FINAL EVALUATION REPORT
OF THE
AMERICAN MEDICAL ASSOCIATION'S
PROGRAM TO IMPROVE HEALTH CARE IN JAILS
(YEAR TWO)

June 6, 1978

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Silver Spring, Maryland

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I. INTRODUCTION

A. Description of the National Program[1]

1. Background and History[2]

In June of 1975, the American Medical Association (AMA) received a grant from the Law Enforcement Assistance Administration (LEAA) to initiate a program to improve health care in the Nation's jails. The program was designed to achieve this goal through the accomplishment of three major activities, namely: developing model health care delivery systems in a number of pilot jail sites, devising standards for jail health care which would serve as the basis for implementing a national accreditation program, and establishing a clearinghouse on jail health to provide information and assistance to correctional and medical professionals as well as the public at large.

During the first year, primary emphasis was placed on developing model systems of health care delivery. The AMA's original proposal[3] called for the selection of six state medical societies to serve as subgrantees. The successful applicants consisted of the following:

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[1] Throughout this report, the term "program" is used to refer to national level activities and staff, while the term "project" is used to refer to those at the state level.

[2] For a more detailed description of the program's prior history and accomplishments, see B. Jaye Anno, Final Evaluation Report of the American Medical Association's Program to Improve Health Care in Jails (Year One), Washington, D.C.: Blackstone Associates (February 18, 1977).

[3] American Medical Association, Proposal for a Pilot Program to Improve Medical Care and Health Services in Correctional Institutions, Chicago, Illinois: December 1974 (unpublished).

Indiana State Medical Association (ISMA)

Medical Association of Georgia (MAG)

Medical and Chirurgical Faculty of the State of Maryland (MED/CHI)

Michigan State Medical Society (MSMS)

State Medical Society of Wisconsin (SMSW)

Washington State Medical Association (WSMA)

Each of these medical societies then selected from three to seven jails in their areas to serve as pilot sites, which resulted in a total of thirty jails across all six states.[4/]

The states' major first-year tasks were essentially planning activities. First, they documented the status of existing health care delivery systems in their pilot sites and identified deficiencies. Next, they determined what the most pressing health care needs of inmates in these facilities were by examining and interviewing a sample of residents. Based on what they had learned, the medical societies then designed individual action plans for each jail which would upgrade the care and services previously offered. The balance of the first year at the state level was devoted to beginning the necessary activities to implement those individual plans.

At the national level, first year activities were focused on providing technical assistance to the six state projects

[4]For more information regarding characteristics of the jails selected as pilot sites, see B. Jaye Anno, Analysis of Jail Pre-Profile Data, Washington, D.C.: Blackstone Associates, June 1977; and B. Jaye Anno and Allen H. Lang, Analysis of Pilot Jail Post-Profile Data, Silver Spring, Maryland: B. Jaye Anno Associates, April 1978.

and on developing standards for health care in jails. With respect to the latter task, the AMA selected a panel of correctional and medical experts to assist its program staff in formulating the standards and designing an accreditation program. After several drafts, a set of standards on jail medical care and health services was established. These standards were subsequently field tested in the thirty pilot sites, but as anticipated, were not finalized during the first year.

In addition to the above accomplishments, the AMA jail program also set up a clearinghouse to gather and disseminate information relevant to various aspects of jail health, and published a series of monographs.

The first year of program operation terminated on February 28, 1977. The evaluator's final report,[5] which was submitted that same month, indicated that the AMA Jail Program had successfully achieved its first year goals.

2. Year Two Program

a. Second year goals

The second year of program operation began on March 1, 1977 and terminated on March 6, 1978. The total amount of federal funding for Year Two was $454,235. In terms of content, the second year program was essentially a continuation of the first year's activities. As stated in its refunding proposal, the

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[5] See Anno, Final Evaluation Report ... (Year One), supra at note 2.

program's Year Two goals were as follows:[6]

Goal I - Continue the development of models for health care delivery and the upgrading of jail health care systems through implementation of the first year action plans in existing pilot sites and expanding to other sites as indicated.

Goal II - Continue the testing and revising of the standards on jail health care and initiate the accreditation program.

Goal III - Stimulate interest in jail health among correctional workers, health care professionals and others:

A. Through the development, publication and dissemination of materials such as

1. A prescriptive package on how to improve medical care and health services in jails;

2. A series of monographs on various aspects of jail health care including medicolegal issues; and

3. A documentary film on jail health designed primarily to inform and involve representatives of organized medicine at the state and local levels;

B. Through the wide distribution of materials developed in Year One; and

C. Through other efforts to publicize the AMA program.

Goal IV - Hold a National Conference on jail health in the late fall of 1977 for the purpose of bringing together a wide variety of professionals, increasing their knowledge and understanding of the problems and issues in jail health care, and providing them with more "technical know-how" to improve their own systems.

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[6] Abstracted from the following document: American Medical Association, Second Year Proposal for the AMA Program to Improve Medical Care and Health Services in Jails, Chicago, Illinois: September 29, 1976 (unpublished), pp. 2-6.

b. Organization and staffing[7]

At the national level, staff positions and the personnel filling them remained essentially unchanged. The Jail Program Director (JPD), the Associate Director who serves as the "Health Care Systems Specialist" (HCSS), and the Clearinghouse Director (CD)[8] are all carry-overs from the first year of program operations. Other full-time staff include an Administrative Secretary and a Clerk Typist.

In addition, central staff is assisted by a paid half-time consultant and by a voluntary National Advisory Committee (NAC). The former serves as an executive liaison with the state medical societies and as editor of the bimonthly newsletter, The Correctional Stethoscope, in addition to performing administrative duties. The primary task of the NAC is to review, revise and approve the standards and the accreditation program procedures as needed, and to make the final determination regarding the accreditation status of jails which apply. As last year, the NAC is composed of six health care professionals and four representatives of criminal justice groups.

Finally, AMA leadership staff[9] continued to stay informed on program activities and involved in policy decisions. Like

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[7]For more detailed information regarding staff positions and characteristics of the National Advisory Committee members, see Anno, Final Evaluation Report ... (Year One), supra at note 2, pp. 8-10.

[8]In this report, these three positions are often referred to collectively as "AMA central staff."

[9]This term refers primarily to the Director of the Division of Medical Practice and to the Group Vice President of External Affairs.

the NAC members, their time is donated.

B. Description of the State Projects

1. Background and History

While all six of the state medical societies except Georgia had had some prior informal involvement in jail health, formal activities did not occur until their participation in the AMA's program. The state projects became operational in January of 1976. At the termination of the first year's activities in February of 1977, all six subgrantees were judged to have performed at least satisfactorily, and in one or two cases, exceptionally.

The second year, the state projects shared the same funding period as the national program, namely, March 1, 1977 through March 5, 1978. Each medical society received up to $25,000 to conduct its activities. An additional $7,500 was available to each subgrantee to fund special demonstration projects in selected pilot sites.

2. Second Year Tasks and Goals

a. National performance requirements

The state projects shared the overall aim of the national program of improving health care in jails. Their relationship with the national program went deeper than that, however, since they were also, in effect, one of its major components. The jails in the pilot states served as the experimental sites where program efforts such as new health care delivery models, the standards and the accreditation program were ultimately tested.

Consequently, the state projects were expected to perform a number of tasks to satisfy requirements of the national program. Specifically, the state contracts called for the following objectives to be met during the second year:

1) The implementation of first-year action plans in the thirty pilot sites;

2) The development of short-term demonstration projects in pilot sites to improve direct patient care;

3) The collection of data concerned with documenting changes which occurred in the pilot jails' characteristics, health care delivery systems, and the needs and health status of inmates;

4) The retesting and finalization of the jail health care standards;

5) The testing and implementation of the accreditation program in pilot jails;

6) The expansion to additional sites if warranted;

7) The continuation of efforts to inform and involve medical/correctional professionals and the public in their areas; and

8) The submission of monthly progress reports.

b. Unique goals

In addition to the national performance requirements, each state medical association project had goals of its own. A brief synopsis of the individual project's objectives as abstracted from their second year proposals is presented below.

Georgia was interested in:

1) Developing a protocol to assist its jails in writing policies and procedures for their health care systems, including a practical guide for sheriffs regarding procedures for administering drugs, handling medical records, etc.;

2) Developing, implementing and evaluating training modules in receiving screening and other topics for various types of jail personnel;

3) Conducting a workshop for Georgia physicians who treat jail inmates.

Indiana outlined specific goals for its seven pilot jails. Essentially, Indiana's aim was to implement all of the AMA standards in each of its sites. In addition, subsequent correspondence revealed Indiana's interest in: 1) the special needs of the mentally ill in jails; 2) developing a handbook on exercise facilities and programs; and 3) forming an association of jail physicians.

Maryland's proposal and other correspondence indicated emphasis would be placed on:

1) Developing protocols for handling medication;

2) Developing/updating protocols for standing orders;

3) Developing protocols for receiving screening;

4) Informing all county medical society executives of the jail project;

5) Meeting with local medical societies in pilot counties and elsewhere to review jail health care delivery systems;

6) Developing written "Models" describing total health care delivery systems or component parts of these systems to be used as guides for other jails;

7) Working for health care reform through legislative action;

8) Developing a training program for jailers on distributing medications; and

9) Establishing standards on minimum requirements for space and equipment at jail medical facilities.

Michigan's state level initiatives included:

1) Striving to get the AMA standards adopted by the Michigan Department of Corrections (DOC);

2) Encouraging the AMA National Advisory Committee to adopt the Manual for Health Care in Jails[10] as an implementation tool for the national standards, and revising it as necessary;

3) Sponsoring special training courses for jail corrections personnel on various health care topics and procedures; and

4) Promoting the establishment of a state organization for jail nurses.

Washington's proposal indicated its activities would be focused on:

1) Testing and revising the medical record set and the Jail Health Care Reference Manual developed last year;

2) Developing a Jail Health Guidebook to assist jailers in improving their current systems (to include such things as sample budgets, contracts and forms, as well as addressing legal issues as they apply in the state of Washington);

3) Developing a Mental Health Handbook;

4) Lobbying for the enactment of a Jail Standards bill which was before the Legislature for the fourth time;

5) Holding a Jail Health Workshop for members of the health care teams in its four pilot counties; and

[10]This document was developed by the Michigan project the first year.

6) Conducting training sessions for jailers to upgrade their current health care skills.

The special emphasis of Wisconsin's project was to be on:

1) Identifying and meeting the special health and medical needs of women inmates; and

2) Continuing to provide support and consultation to the University of Wisconsin Extension in the development of its new jailer training curriculum.

3. Organization and Staffing

At the state level, staffing patterns remained essentially unchanged from Year One, although some of the personnel filling particular positions were new.[11] Each of the states had a Pilot Project Director (PPD) who assumed responsibility for the overall administration and coordination of the project activities. PPDs in Indiana, Maryland and Washington devoted 100% of their time to their projects, while those in the other three states averaged between 40% to 60%.

In addition, four of the states had part-time Research Assistants (RAs). Those in Georgia and Wisconsin were employed by their medical societies and spent an average of about 65% of their time on jail health activities. RAs in Michigan and Washington were somewhat unique. In the former case, the Michigan Department of Corrections, Office of Jail Services, donated the time of one of its staff members on an "as needed" basis. In the latter case, Washington continued to use medical student

[11] Specifically, new personnel included the Project Directors in Georgia and Indiana, Georgia's Research Assistant and the students used in the Washington project.

volunteers from the University of Washington to collect data, write reports, etc. During the Spring 1977 semester, there were nine medical students involved in various aspects of the Washington Jail Health Project.

Further, a couple of the states used paid consultants on a temporary basis to produce certain products. For example, Georgia paid a team of consultants to develop a receiving screening training package and Washington paid a law student to research and write legal guidelines on jail health care issues as they apply within that state. During the Summer months, Washington also had the services of another student who assisted in developing a handbook on mental health. In this instance, though, the student was paid through a stipend from the University.

Each of the states also had a Project Advisory Committee (PAC). Those in Georgia and Washington were composed almost entirely of physicians, while the PACs in the other four states included representatives of other health professions as well as correctional officials and representatives of other agencies. The time and services of PAC members were donated in all of the states except Michigan. Here, the physician representatives were paid for their participation in project activities, although other PAC personnel were not.[12/]

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[12] See Appendix B for additional information regarding characteristics of the state PACs.

Finally, in addition to the above personnel, all of the projects made provisions for clerical work and administrative, fiscal and legal support. However, the difference between and the significance of these staffing patterns were not sufficient to warrant further discussion.

II. EVALUATION ACTIVITIES, METHODOLOGIES AND TIME PERIOD

A. Tasks and Time Period

The primary tasks of the evaluator were two-fold: first, to provide supervision and consultation services to the state staffs regarding their data collection activities and, second, to assess at two points during the year the progress and process of both the national and state staffs in meeting their goals.

In regard to the former responsibility, the major research efforts consisted of the re-application of the Jail Profile and the Inmate/Patient Profile to document the type and extent of changes that had taken place in the pilot jails' health care delivery systems. These two profiles represented the major impact assessment pieces of the evaluation. The results of both the Jail Post-Profile (JP-P) and the Inmate/Patient Profile (I/PP) have been analyzed and are available in separate reports.[13] Summaries of the highlights of these two reports are included in this report in the section dealing with the overall impact of the AMA's program.

In regard to the latter activity, this account represents the second of the two required assessments. As a final report, it is devoted to an examination of the progress made in achieving

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[13] See B. Jaye Anno and Allen H. Lang, Analysis of Pilot Jail Post-Profile Data, Silver Spring, Maryland: B. Jaye Anno Associates, April 1978 and B. Jaye Anno, Analysis of Inmate/Patient Profile Data - Year Two, Silver Spring, Maryland: B. Jaye Anno Associates, May 1978.

program goals during the entire second year. Since the preliminary evaluation report[14/] covered the seven-month period from March 1, 1977 through September 30, 1977, however, the emphasis in this report is on the six month period from October 1, 1977 through the end of March 1978. While, technically, the AMA's second year program ended the first week in March, third year funding was not awarded until the first of April. Hence, second year activities which finished up during the remaining weeks in March are reported on here, whereas third year activities which began in March 1978 will be reported on in the third year preliminary evaluation report.

B. Methodology and Data Sources

The criteria used to judge the efficiency and effectiveness of program activities at both the national and state levels are presented in the next chapter as the status of each is discussed. This section seeks only to describe the methodology and the data sources employed by the evaluator for this report.

For the most part, the methodological techniques used for the process evaluation consisted of reviewing existing reports and records; making on-site visits to the six states and the AMA headquarters to observe meetings and program activities and to interview key staff; and administering questionnaires. Specifically, data sources consisted of the following:

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[14] See B. Jaye Anno, Preliminary Evaluation Report of the American Medical Association's Program to Improve Health Care in Jails (Year Two), Silver Spring, Maryland: B. Jaye Anno Associates, October 18, 1977.

- Information regarding the program's background and history, its first year accomplishments and second year goals was obtained from existing documents such as the program's first and second year proposals and prior evaluation reports.

- Information regarding the operation and management of the central program and its activities was obtained from the AMA's second year proposal; its quarterly progress reports to LEAA; regular correspondence with program staff; copies of all program materials; participant observation at all key meetings of the central staff with its NAC and/or PPDs; on-going liaison and monitoring of program activities through telephone contacts and on-site visits; and finally, from personal interviews conducted with all key program staff members during the latter part of August 1977 and again in February 1978.

- Data specific to the state projects was obtained from their individual second year proposals and progress reports, in addition to the sources noted in the preceding paragraph. Evaluation staff also visited each of the states for a full day during the last two weeks in August and again in February 1978. Structured interviews of four or five hours' duration were conducted with each of the six state Project Directors (and their Research Assistants where applicable) regarding their activities to date. The state staffs also provided feedback on the adequacy of the central staffs' performance. In addition, brief interviews were held with the Executive Secretaries of the six medical societies and with most of the physician chairmen of the state PACs.

- All statistics regarding the disbursement of clearinghouse materials were provided by central staff at the evaluator's request. Additional information regarding procedures was obtained by interviewing the Clearinghouse Director and the Clerk Typist who assisted her, and by reviewing the methods they use to gather, store and disseminate information on jail health. Further, questionnaires were distributed to 200 individuals who were regular recipients of clearinghouse materials to determine whether or not the materials developed and distributed by the AMA Jail Program were of any value to them.

- Feedback on the value of the first national conference on jail health -- which was held in Milwaukee in August 1977 -- was obtained from questionnaires administered to participants and from on-site observation of the proceedings.

The methodological techniques utilized for the impact assessment pieces (i.e., the JP-P and the I/PP) have been fully detailed in the separate reports of the findings of each and need not be reiterated here.[15]

[15] See pp. 3-13 in Analysis of Pilot Jail Post-Profile Data and pp. 5-30 in Analysis of Inmate/Patient Profile Data -- Year Two, both supra at note 13.

III. EXAMINATION OF SECOND YEAR PROGRAM RESULTS

In this chapter, the progress made by the AMA toward achieving its Year Two goals is examined. Strengths and weaknesses of the national program and the state projects are identified and, where applicable, recommendations for changes and/or improvements are made.

There are four major subdivisions in this part of the report, corresponding to the AMA's four second year goals.[16/] Section A is devoted to an examination of the pilot projects and their success in developing models and upgrading jail health care services. Section B reviews the current status of the AMA standards and the accreditation program. The activities of the clearinghouse are discussed in Section C, while Section D is concerned with the success of the "National Jail Conference."

A. The Pilot Projects

In the first sub-section below, activities of the projects are described and the extent of their individual progress in meeting both national performance requirements and unique project goals are noted. The second sub-section seeks to pull all of this information together and to rate the states on their individual and collective achievements. Finally, in the last sub-section, the central staff's role in relationship to the pilot projects is discussed. Here also, feedback is presented

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[16] See page 4 of this report.

from the state staffs regarding the adequacy of the assistance received from central staff members.

1. Activities at the State Level

a. National performance requirements

1) implementation of action plans

This section is devoted to an examination of the extent of implementation of the individual action plans developed for the original thirty pilot sites. Information regarding the accomplishment of specific objectives for each jail was obtained from the PPDs at the time of the evaluation team's on-site visits in February 1978.[17] The states and the jails within each state are discussed in alphabetical order.

