not respond to this question.

Providing counseling, education, or other types of non-medical treatment

	Number of Respondents	Percentage
Not at all challenging	4	7.4%
Not very challenging	12	22.2%
Neutral	19	35.2%
Somewhat challenging	13	24.1%
Very challenging	6	11.1%
Total	54	100.0%

Note. 2 jails did not respond to this question.

Providing HIV-related medications within 24 hours after an inmate enters the jail, regardless of whether the inmate enters on a weekend or after business hours

	Number of Respondents	Percentage
Not at all challenging	7	7.4%
Not very challenging	12	22.2%
Neutral	11	35.2%
Somewhat challenging	13	24.1%
Very challenging	13	11.1%
Total	56	100.0%

Ensuring that inmates rarely or never miss doses of HIV-related medications while in jail

	Number of Respondents	Percentage
Not at all challenging	12	21.4%
Not very challenging	17	30.4%
Neutral	12	21.4%
Somewhat challenging	9	16.1%
Very challenging	6	10.7%
Total	56	100.0%

Ensuring that inmates' medical HIV care continues after they are discharged from the jail

	Number of Respondents	Percentage
Not at all challenging	2	3.7%
Not very challenging	3	5.6%
Neutral	16	29.6%
Somewhat challenging	14	25.9%
Very challenging	19	35.2%
Total	54	100.0%

Note. 2 jails did not respond to this question.

Other

	Number of Respondents	Percentage
Not at all challenging	0	0.0%
Not very challenging	0	0.0%
Neutral	3	60.0%
Somewhat challenging	0	0.0%
Very challenging	2	40.0%
Total	5	100.0%

Note. 51 jails did not respond to this question.

When your jail encounters challenges with HIV care for inmates, how often are the following issues the source of the challenges?

Not enough time

	Number of Respondents	Percentage
Never	8	14.3%
Rarely	20	35.7%
Sometimes	12	21.4%
Often	10	17.9%
Very often	6	10.7%
Total	56	100.0%

Insufficient finances

	Number of Respondents	Percentage
Never	11	19.6%
Rarely	13	23.2%
Sometimes	8	14.3%
Often	11	19.6%
Very often	13	23.2%
Total	56	100.0%

Insufficient staffing

	Number of Respondents	Percentage
Never	13	23.2%
Rarely	21	37.5%
Sometimes	14	25.0%
Often	5	8.9%
Very often	3	5.4%
Total	56	100.0%

Insufficient/inadequate health care space

	Number of Respondents	Percentage
Never	21	37.5%
Rarely	18	32.1%
Sometimes	7	12.5%
Often	5	8.9%
Very often	5	8.9%
Total	56	100.0%

Jail's relationship with the community and elected officials

	Number of Respondents	Percentage
Never	20	36.4%
Rarely	24	43.6%
Sometimes	6	10.9%
Often	2	3.6%
Very often	3	5.5%
Total	55	100.0%

Note. 1 jail did not respond to this question.

Other

	Number of Respondents	Percentage
Never	0	0.0%
Rarely	1	33.3%
Sometimes	0	0.0%
Often	0	0.0%
Very often	2	66.7%
Total	3	100.0%

Note. 53 jails did not respond to this question.

Please indicate how strongly you agree or disagree with the following statements.

Jail personnel are adequately trained to identify those inmates entering the facility who have HIV/AIDS

	Number of Respondents	Percentage
Strongly disagree	2	3.6%
Disagree	7	12.5%
Neutral	24	42.9%
Agree	19	33.9%
Strongly agree	4	7.1%
Total	56	100.0%

Jail personnel are able to provide a course of treatment for inmates with HIV/AIDS that is tailored to each inmate's particular health condition

	Number of Respondents	Percentage
Strongly disagree	6	10.9%
Disagree	11	20.0%
Neutral	15	27.3%
Agree	18	32.7%
Strongly agree	5	9.1%
Total	55	100.0%

Note. 1 jail did not respond to this question.

Jail personnel keep up-to-date on the latest medical and treatment options for HIV/AIDS

	Number of Respondents	Percentage
Strongly disagree	5	8.9%
Disagree	12	21.4%
Neutral	18	32.1%
Agree	18	32.1%
Strongly agree	3	5.4%
Total	56	100.0%

Inmates at this jail have adequate access to HIV specialists

	Number of Respondents	Percentage
Strongly disagree	4	7.1%
Disagree	5	8.9%
Neutral	15	26.8%
Agree	17	30.4%
Strongly agree	15	26.8%
Total	56	100.0%

This jail is taking full advantage of the local resources for HIV care for inmates

	Number of Respondents	Percentage
Strongly disagree	4	7.3%
Disagree	7	12.7%
Neutral	17	30.9%
Agree	22	40.0%
Strongly agree	5	9.1%
Total	55	100.0%

Note. 1 jail did not respond to this question.

We would like local organizations to be more involved in providing care for inmates with HIV non-medical treatment

	Number of Respondents	Percentage
Strongly disagree	0	0.0%
Disagree	2	3.6%
Neutral	25	44.6%
Agree	21	37.5%
Strongly agree	8	14.3%
Total	56	100.0%

Adequate discharge planning is provided to inmates with HIV/AIDS

	Number of Respondents	Percentage
Strongly disagree	6	10.7%
Disagree	9	16.1%
Neutral	25	44.6%
Agree	10	17.9%
Strongly agree	6	10.7%
Total	56	100.0%

Is there any other information that you think should be part of this study?

	Number of Respondents	Percentage
Inmate issues	2	22.2%
Very few HIV inmates	2	22.2%
Challenges	2	22.2%
Other	3	33.3%
Total	9	100.0%

Note. 47 jails did not respond to this question.

What is your position at the jail?

	Large	Small
Health Services Director	42.1%	0.0%
Medical Staff	47.4%	53.1%
Corrections Officer	0.0%	3.1%
Jail Administrator/Warden	5.3%	37.5%
Other	5.3%	6.3%
Total	100.0%	100.0%

Note. Some respondents answered for more than one jail in their county.

In the last twelve months, how many total inmates has your jail housed?

Large	Small
600	420
1,614	683
3,500	950
4,648	1,021
4,968	1,050
5,424	1,171
7,170	1,350
7,500	1,445
9,500	1,466
10,000	1,693
11,480	1,884
12,311	2,192
16,000	2,207
20,000	2,462
24,771	2,577
27,881	2,591
36,000	2,771
	3,058
	3,275
	3,483
	4,473
	4,500
	5,430
	5,802
	6,019
	7,000
	58,400

Of the inmates your jail has housed in the past twelve months, how many are known to have HIV or AIDS?

	Large	Small
0	0.0%	20.0%
1-10	52.9%	70.0%
11-25	11.8%	6.7%
26-50	17.6%	0.0%
51-100	11.8%	0.0%
Over 100	5.9%	0.0%
I do not know	0.0%	3.3%
Total	100.0%	100.0%

Note. Some respondents answered for more than one jail in their county.

Note. 4 jails did not respond to this question.

In your opinion, how well does your jail perform with the following aspects of HIV care? (If your jail has not housed inmates with HIV/AIDS, how well do you think they would perform with the following aspects of HIV care?)