GEORGIA

Atlanta City Jail - Local political pressures prevented any significant changes from occurring at this site. City and county officials have been arguing for five years regarding which level of government has the responsibility to provide health care to inmates and neither wants to assume it. At a meeting in June 1977 of LEAA, AMA and MAG representatives, it was decided to drop this jail as a pilot site if improvements could not be expected within the next few months. The PPD subsequently received renewed assurances of the interest and cooperation of jail officials and some activities began to get underway. For example, MAG staff and jail staff assisted Grady Memorial Hospital personnel in developing a proposal to the Robert Wood Johnson Foundation to establish

[17] A listing of specific objectives for each site was obtained from a letter written to the evaluator by the Health Care Systems Specialist, dated May 19, 1977. The objectives and their projected dates of implementation were abstracted by the HCSS from the individual action plans.

a satellite clinic at the jail. This proposal was subsequently turned down, though, and interest in improving health care at the jail again declined. MAG assisted in providing first aid training to correctional officers, but it was not used. While the Atlanta City Jail applied for accreditation, the survey completed in December of 1977 revealed that it only met fourteen of the sixty applicable Essential standards and four of the twenty-one applicable Important standards.[18] In view of the lack of progress at this site, the evaluator recommends that it be discontinued in the third year.

DeKalb County Jail - All five objectives for this site were accomplished, including: writing triage and treatment protocols, writing sick call procedures, obtaining gynecological resources, tightening access to emergency calls and training jail staff in receiving screening procedures. In addition, this site received full accreditation[19] of its health services from the AMA in August of 1977.

Monroe County Jail - Here, a health procedures manual was developed and a contract was established with a local physician who agreed to assume responsibility for the jail's health services. Both the manual and the contract were approved by jail and county officials. Further, receiving screening was instituted and the overall health care delivery system improved to the extent that the jail and MAG felt it was ready to apply for accreditation. It was site-surveyed in February and the final decision regarding whether it will be accredited will be made at the June 1978 NAC meeting in St. Louis.

Troup County Jail - In view of the fact that few, if any, changes were occurring in the health care delivery system, MAG requested permission to drop this jail as a pilot site in November 1977. This action was officially approved by the AMA in December. Apparently, the major obstacle to improvement was the attitude of the local physician who had been serving the jail for twenty years. When the new PPD visited him in July, he said he was adamantly opposed to the AMA standards, which he considered impractical and unattainable, and was not interested in changing anything to

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[18] See Chart 1, Appendix C, of this report for a summary of the number of standards met by each of the pilot sites.

[19] The AMA awards "full accreditation" if a jail meets a minimum of 90% of the Essential and 80% of the Important standards applicable to that facility. Excess Essential standards met above the 90% needed may be applied to the total number of Important standards to meet the 80% requirement, but not vice versa.

seek accreditation. The PPD stated that Troup should probably have been dropped at that time, but the sheriff was still interested and she was still hopeful that some changes could occur. However, no cooperation was received from the physician in later months. He refused to participate in the I/PPs, and while the sheriff sent two of his jailers to a training workshop sponsored by MAG, receiving screening was not implemented. The written procedures developed by MAG staff to govern the delivery of health care at this jail were not approved by the physician. Hence, in spite of the sheriff's interest and good efforts by MAG staff, the physician's resistance could not be overcome.

Upson County Jail - The health procedures manual was developed and approved and a number of the correctional staff participated in first aid and receiving screening training workshops. Sufficient improvements occurred at this site for it to become provisionally accredited[20] by the AMA in February 1978.

INDIANA

Brown and Morgan County Jails - No significant progress has been made in either of these two jails in the two years they have been involved in the ISMA project. Since neither jail was officially surveyed for accreditation, an exact accounting of the number of standards met by each was not available. In February of 1978, the PPD was asked by the evaluation staff to estimate which of the AMA standards he felt these two jails were complying with at that point in time. In both instances, he estimated that these two jails were only complying with twelve Essential and three Important standards.[21]

In Brown County, the major obstacle to improving the system appeared to be the lack of cooperation from the sheriff. The physician serving the jail was prepared to implement the AMA standards if the necessary funding to initiate changes was found. The sheriff repeatedly told the PPD he would request the additional monies from the county council, but this was never done. He said he was satisfied with the present medical system. In view of the lack of progress, the evaluator recommends this site be discontinued in Year Three.

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[20] Provisional accreditation is awarded by the AMA if a jail has met a minimum of 75% of the Essential and 65% of the Important standards applicable to it. Excess Essential standards can be applied to the Important total, but not vice versa.

[21] See Chart I, Appendix C.

As for Morgan County, much the same circumstances prevented any real improvements from occurring. Here again, the jail physician showed some interest but the sheriff did not. While the PPD still feels there is a chance to effect changes at this site, the evaluator recommends that the jail be dropped for the Third Year. After two years, the improvements which occurred were insignificant and do not warrant any further efforts being expended.

Greene County Jail - Virtually all of the improvements planned for this facility occurred including: the initiation of receiving screening, communicable disease screening and routine physical exams; the training of jailers in medication administration and other health care skills; the development of a procedures manual; improvements in the medical records system; segregation of females and juveniles; and involving the community in jail programs. The other two objectives regarding alternative funding and technical assistance were dropped since efforts in these areas were no longer needed. This site also received full accreditation from the AMA in August of 1977.

Lake County Jail - This jail received a significant amount of technical assistance from the ISMA project. However, legal and political problems prevented most needed changes from taking place. The facility is presently embroiled in a legal action charging the jail with providing inadequate medical care. In addition to (or perhaps because of) this suit, the medical staff (particularly, the physician) has been reluctant to implement recommendations from ISMA. The physician wanted an additional $25,000 per year allocated to the health care system and refused to take on further responsibilities unless this demand was met. The attorney for the plaintiff was prepared to drop the legal action charging the jail with medical neglect if the county agreed to implement the standards. According to the PPD, the sheriff, the jail warden and the jail's Emergency Medical Technicians (EMTs) were prepared to implement the AMA standards, but could not do so without the cooperation of the jail physician.

Since the major roadblock to improvments at this site appeared to be financial, two presentations were made to the county commissioners in November 1977 requesting the additional funds. The commissioners promised to advise all interested parties of their decision, but by the end of December, no action had been taken. Consequently, ISMA decided to drop Lake County as an official pilot site. Nevertheless, the PPD continued his liaison with the jail, the local medical society and the commissioners on an informal basis during January 1978, and even explored the possibility of alternative funding for the jail's health

care system from the Northern Indiana Health Service Area should the county council not provide it. The council was to meet again in February 1978 to decide whether to appropriate the additional monies, but still no decision has been rendered. If and when the funding is approved, ISMA would consider reinstating Lake County as an official site.

Marion County Jail - As with Greene County, virtually all of the planned changes for this facility did take place. Written procedures were established for administering medications, the health care "standard operating procedures" (SOP) were revised along with the jail's rules on inmates' access to care, and others of the AMA standards were incorporated into written policies. Further, the medical record system was improved, special diets are now provided and technical assistance was given to the jail regarding implementing specific orders of the court regarding health care.[22] The only long-term goal not yet met was to provide the jail with appropriate exercise facilities. However, sufficient changes had occurred at this site to enable it to recieve full accreditation of its health services from the AMA in August of 1977.

Monroe County Jail - A number of significant changes took place at this site during the second year including the acquisition of needed medical equipment which was donated by a physician, improvements in the physical condition of the examination room and hiring a physician. In fact, sufficient advancement occurred for this jail to attain full accreditation status in February 1978.

Owen County Jail - Few changes occurred at this site until the latter months of the second year. Then, the jail began implementing the AMA standards at a rapid pace. By February of 1978, the PPD estimated that Owen County was close to complying with a sufficient number of standards to be accredited.[23] The jail applied to be surveyed for Round III of the AMA's Accreditation Process and the decision regarding whether it will be accredited will be made at the NAC meeting in St. Louis the latter part of June.

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[22]This jail has been under Federal court order to improve its health care system since before the inception of the AMA Program.

[23]See Chart I, Appendix C.

MARYLAND

Anne Arundel County Jail - Most of the individual objectives set for this jail were met. The SOPs were revised, procedural protocols were developed for detoxification and therapy continuity, and receiving screening was implemented along with other activities designed to meet the AMA standards. In fact, progress at this site was sufficient for it to attain full accreditation of its health care services from the AMA in August of 1977.

Baltimore City Jail - A number of significant changes also occurred at this facility. For example, the jail's health care responsibilities are now under the direction of one medical authority, most of the AMA standards were incorporated into the jail's written policies, the medical record system format was revamped, and sick call is now conducted in a "hands-on" fashion.[24] While the health care system was not considered ready to be fully accredited, since many of the improvements had not been in place for a sufficient length of time, the jail did attain provisional accreditation status in February of 1978.

Baltimore County Jail - Here, too, important changes occurred in the health care delivery system, including the revision of the SOPs and the health assessment and medication administration procedures, and the involvement of local agencies (e.g., the county health department) in the delivery of care. This facility also received full accreditation from the AMA at the time of the National Jail Conference in August of 1977.

Montgomery County Jail - This site already had elements of a good working system in place prior to the AMA program. Nevertheless, revisions of some of its policies and procedures, its medical record system and its contracts with providers were required to bring it into compliance with the AMA standards. The additional documentation was provided and the jail received full accreditation of its health care system from the AMA in August of 1977.

Prince Georges County Jail - This health care system was also fully accredited by the AMA in August 1977. Moving into a new facility alleviated some of the prior deficiencies in space, equipment and the availability of services. Other deficiencies were corrected by developing written policies and procedures to cover a variety of health care issues and problems. Further, the project's desire to involve the local

[24] Prior to this project, sick call was often conducted from behind a locked door and medical staff visually inspected inmates through a barred window.

mental health department was realized and efforts to arrange for the certification of Physician Assistants (PAs) continue.[25]

Queen Anne's County Jail - Unlike the other pilot sites in Maryland, very little was accomplished here toward upgrading health care. It was not that the PPD did not make sufficient efforts, but rather, that the jail physician and, especially, the sheriff were apathetic. The sheriff is planning to retire in 1978 and was not interested in initiating any changes in the health care system if it meant additional work for him or his staff. The PPD developed an extensive set of written procedures, guidelines and record forms which were enthusiastically received by the sheriff's staff but which he refused to implement. In view of the sheriff's attitude of indifference to change, it was decided to drop this jail as a pilot site in November 1977. However, the PPD remains hopeful that improvements can be initiated here when the present sheriff retires.

Washington County Jail - A few improvements occurred at this site during the second year, including the acquisition of needed equipment which was donated by the medical community, the appointment of a responsible physician and formalizing the health care system by developing written policies, procedures and protocols. However, the new policies and procedures have not yet been implemented since a nurse is needed before the system can become active. While the sheriff remains interested in accreditation, the county commissioners have repeatedly refused to provide the additional funding for a part-time nurse. There is apparently some personal and/or political animosity toward the sheriff on the part of the county commissioners which may partially account for their denial of money. They also refused monies offered by MED-CHI to fund the nurse's position on a demonstration basis, since MED-CHI wanted a commitment from the county to continue the position after the experimental phase was completed. The PPD enlisted the assistance of the executive committee of the local medical society to pressure the county board to appropriate the necessary funds. If these monies are forthcoming, the PPD believes the new health care delivery system could be activated rather quickly. Hence, this site is likely to be retained in the third year, unless it becomes apparent that the needed funds cannot be obtained from the county or elsewhere. The possibility of an alternative funding source should be explored, however.

[25] The first PA was certified last Fall.

MICHIGAN

Individual objectives for the pilot sites in Michigan were the same for all four jails. Specifically, their action plans called for:

a) Appointing responsible physicians;
b) Writing up protocols, SOPs, etc.;
c) Training jailers for medical emergencies;
d) Providing adequate and accessible first aid supplies;
e) Creating and/or equipping examination and treatment rooms;
f) Revamping the medical records systems;
g) Initiating receiving screening;
h) Initiating communicable disease screening and other medical studies on long-stay inmates;
i) Routinely notifying judges of inmates' medical/psychiatric problems; and
j) Routinely forwarding inmates' medical records upon their transfer/release.

In Lake County, all objectives were met with the exception of full implementation of "e)." An examination table is still needed for one thing. Still, this deficiency was not serious enough to prevent the jail from being fully accredited in August 1977.

At the Oakland County Jail, all initiatives were attained with the exception of full implementation of "h)." This jail is still experiencing problems in fully complying with the standard requiring physical examinations on all inmates who are there more than fourteen days. While full physicials are given, the jail is not always able to complete them on all inmates within the specified time period. This is primarily due to the fact that the jail lacked sufficient medical staff. However, additional health care staff positions were requested by the jail and were approved by the county council in 1977, and the extent of medical coverage was sustained in 1978. Hopefully, the current staff will be sufficient to enable this jail to meet the requirements of the AMA standards by the time it comes up for re-accreditation[26] in the third year.

As for the Shiawassee County Jail, all ten aims were achieved and it was fully accredited in August 1977. At the time of the evaluation staff's last visit in February, the PPD indicated that this system continued to function smoothly.

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[26] This jail, too, was fully accredited in August 1977.

At the Washtenaw County Jail, all but objectives "g)" and "i)" were attained. This site was fully accredited in August but the PPD is still not satisfied with the receiving screening form utilized and is not sure that judges are routinely notified of inmates' medical and/or psychiatric problems. A new jail with an expanded medical facility is now being built which will hopefully eliminate deficiencies in the present physical facility. Procedural problems should be alleviated before that time, however.

WASHINGTON

Grays Harbor County Jail - This jail had its ups and downs during the second year. Some improvements (e.g., obtaining the services of a PA) were initiated early on, but the system began to break down during the Summer months. There was little support for change from the jail staff which was, in turn, frustrating to the health professionals. After the death of the PA's sponsoring physician, the new system dissolved. "Stop-gap" nursing services were continued by the local health department, but little else was in place. The internal conflicts between the jail personnel and medical personnel were exacerbated by political conflicts between the jail and community agencies. Consequently, WSMA considered dropping Grays Harbor as a pilot site. However, in September the state PAC decided that one last attempt at reconciling the differences between the local groups should be made.

November 1977 was the beginning of a turn around. The sheriff's department, the county commissioners, the Health Department nursing staff and the WSMA Project Coordinator came to agreement on some basic issues and plans were made to begin the implementation of a comprehensive health care system in February 1978. However, new resistance was encountered from the local Health Officer who decided he did not want to be involved in implementing the new system. In his March 1978 progress report, the PPD indicated that some improvements occurred in the physical condition of the medical room and that some of the needed equipment and supplies were obtained. He further stated that the Health Officer finally agreed to supervise the new system but not to provide any direct patient care. Thus, the PPD indicated that "major problems of finding the primary care physician or mid-level provider for improved in-jail services and getting jail staff to be full partners in a new system remain embroiled in local politics and unresolved." The evaluator recommends that efforts to provide technical assistance to this jail be abandoned if some resolution to these long-standing problems is not forthcoming by July 1978.

Okanogan County Jail - Sufficient improvements were made in this jail's health care delivery system to enable it to become provisionally accredited by the AMA in August of 1977. Shortly after the official survey took place, however, the responsible physician resigned. Efforts to locate another physician to fill this position were unsuccessful and the health care system began to dissolve. The I/PPs done at this site indicated that the medical delivery system might no longer be operative, and the AMA requested that Okanogan be re-surveyed[27] to determine whether the jail was still complying with the standards. The re-survey took place in March. While formal action awaits the decision of the NAC, the jail's provisional accreditation award is expected to be withdrawn.

The PPD is not optimistic that the situation in Okanogan will improve. Apparently, neither the jail nor the county is sufficiently motivated to bring the health care system back to its operative status. Therefore, the evaluator recommends that no further efforts be expended at this site in Year Three.

Whatcom County Jail - This jail's system was fully accredited by the AMA in August 1977. Among other improvements were the following: obtaining a responsible medical authority, involving the local health department, employing a nurse, implementing receiving screening, revising the medical record system, developing policies for administering medications and obtaining physician services in an emergency, and creating a new staff position of "Medical Liaison Officer" whose job is to develop and coordinate the health care system in the jail. At last report, the system was continuing to function smoothly. This jail is expected to apply for re-accreditation during the third year.

Whitman County Jail - Here, all specific objectives were met including: implementing receiving screening and health assessment activities, developing a better medical records system, creating written policies on the administration of medications, enlisting the services of the local public health department and involving the local mental health agency. In addition, jail staff worked on and participated in a Mental Illness Training Program in January 1978. Like Whatcom, this jail also received full accreditation in August and is expected to apply for re-accreditation in Year Three.

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[27] The AMA reserves the right to re-survey at any time any jail it has accredited to determine whether a jail still deserves that status.

WISCONSIN

Adams County Jail - A number of improvements were initiated at this site, particularly in the latter half of the year. For example, the medication log was improved, SOPs were developed, liaison was established between the jail and the county's Unified Services Board, receiving screening and health appraisal were initiated, and drugs are now stored more securely. By February of 1978, the delivery system was fully operative and the jail was awarded full accreditation. The county council has evidenced considerable support for improving the jail's health care system and the PPD does not anticipate that this site will have any problems maintaining its present level of care.

Eau Claire County Jail - A number of important changes took place at this site during the second year including: instituting sick call three times a week, developing an adequate medical records system, implementing receiving screening and communicable disease screening, initiating routine physical exams, writing up SOPs to cover a variety of health care activities and enlisting services from the local mental health department. This jail received full accreditation of its health care system in August of 1977, and at last report, was continuing to function smoothly. According to the PPD, it should have no problem being re-accredited in the third year.

Milwaukee County Jail - Good progress was made in improving this delivery system during the first part of the second year. For example, the relationship with the responsibile medical authority was formalized, written policies governing medical activities were established along with written protocols and SOPs, receiving screening was initiated, some improvements occurred in the medical record system, and additional staff including a nurse and a dentist were hired. While additional work was still needed, the health facility did obtain provisional accreditation from the AMA in August of 1977. However, the PPD expressed some doubt regarding whether the jail will be able to become fully accredited during the third year. Existing staff are not sufficient for the jail to meet the AMA's requirement to provide full physical examinations to all inmates who are there longer than fourteen days. The possibility of recruiting volunteers or inexpensive part-time staff to perform the physicals is being explored. The sheriff continues to be enthusaistic about the project, and hopefully, can persuade the county council to provide additional funds for medical staff so that the AMA's requirements for standard compliance can be fully met.

In summary then, of the thirty original pilot sites, three were dropped, sixteen were fully accredited, four were provisionally accredited but one had its provisional accreditation withdrawn, and the remaining seven were not accredited.[28] The nineteen jails which were still either provisionally or fully accredited at the end of the second year are expected to reapply for accreditation in the third year of the AMA's program. By doing so, they will enable the evaluator to determine whether or not jails are able to sustain the level of care needed to become accredited over any period of time. In addition, two other sites (Monroe County Jail in Georgia and the Owen County Jail in Indiana) will continue in the third year since both of these jails recently applied for accrediation. As for the other six jails which were still part of the AMA's Program at the end of Year Two, the evaluator recommends the following:

> The Atlanta City Jail in Georgia, the Brown and Morgan County Jails in Indiana, and the Okanogan County Jail in Washington should be dropped in the third year. Too little has been accomplished at these sites to justify expending additional efforts. The Washington County Jail in Maryland and the Grays Harbor County Jail in Washington should be retained in the third year. However, they should be closely followed to determine whether the expected improvements are likely to occur in the near future. If changes are not imminent, efforts to improve the health care systems at these two sites should be abandoned before the middle of Year Three.

2) development of short-term demonstration projects

A maximum of $7,500 per state was set aside by the AMA to fund short-term demonstration projects to improve patient care.

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[28] See Table I on the next page.

TABLE I

Accreditation Status of Original
Pilot Jails as of March 1978

State	Jail Code	Current Status
GEORGIA	1-1	Surveyed Feb.'78 - Not Accredited.
	1-2	Surveyed Aug. '77 - Fully Accredited.
	1-3	Not Surveyed - Not Accredited.
	1-4	Dropped from Project Dec. '77.
	1-5	Surveyed Feb. '78 - Provisionally Accredited.
INDIANA	2-1	Not Surveyed - Not Accredited.
	2-2	Surveyed Aug. '77 - Fully Accredited.
	2-3	Dropped from Project Dec. '77.
	2-4	Surveyed Aug. '77 - Fully Accredited.
	2-5	Surveyed Feb.'78 - Fully Accredited.
	2-6	Not Surveyed - Not Accredited.
	2-7	Not Surveyed - Not Accredited
MARYLAND	3-1	Surveyed Aug. '77 - Fully Accredited.
	3-2	Surveyed Feb. '78 - Provisionally Accredited.
	3-3	Surveyed Aug. '77 - Fully Accredited.
	3-4	Surveyed Aug. '77 - Fully Accredited.
	3-5	Surveyed Aug. '77 - Fully Accredited.
	3-6	Dropped from Project Nov. '77.
	3-7	Not Surveyed - Not Accredited.
MICHIGAN	4-1	Surveyed Aug. '77 - Fully Accredited.
	4-2	Surveyed Aug. '77 - Fully Accredited.
	4-3	Surveyed Aug. '77 - Fully Accredited.
	4-4	Surveyed Aug. '77 - Fully Accredited.
WASHINGTON	5-1	Not Surveyed - Not Accredited.
	5-2	Surveyed Aug. '77 - Provisionally Accredited. Resurveyed March '78 to check compliance with standards. Provisional accreditation was subsequently withdrawn.
	5-3	Surveyed Aug. '77 - Fully Accredited.
	5-4	Surveyed Aug. '77 - Fully Accredited.
WISCONSIN	6-1	Surveyed Feb. '78 - Fully Accredited.
	6-2	Surveyed Aug. '77 - Fully Accredited.
	6-3	Surveyed Aug. '77 - Provisionally Accredited.

For the most part, these short-term efforts consisted of funding new staff to deliver services, in exchange for a commitment from the facility to pick up the expenses in the next budget if the arrangement proved satisfactory. The status of the states' activities in this regard is discussed below. The states are presented in alphabetical order.

Unlike the other states, Georgia did not utilize its demonstration monies to fund new health care positions in individual jails. Instead, the monies were used for two training programs in which staff from all of the pilot sites were invited to participate. The first effort consisted of developing a package to train correctional officers to perform receiving screening on inmates. Both instructor and participant manuals were developed. The first two-day session was offered in November 1977 and twelve correctional staff from four of the pilot sites attended. A second two-day session was held in February 1978 and fourteen correctional staff from three of the original jails and the two new second year sites participated. In addition, this workshop was video-taped so that the training package could be utilized next year without the expense of hiring an instructor for each session. Further, MAG Jail Project staff are working with Georgia's P.O.S.T. Council to have this training package incorporated into the regular curriculum for training correctional officers.

The second training effort was directed at physicians serving correctional institutions rather than correctional staff.

A one day "Physicians' Symposium on Health Care" was held on March 4, 1978 and attracted thirty-two physician participants from around the state. While the evaluator did not attend, feedback from AMA central and leadership staff who were present indicated that the symposium was well received. MAG and the AMA indicated their support for the jail project's effort by certifying that "... this continuing medical education activity met the criteria for seven (7) hours of credit in Category 1 for the Physician's Recognition Award of the American Medical Association."[29]

In Indiana, demonstration funds were used primarily to improve direct patient care. The Marion County Jail received $3,500 to cover the costs of a part-time dentist through December of 1977. The jail then requested funds from the county to continue these dental services in 1978. The Monroe County Jail also received $3,500 to hire a physician to provide primary care. When these funds were depleted, the county assumed the expense for the physician's services. In addition, the Owen County Jail was given a small award of $300 to assist it in setting up a medical record system and initiating receiving screening.

As for Maryland, the Prince Georges County Jail applied for $3,000 to cover the costs of a part-time psychologist. This proposal was approved by the Maryland PAC in August, pending a

[29]This notice was printed on the symposium program agenda.

commitment from the sheriff to continue these mental health services after the demonstration funds were expended. The sheriff agreed to do so and the funds were awarded. Prince Georges County now has a proposal in to the State Planning Agency (SPA) for funds to continue its psychological services. As noted previously, Maryland also planned to fund a part-time nurse position at the Washington County Jail, but did not do so because the county commissioners would not agree to continue the nurse's services after the demonstration funds were exhausted.

The Michigan project received approval from the AMA to finance the services of a part-time physician at the Shiawassee County Jail. The grant covered the six-month period of July through December 1977. The amount awarded was $3,500. The continuance of the physician services was assured for 1978, since a resolution to fund this position was passed by the local county board of commissioners last year. Shiawassee was the only one of Michigan's jails to receive demonstration funds.

In Washington, the only proposal submitted was one to double the amount of time and services provided by the nurse who serves the Whatcom County Jail. This action was approved by WSMA and the AMA and a total of $588 was appropriated to increase the nurse's coverage from September through December of 1977. Prior to awarding these funds, the WSMA Project Coordinator extracted a promise from the sheriff to continue the same amount of nursing coverage during 1978. This commitment is being fulfilled.

Wisconsin had hoped to use $1,000 of its demonstration funds to provide some physician services at the Adams County Jail. However, the request was made late in the project year and insufficient time remained to expend the funds within the second year. In addition, there was no assurance that the county would pick up these expenses after the demonstration period. Hence, no award was made.

3) data collection activities

For the second year, the states had two primary data collection tasks to complete. The first of these was to do a post-profile of the pilot jails and their health care delivery systems. The Jail Post-Profile (JP-P) was an update of the first year pre-profile and helped to document the extent of changes that took place in the pilot sites' delivery systems as a result of the AMA program. The second research task was to repeat the Inmate/Patient Profiles (I/PPs). The results of the first and second year I/PPs were compared to determine (among other things) whether the incidence of undetected and untreated illnesses declined as a result of the improvements made in the pilot jails' health care systems.

As noted previously, the results of both research efforts have been analyzed and the findings are available in separate reports.[30] What is of interest here is the extent to which the six states adequately performed their data collection tasks.

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[30] For the appropriate references to these reports, see page 13 supra, note 13.

In regard to the JP-P data collection activities, suffice it to say that all six of the states' efforts were satisfactory. Some of the PPDs experienced difficulties in obtaining certain data such as cost figures in some of their sites. However, where data could not be obtained, it was perhaps more often due to a lack of sufficient documentation at the jails themselves than to a lack of diligence on the part of medical society staff.

As for the I/PPs, the overall efforts in the various states were again satisfactory. The major differences between the states performances were in the number of I/PP forms submitted and when they were completed. In terms of absolute numbers, Maryland conducted the most I/PPs (N = 124) and Washington the fewest (N = 59). To a large extent though, the number of forms submitted was a function of the number and size of the pilot sites in each state. On this basis, most of the states submitted what was expected of them, albeit Washington and, especially, Maryland, completed proportionately fewer I/PPs than the other states. Indiana and Georgia both submitted almost 100% of their expected number whereas the other two states completed about 90% of the anticipated number.[31]

In terms of time, Indiana and especially, Georgia, conducted I/PPs somewhat later in the year than the other states. However, the real criterion was whether Year Two I/PPs at individual jails

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[31] See Table II, page 20 in Analysis of Inmate/Patient Profile Data - Year Two, supra at note 13.

occurred approximately one year from the date of the first I/PPs. Georgia and Maryland came the closest to fulfilling this requirement since the mean time difference between the two sets of I/PPs at jails in both their states was 11.8 months. Michigan's mean time difference was the highest at 13.8 months while the mean time difference in the other three states was about 13 months.

More important than the number of I/PPs or when they were submitted was the accuracy and completeness of the data themselves. On this basis, all of the states performed reasonably well.

4) and 5) retesting of the standards and testing of the accreditation program

The states were also expected to retest the revised AMA standards and to try out the accreditation process in their pilot sites. Both of these components are discussed in more detail in Section B. All that need concern us here is how well the states performed their role.

During the second year, there were two rounds of accreditation. For the first round, the states received the necessary materials to conduct on-site surveys the first week in June and were given until mid-July to complete the process and submit the requisite data to the AMA for review. The first time, Maryland, Michigan and Washington each surveyed four jails, whereas Indiana and Wisconsin did two apiece and Georgia only one.

On-site surveys for Round II of the accreditation process were conducted during the late Fall of 1977. This time, Georgia surveyed two sites as did Wisconsin; Washington did none and the other three states each surveyed one additional site. Thus, by the end of the second year, all of the states had surveyed at least three jails.[32/]

The states' actual experience in doing the surveys represented the most important testing of the adequacy and practicality of the AMA standards and the accreditation process itself. Hence, the state staffs were encouraged to provide feedback to the AMA staff regarding any problems they encountered with the standards, the survey instruments or the accreditation process. All of the states did so, whether by individual letters or telephone conversations, at various group meetings or more formally, at the time of the evaluator's preliminary and final assessment visits to each state.[33/] Thus, it seems fair to say that all six of the states satisfactorily fulfilled these two national performance requirements.

6) expanding to new sites

The AMA's second year proposal also called for the states to expand their projects to additional jails. This requirement

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[32]Georgia and Indiana surveyed three jails each, Washington and Wisconsin did four each and Maryland and Michigan did five each.

[33]See pp. 44-47 and Appendix C of the Preliminary Evaluation Report ... (Year Two), supra at note 14.

was initially to be contingent upon the states having made sufficient progress in their existing sites. Instead, AMA staff decided to require each state to add two new jails regardless of the number of sites a state was working with initially or the number still remaining to be accredited. While all of the states did add at least two more jails to their projects, a couple of them were not able to do so until almost the end of the second year. The states are discussed below in alphabetical order.

Georgia's two new sites were the Gwinnett County Jail and the Muscogee County Jail (one medium-sized and one large). In the former instance, the jail manager had heard about the MAG project and wanted to participate, whereas in the latter jail, one of the PAC physicians requested that this jail be given technical assistance. These two sites were not added until February 1978, so Georgia staff did not have much time to work with these jails in the second year. Nevertheless, correctional staff from both Gwinnett and Muscogee were able to participate in the February Receiving Screening Training Workshop and these two jails will be continued in Year Three.

Indiana added three county jails: Vanderburgh and La Porte joined the project in November 1977 and Allen County in January 1978. While the Indiana PPD provided short-term technical assistance to all three jails, La Porte County with an average daily population of about fifty inmates required the most help. Sufficient progress was made in formalizing the delivery systems in these sites that all three applied for accreditation in Round III.

Maryland added its two new sites, the Cecil and Frederick County Jails, in December. Sheriffs in both of these counties had shown interest in this project for some time. Both jails were provided with a considerable amount of technical assistance in the last quarter of Year Two. However, neither site was deemed ready to seek accreditation. These two sites will also be continued in Year Three.

As for Michigan, it phased in the Muskegon County Jail in October and the Ingham and Genesee County Jails in January. Only short term technical assistance (TA) was needed at Muskegon and it applied for accreditation in Round II. It was awarded provisional accreditation status by the AMA in February 1978, and since then, Muskegon applied to be re-surveyed for full accreditation in Round III. The Ingham County Jail had been receiving technical assistance from the Michigan PPD since November. While this jail was said to be providing the necessary health care services, it needed assistance in developing written policies and procedures to formalize its delivery system. Hopefully, it will be ready to apply for accreditation sometime during the third year. TA to the third new site in Genessee County was just getting underway by the end of the second year.

Washington added two new pilot sites in October (the Klickitat and Skamania County Jails) and one more in December (Kittitas County Jail). All three are small facilities and had no systems for delivering health care when they joined the WSMA project. Technical Assistance has been provided at all sites to date and will be continued in the third year.

In Wisconsin, short-term technical assistance was begun at the Dane County Jail in September. This is a large jail in an urban setting and many of the required health care services were already being offered. In addition, the jail had received a copy of the AMA standards a year before and had been doing some work on its own. Hence, this site was ready to apply to be surveyed shortly after joining the SMSW project. It received full accreditation in February 1978. In January, SMSW jail staff began looking for additional sites. Three more jails were added in February from Walworth, Dodge and Rock Counties. However, time was not sufficient to provide more than minimal TA to these sites before the close of the second year.

Table II below summarizes the number of pilot jails in each state at the close of the second year.

TABLE II

Number of Second Year Sites, by State

State	Number of Original Pilot Sites Still Active	Number of New Second Year Sites Added	Total Number of Jails at the End of Year Two
GEORGIA	4	2	6
INDIANA	6	3	9
MARYLAND	6	2	8
MICHIGAN	4	3	7
WASHINGTON	4	3	7
WISCONSIN	3	4	7
TOTALS	27	17	44

7) publicity and outreach

The states were also expected to generate interest in and support for their projects in a variety of ways. Their success in doing so is examined below. The states are discussed in alphabetical order.

Georgia's outreach efforts increased substantially this year. Necessary liaisons were established and maintained with a number of statewide and community organizations such as the Jail Managers' Association, the Department of Human Resources, the Peace Officers Standards and Training Council, the Municipal Health Services Task Force in Atlanta, the Association of County Commissioners and local chapters of the American Red Cross, among others. Both the PPD and RA made presentations at meetings of the Jail Manager's Association and the Georgia Police Academy and conducted two workshops on receiving screening for both project and non-project jail personnel. In addition, a booth was set up at the last Sheriff's Association meeting to provide information on Jail health care.

Outreach to MAG members also increased significantly. The PAC physician chairman made regular reports at MAG leadership meetings, submitted a paper at the last annual session of the general MAG membership, and contributed an article to the MAG Journal. Georgia physicians were also notified regarding the AMA's National Jail Conference through an item carried in the MAG Journal and further informed about state project activities through monthly notices in the MAG newsletter.

Early in the project year, state staff wrote to all Georgia sheriffs (N = 155) to notify them of the project's existence and of the availability of monographs and other assistance as well as to ask them to identify the physicians serving their jails. These physicians were subsequently invited to attend the physician symposium on health care.

Increased project contact with the local county medical societies also took place. Two members of the PAC made presentations to local medical societies about the MAG jail project. Volunteers were also solicited from county medical societies in order to conduct the second round of the I/PPs. The first year, Georgia was one of the two states where it was necessary to hire medical professionals to conduct the I/PP physicials because volunteers could not be located.

As with outreach efforts, publicity concerning the project also increased in Year Two. Articles appeared in local newspapers regarding physician volunteers conducting the I/PPs as well as articles on the accreditation of county jails by the AMA. In addition, the PPD worked closely with a reporter from the Atlanta Journal/Constitution on a series of articles about health care in jails.

In Indiana, outreach and publicity activities increased considerably as the second project year progressed. Avenues of contact with local medical society executives were developed and

strengthened as the PPD enlisted their aid in securing the needed personnel for the second round of I/PPs. In addition, the PPD addressed two local medical society board meetings about the status of the jail project in their respective counties. Liaison was also established and maintained with various other groups throughout the state, including the Sheriffs' Association (at both the state and regional levels), the state Pharmacy Board, the state Lawyers Commission, and the Health Service Agency. Numerous meetings were held and presentations made with these groups. In addition, ISMA's Executive Director consulted with the Governor of Indiana at various times throughout the project year concerning health care in Indiana jails. Legislation concerning the same was proposed.

Technical assistance (TA) to non-project jails increased considerably in the latter half of Year Two, which resulted in some of these same jails formally applying to join the project. Further, the PPD gave TA to the Federal penitentiary at Terre Haute and met with various parties involved in litigation concerning the health care provided by several jails within the state.

As the second half of the project year unfolded, publicity efforts substantially increased. Articles concerning jail health care and AMA accreditation of jails appeared in various local newspapers, as well as the Sheriffs' Association newsletter and the ISMA Journal. The PPD also taped a radio program with a local station. Although publicity and outreach began slowly, recent

efforts have been good. If continued, this should create the needed strong base of support throughout the state, especially at the regional and county levels. The evaluator still recommends that efforts to revive the Indiana PAC be resumed.