	Large			Small		
	M	*n*	*SD*	*M*	*n*	*SD*
Identifying inmates with HIV/AIDS when entering jail	4.10	20	1.02	3.83	35	0.95
Finding undiagnosed cases of HIV/AIDS among inmates	3.17	18	1.10	2.97	34	1.11
Keeping up to date with developments in the treatment of HIV/AIDS	3.80	20	1.06	3.19	36	1.04
Providing access to HIV specialists	4.55	20	0.89	3.56	36	1.36
Developing courses of treatment appropriate to an inmate's specific condition	4.20	20	1.01	3.56	36	1.18
Providing social work, counseling, education, or other types of non-medical services to inmates with HIV/AIDS	3.50	20	1.10	3.00	36	1.26
Providing HIV-related medications immediately when an inmate arrives at the jail, regardless of whether the inmate enters on a weekend or after business hours	3.70	20	1.08	3.47	36	1.32
Ensuring that inmates rarely or never miss doses of HIV-related medications while in jail	4.25	20	0.72	4.22	36	0.96
Ensuring that inmates' HIV care continues after they are discharged from the jail	2.75	20	1.02	2.74	35	1.22

Which of the following statements best describes your jail's policies and procedures for HIV testing?

	Large	Small
All inmates entering the facility are offered an HIV test	0.0%	3.0%
All inmates entering the facility may request an HIV test	40.0%	18.2%
Inmates admitting to certain risk behaviors associated with HIV/AIDS are offered an HIV test	35.0%	21.2%
Inmates with certain medical diagnoses or inmates who are exhibiting symptoms of certain medical conditions associated with HIV/AIDS are offered an HIV test	80.0%	54.5%
Inmates cannot be required to take an HIV test	40.0%	30.3%
We provide genotype testing to detect drug resistance	5.0%	0.0%
HIV testing is not available for our inmates	10.0%	21.2%

Note. Respondents could choose multiple responses.

To the best of your knowledge, how often do the following situations cause an inmate to miss one or more doses of HIV-related medication?

	Large			Small		
	M	*n*	*SD*	*M*	*n*	*SD*
Inmate arrives at jail on weekend or after business hours	2.75	20	0.79	2.53	36	1.03
Inmate is transferred between jails	2.63	19	0.96	2.44	36	0.84
Inmate is transferred between jail and prison	2.89	19	0.88	2.42	36	0.91
HIPPA prevents obtaining information on inmate's prescriptions in a timely manner	2.47	19	1.12	2.78	36	1.17
Inmate's prescribed HIV-related medications are not on the jail's formulary	1.84	19	1.34	2.31	36	1.41
No prescriber available to prescribe HIV-related medications	1.68	19	0.95	2.14	36	1.02
Inmate is away from jail for court hearing or other approved activity	2.05	19	0.85	2.06	36	0.92
Inmate refuses medication	2.84	19	0.96	2.72	36	0.81
Inmate cannot be depended upon to take medications at correct times	2.00	19	1.15	2.25	36	1.05
Staff not able to monitor all doses of medications	1.21	19	0.42	1.61	36	1.08
Other	2.50	2	2.12	1.80	5	1.79

Do your jail's policies allow anyone (such as an inmate, their family, or their case manager) to bring an inmate's HIV-related medications to the jail?

	Large	Small
Yes	90.0%	100.0%
No	10.0%	0.0%
Total	100.0%	100.0%

If you answered No to the previous question, please tell us the reasons your jail does not allow anyone to bring an inmate's HIV-related medications to the jail.

	Large	Small
We are not able to confirm that medications brought in are actually those prescribed for the inmate	100.0%	N/A
Confirming the medications are those prescribed for the inmate places too great a strain on our resources	0.0%	N/A
HIPPA regulations prevent us from verifying prescription medications brought in to the jail	100.0%	N/A
Other	0.0%	N/A

Note. Respondents could choose multiple responses.

When inmates with HIV or AIDS are released from jail, are they given a temporary supply of HIV-related medications?

	Large	Small
Yes	50.0%	47.2%
No	50.0%	52.8%
Total	100.0%	100.0%

If yes, who pays for the medications?

	Large	Small
Jail	50.0%	50.0%
Health Department	10.0%	28.6%
Inmate, Family, or Personal Insurance	20.0%	21.4%
Other	20.0%	0.0%
Total	100.0%	100.0%

If you answered No to the previous question, please tell us the reasons the jail does not provide HIV-related discharge medications.

	Large	Small
Medical staff are not given enough notice to prepare discharge prescriptions	30.0%	31.3%
Our budget does not allow us to provide discharge medications	50.0%	75.0%
Potential liability for the jail prevents us from providing discharge medications	50.0%	43.8%
No prescribers are willing to prescribe discharge medications	10.0%	12.5%
Other	50.0%	25.0%

Note. Respondents could choose multiple responses.

What local organizations provide HIV care services to inmates at your jail?

	Large	Small
Health Department	40.0%	41.7%
Local hospital	50.0%	38.9%
AIDS task force	15.0%	8.3%
Faith-based organization	10.0%	2.8%
Other	55.0%	16.7%
No local organizations provide HIV care services to our inmates with HIV/AIDS	20.0%	30.6%

Note. Respondents could choose multiple responses.

Does your jail draw on local resources (such as the local health department or AIDS task force) to provide any of the following aspects of HIV care?

	Large	Small
HIV testing	31.6%	28.6%
Non-medical care such as counseling or substance abuse treatment	47.4%	40.0%
HIV-related medication while inmates are in jail	21.1%	11.4%
HIV-related medication for inmates leaving the jail	10.5%	2.9%
Other aspects of discharge planning besides HIV-related medications (medical referrals, counseling, case management, etc.)	57.9%	22.9%
Other	10.5%	14.3%
No HIV care is provided by local organizations	21.1%	34.3%

Note. Respondents could choose multiple responses.

How challenging is it for your jail to provide the following components of HIV care?

	Large			Small		
	M	*n*	*SD*	*M*	*n*	*SD*
Identifying inmates entering jail with HIV/AIDS	2.95	20	1.00	3.25	36	0.87
Finding undiagnosed cases of HIV/AIDS among inmates	3.65	20	1.04	3.92	36	0.94
Paying for HIV-related medications for inmates	3.63	19	1.34	3.85	34	1.35
Paying for HIV-testing for inmates	3.05	20	1.54	3.33	36	1.31
Providing access to HIV specialists	2.35	17	1.32	3.38	32	1.26
Keeping up to date with developments in the treatment of HIV/AIDS	2.80	20	1.06	3.47	36	1.08
Developing courses of treatment appropriate to an inmate's specific health condition	2.68	19	1.00	2.97	34	1.00
Providing counseling, education, or other types of non-medical treatment	2.79	19	1.18	3.26	35	1.04
Providing HIV-related medications within 24 hours after an inmate enters the jail, regardless of whether the inmate enters on a weekend or after business hours	3.40	20	1.31	3.14	36	1.40
Ensuring that inmates rarely or never miss doses of HIV-related medications while in jail	2.70	20	1.38	2.61	36	1.25
Ensuring that inmates' medical HIV care continues after they are discharged from the jail	3.95	19	1.03	3.77	35	1.14
Other	3.00	2	0.00	4.33	3	1.15

When your jail encounters challenges with HIV care for inmates, how often are the following issues the source of the challenges?

	Large			Small		
	M	*n*	*SD*	*M*	*n*	*SD*
Not enough time	2.85	20	1.27	2.69	36	1.21
Insufficient finances	2.90	20	1.52	3.11	36	1.47
Insufficient staffing	2.15	20	1.04	2.47	36	1.13
Insufficient/inadequate health care space	1.90	20	1.17	2.36	36	1.33
Jail's relationship with the community and elected officials	1.70	20	0.80	2.14	35	1.17
Other	5.00	2	0.00	2.00	1	.