Maryland's publicity and outreach efforts during the second year were extensive. Most significant was Maryland's outreach at the local level. More was done to involve county medical societies in this state than in the other five. In fact, local jail committees were established in all but the two smallest of the county societies. These local physician groups were involved in a number of the project's activities including the accreditation process and the I/PPs. In addition, interest and outreach at the local level were enhanced by holding bi-monthly PAC meetings on-site at the various project jails throughout the state. Locally interested persons thus had an opportunity to become better informed regarding the project's operations.

The PPD and the state PAC chairman continued to establish and maintain contact with other groups and agencies. For example, the PPD served on the Baltimore City Jail's Oversight Committee which was established to monitor the health care activities of this facility's new medical authority. Further, both the PPD and the PAC members stayed in close touch with the Special Joint Committee on Corrections in the state legislature

where efforts were underway to create a position of "Medical Administrator" within the Department of Corrections. Also, the University of Maryland's School of Pharmacy was asked to develop a training program for correctional officers in the proper handling and administering of medications.

During the latter half of the project year, the PPD made special efforts to increase the involvement of the state Sheriffs' Association -- an action that was needed. In addition, the PPD kept lines of communication open with the Director of Medical Services of Maryland's Department of Health and Mental Hygiene, the Governor's Commission on Law Enforcement and Maryland's Association of County Executives, as well as with non-project jails which requested technical assistance.

Publicity generated during the second year increased exposure for the project within the state. Numerous articles appeared in local newspapers regarding the accreditation process itself and the improved health care systems within newly accredited jails. Media coverage of the project was especially prevalent in Baltimore, where health care services in the city jail had been the focus of much public attention.

Maryland physicians were kept informed of project activities through several articles in the state medical journal, a booth set up at MED/CHI's annual meeting, and references made to the project in the annual report of the Chairman of the Maryland Foundation for Health Care.

Michigan was able to generate a lot of publicity about its project and the national program. At least two formal press releases were issued which resulted in extensive coverage of the project and its activities by newspapers and radio stations. Much of this press coverage centered around the accreditation of Michigan's four pilot jails. In addition, MSMS's physician constituency was kept apprised of the project's activities and progress through items appearing in the monthly newsletter, a feature story in Michigan Medicine in September and through verbal reports by the state PAC chairman to MSMS's Board of Directors and House of Delegates.

Michigan's outreach efforts, though minimal, did increase somewhat during the latter half of the project year. The PPD made a presentation to a select group of the State Sheriffs' Association and arranged meetings with county commissioners and jail personnel interested in the health care project. Most significantly, the PPD maintained his close working relationship with the state Department of Corrections, Office of Jail Services. This agency recommended the AMA standards to all county jails, thus further publicizing the project throughout the state. Attempts are also underway to get the AMA standards adopted as part of the official state jail regulations.

Washington's efforts to reach numerous groups and agencies of various types were quite good. Presentations were made before the Sheriffs' and Chiefs' Association and the State Jailers' Association. The PPD also gave a two hour training seminar on

jail health at the State Correctional Officers' Training Academy. In addition, a proposal was made for the Washington State Jail Commission to adopt the AMA standards. Other contacts were initiated and maintained with the state Nurses' Association, the state Council on Crime and Delinquency, the Attorney General's Office, and the state Bar Association.

Realizing the importance of local involvement in successful project performance, the PPD and the state PAC members also nurtured their contacts at this level. The PAC chairman made presentations at a couple of county medical society meetings, and the PPD was a regular participant of a task force in a non-pilot jail which was formed to improve health care. In addition, the PPD was involved with some of the local bar associations and one county's Jail Prisoner Integration Service. Further, information concerning the project was given to a delegation of medical personnel visiting the state from a New York City jail, and an interested party from Illinois was informed of the "Medical Officer Liaison Program" at the Whatcom County Jail.

While outreach efforts in the state were at a high level throughout the second project year, most publicity occurred only during the second half. The state PAC decided to postpone any large public relations effort until 1978. However, some local newspaper coverage did occur in 1977 concerning the accreditation of three county jails, and the PPD issued a news release in November about the filming of part of the AMA's documentary at the Whatcom County Jail. Further, efforts to keep physicians and

other health care groups better informed about the project improved in the second half of the year. An information booth was operated throughout WSMA's annual convention, and the project's Physician Director gave an address to the House of Delegates at which time the accreditation awards were presented to three county medical societies. An article also appeared in the January WSMA Bulletin concerning health and medical care standards in jails.

Wisconsin did a good job of informing medical and correctional groups as well as the public about its project. In addition to several newspaper articles about activities at the pilot jails and the accreditation of pilot sites, regular items appeared in SMSW newsletters and the state Medical Society Journal. A longer article was published in the May issue of the Badgerscope -- a journal for medical assistants. The assistant PPD also appeared on two local radio programs in October. Further, presentations were made and literature distributed at meetings of the following groups: the Wisconsin Society of the American Association of Medical Assistants, the Wisconsin Sheriffs and Deputy Sheriffs' Association, and at a meeting of medical school interns. Project staff also manned a booth at the annual SMSW convention and a report on the project was included in the Handbook distributed to the House of Delegates. Outreach activities, though, were fairly minimal. Contact with local medical societies primarily consisted of soliciting their assistance in locating volunteer physicians to perform the I/PPs or in locating physicians interested

in serving jails. While close relationships were maintained with the state jail inspectors, regular contact with other correctional groups was lacking. In addition, the state PAC was totally inactive during the second year. SMSW jail project staff are aware that their past outreach activities have been limited and that they need to interest and involve other groups in Year Three. Further, the PAC should be reactivated.

8) submitting monthly progress reports

While not a particularly demanding task, the states were expected to report regularly on their progress. Suffice it to say that all of them have done so, albeit some (notably Wisconsin's) are occasionally late and others (notably Michigan's) are too short to be of much assistance in gauging actual progress.

b. Unique objectives

Individual goals for each of the six state projects were outlined in a previous section of this report. Here, their progress in meeting these objectives is examined.[34] The states are reviewed in alphabetical order.

The success of Georgia's efforts to achieve its unique goals was as follows:

1) A draft of a practical guide for sheriffs was completed and sent to the AMA for review. Sample procedures were developed to cover a variety of health care services and the Research Assistant (who is a Registered Records Administrator) devised a set of sample forms for a medical record package.

[34] In the interests of brevity, the objectives are referred to by number. Please see pages 7-10 for the corresponding statements of each project's goals.

2) As noted previously, lesson plans for a course in receiving screening were finished and the training sessions were held. The training module on administering medications was not developed, although a section of the practical guide was devoted to describing appropriate procedures for handling and administering prescribed drugs.

3) The workshop for jail physicians was held on March 4, 1978.

In Indiana, the project's major efforts the second year were directed toward implementing the AMA standards in its pilot sites. Nevertheless, regarding its other interests, the following were accomplished:

1) The PAC physician chairman wrote a monograph on the mentally ill in jails which was subsequently published by the AMA. It was also incorporated into the policies and procedures at the Marion County Jail.

2) Activities got underway to develop a handbook on exercise facilities and programs. It was not finished by the end of the year, but progress was being made. A local attorney provided input regarding legal issues involved in jail exercise programs and a university professor is writing a piece on the space and equipment needed to provide an adequate exercise program.

3) The project did not pursue its initial efforts to form an association of jail physicians.

In addition to these activities, Indiana also designed sample contracts for jails to use in hiring health care providers and sample consent forms to be used for inmates receiving medical services.

Maryland's efforts to meet its objectives are summarized as follows:

1) and 2) Protocols for handling medications and for standing orders were developed in all seven pilot sites.

3) Protocols for receiving screening in three counties were completed.

4) All county medical society executives were informed of the jail project and are regularly apprised of its progress.

5) Meetings with local medical societies to review jail health care systems occurred in a number of counties.

6) The model health care systems in the four fully and one provisionally accredited sites were written up and submitted to the AMA.

7) Liaison with the State Legislature's Committee on Corrections was initiated and maintained.

8) Preliminary activities to develop a training package for jailers on distributing medications got underway. Maryland's jail project staff is working with representatives of the state university's School of Pharmacy. This training effort should be completed in Year Three.

9) A subcommittee of the PAC was established to work on developing standards governing physical aspects of medical facilities (e.g., space and equipment requirements). A draft was written and is currently being revised. In addition, PAC subcommittee members provided TA to a couple of jails regarding space and equipment needs.

10) A subcommittee on physical facilities has been established to work toward the development of standards in this area.

In addition, Maryland put together a package on special diets which is available for distribution.

Michigan's activities toward achieving its individual goals included the following:

1) Liaison with the Michigan DOC's Office of Jail Services was on-going during Year Two, but this group has not yet formally adopted the AMA standards. Efforts toward accomplishing this are continuing.

2) The dental section of the Michigan Manual was revised and a new section on handling pregnant inmates was developed. While the Manual was not adopted in total by the AMA Advisory Committee, certain sections were incorporated into the Practical Guide which the AMA developed. Michigan's Manual was distributed to interested sheriffs as well as medical and university personnel.

3) This objective was deleted from the Michigan plan in October in view of activities at the national level.[35] It was replaced in November by the following objective:

"Work with the Medical Practice Board, Michigan Board of Pharmacy, Michigan Board of Nursing, Board of Osteopathic Medicine, and Surgery, and the Michigan Department of Corrections, to achieve agreement on the authorities, responsibilities and relationships that physicians, physicians assistants, nurses, paramedical personnel and correctional officers should have in delivering medical care in county jails."[36] Aside from a few exploratory contacts, however, this objective was not actively pursued.

4) Aside from the participation of jail nurses at some of the PAC sessions, little else was done to stimulate the development of a jail nurse association.

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[35]The AMA received a grant in 1977 from the National Institute of Corrections (NIC) to develop training courses on several health care issues. Two of the pilot states other than Michigan are working with the national staff on this program. Thus, there seemed to be little point to Michigan's duplicating these efforts.

[36]Letter from Michigan Project Director to AMA Associate Director on November 15, 1977.

Washington's endeavors to achieve its special goals are described below:

1) The Jail Health Care Reference Manual was revised as was the medical record set developed last year.

2) A Jail Health Care Guidebook was developed. It was tested in two non-project jails in August and has been used in pilot sites as well.

3) A Mental Health Handbook was drafted and sent to a number of program staff for their review and comments. It is also being revised based on the feedback received. This document was used as a resource book for training staff at one of the pilot sites.

4) WSMA did support the enactment of the Jail Standards Act which was subsequently passed. Project staff were subsequently asked to assist the commission which was established to develop standards for medical care. Work with the Washington State Jail Commission continues.

5) A health care workshop for medical professionals and jail staff in the pilot counties was held in April of 1977.

6) No training sessions for jailers were held during the second project year. However, plans were underway to resume this training in Year Three.

In addition, Washington devised some sample budgets and contracts for health care systems in smaller jails, and prepared a monograph on the legal obligations in Washington state to provide health care to inmates.

Wisconsin's progress toward meeting its unique objectives can be summarized as follows:

1) While Wisconsin identified some of the special health care needs of women by surveying local sheriffs in January and again in June of 1977, no activities were initiated to help meet the needs of female inmates.

2) SMSW project staff and physicians had some input into the health care section of the training curriculum developed by the University. However, at the first training sessions held in June, only one jailer from one of the pilot sites participated.

2. Ratings of the Pilot Projects

In the previous section, the states' progress in fulfilling the national requirements and their own objectives was simply described. No attempt was made to compare the states and to rate them across all of their efforts. That is what this section seeks to do.

This process is complicated, however, by the fact that the various activities were not all of equal significance in determining whether the projects were successful. For example, submitting regular progress reports was an administrative task which contributed little toward eventual goal achievement. On the other hand, implementing action plans and meeting unique objectives were crucial tasks. Collecting the requisite data was also important since this information constituted the only objective measures of the overall program's impact in upgrading health care. Further, attempts to inform and involve various groups became increasingly significant as the program moved toward expansion.

These latter tasks, then, formed the primary basis for comparing the states' progress during the second year. The remaining tasks were given less consideration either because they were of less significance or because the differences between the states' performances were slight. Strengths and weaknesses of the state projects are discussed below, along with the evaluator's recommendations where appropriate.

On an overall basis, Maryland's project was the most successful. By the end of the second year, all but one of its remaining six sites were accredited (four fully and one provisionally). In addition, Maryland accomplished virtually all of its unique goals and had an active outreach program as well. The required new sites were added, TA was provided to other non-project jails, and liaison with relevant medical and criminal justice organizations was maintained. Efforts to inform and involve physicians and local medical societies were especially good. General publicity activities were sufficient and data collection efforts were satisfactory.

Maryland's second year achievements were particularly noteworthy, since it not only had the biggest workload of the six states,[37] but also had accomplished less than some of the other states the first year. Undoubtedly, one of the reasons Maryland's project performed so well was due to the amount of time and effort devoted to jail project activities. The PPD spent 100% of her time on this project and the Maryland PAC was twice as active

[37] Only Indiana had as many sites to work with and, on the whole, Maryland's were larger and more complex.

as Advisory Committees in any of the other states. The structure, organization and operation of Maryland's PAC represent a good model for other states to follow.

Washington's strongest accomplishment was the development of numerous products which were used by jails to improve their health care systems. Virtually all of its second year objectives were successfully attained. Outreach was extended to a variety of criminal justice and community organizations as well as to medical groups. TA was provided to several non-project jails and publicity efforts increased in recent months. While Washington was able to accredit only two of its four original sites,[38] the thwarting of its efforts in the other two sites brought about a change of strategy in this state. The WSMA Project Coordinator and the PAC physician chairman are both working closely with the Washington State Jail Commission toward the development and adoption of mandatory state standards governing the delivery of health care in jails.

Again, the most significant factor contributing to Washington's success was probably the extensive resources which were brought to bear on the jail project. The PPD devoted 100% of his time to the jail project and made considerable use of student and other volunteers. Further, while the full advisory committee was not as active as Maryland's it was more active than some of the others, and was heavily involved in a number of activities. In

[38] Provisional accreditation awarded a third site is expected to be rescinded by the AMA in June 1978.

addition, the PPD compensated for the fact that his PAC was composed entirely of physicians by establishing an extensive liaison network with other relevant agencies.

Georgia's progress during the second year was especially gratifying. It had lagged behind the other states during Year One and was further handicapped at the beginning of Year Two by the loss of continuity which occurred when the PPD was replaced. Not only did the new staff have to become quickly oriented themselves, but they had to re-establish all of the necessary liaison with their pilot jails and cooperating agencies. In effect, then, the Georgia project started over in Year Two.

These factors render the progress that was made all the more noteworthy. Two of Georgia's four remaining original sites were accredited (one fully and one provisionally) and one more applied for accreditation in Round III. The Atlanta City Jail was the only site where insufficient progress occurred in implementing its action plan, and for reasons previously stated, the evaluator recommended it be dropped in the third year. Georgia was also able to satisfactorily achieve the unique goals it had established. The receiving screening training package which was developed should prove to be of valuable assistance to other jails in the third year and the symposium for physicians was said to be well received.

Georgia's data collection efforts improved considerably over those of the first year, as did its publicity and outreach activities. Its PAC was also more active, albeit additional use should be made of this advisory group in the third year.

Michigan and Wisconsin had somewhat similar strengths and deficiencies. Both states were able to get a sizeable number of jails accredited. Michigan had all four of its original pilot sites fully accredited in August of 1977 and one of its new jails was provisionally accredited in February as well. As for Wisconsin, all three of its original sites were accredited (two fully and one provisionally) by the end of Year Two and one more new site was fully accredited besides. While publicity efforts were quite good in both states, outreach activities were seriously lacking. Further, neither state accomplished much of significance toward achieving its unique goals, although Michigan was somewhat more active in this regard. The Michigan Manual continued to be of valuable assistance in a number of areas.

Michigan's lack of progress during the latter half of Year Two was disappointing. It took a strong lead early on in the project year, but then activities slowed. The most likely explanation for Michigan's decreased productivity was probably the corresponding reduction in resources which occurred. The PPD was only budgeted to spend 40% of his time on the jail project but initially spent more. During the latter half of the year, the PPD's other responsibilities within the medical society became more pressing and the jail project was allowed to lag. For the third year, the evaluator recommends that MSMS allot one person at least half-time to the jail project. In addition, efforts should be increased to inform and involve medical and criminal justice groups. On a minor point, the PPD should try to make his progress reports more informative regarding monthly activities.

While Wisconsin's staffing appears to be sufficient, more could undoubtedly have been accomplished in meeting its unique goals if representatives from other groups had been involved. In the third year, Wisconsin should try to resurrect its broad-based advisory committee to assist in its efforts to expand to new areas. Other outreach activities are also needed to provide a more lasting base of support for improving jail health care. Again, on a minor point, the PPD should try to submit his progress reports in a more timely fashion.

Indiana's project also improved considerably during the second year. Like Georgia's, this project was initially handicapped by a change in PPDs and a lack of activity during the first year. The new PPD devoted almost all of his efforts to gearing up the pilot sites for accreditation. By the end of the year, three of the original pilot jails had been fully accredited and one more applied for accreditation in Round III along with three of the new second year sites.[39] While publicity efforts were sufficient and data collection activities were adequate, nothing very innovative was accomplished with the exception of the monograph on mental illness in jails. Indiana's PAC was totally inactive and should be revived in the third year. Other outreach efforts initiated in the latter half of Year Two should be continued.

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[39] While efforts to upgrade health care in these last four jails were initiated in the second year, they will not be completed until Year III.

On balance, all six of the state projects performed well during the second year. Health care improved considerably in the pilot sites on an aggregate basis[40] and differences among the states were not especially wide.[41] The fact that three of the states (Indiana, Michigan and Wisconsin) chose to devote most of their time to the accreditation effort should not be construed as a negative finding. Rather, it was that the other states received "extra points" for activities beyond attempts to improve the level of care in specific jails.

3. The National Role

The national role vis-a-vis the pilot projects essentially consisted of setting guidelines and providing support and technical assistance (TA) as required. In addition to the constant contact which was maintained by telephone and written correspondence, central staff members were often required to make on-site visits as well. Most of the on-site TA consisted of central staff helping to train the accreditation survey teams or accompanying state staff during the surveys themselves. Occasionally, representatives of the national staff attended meetings of the state PACs or consulted with state project staff on individiual matters.

At the time of the evaluation team's February site visits, project staff members were asked to comment on the performance

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[40] See bottom totals on Chart I, Appendix C

[41] See Chart II, Appendix C.

of the central program staff. For the most part, the states were satisfied with the direction and assistance they received. The only negative comments included the following:

- Many of the state staffs still felt that the AMA continued to give insufficient notice regarding deadlines. This problem was particularly acute with respect to surveying jails for accreditation, and it did not appreciably improve for Round II. However, the timetable for Round III was revised and distributed well in advance of the first deadline. Further, expected timetables for Rounds IV - V have also been sent out. Hence, it appears that this problem is being resolved, at least with respect to timetables for accreditation.

- Some of the PPDs questioned the central staff's need for copies of items sent to the evaluator and vice versa. They particularly objected to sending duplicate copies to the AMA of data submitted for the JP-P and I/PP reports. Since the AMA did not analyze these data, the states felt it was an unnecessary waste of time and money. It should be noted that AMA central staff and the evaluator are aware of this problem and have taken steps to alleviate this burden on the state staffs by agreeing to utilize joint forms and share data in Year Three.

- Some of the PPDs continued to feel isolated and wanted more contact with their state counterparts. During this funding period, the only formal opportunities they had to share problems, ideas and solutions occurred in conjunction with the AMA's National Jail Conference in August and at a separate meeting of the PPDs in January.

On a positive note, aside from general characterizations of the national staff as "prompt," "responsive" or "very helpful," TA in specific areas was singled out as deserving of special praise. Among these were the assistance offered by the national program in the area of publicity, the continued interest and involvement of AMA leadership, and the articles and materials regularly distributed through the clearinghouse activity.

In addition to the project staff, the executive directors of the six state medical societies were also interviewed and were asked to comment on the national program's role. None of the six reported any major policy differences with the AMA in regard to the jail program. All were positive about the AMA's activities in this area and pleased that their own associations were involved. None had received any negative feedback about the AMA program from their own physician constituencies and all reaffirmed their society's continued interest and support.[42]

At the time of the preliminary evaluation, some of the executive directors of the state medical societies had requests and comments which they wanted the AMA to respond to.[43] The Jail Project Director addressed a number of these issues in a memorandum sent to the executive directors on February 10, 1978. No additional suggestions were made at the time of the evaluation team's final assessment visits.

Some of the physician chairmen of the state PACs were also interviewed. For the most part, their feedback on the national role was reflected in the comments of other staff noted above. Additional suggestions from state representatives will be discussed in the section on the standards and the accreditation process.

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[42] It is worth noting that all of the PPDs felt they were getting sufficient support from the leadership in their state societies.

[43] See pp. 43-44 in Preliminary Evaluation Report ... Year Two, supra at note 14.

4. Impact of the Pilot Projects

Having considered the progress made in the original pilot sites, the success of the states in meeting their Year Two goals and the contributory role of the national staff, one important question remains to be answered. Did the initiation of the AMA program make any difference in terms of improving the health care delivery systems in the original pilot jails, and if so, did this have any impact on improving the health status of inmates?

The Jail Pre/Post-Profile (JP-P) was designed to answer the first part of the question above and the comparison of data from the first and second Inmate/Patient Profiles (I/PPs) was designed to answer the latter. The results obtained from these two research endeavors have been analyzed and are available in separate reports.[44] Specific findings of pre/post comparisons were sufficiently detailed in those reports and need not be reiterated in full. Nevertheless, a brief summary of a few of the highlights seems warranted.

In the first instance, it seems clear that the AMA program did have a significant impact on improving health care delivery systems in the thirty original pilot jails. Positive changes were most evident in terms of increasing both the availability and adequacy of health care services. Consider the following statistics which were abstracted from the second year JP-P report:[45]

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[44] For the appropriate references, see page 13, supra , at note 13.

[45] See pp. 75-77 of Analysis of Pilot Jail Post-Profile Data, supra at note 13.

- Of the twenty-six remaining sites for which data could be gathered, overall availability in seven of the most important health care service categories increased from a total of 82 pre-program, to 139 at the end of Year Two. This represented a 70% increase in availability of these selected services.

- Further, 136 of these 139 selected services available at the end of Year Two were determined to be adequate as well, as defined by compliance with the specific AMA standards in these areas.

- Improvements in both the availability and adequacy of health care occurred in every service category, including:

  -- An increase from fifteen jails where chronic and convalescent care was available pre-program to twenty-one sites at the end of Year Two, where it was not only available but adequate;

  -- An increase from seven to twenty sites meeting the definition of adequacy with respect to in-house clinics;

  -- An increase from ten jails which provided some type of physical exams to some inmates pre-program to fifteen sites which fully complied with the AMA's requirement to provide all inmates with complete health appraisals within fourteen days of admission (four other jails were in nearly full compliance with this standard at the end of the second year);

  -- An increase from twelve to twenty-two sites providing regular sick call to inmates;

  -- An increase from seven to twenty-one jails offering detoxification for both alcohol and drug abusers;

  -- An increase from sixteen to twenty-three sites providing special diets to inmates;

  -- An increase from sixteen to twenty-two jails offering routine mental health services;

  - An increase from two to eleven sites providing some type of routine dental services; and

  -- An increase from nine jails having any written policies and procedures pre-program to twenty-two sites at the end of the second year which had written policies and procedures to govern all aspects of their health care delivery systems.

- In addition, other improvements occurred, including:
  - -- Changes in the policies and procedures governing the storing, handling and distribution of medications;
  - -- The initiation of receiving screening in nineteen of the pilot sites;
  - -- A reduction in the number of deaths occurring at the pilot jails;
  - -- Changes in both "management information" and "inmate/patient treatment" record-keeping systems to bring them into complaince with the AMA standards in these two areas; and
  - -- Increases in the number of medical personnel serving the jails as well as increases in the frequency and extent of coverage offered.

The comparisons of data from the two sets of I/PPs[46] confirmed the fact that increases in the availability of health care services had, indeed, occurred at the pilot sites. In addition, these data indicated that there were statistically significant reductions in the proportion of inmates who reported being barred from obtaining medical services in accredited jails over time. Thus, access to medical services also improved.

The real question of interest, however, was whether or not jails which were now accredited were meeting significantly more of inmates' health care needs. In other words, was there a significant increase over time in the proportion of inmates' illnesses which were being identified and treated by the pilot sites? I/PP data indicated that this was, in fact, the case.

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[46] See Analysis of Inmate/Patient Profile Data - Year Two, supra at note 13, especially pages 99-124.

Interestingly, some improvements occurred even in non-accredited facilities over time, albeit these changes were seldom statistically significant. Consider the following:

- In terms of the abnormalities picked up in the four lab tests administered -- tests for tuberculosis, syphilis, hepatitis and various urine abnormalities -- reductions occurred over time in the proportion that had not been previously identified and/or treated by the pilot jails across all three types of accreditation status. Only the reductions occurring in the fully and provisionally accredited jails were significant, though.

- There was also a reduction over time in the proportion of body abnormalities picked up during the I/PP physical examinations which had not been previously identified and/or treated by the pilot jails. Again, this was true across all three types of accreditation status, but again, only the reductions in provisionally and fully accredited jails were significant.

- Significantly fewer of the abnormalities not previously identified by the accredited jails over time were considered serious enough by the I/PP examiners to warrant recommendations for follow-on testing and/or treatment.

Thus, it appears that improving the availability and adequacy of health care services in jails does have a positive effect on improving the health status of inmates. Significantly more of inmates' health care needs were being met in jails which were subsequently accredited than had been the case in these same facilities prior to the AMA's program.

B. The Standards and the Accreditation Program

The AMA's second year proposal also called for retesting and finalizing its health care standards and beginning the implementation of an accreditation program for jail health care delivery systems. During the second year, the AMA accomplished both of these objectives.

1. The AMA Health Care Standards

After the AMA standards were tested in the pilot sites late the first year, they were again revised. Additional feedback on the standards was then sought from a variety of sources. For example, sheriffs and health providers in non-project sites were sent a questionnaire in May of 1977. For each of the eighty-three standards, they were asked to indicate whether it was realistic, whether it was essential, whether it was understandable, whether it should be deleted and whether their facility currently met the standard. The results from the thirty who responded were then tallied by AMA staff, and considered in subsequent meetings to revise the standards.

In addition, the standards were formally reviewed by the National Sheriff's Association Detention and Corrections Committee and by the Commission on Accreditation for Corrections. Both of these groups provided valuable feedback which was incorporated into subsequent drafts.

Finally, as a result of utilizing the standards in the accreditation process, the state staffs had some practical

suggestions to make regarding their revision. Feedback from the PPDs was written up by the evaluator and submitted to the AMA.

Input from all of these various sources was considered by the AMA's National Advisory Committee (NAC) at each of its meetings during Year Two. At the last NAC meeting in February of 1978, most of the issues raised by the state staffs regarding the standards were addressed. Following this February session, the AMA standards were again revised.

This most recent version of the AMA standards[47] is the one which will govern Rounds IV and V of the accreditation process in Year Three. The original eighty-three standards have been pared to forty-two. It should be noted, however, that the essence of most of the originial standards was incorporated into the latest draft. While a few of the initial eighty-three standards were eliminated based upon the feedback received, most of the remainder were improved and re-formatted. For example, the separate standards requiring written policies and procedures in seventeen different areas in the old document were incorporated into a single standard with seventeen parts in the new document. Hence, the original principles established by the AMA and its Advisory Committee were maintained in the latest draft, while at the same time, the standards were made more workable and precise.

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[47] American Medical Association, Standards for the Accreditation of Medical Care and Health Services in Jails, Chicago, Illinois: Spring, 1978.

Since the basic content of the AMA standards was not altered dramatically, it is worth reviewing which of the original standards the pilot jails had difficulties in meeting. Chart III, Appendix C summarizes the number of pilot jails meeting each of the original eighty-three standards on health care at the end of the second year. In interpreting these data, the reader should note that information on compliance with the standards was not available on two of the twenty-seven pilot sites remaining in the program. Further, five of the twenty-five sites where data were available did not go through an official survey process for accreditation. Hence, information regarding standard compliance in these five jails was estimated by asking the appropriate PPDs which of the specific standards they thought these jails were meeting.

Chart III indicates that, for each of seventy standards, at least two-thirds of the twenty-five jails met it. Hence, there were only thirteen standards (15.7%) which were not met by at least two-thirds of the sites at the end of the second year. Since the standards which were not met could represent potential problems in accrediting additional jails in the third year, they are discussed individually below:

- Eleven jails could not meet the Essential Standard requiring complete health appraisals to be performed on all inmates within fourteen days (Old # 1010 -- New # 1012). However, the evaluator would not recommend that this standard be changed to provide jails with more time to do these appraisals. To the contrary, she recommends that the time period be lessened if anything. While the comparison of the first and second year I/PP results showed that significant improvements had occurred in terms of identifying diseases in jails which were subsequently accredited,

it also clearly showed that present requirements for performing communicable disease screening and physical examinations were not sufficient. Since the majority of inmates passing through any given jail in the course of a year do not stay as long as fourteen days, significant proportions of their abnormalities continued to go undetected and untreated even in accredited facilities.[48]

- Fifteen of the jails could not meet the Important Standard requiring that patient education be carried out on a planned, programmed basis (Old # 1031). This standard was altered in the new version (see #1021) by eliminating the requirement for "a planned, programmed basis." This should make it easier for jails to meet.

- Only one of the twenty-five jails could meet the Important Standard requiring that inmates be allowed one hour of exercise daily on a planned, programmed basis (Old #1032). This standard was retained "as is" in the new version (#1034). In view of the almost total inability for jails to meet this standard though, the NAC may wish to consider revising it in some fashion.

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[48] See pp. 107-110 and charts 6-8, Appendix I in Analysis of Inmate/Patient Profile Data - Year Two, supra at note 13. It should further be noted that some accredited jails which were initially certified as meeting the 14-day health appraisal requirement are apparently having difficulties meeting it on a continual basis. Examinations of I/PP results on "physical exam" and "routine treatment" variables by length of stay showed some discrepancies in compliance. Moderately high proportions of inmates who had been in Jails 1-2, 2-4 and especially 4-2, over 14 days had not yet been given physicals. Similarly, moderately high proportions of inmates who had been in 15 days or more in jails 1-2, 2-2, 2-4, 3-3, 4-1, 4-3, 5-6, 6-2 and especially 4-2, reported not having seen a medical person for other than an admission physical. The AMA should be aware of this problem since many of these jails will be coming up for re-accreditation in Year Three.

o As indicated below, few of the jails could meet the requirements for dental services:

Requirement	Old Standard #	Rating	# of Jails Not Meeting It
Written guideline for dental screening within 14 days	1034	Important	13
Written guidelines for dental preventive services within 14 days of an inmate's admission	1035	Important	20
Written guidelines for dental examination of all inmates within three months	1036	Important	17
Written guidelines for dental treatment of inmates within 3 months if the inmate's health would otherwise be adversely affected	1037	Essential	11

These standards were incorporated into one standard in the new version (#1023), but the requirements remained unchanged. This undoubtedly means that fewer jails in the third year will be able to meet the dental standard, since all parts must be fully met in order for the jail to be in compliance. However, the evaluator does not recommend that the dental requirements be made less rigid. The second year I/PP results indicated that dental problems continued to be one of the most significant untreated abnormalities in the pilot jails. Almost 40% of the 519 inmates examined had some dental problem requiring follow-on care, and the pilot jails were only treating 14 of these 204 cases.[49] The evaluator does recommend that the AMA and the NAC develop special materials to assist jails in upgrading their dental services.

[49] See pp. 69-70 and 111-112, ibid.

- Several of the jails did not meet certain of the standards relating to the management of pharmaceuticals. Specifically, thirteen jails did not meet Essential Standard #1049 requiring jails to adhere to state and Federal regulations regarding the dispensing of medications; eight jails did not comply with Essential Standard #1051 requiring a written policy restricting the use of behavior modifying drugs and those subject to abuse; and fourteen jails did not comply with Important Standard #1057 requiring weekly inventory of controlled substances, syringes, needles and surgical instruments. These three standards were retained essentially unchanged in the Spring 1978 version as parts of Standard #1028. There is no evidence to indicate that these elements should be further altered in subsequent drafts, even though a substantial portion of the jails did not meet them.

- Thirteen of the pilot sites did not comply with Important Standard #1064 requiring routine transfer of summaries or copies of inmates' medical records when they were transferred to other institutions. This standard was retained as #1033 in the new version. Since this standard is simple enough for jails to comply with, the evaluator sees no reason for it to be changed in the future. The principle of continuity of care outweighs any minor administrative inconvenience this standard might cause the jails, and the cost of implementation is minimal.

- Nine jails did not comply with Essential Standard #1067 requiring that informed consent procedures applicable in the community be observed for inmate care. This standard was also retained unchanged in the latest draft as #1008. Like the previous one, this standard is simple enough to comply with and should continue to be required.

- Finally, eleven jails did not meet Important Standard #1069 requiring copies of health care personnel's licensing and certification credentials to be on file at the jail. Some health care staff (especially physicians) objected to having copies of their credentials on file as constituting the only satisfactory method of complying with this standard's intent. Thus, it was altered in the Spring 1978 version to allow alternative ways of verifying that health care staff are properly licensed or certified (#1005) and was raised to an Essential level. These changes should make it easier for jails to comply with the standard while preserving the underlying principle. In addition, the re-phrasing should eliminate objections from health care personnel as well.

On a positive note, it should be pointed out that the attention given previously to establishing different levels of compliance with certain standards for jails of different sizes is apparently sufficient. Chart IV, Appendix C, indicates that there were no significant differences between small, medium and large size jails in terms of the proportion of standards met by jails in these size categories.

2. The Accreditation Process

The first round of the accreditation process was launched during the Summer of 1977 and Round II was completed toward the end of the second year. By March of 1978, the AMA had fully accredited seventeen jails and five others attained provisional status. As noted elsewhere, the provisional status of one of these jails is expected to be withdrawn. All but two of the twenty-one sites retaining accreditation were original pilot jails.

Round III of the accreditation process was initiated in January 1978 with fifteen of the old and new second year sites participating. However, it will not be completed until late June when the accreditation awards are announced in St. Louis at the AMA's annual convention.

At the September 1977 NAC meeting, it was decided not to revise the format and methodology of the accreditation process for the next two rounds. While this seemed reasonable in view of the time factor and in fairness to the remaining sites, it should also be noted that the current process is still experimental. Therefore the evaluator's synthesis of feedback from

the first two survey processes is presented below along with additional comments, for the AMA's consideration in Year Three.

Recommendations include the following:

- Decisions should be made regarding how long various parts of the delivery systems (e.g., receiving screening, health assessments, etc.) should be in place before the system can be considered in compliance with specific standards.

- Alternative procedures should be established in written form regarding how to verify compliance with particular standards when conflicting information is obtained from different respondents (e.g., correctional officials versus inmates).

- While many of the PPDs indicated that the revised survey forms and instruction sheets were much improved, some changes were still required. For example, several of the PPDs indicated that the inmate and food service worker questionnaires (Worksheet I and M respectively) still needed to be rephrased to prevent laughter. They did not feel comfortable asking questions such as, "Please describe how you shave" or "What happens if you report to work with diarrhea?" for fear they would receive responses like, "Well, I take my razor in my right hand..." or "Well, I feel real bad all day." Additional suggestions for changing the worksheets are included as Appendix D of this report and should be reviewed by AMA staff prior to the next round of accreditation surveys.

- All of the various materials relating to the standards, the accreditation process and the on-site surveys should be pulled together into a single document which is appropriately indexed and cross-referenced. It should be bound in looseleaf fashion to allow any subsequent changes or revisions to be incorporated.

- It is imperative that new state staff have sufficient training in handling the accreditation survey process. Shared understanding of what constitutes satisfactory compliance with specific AMA standards must be ensured if the accreditation program is to operate in an equitable and uniform manner. This is crucial since the AMA delegates the on-site survey responsibilities to the states. In addition to AMA representatives training the new state staffs, on-site technical assistance in training

survey teams may also be required. If on-site TA is precluded by cost considerations, the AMA should provide state staffs with a manual to assist them in training the survey teams.