Please indicate how strongly you agree or disagree with the following statements.

	Large			Small		
	M	*n*	*SD*	*M*	*n*	*SD*
Jail personnel are adequately trained to identify those inmates entering the facility who have HIV/AIDS	3.50	20	1.05	3.17	36	0.81
Jail personnel are able to provide a course of treatment for inmates with HIV/AIDS that is tailored to each inmate's particular health condition	3.45	20	1.15	2.89	35	1.13
Jail personnel keep up-to-date on the latest medical and treatment options for HIV/AIDS	3.25	20	1.12	2.92	36	1.02
Inmates at this jail have adequate access to HIV specialists	4.20	20	1.06	3.28	36	1.14
This jail is taking full advantage of the local resources for HIV care for inmates	3.45	20	1.23	3.23	35	0.94
We would like local organizations to be more involved in providing care for inmates with HIV non-medical treatment	4.05	20	0.76	3.39	36	0.69
Adequate discharge planning is provided to inmates with HIV/AIDS	3.10	20	1.12	2.97	36	1.11

Is there any other information that you think should be part of this study?

	Large	Small
Inmate issues	33.3%	16.7%
Very few HIV inmates	0.0%	33.3%
Challenges	33.3%	16.7%
Other	33.3%	33.3%
Total	100.0%	100.0%

What is your position at the jail?

	Managed Care	Non-Managed Care
Health Services Director	11.8%	17.6%
Medical Staff	64.7%	44.1%
Corrections Officer	0.0%	2.9%
Jail Administrator/Warden	23.5%	26.5%
Other	0.0%	8.8%
Total	100.0%	100.0%

Note. Some respondents answered for more than one jail in their county.

In the last twelve months, how many total inmates has your jail housed?

Managed Care	Non-Managed Care
420	683
600	950
1,350	1,021
1,614	1,050
2,462	1,171
2,577	1,445
3,275	1,466
3,500	1,693
5,802	1,884
10,000	2,192
12,311	2,207
24,771	2,591
36,000	2,771
	3,058
	3,483
	4,473
	4,500
	4,648
	4,968
	5,424
	5,430
	6,019
	7,000
	7,170
	7,500
	9,500
	11,480
	16,000
	20,000
	27,881
	58,400

Of the inmates your jail has housed in the past twelve months, how many are known to have HIV or AIDS?

	Managed Care	Non-Managed Care
0	6.3%	16.1%
1-10	75.0%	58.1%
11-25	6.3%	9.7%
26-50	0.0%	9.7%
51-100	6.3%	3.2%
Over 100	0.0%	3.2%
I do not know	6.3%	0.0%
Total	100.0%	100.0%

Note. Some respondents answered for more than one jail in their county.

In your opinion, how well does your jail perform with the following aspects of HIV care? (If your jail has not housed inmates with HIV/AIDS, how well do you think they would perform with the following aspects of HIV care?)

	Managed Care			Non-Managed Care		
	M	*n*	*SD*	*M*	*n*	*SD*
Identifying inmates with HIV/AIDS when entering jail	4.00	19	0.75	3.89	36	1.09
Finding undiagnosed cases of HIV/AIDS among inmates	2.74	19	1.15	3.21	33	1.05
Keeping up to date with developments in the treatment of HIV/AIDS	3.47	19	1.17	3.38	37	1.04
Providing access to HIV specialists	3.95	19	1.08	3.89	37	1.41
Developing courses of treatment appropriate to an inmate's specific condition	3.68	19	0.95	3.84	37	1.26
Providing social work, counseling, education, or other types of non-medical services to inmates with HIV/AIDS	3.16	19	1.12	3.19	37	1.29
Providing HIV-related medications immediately when an inmate arrives at the jail, regardless of whether the inmate enters on a weekend or after business hours	3.26	19	1.28	3.70	37	1.20
Ensuring that inmates rarely or never miss doses of HIV-related medications while in jail	4.37	19	0.90	4.16	37	0.87
Ensuring that inmates' HIV care continues after they are discharged from the jail	2.56	18	1.10	2.84	37	1.17

Which of the following statements best describes your jail's policies and procedures for HIV testing?

	Managed Care	Non-Managed Care
All inmates entering the facility are offered an HIV test	5.3%	0.0%
All inmates entering the facility may request an HIV test	10.5%	35.3%
Inmates admitting to certain risk behaviors associated with HIV/AIDS are offered an HIV test	0.0%	41.2%
Inmates with certain medical diagnoses or inmates who are exhibiting symptoms of certain medical conditions associated with HIV/AIDS are offered an HIV test	52.6%	70.6%
Inmates cannot be required to take an HIV test	26.3%	38.2%
We provide genotype testing to detect drug resistance	0.0%	2.9%
HIV testing is not available for our inmates	26.3%	11.8%

Note. Respondents could choose multiple responses.

To the best of your knowledge, how often do the following situations cause an inmate to miss one or more doses of HIV-related medication?

	Managed Care			**Non-Managed Care**		
	M	*n*	*SD*	*M*	*n*	*SD*
Inmate arrives at jail on weekend or after business hours	2.53	19	0.90	2.65	37	0.98
Inmate is transferred between jails	2.37	19	0.96	2.58	36	0.84
Inmate is transferred between jail and prison	2.47	19	0.84	2.64	36	0.96
HIPPA prevents obtaining information on inmate's prescriptions in a timely manner	2.37	19	1.12	2.83	36	1.16
Inmate's prescribed HIV-related medications are not on the jail's formulary	2.53	19	1.65	1.94	36	1.22
No prescriber available to prescribe HIV-related medications	2.05	19	1.08	1.94	36	0.98
Inmate is away from jail for court hearing or other approved activity	1.89	19	0.81	2.14	36	0.93
Inmate refuses medication	2.47	19	0.90	2.92	36	0.81
Inmate cannot be depended upon to take medications at correct times	1.79	19	0.85	2.36	36	1.15
Staff not able to monitor all doses of medications	1.21	19	0.42	1.61	36	1.08
Other	2.40	5	1.95	1.00	2	0.00

Do your jail's policies allow anyone (such as an inmate, their family, or their case manager) to bring an inmate's HIV-related medications to the jail?

	Managed Care	Non-Managed Care
Yes	100.0%	94.6%
No	0.0%	5.4%
Total	100.0%	100.0%

If you answered No to the previous question, please tell us the reasons your jail does not allow anyone to bring an inmate's HIV-related medications to the jail.

	Managed Care	Non-Managed Care
We are not able to confirm that medications brought in are actually those prescribed for the inmate	N/A	100.0%
Confirming the medications are those prescribed for the inmate places too great a strain on our resources	N/A	0.0%
HIPPA regulations prevent us from verifying prescription medications brought in to the jail	N/A	100.0%
Other	N/A	0.0%

Note. Respondents could choose multiple responses.

When inmates with HIV or AIDS are released from jail, are they given a temporary supply of HIV-related medications?

	Managed Care	Non-Managed Care
Yes	42.1%	51.4%
No	57.9%	48.6%
Total	100.0%	100.0%

If yes, who pays for the medications?

	Managed Care	Non-Managed Care
Jail	42.9%	52.9%
Health Department	14.3%	23.5%
Inmate, Family, or Personal Insurance	28.6%	17.6%
Other	14.3%	5.9%
Total	100.0%	100.0%

If you answered No to the previous question, please tell us the reasons the jail does not provide HIV-related discharge medications.