- o AMA central staff should ensure that jails which are accredited clearly meet the numerical cut-off points established by the AMA and its National Advisory Committee. There are presently three instances where designations of "full accreditation" are questionable, unless these jails were given the benefit of numerical rounding beyond the traditionally acceptable levels.[50]

- o One of the PAC physician chairman suggested that the AMA jail staff ask other AMA personnel familiar with accreditation and certification programs in different areas of health care to review the accreditation process established for the jail program. This seems like an excellent suggestion and should be pursued if it has not already been done.

- o Establishing numerical cut-offs for awarding accreditation status -- e.g., "A jail must meet 90% of the Essential Standards and 80% of the Important ones to be fully accredited" -- means that jails still have some leeway in terms of which standards they choose to meet. The NAC should consider whether there are any standards which are so absolute that it would not want to accredit a jail without compliance in these areas.[51]

It should be noted that some of the previous recommendations regarding the accreditation process made in the preliminary evaluation report have already been addressed by the AMA and the NAC and were incorporated for Round III. The third year intensive evaluation should provide some feedback regarding whether these changes

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[50] See the three jails marked with an asterisk in Chart I, Appendix C of this report.

[51] AMA central staff are already aware of this issue. It was scheduled to be discussed at the February NAC meeting, but was tabled due to lack of time.

resulted in any improvements. In particular, the NAC decided it would no longer ask the states to formally determine whether the jails they survey meet the requirements for standard compliance and accreditation. Instead, this determination will take place at the national level, albeit informal recommendations from the states will still be considered.

C. Clearinghouse Activities

The clearinghouse has two major functions. The first is to provide TA to anyone interested in improving health care in jails by developing and distributing relevant materials. The second is to generate interest in and support for the AMA Jail Program by publicizing its goals and activities. Efforts in both of these areas are discussed below.

1. Development and Distribution of Materials

The types of materials most frequently distributed by the clearinghouse are listed in Appendix E. With the exception of items 4a, 4b, 4e and 4f (which were the evaluator's responsibility), and those under codes 8 and 9, all were developed by program staff.

Several new monographs were published this year, including four on various legal issues, one on the use of volunteers and one written by the Indiana PAC physician chairman on how to recognize and handle mentally ill inmates. During the last half of the year, other documents were completed including a monograph entitled "Orienting Health Providers to the Jail Culture," a "Model Speech" for state staff to use in addressing local medical societies and others, and the long awaited Practical Guide.

This latter publication was designed to assist jails in implementing the AMA standards. It contains useful information on developing written procedures and carrying out specific tasks such as receiving screening, medication administration and

statistical reporting. It also includes samples of contracts, medical treatment records and management information records among others.[52]

In addition, The Correctional Stethoscope (a bimonthly newsletter) has increased its circulation and is now reaching several hundred correctional and health care personnel.

Further, a documentary film was developed. Its primary aim is to interest and involve physicians in jail health. The first cut of the film -- entitled "Out of Sight - Out of Mind" -- was shown at the AMA's National Jail Conference in August and was generally well-received. The film was revised and finalized at the end of Year Two and is now available for general use.

The distribution of materials has increased substantially this year. Chart I in Appendix E shows that over 17,000 pieces of material were sent out in recent months. The overall totals for the second year (see Chart II, Appendix E) indicate that almost 80,000 publications were distributed in Year Two, compared with less than 7,000 for the whole first year. Significantly, almost 90% of these materials were distributed to non-project personnel -- including 52.1% to sheriffs and correctional workers, 33.3% to health professionals and 3.9% to other interested individuals.

In addition to determining how many pieces of material were distributed, the evaluator wanted some measure of their value

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[52] The "Table of Contents" of the AMA's Practical Guide is included as Appendix F of this report.

to recipients as well. Consequently, a questionnaire was developed and sent to two hundred individuals randomly selected from the AMA clearinghouse's mailing list. A total of sixty-three questionnairs were returned to the evaluator, of which fifty-nine were usable. This represented a response rate of almost a third, which is good for a mail-out questionnaire.

The responents were divided into the following occupational categories:

Medical Personnel (MP): N = 31

(3 dentists, 7 nurses, 10 physicians, 4 health care administrators, 1 health professional-counselor, 1 county medical staff member, 3 hospital administrators, 1 executive director of a national medical association and 1 mental health director)

Correctional Personnel (CP): N = 6

(1 undersheriff, 1 sheriff, 3 chief jailers, 1 corrections officer)

Other Criminal Justice Personnel (OCJP): N = 16

(1 Legal Aid Society planner, 1 coordinator of Law and Justice, 2 criminal justice trainers, 9 criminal justice planners, 3 attorneys)

Other: N = 6

(3 professors, 1 federal employee, 2 unspecified others)

Respondents were asked first, whether they had received each of the selected clearinghouse materials. Next, they were requested to specify whether they had read each manuscript or not, and if so, to determine the materials' value. Summaries of the feedback from the clearinghouse questionnaires follow and charts of the responses by occupational category can be found in Appendix G.

Manuscript A: "The Use of Allied Health Personnel in Jails"

Fifty-seven people provided information about this pamphlet. Of those, thirty-eight had received the monograph and thirty-seven also reported having read it. Thirty-two of the thirty-seven rated the material as good or excellent.

Manuscript B: "Models for Health Care Delivery in Jails"

Of the fifty-seven people responding to this item, fifty-eight percent (33) had received the pamphlet; and, of those, thirty had read the material. Twenty-five of those who had read the monograph evaluated it as good or excellent.

Manuscript C: "The Role of State and Local Medical Society and Jail Advisory Committees"

Thirty-eight of the fifty-five respondents had not received the material. Of the thirty-one percent who had received the pamphlet, sixteen had also read the material. Eight of those readers rated the pamphlet good.

Manuscript D: "Organizing and Staffing Citizen Advisory Committees"

Fifty-four people responded. Seventy-four percent (N=40) had not received the material. Of the fourteen who had received the pamphlet, eleven had also read the monograph. The majority of the readers said the pamphlet was good or excellent.

Manuscript E: "The Use of Volunteers in Jails"

Forty-nine percent of the fifty-five respondents had received the monograph. Twenty-five of those had also read the material. Nearly half evaluated the pamphlet as good.

Manuscript F: "The Recognition of Inmates with Mental Illness"

Of the fifty-four respondents, seventeen had received the material. Of those seventeen, fourteen had also read the pamphlet. All of the readers evaluated the material and over half of them rated the pamphlet excellent.

Manuscript G: "Orienting Health Providers to the Jail Culture"

Fifteen of the total fifty-three respondents had received the manuscript and thirteen of these had read the pamphlet. Only twelve people evaluated the material, with the majority of the ratings being good or excellent.

Manuscript H: "Constitutional Issues of the Prisoner's Right to Health Care"

Twenty-eitht of the fifty-five respondents had received the material; and, of those, twenty-seven had also read the pamphlet. The majority of the twenty-seven who evaluated the pamphlet rated it excellent.

Manuscript I: "Health Care in Jails: Legal Obligations"

Fifty percent of the total fifty-four respondents had received the material. Twenty-five also reported reading the pamphlet, and of those, twenty-three evaluated it as good or excellent.

Manuscript J: "The Use of Allied Health Personnel in Jails ..."

Fifty people responded to this item. Fifty-seven percent (N=28) claimed they had received the manuscript and twenty-seven had read the material. Fourteen of those who had received and read the manuscript rated it good.

Manuscript K: "Health Care in Jails: Inmate's Medical Records"

Thirty-five of the fifty-six respondents had not received the manuscript. Of the twenty-one who reported having received the material, twenty had also read it. Half the readers gave the pamphlet an evaluation of excellent.

Manuscript L: "Summary of the Jail Pre-Profile"

Eighty-six percent of the fifty-two respondents had not received this summary. Seven read the material and seven also evaluated it. Five rated it good and two, excellent.

Manuscript M: "Summary of the Jail Inmate/Patient Profile"

Fifty-one people provided information about this item. Eighty-eight percent had not received the material. Six had received the summary, and the same number had also read it. Five rated the material good.

Manuscript N: Standards for the Accreditation of Medical Care and Health Services

Only nineteen of the fifty who responded reported having received this material. Of the nineteen who had read the document, seven rated it excellent, nine rated it good, and three felt if was only fair.

Correctional Stethoscope

Twenty-four (42%) of the fifty-five respondents had received the newsletter. Twenty-one of these twenty-four felt the newsletter had value. Most people who evaluated the material used it as a means of keeping abreast of current information in the field and as a preliminary source for other materials. However, some felt that the newsletter was lacking in information and/or repetitious.

In addition, respondents were asked to state the number of people who read the monographs. The numbers ranged from one to more than twelve additional readers.

Also, responses were mixed with respect to the dissemination of supplementary clearinghouse materials. Of the few who answered this item, some felt that the additional material was both informative and promptly delivered. However, many complained that not only had they not received supplementary monographs, they had not received any of the materials listed in the questionnaire. A few were disturbed that their address changes had gone unheeded.

Many respondents suggested topic areas which needed further discussion. Some people desired more information about the following things: medico-legal developments in jail health care; the politics of drug abuse in jails; and jail health policy guidelines. More medically-minded persons wished to see more information about: the relationships between jail and community hospital care; dental care in jail; analyses of the attitudes of jail medical personnel; symptoms and treatment of drug and alcohol abuse; psychological problems of homosexuals; and control of medication in jails. Those interested in education wished to see more material regarding training programs for jail health staffs, the use of health resources outside jail, and the implementation of health education for inmates.

Thus, it would appear that, for the most part, recipients of clearinghouse materials felt that the majority of the monographs were of value to them. Additional comments from some respondents prompt the evaluator to recommend the following:

- The AMA Clearinghouse should up-date its mailing list to remove duplicate entries and delete the names of people who have died or are no longer interested in receiving materials.
- In addition, a better system should be devised for determining which materials are sent to which subscribers.
- Further, the AMA should give consideration to developing new materials in Year Three from the list of topic areas suggested by respondents.

In regard to the process deficiencies noted by the evaluator in the preliminary report,[53] most of these have now been corrected. Shelves were provided and the necessary cataloging of materials was begun. In addition, several of the central staff have been helping with the annotating, numbering and filing of materials, so considerable progress has been made since the last report. Library cataloging is also in progress.

Before leaving this section, it should be noted that, overall, the states felt the personal TA provided by the Clearinghouse Director was good. Requested materials were received promptly and the CD made every attempt to answer satisfactorily any questions put to her.

2. Publicity and Outreach Efforts

Attempts to generate interest in the AMA program and in jail health have taken many forms. Besides articles which have appeared in the AMA Newsletter and the American Medical News -- both "in-house" publications -- a significant amount of "out-

[53] See p. 14, supra at note 14.

side" media coverage has occurred as well. Articles focusing on various aspects of the jail program's activities appeared in major papers such as the New York Times, the Washington Post, the Wall Street Journal and the Chicago Tribune, among others. Further, Parade Magazine, which is carried as a "Sunday supplement" in hundreds of newspapers across the country, did a feature story on the AMA program in June of 1977. Additional press coverage occurred regarding the accreditation program.

During the preceding months, AMA central staff (notably, the Project Director) have made presentations before a number of professional organizations such as: the National Jail Managers' Association, the National Sheriffs' Association, the American Association of Medical Society Executives, the Southern Health Care Foundation, the National Jail Association and the American Society of Criminology. In addition, central staff participated in press conferences and in meetings of physician groups and other organizations in the pilot states.

Finally, central staff served as technical consultants to other LEAA-funded correctional health care projects such as those of the University Research Corporation and the University of Michigan.

D. The National Conference

The AMA's first National Jail Conference was held in Milwaukee on Sunday, August 21, 1977. It was estimated that approximately 315 health care and criminal justice professionals attended this full-day session. In addition, the AMA held a two-hour workshop on Monday, August 22, in conjunction with the ACA Congress on Corrections, which was attended by about 200 individuals.

Evaluation forms were distributed at both the Sunday conference and the Monday workshop. Analyses of the results from both data sets were discussed fully in the Preliminary Evaluation Report[54] and need not be reiterated here. Suffice it to say that on an overall basis the first conference was very well received. Recommendations emerging from participants' feedback included the following:

- Improvements were needed in some logistical and administrative aspects of the conference such as seating arrangements, tight agenda scheduling, insufficient hand-out materials for all participants, etc.
- The second conference should include small group workshop sessions as well as speeches to the general audience.
- The title of the next conference should be something like "The AMA National Conference on Jail Health." This would be more descriptive and appropriate than the previous title of "The AMA National Jail Conference."

[54] See pp. 51-56 and Appendices E and F, supra at note 14.

IV SUMMARY OF CONCLUSIONS AND RECOMMENDATIONS

On balance, it can clearly be stated that the AMA Jail Program successfully accomplished its second year goals. The standards were finalized, the accreditation program was launched, and the conference held on health care in jails was well-received. Several monographs were published, the Practical Guide was completed and a documentary film was produced. The Clearinghouse became increasingly active, and publicity efforts during the second year were good.

The six state projects also made considerable headway during Year Two. Several of the pilot sites were accredited and efforts to improve the delivery systems in remaining sites continued. The required data were collected, more publicity was generated and work toward attaining unique objectives was often successful as well. Most importantly, results from the second year I/PP and JP-P reports indicated that the AMA program did, indeed, have a significant impact on improving jail health care delivery systems and on improving the health status of inmates themselves.

Since the AMA program is scheduled for a third year of operation, the evaluator made a number of recommendations throughout this report. It is hoped that these suggestions will contribute toward the continuing successful operation of the Jail Program. Specific recommendations for improving the national program and the state projects have been sufficiently detailed in the body of this report and need not be reiterated here. Nevertheless, a brief summary may be of some benefit.

Recommendations for Year Three include the following:

1. The Atlanta City Jail, Indiana county jails in Brown and Morgan and the Okanogan County Jail in Washington, should be dropped. Jails in Washington County, Maryland and Grays Harbor, Washington should be continued only if expected changes have occurred by mid-way through the third year. All other old and new second year sites should be retained and encouraged to participate in the accreditation process (see pp. 18-29).

2. Advisory Committees in Indiana and Wisconsin should be resurrected (see p. 59).

3. Michigan and Wisconsin should step up their outreach activities and improve their progress reports as noted in the text (see pp. 58-59).

4. AMA central staff should consider the feedback from the states regarding how to improve their role (see pp. 60-61).

5. AMA central staff and the National Advisory Committee should review the standards not met by at least two-thirds of the pilot sites by the end of the second year (see pp. 69-73) and consider the following:

   a. Shortening the time requirements for completing physical examinations and communicable disease screening;

   b. Revising the present requirement for exercise programs;

   c. Developing special materials to help jails meet the present requirements for dental services;

   d. Retaining the standards regarding procedures for handling pharmaceuticals, transfer of medical records and inmate informed consent "as is."

6. AMA central staff and the National Advisory Committee should review the section on the accreditation process and review the specific recommendations listed there (see pp. 73-76). At the very least, the worksheets should be revised as specified in Appendix D and a manual should be developed.

7. The clearinghouse mailing list should be updated, a better system for distribution of materials should be

devised and new topic areas for monographs should be researched (see pp. 82-83).

8. The title of the next national conference should be changed, logistical arrangements improved and small group workshops included. (See p. 85.)

APPENDIX A

Abbreviation Key

CONTINUED

1 OF 2

ABBREVIATION KEY

National Level

- ACA - American Correctional Association
- AMA - American Medical Association
- HSA - Health Service Agency
- LEAA - Law Enforcement Assistance Administration
- NIC - National Institute of Corrections
- NSA - National Sheriffs' Association

State Medical Societies

- ISMA - Indiana State Medical Association
- MAG - Medical Association of Georgia
- MED/CHI - Medical and Chirurgical Faculty of the State of Maryland
- MSMS - Michigan State Medical Society
- SMSW - State Medical Society of Wisconsin
- WSMA - Washington State Medical Association

AMA Central Staff

- CD - Clearinghouse Director
- HCSS - Health Care Systems Specialist
- JPD - Jail Program Director
- NAC - National Advisory Committee

State Staff

- PAC - Project Advisory Committee
- PPD - Pilot Project Director
- RA - Research Assistant

General

- DOC - Department of Corrections
- EMT - Emergency Medical Technician
- I/PP - Inmate Patient Profile
- JP-P - Jail Post-Profile
- N - Number
- N/A - Not Applicable
- RRA - Registered Record Administrator
- SOP - Standard Operating Procedures
- OC - Occupational Category

Jail Codes

1.	Georgia	1. Atlanta City 2. De Kalb County 3. Monroe County 4. Troup County 5. Upson County
2.	Indiana	1. Brown County 2. Greene County 3. Lake County 4. Marion County 5. Monroe County 6. Morgan County 7. Owen County
3.	Maryland	1. Anne Arundel County 2. Baltimore City 3. Baltimore County 4. Montgomery County 5. Prince Georges County 6. Queen Anne's County 7. Washington County
4.	Michigan	1. Lake County 2. Oakland County 3. Shiawassee County 4. Washtenaw County
5.	Washington	1. Grays Harbor County 2. Oakanogan County 3. Whatcom County 4. Whitman County
6.	Wisconsin	1. Adams County 2. Eau Claire County 3. Milwaukee County

APPENDIX B

Characteristics of the
Project Advisory Committees

Chart 1: Committee Makeup

Chart 2: Other Characteristics

Characteristics of the Project Advisory Committee

1. Committee Makeup

State	Total #	Health Representatives	Correctional Representatives	Legal Representatives	Other
GEORGIA***	10	9 physicians (including a psychiatrist, a pediatrician and a medical educator	1 DOR Health Services Director	None	None
INDIANA	24	5 physicians (including a forensic psychiatrist) 1 pharmacist 1 dentist 2 medical educators 1 DOC medical administrator	1 jail inspector 1 Sheriffs' Association executive 1 administrator of an ex-offender program	1 criminal court judge 1 public defender 1 state legislator 4 attorneys (representatives of the Bar Association and the ILC)	1 Chamber of Commerce executive 1 Association of Counties executive 1 AA representative 1 SPA representative
Sub-Totals		10	3	7	4
MARYLAND	17	8 physicians (7 from each of the pilot counties and 1 forensic psychiatrist) 2 representatives of the state health department	1 jail inspector 1 Sheriffs' Association representative* 1 Jail Administrators' Ass'n. representative 1 correctional trainer	1 attorney from the Bar Association	1 Association of Counties executive 1 SPA representative
Sub-Totals		10	4	1	2
MICHIGAN	13	5 physicians (4 serving as county coordinators from each of the pilot areas and 1 chairman) 1 DOC physician-advisor status** 1 DOC phychiatrist - advisor status** 1 dentist - advisor status** 1 jail nurse - advisor status** 1 county medical society executive - advisor status**	2 representatives of the DOC Office of Jail Services - advisor status** 1 Sheriffs' Association executive - advisor status**	None	None
Sub-Totals		10	3	0	0
WASHINGTON ***	10	9 physicians 1 medical student	None	None	None
Sub-Totals		10	0	0	0
WISCONSIN	21	6 physicians 1 dentist 1 hospital administrator 1 Division of Health rep. 2 medical educators 1 Hospital Association representative	1 Sheriffs' Association executive 1 Police Chiefs' Association representative 1 DOC administrator 1 female ex-offender	1 Bar Association executive	1 League of Women Voters representative 1 Council of Churches representative 1 SPA representative 1 County Board Association Representative
Sub-Totals		12	4	1	4

*Appointed to PAC but has never attended meetings.

**The five physicians are the only official PAC members. The others serve as advisors on an unofficial basis.

***Note: Georgia and Washington have formed extensive liaison networks with a number of relevant organizations. Their official committees, however, consist of only these physician members.

Characteristics of the Project Advisory Committee

2. Other

State	Date Formed	# of Meetings (as of 3/31/78)	Voluntary?	Major Role	Committee Task Forces?
GEORGIA	NOV. 1975*	1 - July '77 1 - September 1977 1/3 - Jan. '78	Voluntary	Policy-making, project review and planning. Limited use of full committee to date.	None to date, although members have been utilized on an individual basis to review and critique the standards, accreditation process, etc.
INDIANA	March 1976	None	Voluntary	Policy-making, project review and planning. Full committee not used since December 1976	A legislative subcommittee was formed to work on a medical section for a proposed Jail Standards Code for Indiana. Their first meeting was held in December 1977. There has also been some use of individual members on an ad hoc basis, particularly the PAC physician chairman.
MARYLAND	April 1976	1 - March '77 1 - April '77 1 - June '77 1 - August '77 1 - Sept. '77 1 - Nov. '77 1 - Jan. '78 1/8 - March '78	Voluntary	Policy-making, project review and planning plus specific activities of task forces. Extensive use of full committee. Meetings held at a different pilot jail each time.	Yes - task forces established on 1) standards; 2) Inmate Patient Profile; 3) standing orders and medical records; and 4) physical facilities. All except #3 have been active this year.
MICHIGAN	Jan. 1976	1 - April '77 1 - July '77 1 - Oct. '77 1/4 - Feb. '78	Physician representatives are paid. Advisors to the project are not.	Policy-making, project review and planning. Moderate use of full committee to date.	Yes - Physician Task Force has focused on reviewing standards and revising its manual of policies and procedures for jail health care.
WASHINGTON	1972 **	1 - March '77 1 - Sept. '77 1/3 - Feb. '78	Voluntary	Policy-making, project review and planning. Limited use of full committee to date.	No formal subgroups although PAC members work closely with the PPD on revising the manual and training package, lobbying for legislation, working with pilot counties, etc.
WISCONSIN	Jan.	None	Voluntary	Policy-making, project review and planning. Not used since January of 1977, however.	None to date. Individual members used on an ad hoc basis to review standards, critique forms, etc.

*This committee also serves the DOC health program.

**The original Jail and Prison Health Care Committee carried over to this project.

APPENDIX C

The Pilot Jails and Compliance with AMA Health Care Standards

Chart I: Number of AMA Health Care Standards Met by Each Pilot Jail

Chart II: Jail Compliance with AMA Health Care Standards (Spring 1977 Draft) by State

Chart III: Number of Pilot Jails Meeting Specific AMA Health Care Standards

Chart IV: Jail Compliance with AMA Health Care Standards (Spring 1977 Draft) by Jail Size

NU[illegible] OF A[illegible]ALTH [illegible] ST[illegible]S
MET BY EACH PILOT JAIL

State/ Jail Code	SIZE (S)mall (M)edium (L)arge	ACCREDITATION STATUS FA = Fully Accredited PA = Provisionally Accredited NA = Not Accredited	Number of Essential Standards Fully Met	Number of Essential Standards Applicable Out of a Possible 62	Percent of Applicable Essential Standards Fully Met	Number of Important Standards Fully Met	Number of Important Standards Applicable Out of a Possible 21	Percent of Applicable Important Standards Fully Met
1-1	L	NA	14	60	23%	4	21	19%
1-2*	L	FA	57	61	93%	14	20	70%
1-3[a]	S	NA	59	61	97%	15	21	71%
1-5	S	PA	51	61	84%	12	21	57%
2-1[a]	S	NA	12	61	20%	3	21	14%
2-2	S	FA	56[e]	61	92%	17	20	85%
2-4	L	FA	58[e]	62	94%	17	20	85%
2-5	M	FA	57	60	95%	15	21	71%
2-6[a]	M	NA	12	61	20%	3	21	14%
2-7[a]	S	NA	54	61	89%	16	21	76%
3-1	M	FA	58	60	97%	13	21	62%
3-2	L	PA	54	61	89%	11	21	52%
3-3	M	FA	56	60	93%	17	21	81%
3-4	M	FA	56	60	93%	15	20	75%
3-5	L	FA	53	59	90%	16	19	84%
3-7[a]	M	NA	10	61	16%	5	21	24%
4-1	S	FA	52[e]	58	91%	18	21	86%
4-2	L	FA	57	60	95%	15	21	71%
4-3	M	FA	61	61	100%	17	20	85%
4-4	M	FA	57[e]	62	92%	16	21	76%
5-1[a]	M	NA[b]	-	-	-	-	-	-
5-2	S	PA then NA [c]	-	-	-	-	-	-
5-3	M	FA	57[e]	61	93%	15	21	71%
5-4*	S	FA	52	56	93%	14	21	67%
6-1*	S	FA	56	61	92%	15	20	75%
6-2	M	FA	55[e]	59	93%	17	20	85%
6-3	L	PA	50	60	83%	14	21	67%
Totals[d] 27 jails	9 Small 11 Medium 7 Large	16 - Fully 3 - Provisionally 7 - Non	1,214	1,508	81%	333	516	65%

a. These six jails did not go through accreditation surveys. All information concerning which standards were fully complied with in these jails was derived from the "best estimates" of the appropriate pilot project directors.

b. Data were not collected on this jail since it was expected to be dropped from the project. However it was retained as a pilot site and continues in the project as of this date.

c. This jail was resurveyed on March 29, 1978 and is expected to lose its provisional accreditation.

d. It should be noted that three of the original thirty pilot jails were dropped from the project in Year Two. These jails were number 1-4, 2-3 and 3-6.

e. These seven jails participated in the first round of accreditation surveys. At that time they fully complied with the essential standard which required the jail to seek medical treatment for alcoholics in lieu of incarceration. While this standard was subsequently dropped, it is included in the totals for those jails which met it at the time it was still applicable.

* Designation of "full accreditation" for these sites seems questionable, unless they were given the benefit of numerical rounding beyond the traditionally acceptable levels.

Chart II

JAIL COMPLIANCE WITH AMA HEALTH CARE STANDARDS
(SPRING 1977 DRAFT) BY STATE

State	Number of Jails	Total Number of Essential Standards Fully Met in Each State	Total Number of Essential Standards Applicable in Each State	Percent of Essential Standards Fully Met	Total Number of Important Standards Fully Met in Each State	Total Number of Important Standards Applicable in Each State	Percent of Important Standards Fully Met
GEORGIA	4	181	243	74%	44	83	53%
INDIANA	6	249	366	68%	71	124	57%
MARYLAND	6	287	361	80%	77	123	63%
MICHIGAN	4	227	241	94%	66	83	80%
WASHINGTON	2*	109	117	93%*	30	42	71%*
WISCONSIN	3	161	180	89%	45	61	74%
TOTALS	25	1,214	1,508	81%	333	516	65%

*No information was available for two of Washington's four pilot jails. Since neither of these two sites has accreditation status at this time, the percent of standards fully met in this state must be considered an inflated figure.

Chart III

NUMBER OF PILOT JAILS MEETING
SPECIFIC AMA HEALTH CARE STANDARDS

Standard #	Type of Standards: (E)ssential/ (I)mportant	Number of Jails Fully Meeting This Standard	Number of Jails Not Meeting This Standard	Number of Jails Where This Standard Is Not Applicable	Total Number of Jails*
1001	E	22	3	0	25
1002	E	24	1	0	25
1003	E	18	7	0	25
1004	I	21	4	0	25
1005	I	19	6	0	25
1006	E	19	6	0	25
1007	E	19	6	0	25
1008	E	21	4	0	25
1009	E	20	5	0	25
1010	E	14	11	0	25
1011	E	21	4	0	25
1012	E	19	6	0	25
1013	E	19	6	0	25
1014	E	19	6	0	25
1015	E	21	4	0	25
1016	I	19	6	0	25
1017	E	20	5	0	25
1018	E	20	5	0	25
1019	E	21	4	0	25
1020	E	21	4	0	25
1021	E	12	5	8	25
1022	E	23	2	0	25
1023	E	19	4	2	25
1024	E	21	4	0	25
1025	E	22	3	0	25
1026	E	21	4	0	25
1027	I	21	4	0	25
1028	E	20	5	0	25
1029	E	20	5	0	25
1030	I	20	5	0	25
1031	I	10	15	0	25
1032	I	1	24	0	25
1033	E	22	3	0	25
1034	I	12	13	0	25
1035	I	5	20	0	25
1036	I	8	17	0	25
1037	E	14	11	0	25
1038	E	23	2	0	25
1039	E	18	7	0	25
1040	E	21	4	0	25
1041	E	22	3	0	25
1042	E	20	5	0	25

*Of the thirty original pilot sites, three were dropped and data were not available on two others.

Standard #	Type of Standards: (E)ssential/ (I)mportant	Number of Jails Fully Meeting This Standard	Number of Jails Not Meeting This Standard	Number of Jails Where This Standard Is Not Applicable	Total Number of Jails*
1043	E	19	6	0	25
1044	E	22	3	0	25
1045	E	19	6	0	25
1046	E	7	0	18	25
1047	E	18	5	2	25
1048	E	21	4	0	25
1049	E	12	13	0	25
1050	I	18	7	0	25
1051	E	17	8	0	25
1052	E	21	4	0	25
1053	E	20	5	0	25
1054	E	20	5	0	25
1055	E	19	6	0	25
1056	I	22	3	0	25
1057	I	11	14	0	25
1058	E	23	2	0	25
1059	E	18	7	0	25
1060	E	21	4	0	25
1061	E	21	4	0	25
1062	E	18	7	0	25
1063	E	20	5	0	25
1064	I	12	13	0	25
1065	I	21	4	0	25
1066	I	21	4	0	25
1067	E	16	9	0	25
1068	E	23	2	0	25
1069	I	14	11	0	25
1070	E	18	4	3	25
1071	E	19	3	3	25
1072	E	18	4	3	25
1073	E	21	1	3	25
1074	I	19	5	1	25
1075	E	19	6	0	25
1076	E	24	1	0	25
1077	I	24	1	0	25
1078	I	16	1	8	25
1079	E	18	7	0	25
1080	I	19	6	0	25
1081	E	21	4	0	25
1082	E	23	2	0	25
1083	E	23	2	0	25

Totals:
62 Essential Standards Possible
21 Important Standards Possible
1,214 Essential Standards Fully Met
333 Important Standards Fully Met
51 Standards Not Applicable at Individual Jails

Chart IV

JAIL COMPLIANCE WITH AMA HEALTH CARE STANDARDS
(SPRING 1977 DRAFT) BY JAIL SIZE

Jail Size	Number of Jails	Total Number of Essential Standards Fully Met in Each Size Category	Total Number of Essential Standards Applicable in Each Size Category	Percent of Essential Standards Fully Met	Total Number of Important Standards Fully Met in Each Size Category	Number Number of Important Standards Applicable in Each Size Category	Percent of Important Standards Fully Met
SMALL	8	392	480	82%	110	166	66%
MEDIUM	10	479	605	79%	133	207	64%
LARGE	7	343	423	81%	90	143	63%
TOTALS	25	1,214	1,508	81%	333	516	65%

APPENDIX D

Suggestions for Changing the Accreditation Survey Worksheets

Suggestions for changing the worksheets for the on-site accreditation surveys included the following:*

Worksheets B, E, G, H, I, J and L

The questions and the standard referred to (#1067) do not agree. The standard asks whether informed consent procedures applicable in the community are observed in the jail, and the questions ask whether inmates' have the right to refuse medical examinations or treatment. These are not the same thing. The phrasing of standards and questions should be consistent.

Worksheets F, G and H

Questions related to the specification of emergency training received by correctional staff (#1026) need to be stated more clearly and precisely. The phrasing is awkward at best and confusing as well.

Worksheets G, H and I

The questions relating to Standard #1080 asking "How do inmates shave?" and "How do inmates get haircuts?" are poorly phrased. They should be reworded to reflect the language and intent of the standard.

Worksheets G and H

a. Questions on first aid training are included twice (at #1026 and again at #1074). It should only be asked once and eliminated elsewhere.

b. The questions regarding the exercise program (#1032) should be rephrased to ask whether inmates are allowed to exercise rather than if they do exercise.

c. The question on Standard 1040 should be changed to read "Were you taught to recognize symptoms of mental illness?"

d. The question for Standard 1062 should be expanded to ask "If yes, under what conditions?" The standard itself does not preclude correctional staff from seeing inmate records under all circumstances.

Worksheet I

a. There must be a better way to determine if dental screening has been done (#1034) than by asking an inmate "Has anyone looked in your mouth?" The inmate should be asked whether any medical or dental personnel has checked his/her teeth, regardless of whether or not any treatment was initiated.

b. The question "Have you had dental treatment other than emergency?" (#1037) should be asked in a fuller and clearer fashion.

c. The question "Who can read your medical record? __ Yes __ No" (#1062) is not only poorly stated but is perhaps inappropriate to ask of inmates.

*Note that the standard numbers listed here correspond to those in the old draft of the survey questionnaire.

d. All of the questions relating to Standard 1067 need to be reworked. The standard does not specifically require all of these elements in stating that informed consent procedures used in the community apply in the jail as well.

Worksheet M

A. As previously noted, the questions relating to Standard 1081 should be rephrased. In addition (or perhaps, instead) a question should be added asking whether pre-service examinations and periodic re-examinations are required for food handlers.

b. On Standard 1083, there is no language referring to whether special diets are served to the right inmates. This question should probably be deleted in any case, since individuals who prepare food do not necessarily deliver it.

APPENDIX E

Distribution of Clearinghouse Materials

I: Key to Item Coding for Clearinghouse Materials

II: Totals for October 1977 - March 1978

III: Year Two Totals - January 1977 - March 1978

Chart I
Key to Item Coding for Clearinghouse Materials

1. Fact Sheets
   a. Fact Sheet on Program to Improve Medical Care and Health Services in Jails
   b. The Criminal Justice System
   C. Informing and Organizing the Community to Get Things Done

2. Monographs
   a. Models for Health Care Delivery in Jails
   b. The Use of Allied Health Personnel in Jails
   c. The Role of State and Local Medical Society Jail Advisory Committees
   d. Organizing of Citizen Advisory Committees to Upgrade Jail Medical Programs
   e. Orienting Health Providers to the Jail Culture
   f. Constitutional Issues of the Prisoners' Right to Health Care
   g. Legal Obligations to the Pre-Trial Detainee
   h. The Use of Allied Health Personnel in Jails: Legal Considerations
   i. Inmates' Medical Records and Jail Inmates' Right to Refuse Medical Treatment
   j. The Use of Volunteers in Jails
   k. The Recognition of Jail Inmates with Mental Illness: Their Special Problems and Needs for Care

3. Newsletters
   a. January/February 1976
   b. Correctional Stethoscope (bi-monthly publication: February, April, June, August, October, December of 1977 and February 1978)

4. Baseline Data Forms/Reports
   a. Jail Pre-Profile Forms
   b. Inmate/Patient Profile Forms
   c. Informed Consent Forms
   d. Jail Pre-Profile Summary
   e. Jail Pre-Profile Report
   f. Inmate/Patient Profile Summary
   g. Inmate/Patient Profile Report

5. Bibliographies
   a. "Ten Most Wanted"

6. Meeting Minutes
   a. State Pilot Project Directors' Meetings
   b. National Advisory Committee Meetings

7. Project Materials
   a. First Year Proposal (Full or Narrative)
   b. Publications List
   c. Speech - Nidetz, December 1975
   d. Synopsis of Pilot States' Action Plans

e. Second Year Proposal to LEAA
f. AMA News Releases
g. Drafts of Standards
h. Drafts of Survey Questionnaire
i. Accreditation Materials
j. Conference Materials

8. Non-Project Materials
   a. Newspaper Articles
   b. Magazine and Journal Articles
   c. Reprinted Pamphlets
   d. Prescriptive Package (Health Care in Corrections)

9. Films
   a. "The Revolving Door"
   b. "Children in Trouble"

10. Technical Assistance (e.g., answer questions re: project, make referrals, answer requests for information, research special items, etc.)