	Managed Care	Non-Managed Care
Medical staff are not given enough notice to prepare discharge prescriptions	30.0%	31.3%
Our budget does not allow us to provide discharge medications	60.0%	68.8%
Potential liability for the jail prevents us from providing discharge medications	40.0%	50.0%
No prescribers are willing to prescribe discharge medications	30.0%	0.0%
Other	20.0%	43.8%

Note. Respondents could choose multiple responses.

What local organizations provide HIV care services to inmates at your jail?

	Managed Care	Non-Managed Care
Health Department	36.8%	43.2%
Local hospital	21.1%	54.1%
AIDS task force	15.8%	8.1%
Faith-based organization	15.8%	0.0%
Other	26.3%	32.4%
No local organizations provide HIV care services to our inmates with HIV/AIDS	31.6%	24.3%

Note. Respondents could choose multiple responses.

Does your jail draw on local resources (such as the local health department or AIDS task force) to provide any of the following aspects of HIV care?

	Managed Care	Non-Managed Care
HIV testing	16.7%	36.1%
Non-medical care such as counseling or substance abuse treatment	22.2%	52.8%
HIV-related medication while inmates are in jail	27.8%	8.3%
HIV-related medication for inmates leaving the jail	11.1%	2.8%
Other aspects of discharge planning besides HIV-related medications (medical referrals, counseling, case management, etc.)	38.9%	33.3%
Other	11.1%	13.9%
No HIV care is provided by local organizations	38.9%	25.0%

Note. Respondents could choose multiple responses.

How challenging is it for your jail to provide the following components of HIV care?

	Managed Care			Non-Managed Care		
	M	*n*	*SD*	*M*	*n*	*SD*
Identifying inmates entering jail with HIV/AIDS	3.26	19	0.73	3.08	37	1.01
Finding undiagnosed cases of HIV/AIDS among inmates	4.00	19	0.88	3.73	37	1.02
Paying for HIV-related medications for inmates	3.94	18	1.21	3.69	35	1.41
Paying for HIV-testing for inmates	3.79	19	1.23	2.95	37	1.39
Providing access to HIV specialists	3.00	17	1.50	3.03	32	1.31
Keeping up to date with developments in the treatment of HIV/AIDS	3.16	19	1.38	3.27	37	0.96
Developing courses of treatment appropriate to an inmate's specific health condition	2.74	19	0.99	2.94	34	1.01
Providing counseling, education, or other types of non-medical treatment	3.16	19	1.21	3.06	35	1.06
Providing HIV-related medications within 24 hours after an inmate enters the jail, regardless of whether the inmate enters on a weekend or after business hours	3.84	19	1.17	2.92	37	1.36
Ensuring that inmates rarely or never miss doses of HIV-related medications while in jail	2.53	19	1.12	2.70	37	1.37
Ensuring that inmates' medical HIV care continues after they are discharged from the jail	4.32	19	0.75	3.57	35	1.17
Other	5.00	2	0.00	3.00	3	0.00

When your jail encounters challenges with HIV care for inmates, how often are the following issues the source of the challenges?

	Managed Care			Non-Managed Care		
	M	*n*	*SD*	*M*	*n*	*SD*
Not enough time	2.63	19	1.26	2.81	37	1.22
Insufficient finances	3.47	19	1.61	2.81	37	1.37
Insufficient staffing	2.63	19	1.21	2.22	37	1.03
Insufficient/inadequate health care space	2.26	19	1.24	2.16	37	1.32
Jail's relationship with the community and elected officials	1.89	19	0.94	2.03	36	1.13
Other	5.00	1	.	3.50	2	2.12

Please indicate how strongly you agree or disagree with the following statements.

	Managed Care			Non-Managed Care		
	M	*n*	*SD*	*M*	*n*	*SD*
Jail personnel are adequately trained to identify those inmates entering the facility who have HIV/AIDS	3.00	19	0.88	3.43	37	0.90
Jail personnel are able to provide a course of treatment for inmates with HIV/AIDS that is tailored to each inmate's particular health condition	3.11	19	1.05	3.08	36	1.23
Jail personnel keep up-to-date on the latest medical and treatment options for HIV/AIDS	2.89	19	1.24	3.11	37	0.97
Inmates at this jail have adequate access to HIV specialists	3.58	19	1.17	3.62	37	1.21
This jail is taking full advantage of the local resources for HIV care for inmates	3.42	19	0.84	3.25	36	1.16
We would like local organizations to be more involved in providing care for inmates with HIV non-medical treatment	3.74	19	0.73	3.57	37	0.80
Adequate discharge planning is provided to inmates with HIV/AIDS	3.11	19	1.05	2.97	37	1.14

Is there any other information that you think should be part of this study?

	Managed Care	Non-Managed Care
Inmate issues	0.0%	28.6%
Very few HIV inmates	0.0%	28.6%
Challenges	50.0%	14.3%
Other	50.0%	28.6%
Total	100.0%	100.0%

What is your position at the jail?

	Urban	Rural
Health Services Director	50.0%	7.3%
Medical Staff	20.0%	58.5%
Corrections Officer	0.0%	2.4%
Jail Administrator/Warden	30.0%	24.4%
Other	0.0%	7.3%
Total	100.0%	100.0%

Note. Some respondents answered for more than one jail in their county.

In the last twelve months, how many total inmates has your jail housed?

Urban	Rural
683	420
1,145	600
3,058	950
11,480	1,021
12,311	1,050
20,000	1,171
24,771	1,350
27,881	1,466
36,000	1,614
	1,693
	1,884
	2,192
	2,207
	2,462
	2,577
	2,591
	2,771
	3,275
	3,483
	3,500
	4,473
	4,500
	4,648
	4,968
	5,424
	5,430
	5,802
	6,019
	7,000
	7,170
	7,500
	9,500
	10,000
	16,000
	58,400

Of the inmates your jail has housed in the past twelve months, how many are known to have HIV or AIDS?

	Urban	Rural
0	0.0%	15.8%
1-10	33.3%	71.1%
11-25	22.2%	5.3%
26-50	11.1%	5.3%
51-100	22.2%	0.0%
Over 100	11.1%	0.0%
I do not know	0.0%	2.6%
Total	100.0%	100.0%

Note. Some respondents answered for more than one jail in their county.

In your opinion, how well does your jail perform with the following aspects of HIV care? (If your jail has not housed inmates with HIV/AIDS, how well do you think they would perform with the following aspects of HIV care?)

	Urban			Rural		
	M	*n*	*SD*	*M*	*n*	*SD*
Identifying inmates with HIV/AIDS when entering jail	4.18	11	1.33	3.86	44	0.88
Finding undiagnosed cases of HIV/AIDS among inmates	2.73	11	1.19	3.12	41	1.08
Keeping up to date with developments in the treatment of HIV/AIDS	3.73	11	0.90	3.33	45	1.11
Providing access to HIV specialists	4.36	11	1.29	3.80	45	1.29
Developing courses of treatment appropriate to an inmate's specific condition	4.18	11	0.87	3.69	45	1.20
Providing social work, counseling, education, or other types of non-medical services to inmates with HIV/AIDS	3.27	11	1.10	3.16	45	1.26
Providing HIV-related medications immediately when an inmate arrives at the jail, regardless of whether the inmate enters on a weekend or after business hours	3.64	11	1.12	3.53	45	1.27
Ensuring that inmates rarely or never miss doses of HIV-related medications while in jail	4.09	11	0.70	4.27	45	0.91
Ensuring that inmates' HIV care continues after they are discharged from the jail	2.82	11	0.75	2.73	44	1.23

Which of the following statements best describes your jail's policies and procedures for HIV testing?

	Urban	Rural
All inmates entering the facility are offered an HIV test	0.0%	2.3%
All inmates entering the facility may request an HIV test	40.0%	23.3%
Inmates admitting to certain risk behaviors associated with HIV/AIDS are offered an HIV test	50.0%	20.9%
Inmates with certain medical diagnoses or inmates who are exhibiting symptoms of certain medical conditions associated with HIV/AIDS are offered an HIV test	80.0%	60.5%
Inmates cannot be required to take an HIV test	50.0%	30.2%
We provide genotype testing to detect drug resistance	0.0%	2.3%
HIV testing is not available for our inmates	20.0%	16.3%

Note. Respondents could choose multiple responses.

To the best of your knowledge, how often do the following situations cause an inmate to miss one or more doses of HIV-related medication?

	Urban			Rural		
	M	*n*	*SD*	*M*	*n*	*SD*
Inmate arrives at jail on weekend or after business hours	2.45	11	0.93	2.64	45	0.96
Inmate is transferred between jails	2.36	11	0.81	2.55	44	0.90
Inmate is transferred between jail and prison	2.45	11	0.93	2.61	44	0.92
HIPPA prevents obtaining information on inmate's prescriptions in a timely manner	2.27	11	1.10	2.77	44	1.16
Inmate's prescribed HIV-related medications are not on the jail's formulary	1.27	11	0.65	2.36	44	1.45
No prescriber available to prescribe HIV-related medications	1.55	11	0.93	2.09	44	1.01
Inmate is away from jail for court hearing or other approved activity	2.18	11	0.75	2.02	44	0.93
Inmate refuses medication	2.82	11	0.87	2.75	44	0.87
Inmate cannot be depended upon to take medications at correct times	1.55	11	0.69	2.32	44	1.12
Staff not able to monitor all doses of medications	1.18	11	0.40	1.55	44	1.00
Other	4.00	1	.	1.67	6	1.63

Do your jail's policies allow anyone (such as an inmate, their family, or their case manager) to bring an inmate's HIV-related medications to the jail?

	Urban	Rural
Yes	81.8%	100.0%
No	18.2%	0.0%
Total	100.0%	100.0%

If you answered No to the previous question, please tell us the reasons your jail does not allow anyone to bring an inmate's HIV-related medications to the jail.

	Urban	Rural
We are not able to confirm that medications brought in are actually those prescribed for the inmate	100.0%	N/A
Confirming the medications are those prescribed for the inmate places too great a strain on our resources	0.0%	N/A
HIPPA regulations prevent us from verifying prescription medications brought in to the jail	100.0%	N/A
Other	0.0%	N/A

Note. Respondents could choose multiple responses.

When inmates with HIV or AIDS are released from jail, are they given a temporary supply of HIV-related medications?

	Urban	Rural
Yes	36.4%	51.1%
No	63.6%	48.9%
Total	100.0%	100.0%

If yes, who pays for the medications?

	Urban	Rural
Jail	75.0%	45.0%
Health Department	0.0%	25.0%
Inmate, Family, or Personal Insurance	25.0%	20.0%
Other	0.0%	10.0%
Total	100.0%	100.0%

If you answered No to the previous question, please tell us the reasons the jail does not provide HIV-related discharge medications.

	Urban	Rural
Medical staff are not given enough notice to prepare discharge prescriptions	28.6%	31.6%
Our budget does not allow us to provide discharge medications	71.4%	63.2%
Potential liability for the jail prevents us from providing discharge medications	71.4%	36.8%
No prescribers are willing to prescribe discharge medications	0.0%	15.8%
Other	57.1%	26.3%

Note. Respondents could choose multiple responses.

What local organizations provide HIV care services to inmates at your jail?

	Urban	Rural
Health Department	45.5%	40.0%
Local hospital	81.8%	33.3%
AIDS task force	18.2%	8.9%
Faith-based organization	0.0%	6.7%
Other	45.5%	26.7%
No local organizations provide HIV care services to our inmates with HIV/AIDS	18.2%	28.9%

Note. Respondents could choose multiple responses.

Does your jail draw on local resources (such as the local health department or AIDS task force) to provide any of the following aspects of HIV care?

	Urban	Rural
HIV testing	36.4%	27.9%
Non-medical care such as counseling or substance abuse treatment	45.5%	41.9%
HIV-related medication while inmates are in jail	27.3%	11.6%
HIV-related medication for inmates leaving the jail	18.2%	2.3%
Other aspects of discharge planning besides HIV-related medications (medical referrals, counseling, case management, etc.)	54.5%	30.2%
Other	27.3%	9.3%
No HIV care is provided by local organizations	9.1%	34.9%

Note. Respondents could choose multiple responses.

How challenging is it for your jail to provide the following components of HIV care?

	Urban			Rural		
	M	*n*	*SD*	*M*	*n*	*SD*
Identifying inmates entering jail with HIV/AIDS	3.36	11	1.12	3.09	45	0.87
Finding undiagnosed cases of HIV/AIDS among inmates	3.82	11	1.17	3.82	45	0.94
Paying for HIV-related medications for inmates	3.18	11	1.54	3.93	42	1.26
Paying for HIV-testing for inmates	3.55	11	1.63	3.16	45	1.33
Providing access to HIV specialists	2.60	10	1.51	3.13	39	1.32
Keeping up to date with developments in the treatment of HIV/AIDS	2.82	11	1.17	3.33	45	1.09
Developing courses of treatment appropriate to an inmate's specific health condition	2.73	11	0.79	2.90	42	1.05
Providing counseling, education, or other types of non-medical treatment	3.09	11	1.45	3.09	43	1.02
Providing HIV-related medications within 24 hours after an inmate enters the jail, regardless of whether the inmate enters on a weekend or after business hours	2.64	11	1.36	3.38	45	1.34
Ensuring that inmates rarely or never miss doses of HIV-related medications while in jail	2.27	11	1.27	2.73	45	1.29
Ensuring that inmates' medical HIV care continues after they are discharged from the jail	3.64	11	1.03	3.88	43	1.12
Other	3.00	2	0.00	4.33	3	1.15

When your jail encounters challenges with HIV care for inmates, how often are the following issues the source of the challenges?

	Urban			Rural		
	M	*n*	*SD*	*M*	*n*	*SD*
Not enough time	3.27	11	1.35	2.62	45	1.17
Insufficient finances	2.91	11	1.45	3.07	45	1.50
Insufficient staffing	2.09	11	1.04	2.42	45	1.12
Insufficient/inadequate health care space	2.09	11	0.94	2.22	45	1.36
Jail's relationship with the community and elected officials	1.73	11	0.90	2.05	44	1.10
Other	5.00	1	.	3.50	2	2.12

Please indicate how strongly you agree or disagree with the following statements.

	Urban			Rural		
	M	*n*	*SD*	*M*	*n*	*SD*
Jail personnel are adequately trained to identify those inmates entering the facility who have HIV/AIDS	4.00	11	0.77	3.11	45	0.86
Jail personnel are able to provide a course of treatment for inmates with HIV/AIDS that is tailored to each inmate's particular health condition	3.27	11	1.49	3.05	44	1.08
Jail personnel keep up-to-date on the latest medical and treatment options for HIV/AIDS	3.55	11	0.93	2.91	45	1.06
Inmates at this jail have adequate access to HIV specialists	4.45	11	0.82	3.40	45	1.18
This jail is taking full advantage of the local resources for HIV care for inmates	3.73	11	1.10	3.20	44	1.02
We would like local organizations to be more involved in providing care for inmates with HIV non-medical treatment	4.09	11	0.70	3.51	45	0.76
Adequate discharge planning is provided to inmates with HIV/AIDS	2.91	11	1.22	3.04	45	1.09

Is there any other information that you think should be part of this study?