Chart II

Distribution of Clearinghouse Materials:
(October 1977 - March 1978)

Recipient	1 a	1 b	1 c	1 d	2 a	2 b	2 c	2 d	2 e	2 f	2 g	2 h	2 i	2 j	2 k
Program Personnel															
1. Pilot Projects (A_1)	5	0	0	1	56	56	55	5	2	158	54	104	17	6	205
2. Other* (A_2)	201	0	0	1	3	3	2	2	103	3	4	3	4	2	3
Sub-Total (A)	206	0	0	2	59	59	57	7	105	161	58	107	21	8	208
Personnel Outside Program															
1. Sheriffs & Correctional Administrators (B_1)	23	0	1	5	1,084	1,079	1,081	92	1,039	1,180	1,106	1,075	104	93	109
2. Physicians & Health Professionals (including Cooperating States) (B_2)	63	0	7	8	182	187	191	189	35	274	287	260	224	268	204
3. Other** (B_3)	7	0	2	1	51	43	13	50	9	123	57	65	70	46	56
Sub-Total (B)	93	0	10	14	1,317	1,309	1,285	331	1,083	1,577	1,450	1,400	398	407	369
Total	299	0	10	16	1,376	1,368	1,342	338	1,188	1,738	1,508	1,507	419	415	577

*Includes National Advisory Committee Members, LEAA Representatives and evaluator.
**Includes attorneys, professors, students, other agency representatives, etc.

(con't)

Chart II (con't)

Recipient	7 (con't) e	f	g	h	i	j	8 a	b	c	d	9 a	b	10	Totals N	%
Program Personnel															
1. Pilot Projects (A_1)	0	0	13	37	1	0	0	0	0	0	0	0	2	1,762	10.0
2. Other* (A_2)	0	0	4	20	1	0	0	0	0	0	0	0	0	767	4.4
Sub-Total (A)	0	0	17	57	2	0	0	0	0	0	0	0	2	2,529	(14.3)
Personnel Outside Program															
1. Sheriffs & Correctional Administrators (B_1)	0	0	45	21	2	0	0	0	0	0	0	0	2	9,819	55.7
2. Physicians & Health Professionals (including Cooperating States) (B_2)	0	0	79	22	3	0	0	0	0	0	0	0	2	4,185	23.7
3. Other** (B_3)	0	0	24	1	1	0	0	0	0	0	0	0	0	1,095	6.2
Sub-Total (B)	0	0	148	44	6	0	0	0	0	0	0	0	4	15,099	(85.7)
Total	0	0	165	101	8	0	0	0	0	0	0	0	6	17,628	100.0

*Includes National Advisory Committee Members, LEAA Representatives and evaluator.
**Includes attorneys, professors, students, other agency representatives, etc.

Chart II (con't)

Recipient	3		4							5	6		7 (con't)			
	a	b	a	b	c	d	e	f	g	a	a	b	a	b	c	d
Program Personnel																
1. Pilot Projects (A_1)	0	900	0	0	0	4	1	78	0	0	0	0	0	2	0	0
2. Other* (A_2)	0	400	0	0	1	2	0	3	0	0	0	0	0	2	0	0
Sub-Total (A)	0	1,300	0	0	1	6	1	81	0	0	0	0	0	4	0	0
Personnel Outside Program																
1. Sheriffs & Correctional Administrators (B_1)	0	1,600	0	0	7	20	7	19	0	0	0	0	0	24	1	0
2. Physicians & Health Professionals (including Cooperating States) (B_2)	0	1,543	0	0	24	31	10	46	1	0	0	0	0	43	2	0
3. Other** (B_3)	0	400	0	0	7	4	2	9	0	0	0	0	0	54	0	0
Sub-Total (B)	0	3,543	0	0	38	55	19	74	1	0	0	0	0	121	3	0
Total	0	4,843	0	0	39	61	20	155	1	0	0	0	0	125	3	0

*Includes National Advisory Committee Members, LEAA Representatives and evaluator.
**Includes attorneys, professors, students, other agency representatives, etc.

Chart III

Distribution of Clearinghouse Materials:
Year Two Totals (January 1977 - March 1978)

Recipient	1 a	1 b	1 c	1 d	2 a	2 b	2 c	2 d	2 e	2 f	2 g	2 h	2 i	2 j	2 k	3 (con't) a
Program Personnel																
1. Pilot Projects	37	0	0	1	1,075	930	1,448	13	10	322	218	268	18	7	505	0
2. Other*	217	0	0	1	6	6	140	3	103	3	4	3	4	2	3	0
Sub-Total	254	0	0	2	1,081	936	1,588	16	113	325	222	271	22	9	508	0
Personnel Outside Program																
1. Sheriffs & Correctional Administrators	315	0	1	5	2,038	2,031	2,029	3,197	1,046	4,697	4,616	4,584	3,208	3,197	3,237	0
2. Physicians & Health Professionals (including Cooperating States)	669	0	7	8	413	417	415	2,603	47	2,561	2,603	2,568	2,657	2,703	2,650	0
3. Other**	36	4	5	1	276	268	238	63	9	128	60	68	70	46	56	6
Sub-Total	1,020	4	13	14	2,727	2,716	2,682	5,863	1,102	7,386	7,279	7,220	5,935	5,946	5,943	9
Total	1,274	4	13	16	3,808	3,652	4,270	5,879	1,215	7,711	7,501	7,491	5,957	5,955	6,451	9

*Includes National Advisory Committee Members, LEAA Representatives and evaluator.
**Includes attorneys, professors, students, other agency representatives, etc.

(con't)

Chart III(con't)

Recipient	3 (cont) b	4 a	4 b	4 c	4 d	4 e	4 f	4 g	5 a	6 a	6 b	7 (con't) a	7 (con't) b	7 (con't) c	7 (con't) d	7 (con't) e
Program Personnel																
1. Pilot Projects	1,136	0	0	100	141	80	220	91	0	37	5	0	2	0	0	0
2. Other*	435	0	0	1	102	0	103	0	0	1	31	57	4	1	1	3
Sub-Total	1,571	0	0	101	243	80	323	91	0	38	36	57	6	1	1	3
Personnel Outside Program																
1. Sheriffs & Correctional Administrators	2,521	0	0	7	28	7	29	0	0	0	0	0	25	1	0	0
2. Physicians & Health Professionals (including Cooperating States)	2,238	0	0	24	88	13	107	4	1	6	6	2	50	12	0	0
3. Other**	1,020	0	0	7	35	2	40	0	0	1	0	0	54	2	0	0
Sub-Total	5,779	0	0	38	151	22	176	4	1	7	6	2	129	15	0	0
Total	7,350	0	0	139	394	102	499	95	1	45	42	59	135	16	1	3

*Includes National Advisory Committee Members, LEAA Representatives and evaluator.
**Includes attorneys, professors, students, other agency representatives, etc.

(con't)

Chart III (con't)

Recipient	7 (con't) f	g	h	i	j	8 a	b	c	d	9 a	b	10 a	Totals N	%
Program Personnel														
1. Pilot Projects	0	140	41	73	2	62	159	0	2	0	0	20	7,163	9.0
2. Other*	3	11	22	2	1	12	23	0	0	0	0	12	1,320	1.7
Sub-Total	3	151	63	75	3	74	182	0	2	0	0	32	8,483	(10.7)
Personnel Outside Program														
1. Sheriffs & Correctional Administrators	2	91	23	3	4,438	3	0	0	0	0	0	52	41,431	52.1
2. Physicians & Health Professionals (including Cooperating States)	0	258	72	8	3,154	10	1	0	5	0	0	92	26,475	33.3
3. Other **	4	59	7	1	503	7	0	0	2	0	0	20	3,098	3.9
Sub-Total	6	408	102	12	8,095	20	1	0	7	0	0	146	71,004	(89.3)
Total	9	559	165	87	8,098	94	183	0	9	0	0	196	79,487	100.0

*Includes National Advisory Committee Members, LEAA Representatives and evaluator.
**Includes attorneys, professors, students, other agency representatives, etc.

APPENDIX F

"Table of Contents" of the
AMA's Practical Guide

This Practical Guide to the American Medical Association Standards for the Accreditation of Medical Care and Health Services in Jails was developed to assist the physician responsible for the jail's medical services and the jail administrator structure the medical delivery system to comply with the Standards

TABLE OF CONTENTS

APPENDIX G

Feedback from Clearinghouse Recipients
Broken Down by Occupational Category

Chart A: "The Use of Allied Health Personnel in Jails"
Chart B: "Models for Health Care Delivery in Jails"
Chart C: "The Role of State and Local Medical Society Jail Advisory Committees"
Chart D: "Organizing and Staffing Citizen Advisory Committees..."
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Chart A

"The Use of Allied Health Personnel in Jails"

Occupational Category*	Received? Yes	No	Totals	Read? Yes	No	Totals
M.P.	18	13	31	17	0	17
C.P.	5	1	6	5	0	5
O.C.J.P.	10	4	14	10	0	10
Other	5	1	5	5	0	5
Totals	38 (61%)	19 (39)	57 (100%)	37	0	37

Evaluation

Occupational Category*	Excellent	Good	Fair	Poor	Totals
M.P.	3	12	3	0	18
C.P.	1	4	0	0	5
O.C.J.P.	2	8	0	0	10
Other	1	2	1	1	5
Totals	7	26	4	1	38

*See Key following charts.

Chart B

"Models for Health Care Delivery in Jails"

Occupational Category*	Received? Yes	No	Totals	Read? Yes	No	Totals
M.P.	14	17	31	11	1	12
C.P.	6	0	6	6	0	6
O.C.J.P.	9	5	14	9	0	9
Other	4	2	6	4	0	4
Totals	33 (58%)	24 (42%)	57 (100%)	30	1	31

Evaluation

Occupational Category*	Excellent	Good	Fair	Poor	Totals
M.P.	5	4	3	0	11
C.P.	3	2	1	0	6
O.C.J.P.	3	6	0	0	9
Other	1	1	1	1	4
Totals	12	13	5	1	30

*See Key following charts.

Chart C

"The Role of State and Local Medical Society Jail Advisory Committees"

Occupational Category*	Received? Yes	No	Totals	Read? Yes	No	Totals
M.P.	8	22	30	8	0	8
C.P.	3	4	7	3	0	3
O.C.J.P.	5	8	13	4	1	5
Other	1	4	5	1	0	1
Totals	17 (31%)	38 (69%)	55 (100%)	16	1	17

Evaluation

Occupational Category*	Excellent	Good	Fair	Poor	Totals
M.P.	3	2	4	0	9
C.P.	1	1	0	0	2
O.C.J.P.	1	0	3	0	4
Other	0	0	1	0	1
Totals	5	3	8	0	16

*See Key following charts.

Chart D

"Organizing and Staffing Citizen Advisory Committees..."

Occupational Category*	Received? Yes	No	Totals	Read? Yes	No	Totals
M.P.	10	20	30	8	1	9
C.P.	2	4	6	2	0	2
O.C.J.P.	2	12	14	1	1	2
Other	0	4	4	0	0	0
Totals	14 ((26%)	40 (74%)	54 (100%)	11	2	13

Evaluation

Occupational Category*	Excellent	Good	Fair	Poor	Totals
M.P.	2	4	2	0	8
C.P.	1	0	0	1	2
O.C.J.P.	1	0	0	0	1
Other	0	0	0	0	0
Totals	4	4	2	1	11

*See Key following charts.

Chart E

"The Use of Volunteers in Jails"

Occupational Category*	Received? Yes	No	Totals	Read? Yes	No	Totals
M.P.	14	17	31	13	1	14
C.P.	5	1	6	5	0	5
O.C.J.P.	6	8	14	6	0	6
Other	2	2	4	1	1	2
Totals	27 (49%)	28 (51%)	55 (100%)	25	2	27

Evaluation

Occupational Category*	Excellent	Good	Fair	Poor	Totals
M.P.	3	6	4	0	13
C.P.	1	1	3	0	5
O.C.J.P.	1	4	1	0	6
Other	0	1	0	0	1
Totals	5	12	8	0	25

*See Key following charts.

Chart F

"The Recognition of Inmates with Mental Illness"

Occupational Category*	Received? Yes	No	Totals	Read? Yes	No	Totals
M.P.	10	20	30	8	2	10
C.P.	1	4	5	1	0	1
O.C.J.P.	4	9	13	3	0	3
Other	2	4	6	2	0	2
Totals	17 (32%)	37 (68%)	54 (100%)	14	2	16

Evaluation

Occupational Category*	Excellent	Good	Fair	Poor	Totals
M.P.	5	3	0	0	8
C.P.	1	0	0	0	1
O.C.J.P.	1	0	2	0	3
Other	1	1	0	0	2
Totals	8	4	2	0	14

*See Key following charts.

Chart G

"Orienting Health Providers to the Jail Culture"

Occupational Category*	Received? Yes	No	Totals	Read? Yes	No	Totals
M.P.	8	21	29	6	2	8
C.P.	0	5	5	0	0	0
O.C.J.P.	4	9	13	4	0	4
Other	3	3	6	3	0	3
Totals	15 (28%)	38 (72%)	53 (100%)	13	2	15

Evaluation

Occupational Category*	Excellent	Good	Fair	Poor	Totals
M.P.	2	3	1	0	6
C.P.	0	0	0	0	0
O.C.J.P.	0	2	1	0	3
Other	1	1	1	0	3
Totals	3	6	3	0	12

*See Key following charts.

Chart H

"Constitutional Issues of the Prisoner's Right to Health Care"

Occupational Category*	Received? Yes	No	Totals	Read? Yes	No	Totals
M.P.	11	18	29	10	1	11
C.P.	5	1	6	5	0	5
O.C.J.P.	8	6	14	8	0	8
Other	4	2	6	4	0	4
Totals	28 (51%)	27 (49%)	55 (100%)	27	1	28

Evaluation

Occupational Category*	Excellent	Good	Fair	Poor	Totals
M.P.	5	2	3	0	10
C.P.	3	1	1	0	5
O.C.J.P.	5	2	1	0	8
Other	2	2	0	0	4
Totals	15	7	5	0	27

*See Key following charts.

Chart I

"Health Care in Jails: Legal Obligations"

Occupational Category*	Received? Yes	No	Totals	Read? Yes	No	Totals
M.P.	10	18	28	10	0	10
C.P.	5	1	6	5	0	5
O.C.J.P.	10	4	14	8	1	9
Other	2	4	6	2	0	2
Totals	27 (50%)	27 (50%)	54 (100%)	25	1	26

Evaluation

Occupational Category*	Excellent	Good	Fair	Poor	Totals
M.P.	3	5	2	0	10
C.P.	4	1	0	0	5
O.C.J.P.	4	4	0	0	8
Other	1	1	0	0	2
Totals	12	11	2	0	25

*See Key following charts.

Chart J

"The Use of Allied Health Personnel in Jails..."

Occupational Category*	Received? Yes	No	Totals	Read? Yes	No	Totals
M.P.	11	15	26	11	0	11
C.P.	6	0	6	6	0	6
O.C.J.P.	7	5	12	7	0	7
Other	5	1	6	4	0	4
Totals	29 (58%)	21 (42%)	50 (100%)	28	0	28

Evaluation

Occupational Category*	Excellent	Good	Fair	Poor	Totals
M.P.	4	5	2	0	11
C.P.	2	3	1	0	6
O.C.J.P.	2	5	0	0	7
Other	1	2	0	1	4
Totals	9	15	3	1	28

*See Key following charts.

Chart K

"Health Care in Jails: Inmates' Medical Records"

Occupational Category*	Received? Yes	No	Totals	Read? Yes	No	Totals
M.P.	13	18	31	12	0	12
C.P.	4	2	6	4	0	4
O.C.J.P.	3	10	13	3	0	3
Other	1	5	6	1	0	1
Totals	21 (38%)	35 (62%)	56 (100%)	20	0	20

Evaluation

Occupational Category*	Excellent	Good	Fair	Poor	Totals
M.P.	4	7	1	0	12
C.P.	3	1	0	0	4
O.C.J.P.	3	0	0	0	3
Other	0	0	1	0	1
Totals	10	8	2	0	20

*See Key following charts.

Chart L

"Summary of the Jail Pre-Profile"

Occupational Category*	Received? Yes	No	Totals	Read? Yes	No	Totals
M.P.	3	24	27	3	0	3
C.P.	1	5	6	1	0	1
O.C.J.P.	0	13	13	0	0	0
Other	3	3	6	3	0	3
Totals	7 (14%)	45 (86%)	52 (100%)	7	0	7

Evaluation

Occupational Category*	Excellent	Good	Fair	Poor	Totals
M.P.	2	1	0	0	3
C.P.	0	1	0	0	1
O.C.J.P.	0	0	0	0	0
Other	0	3	0	0	3
Totals	2	5	0	0	7

*See Key following charts.

Chart M

"Summary of the Jail Inmate/Patient Profile"

Occupational Category*	Received? Yes	No	Totals	Read? Yes	No	Totals
M.P.	2	24	26	2	0	2
C.P.	1	5	6	1	0	1
O.C.J.P.	0	13	13	0	0	0
Other	3	3	6	3	0	3
Totals	6 (12%)	45 (88%)	51 (100%)	6	0	6

Evaluation

Occupational Category*	Excellent	Good	Fair	Poor	Totals
M.P.	0	2	0	0	2
C.P.	0	1	0	0	1
O.C.J.P.	0	0	0	0	0
Other	1	2	0	0	3
Totals	1	5	0	0	6

*See Key following charts.

Chart N

Standards for the Accreditation of Medical Care and Health Services

Occupational Category*	Received? Yes	No	Totals	Read? Yes	No	Totals
M.P.	9	18	27	9	0	9
C.P.	1	5	6	1	0	1
O.C.J.P.	6	7	13	6	0	6
Other	3	3	6	3	0	3
Totals	19 (36%)	33 (64%)	52 (100%)	19	0	19

Evaluation

Occupational Category*	Excellent	Good	Fair	Poor	Totals
M.P.	3	4	2	0	9
C.P.	0	1	0	0	1
O.C.J.P.	3	2	1	0	6
Other	1	2	0	0	3
Totals	7	9	3	0	19

*See Key following charts.

Chart O

"Correctional Stethoscope"

Occupational Category*	Received? Yes	No	Totals	Read? Yes	No	Totals
M.P.	10	18	28	9	1	10
C.P.	2	4	6	2	0	2
O.C.J.P.	8	7	15	6	2	8
Other	4	2	6	4	0	4
Totals	24 (44%)	31 (56%)	55 (100%)	21	3	24

KEY

M.P. - Medical Personnel

C.P. - Correctional Personnel

O.C.J.P. - Other Criminal Justice Personnel

END