	Urban	Rural
Inmate issues	0.0%	25.0%
Very few HIV inmates	0.0%	25.0%
Challenges	0.0%	25.0%
Other	100.0%	25.0%
Total	100.0%	100.0%

In your opinion, how well does your jail perform with the following aspects of HIV care? (If your jail has not housed inmates with HIV/AIDS, how well do you think they would perform with the following aspects of HIV care?)

Note. Experience indicates that the jail has housed one or more inmates with HIV/AIDS in the past 12 months. No Experience indicates the jail has no reported cases of HIV/AIDS in the last 12 months.

Identifying inmates with HIV/AIDS when entering jail

	No Experience	Experience
Poor	0.0%	2.3%
Fair	0.0%	2.3%
Average	33.3%	20.5%
Good	50.0%	40.9%
Excellent	16.7%	34.1%
Total	100.0%	100.0%

Note. 1 jail did not respond to this question.

Finding undiagnosed cases of HIV/AIDS among inmates

	No Experience	Experience
Poor	0.0%	14.6%
Fair	0.0%	14.6%
Average	50.0%	31.7%
Good	33.3%	36.6%
Excellent	16.7%	2.4%
Total	100.0%	100.0%

Note. 4 jails did not respond to this question.

Keeping up-to-date with developments in the treatment of HIV/AIDS

	No Experience	Experience
Poor	0.0%	4.4%
Fair	50.0%	13.3%
Average	16.7%	33.3%
Good	16.7%	33.3%
Excellent	16.7%	15.6%
Total	100.0%	100.0%

Providing access to HIV specialists

	No Experience	Experience
Poor	0.0%	6.7%
Fair	16.7%	8.9%
Average	33.3%	17.8%
Good	0.0%	20.0%
Excellent	50.0%	46.7%
Total	100.0%	100.0%

Developing courses of treatment appropriate to an inmate's specific condition

	No Experience	Experience
Poor	0.0%	2.2%
Fair	0.0%	15.6%
Average	50.0%	13.3%
Good	0.0%	37.8%
Excellent	50.0%	31.1%
Total	100.0%	100.0%

Providing social work, counseling, education, or other types of non-medical services to inmates with HIV/AIDS

	No Experience	Experience
Poor	0.0%	8.9%
Fair	16.7%	24.4%
Average	33.3%	22.2%
Good	16.7%	28.9%
Excellent	33.3%	15.6%
Total	100.0%	100.0%

Providing HIV-related medications immediately when an inmate arrives at the jail, regardless of whether the inmate enters on a weekend or after business hours

	No Experience	Experience
Poor	0.0%	6.7%
Fair	0.0%	17.8%
Average	50.0%	17.8%
Good	16.7%	35.6%
Excellent	33.3%	22.2%
Total	100.0%	100.0%

Ensuring that inmates rarely or never miss doses of HIV-related medications while in jail

	No Experience	Experience
Poor	0.0%	0.0%
Fair	0.0%	2.2%
Average	33.3%	11.1%
Good	16.7%	46.7%
Excellent	50.0%	40.0%
Total	100.0%	100.0%

Ensuring that inmates' HIV care continues after they are discharged from the jail

	No Experience	Experience
Poor	0.0%	20.5%
Fair	16.7%	11.4%
Average	50.0%	50.0%
Good	16.7%	13.6%
Excellent	16.7%	4.5%
Total	100.0%	100.0%

Note. 1 jail did not respond to this question.

In your opinion, how well does your jail perform with the following aspects of HIV care? (If your jail has not housed inmates with HIV/AIDS, how well do you think they would perform with the following aspects of HIV care?)

	No Experience			Experience		
	M	*n*	*SD*	*M*	*n*	*SD*
Identifying inmates with HIV/AIDS when entering jail	3.83	6	0.75	4.02	44	0.93
Finding undiagnosed cases of HIV/AIDS among inmates	3.67	6	0.82	2.98	41	1.11
Keeping up to date with developments in the treatment of HIV/AIDS	3.00	6	1.26	3.42	45	1.06
Providing access to HIV specialists	3.83	6	1.33	3.91	45	1.28
Developing courses of treatment appropriate to an inmate's specific condition	4.00	6	1.10	3.80	45	1.12
Providing social work, counseling, education, or other types of non-medical services to inmates with HIV/AIDS	3.67	6	1.21	3.18	45	1.23
Providing HIV-related medications immediately when an inmate arrives at the jail, regardless of whether the inmate enters on a weekend or after business hours	3.83	6	0.98	3.49	45	1.22
Ensuring that inmates rarely or never miss doses of HIV-related medications while in jail	4.17	6	0.98	4.24	45	0.74
Ensuring that inmates' HIV care continues after they are discharged from the jail	3.33	6	1.03	2.70	44	1.09

GUIDE TO CONSORTIA REPORT PREPARATION

HIV Care in Full Service Jails Assessment

The Ohio Department of Health (ODH), HIV Care Services section, hired the Voinovich School to gather information on the way Full Service Jails (FSJs) in Ohio care for inmates with HIV/AIDS. (A FSJ is a jail that holds adults for more than 120 hours; this distinguishes these jails from more temporary holding facilities or minimum security facilities.) We surveyed 51 jails and interviewed 55 jails to gather information on all aspects of HIV care, from how jails initially indentify inmates who have HIV/AIDS to whether they assist the inmate with arranging HIV care as they leave the jail.

ODH has divided the state of Ohio into 11 Ryan White HIV Care Consortia. ODH has asked us to provide consortia-level reports of findings for our study in addition to a state-level report. In order to protect the confidentiality of some of our respondents, we will be combining some consortia into a single report. There will be a single report for Consortia 5 and 9A and a single report for Consortia Six, Seven, and Eight.

This guide explains the data sources available to you as you write the report for your assigned consortium/a, and provides an outline for the report.

DATA

You will work from two different data sources as you write the consortia reports: interview data and survey data. The materials you will use are:

INTERVIEW DATA

- Interview Database entries (photocopies provided to you; also available directly from the project folder)
- Interview recordings (available in the project folder, though note that not every interview was recorded). Check out the interview recordings if you have a question about something you see in the interview database entries.
- Quantitative interview data summaries (printouts provided to you; also available in your consortium's folder). These summaries provide a compilation of that interview data for your consortium that was deemed quantifiable. These have already been compiled so that we can be sure it was done in exactly the same way for all consortia. *Please double-check this data as you use it; by verifying the data you use you will be performing one of the data checks for the consortia reports.*

SURVEY DATA

- SPSS output for the jails in your consortium that completed surveys. You'll get a printout of this, and the formatted file is also available in the project folder. Look for the file named "Consortium X Survey Data" in your consortium's folder.

COMBINED DATA

- In the case of a small number of interview and survey questions it was possible to combine the answers to get an overall response for the consortium (so you won't have to present survey and interview findings separately). You are receiving a printout of this;

the file is called –Consortium X Combined Data" (also located in the –materials for coders" folder) for your consortium.

OTHER MATERIALS

- A copy of the Consortium Three report to use as a model.
- A copy of the Consortium Three report with editing comments to illustrate the process of triangulation.
- A draft cover sheet for your consortium. *Please data check the figures on this sheet.*
- A copy of the data collection instruments (survey and interview script).
- A copy of selected *state-level* survey results to provide some context for your consortium's survey findings.

PROCEDURE FOR WRITING CONSORTIA REPORTS

Phase One: The first analyzer will write the draft of the consortium report using the outline provided in this document and using the report for Consortium Three as a model. The person writing the initial draft has not done any of the interviews for the consortium and so should be bringing a fresh perspective to the data.

Phase Two: The second analyzer for the consortium is a person who has done some or all of the interviews for that area. Their job is to review the draft report to look for any errors and to make sure it meshes with their overall impressions of the consortium.

Phase Three: The two analysts for the consortium will get together to reconcile any differences and then will save the file to the project folder.

MISCELLANEOUS:

- Please use APA style when writing your report. In particular, please leave one space only after each sentence.

- Please refer to the survey as you read the survey data for your consortium. Since SPSS does not automatically list responses that were not selected (in the case of multiple response questions) it will not be obvious that, for example, no jail in your consortium provides genotyping for inmates (e.g., no jail selected option f for survey question 5 about HIV testing).

- We will be including representative quotes in the state report. As you go through the interview data please make a note of any quotes you see that might be useful for the state report. Good quotes would be ones that seem to encapsulate themes you see emerging in your region. If you are the analyst who has done interviews in the region, please indicate whether you think the respondent being quoted is a credible source. This will be tremendously helpful for the writing of the state report.

OUTLINE OF CONSORTIUM REPORT

I. OVERVIEW

This should be a brief (roughly 3-5 sentences will do) explanation of the data you're drawing from and the key findings from the region.

- Each consortia report will have a cover sheet with detailed information on the number of interviews and surveys, so you should need only one sentence or so to say "This information is compiled from xx interviews and xx surveys completed by jails in Consortium X."

Data Source: this information can be found in the "Consortium X Combined Data" file for your consortia.

- Examples of key findings would be: there are extensive connections between jails in the consortia and local HIV care providers; the biggest challenges jails in these consortia report are lack of funds for medication and HIV testing; many jails in this consortium report that there are no specialists in their area who will treat their inmates, etc.

Data Source: there is no one source for this information; this will be the result of your overall analysis.

II. JAILS' PERCEPTIONS OF HIV CARE

The purpose of putting this section at the beginning of the report is to provide readers a framework with which to process the data that will be coming at them in the later sections. This information will primarily be drawn from survey questions 4, 13, 14, and 15.

In this section please explain…

A. What do jails perceive as their biggest strengths when it comes to providing care for inmates with HIV/AIDS? **S4**

B. What do jails perceive as their liabilities/gaps when it comes to providing care for inmates with HIV/AIDS? **S13**

C. What do jails identify as the sources of these challenges? **S14**

D. What are jails' overall assessments of their capacity to provide HIV care to inmates? **S15**

Data sources for this section: survey questions listed above as well as interview questions: Q10, Q19, Q22d, Q27, Q28, Q29.
Quantitative information provided for survey and Q22d. See "Consortium X Quantitative Interview Data"

Note. Q# refers to an interview question number and S# refers to a survey question number.

II. IDENTIFYING INMATES WITH HIV/AIDS

This section will explain how jails identify inmates who have HIV/AIDS. There are three main ways for inmates with this disease to be identified:

Self identification: Inmates may disclose their HIV status to Corrections Officers or medical staff. Relevant questions for this topic are: What opportunities do jails give inmates to reveal that they have HIV/AIDS? Is this in a confidential setting? Can they request a visit to the medical staff so they don't have to tell a corrections officer?

HIV testing: Jails, Health Departments, or other local agencies may provide HIV testing for inmates. Relevant questions for this topic are: Do jails provide HIV testing for inmates? Under what conditions? Who pays for the test (the jail, the inmate, the local health department, a local AIDS task force, etc.)?

Health Screening: Jails conduct a health assessment of an inmate by their fourteenth day at the jail. This screening can provide the opportunity for an inmate to self-identify as HIV-positive or to request an HIV test; it can also provide the jail medical staff the opportunity to spot symptoms of HIV, identify inmates with risk factors associated with HIV, and/or to offer an HIV test to the inmate. Relevant information about the health screening might be: at what point in an inmate's stay does the jail conduct the health screening? When are medical staff available to perform the screening? Do they ask about HIV at the screening?

A larger question related to the identification of inmates with HIV/AIDS is whether jails view it as their role to uncover this condition in the first place. The literature on HIV care in the correctional setting views incarceration as a public health opportunity—since inmates are statistically more likely to be infected than the non-incarceration population (because of higher rates of IV drug use in particular) and since they are in a controlled environment, it seems a good opportunity to identify and start treating HIV. Many jails, on the other hand, are preoccupied with security issues and know that any inmate they see may not be in the jail very long. In the interview we asked jails where they fell on this spectrum: do jails see themselves as contributing to a public health effort – that is, do they want to uncover new cases of HIV/AIDS—or do they view themselves as there to provide adequate support for those who self-identify as having HIV/AIDS? If the data seem to show that jails in your consortium feel one way or the other, it would be worth reporting.

Data sources for this section:
Self-identification: Q7
HIV testing: Q9, S5, S12a
Health Screening: Q6
Uncover new conditions: Q8
Q10 might also be helpful.
Quantitative data provided for Q6b, Q8, Q9

III. HIV STATISTICS

We solicited this information with both the interview and the survey. In this section please provide an idea of how many inmates are known to have HIV/AIDS in this consortium's jails. It's important to phrase these numbers in terms of *known* cases of HIV/AIDS because the actual prevalence rate for HIV is of course higher than any number we have.

The numbers we received from the survey are in the form of ranges and the numbers from the interviews are typically discrete numbers. Please look at the data available for your consortium and determine the most straightforward way to report this data.

Data source for this section: S3, Q3
Quantitative data provided for Q3

IV. AVAILABILITY OF TRAINED OR KNOWLEDGEABLE MEDICAL CARE PERSONNEL

In this section we'd like to give an idea of who provides medical care to jail inmates with HIV/AIDS. Are jails sufficiently staffed to provide this care? Are medical services available around the clock or only on certain days, at certain times, etc.? It's also important to know if jails are able to provide HIV specialty care to inmates with HIV/AIDS. Are there specialists in their area? Can they transport inmates to these specialists (or, in a few cases, can they bring these specialists to their inmates)?

In this section please discuss…

A. Medical Staff

1. Who is providing medical care for inmates in jails (type of medical personnel)? **Q5a**
2. When are medical care personnel available (e.g., 24/7, business hours weekdays, etc.)? **Q5b**
3. What happens in jails when medical personnel are not available? What are the gaps in medical care at the jails? **Q6b, S6f, S4c**
4. Do jails provide *medical* personnel with continuing education/training opportunities related to HIV/AIDS? If so, what types? How often? **Q22, S4c, S13f, S15c**
5. What community resources/social agencies provide jails with *medical* care for inmates with HIV/AIDS? What services do they provide for inmates in jails? How are inmates referred to services from these agencies? **Q21**

Quantitative data provided for Q5, Q22.

B. Access to Specialists

1. Who designs and monitors HIV treatment for inmates? **Q16, S5f**
2. Do jails provide genotyping to indentify whether an inmate is resistant to certain lines of therapy? **S5**[1]

[1] *Note.* the question about genotype testing is in the survey (S5f), but if no jail in your consortium selected —we provide genotype testing" then it will not be listed on your survey data readout for the question.

3. Do jails have access to HIV specialists? **Q16, Q19**

4. Who provides specialty HIV/AIDS care to jails? Who designs the HIV/AIDS care plan? **Q19**

5. Where do inmates see the specialist (in jail, in community)? **Q19**

6. How do inmates access care after release (i.e., is there a plan in place for continuity of care?) **Q25**

7. Do jails access Ryan White funds to help with discharge care? Do jails know about Ryan White funds? **Q27**

See also: **S4d, S13e, S15d**
Quantitative data provided for Q16 (part), Q19 (part)

V. MEDICATIONS (WHILE IN JAIL, AT DISCHARGE/TRANSFER, AND CAUSES OF INTERRUPTIONS)

There are a variety of ways for jails to obtain medications. They may get them from inmates, if they or their family bring in the inmate's own supply (some jails do not allow this); the jails may purchase the medications themselves; the jails may rely on a local free clinic or AIDS task force to provide the medications; or the jails may resort to furloughing the inmate periodically so they remain eligible for benefits programs that allow the inmate to provide their own medications.

We asked jails how they obtain medications for their inmates as well as how long it typically takes to get them. Note that obtaining medications is a multi-step process that can include the following: contacting an inmate's physician or pharmacy to verify the information provided by the inmate; setting up an appointment with a specialist to get an initial prescription for inmates who are not currently on medications; verifying any medications that an inmate or their family bring in (this may have to wait until medical staff is available, if an inmate comes in when no med staff are on duty); and waiting for the local pharmacy to special-order the medications if it does not normally keep them in stock.

When discussing how jails get medications for their inmates it's important to note if jails said it can take more than 72 hours. If an inmate is taking antiretrovirals and has a 72 hour interruption in their medication they can become resistant to that line of therapy.

In this section, please discuss…

A. While In Jail

1. Jails that allow meds to be brought in the facility: **Q13, S7, S8**
    a. How does that _system' work? Is it formal or informal?
    b. What are the circumstances upon which an inmate is permitted to receive meds from the outside? **Q13a**
    c. How is medication verified? **Q13b**
    d. Are there any issues related to non-formulary medication? **Q13c, S6e**
2. For inmates not providing their own meds: **Q14**
    a. How are medications provided? Are there meds on-site? Where do they come from (local, mail order, etc.)? **Q14, Q14a**
    b. How long does it take to get meds? (Please note if jails qualified the times they gave—as in —24 hours *so long as the prescription has already been*

verified.") Are there any circumstances under which there could be a longer than 72-hour lapse with meds? **Q14b**

c. Are there any limitations on types of HIV meds dispensed? **Q14c, S6e**

d. How does cost impact med choice? How does cost of meds impact jail time served? **Q14d, S13c**

Quantitative data provided for Q13 (part), Q14 (part)

B. At Discharge/Transfer

1. What is the common practice for providing medications upon release from jail? **Q24, S9, S10**

   a. Who pays for discharge medication?

   b. How much medication does the inmate receive? **24a**

   c. Do inmates regularly refuse discharge medication? **24b**

2. Do jails provide medications when inmates are transferred to another facility? [*Note.* jails often have different policies re: transfer to another jail v. transfer to a prison] **Q23a**

   a. How much of a supply (if any)? **Q23b**

   b. Are medical records passed on to the receiving facility? How? **Q23c**

Quantitative data provided for Q23a,b; Q24

For reasons mentioned earlier, it is especially important to note any conditions under which an inmate might go for over 72 hours without their HIV medication. Aside from that, we'd like to give the reasons inmates may miss doses of HIV medications and the stages of incarceration (intake, release, etc.) at which missed doses are most likely. It might be helpful to describe the way medications are administered as well. Are medications brought to the cell blocks or do inmates come to the medical offices? How often are medications distributed? Are inmates directly observed taking their medications? Are they ever able to keep a supply of medications in their cell (keep on person)?

In this section please discuss…

C. Medication Administration

1. Are medications brought to the cell blocks/pods or do inmates come to the medical offices or another designated space? **Q17**

2. How often are medications distributed? **Q17**

3. Are inmates ever able to keep a supply of medications in their cell (~~"k~~keep on person")? **Q17**

4. Are inmates directly observed taking their medications? **Q17**

5. Do medical staff or corrections officers pass medications? (This question was not asked explicitly but respondents often volunteered this information) **Q17**

D. Causes of Medication Interruptions

1. What are the primary non-offender related reasons for medication interruption in jails? [*Note.* there are ~~"o~~ffender-initiated" causes (as in an inmate refusing to take their medication) or ~~"n~~on-offender initiated" causes (as in a jail failing to obtain medications in a timely manner) of missed doses.] **Q17, Q18, S6**

2. What are the primary offender-related reasons for medication interruption in jails? **Q18, S6**

3. What are the key reasons (offender or non-offender related) for 72-hour interruptions in medication? **Q18, S6**

4. Is medication interruption at intake an issue for jails? Why/why not? **Q13, Q14, S4g, S6a, S13i**

5. Is medication interruption at transfer an issue for jails? Why/why not? **Q23; S6b,c**

6. Is medication interruption at discharge an issue for jails? Why/why not? **Q24, S9**

See also: **S4h, S13j**
Quantitative analysis prepared for Q13 (part), Q14 (part), Q17, Q18, Q23

VI. OTHER ASPECTS OF HIV CARE/HIV POLICIES

A. What non-medical services do the *jails* provide for inmates with HIV/AIDS (counseling, case management, etc.)? [*Note.* please try to distinguish between the non-medical services provided by the *jail* and the non-medical services the jail hires community organizations to provide. Community-provided services are covered in another section of the report.] **Q20, S4f, S13h**

B. Do jails transfer out an inmate once it is determined that the inmate has HIV/AIDS? Do they accept transfers from other facilities if they know the inmate has HIV/AIDS? **Q15**

C. Which jail personnel are told of an inmate's HIV status? Are non-medical staff told? Under what conditions? **Q11**

D. Do jails house inmates known to have HIV/AIDS with the general population? Do they automatically segregate? Can inmates request segregation (~~"a~~lternative lifestyle pod," medical segregation, etc.)? **Q12**

E Do jails provide *non*-medical personnel with continuing education/training opportunities related to HIV/AIDS? If so, what types? How often? Is the jail interested in training of this nature? **Q22**

Quantitative data provided for Q12, Q20, Q22.

VII. COMMUNITY LINKAGE

In this section we'd like to explain how well jails are linked into their communities. Do they know about the HIV care resources available to them? Are they interested in finding out about them? Are there any resources available to start with?

In this section please discuss…

A. Are jails knowledgeable about the community/local resources available in their area? **Q21, S11**

B. Are jails willing to access community/local resources? **Q21, S11**

C. Are jails able to access community/local resources? How do these services complement or fill gaps in the services that jails are already providing? **Q21**, **S11**

D. What community/local resources are jails currently using? **Q21, S11**

E. Which aspects of HIV care are provided by local organizations? **S12**

1. testing **Q9**
2. medications **Q14**
3. specialist care **Q16, Q19**
4. other?

F. (How) are inmates linked in to medical and non-medical resources as they leave the jail? **Q25, Q26**

Quantitative data provided for Q9, Q16 (part), Q27.

VIII. CONCLUSION

Please write a short conclusion for your report. We don‘t have a set format or suggestions about what to include. Please make these determinations based on the report you‘ve written.