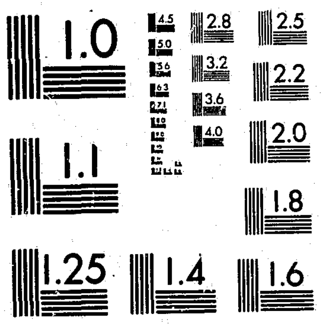

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FINAL EVALUATION REPORT
OF THE
AMERICAN MEDICAL ASSOCIATION'S
PROGRAM TO IMPROVE HEALTH CARE IN JAILS
(YEAR THREE)

June 1979

B. Jaye Anno Associates
Silver Spring, Maryland

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I. INTRODUCTION

A. Background and History[1/]

In June of 1975, the American Medical Association (AMA) received a grant from the Law Enforcement Assistance Administration (LEAA) to initiate a program[2/] to improve health care in the nation's jails. The program was designed to achieve this goal through the accomplishment of three major objectives: 1) developing model health care delivery systems in a number of pilot jail sites; 2) devising standards for health care in jails that would serve as the basis for implementing a national accreditation program; and 3) establishing a clearinghouse on jail health to disseminate information and provide assistance to correctional and medical professionals as well as the general public.

The AMA's original proposal[3/] called for the hiring of a national staff to coordinate the overall program and the selection of six state medical societies to serve as subgrantees. The successful applicants consisted of state medical societies in Georgia, Indiana, Maryland, Michigan, Washington and Wisconsin. Each of these organizations then selected from three to seven jails to serve as the pilot sites in their states. Thirty jails total were chosen for pilot projects.

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[1] 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, DC: Blackstone Associates (February 18, 1977) and B. Jaye Anno, Final Evaluation Report of the American Medical Association's Program to Improve Health Care in Jails (Year Two), Silver Spring, Maryland: B. Jaye Anno Associates (June 6, 1978).

[2] 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.

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for a Pilot Program to Improve Medical Care and Health Services in Correctional Institutions, Chicago: December 1974 (unpublished).

During the first year of funding -- which actually extended until the end of February of 1977 -- the primary emphasis of the AMA's program was on developing model health care delivery systems in the thirty pilot sites. The states first documented the status of their existing health care delivery systems and identified areas of deficiencies. They then determined the most pressing health care needs of the jails' inmates by examining and interviewing a sample of residents. Based on this information, the state medical societies designed and then began implementing action plans aimed at upgrading the care and services offered at each jail. At the national level, the staff provided technical assistance to the six state projects and began developing and field-testing standards for health care in jails. In addition, the clearinghouse on jail health care was initiated.

The second program year -- which began in March of 1977 and ended in April of 1978[4/] -- was essentially a continuation of the first year's activities. In other words, during Year Two the AMA expected to: 1) 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; 2) continue the testing and revision of the standards on jail health care and initiate the accreditation program; and, 3) continue the development and dissemination of materials on jail health through the clearinghouse. In addition, 4) a national conference on jail health care was planned.

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[4]The second year of program operation began on March 1, 1977 and actually terminated on March 6, 1978. However, a short hiatus period existed between the official close of the second year program and the start of the third. For purposes of this report, the hiatus will be considered as part of the second year.

On balance, the AMA Jail Program successfully accomplished its first and second year goals. At the national level, not only was the first national conference a success, but the standards were tested, revised and finalized and the accreditation program launched. In addition, the clearinghouse became increasingly active. Various new monographs were published, a "How-to-do-it" package for jails seeking accreditation was developed, and an award-winning[5] documentary film produced. Publicity efforts during the second year were also good.

At the state level, considerable headway was also made. Nineteen[6] of the original thirty pilot jails were either fully or provisionally accredited as were two of the eighteen new sites added during the latter half of the second year. Efforts to improve the health care delivery systems in the remaining sites continued. In addition to accrediting jails, each state project successfully achieved many of the unique goals which had been set and assisted in the collection of research data which helped to document the impact of the AMA program.[7]

B. The Current Program

1. National Goals

The third year program officially began on April 3, 1978 and was scheduled to run until the first part of April 1979. Grant

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[5]The film won the Medical Education Award of the John Muir Film Festival in June 1978.

[6]Twenty jails actually received an award of accreditation but one jail's award was subsequently withdrawn.

[7]For a complete discussion of the results of the impact assessment see B. Jaye Anno, Analysis of Inmate/Patient Profile Data - Year Two, Silver Spring, Maryland: B. Jaye Anno Associates (May 1978) and B. Jaye Anno and Allen H. Lang, Analysis of Pilot Jail Post-Profile Data, Silver Spring, Maryland: B. Jaye Anno Associates (April 1978).

adjustments were subsequently applied for and received, which extended the termination date first to May 31 and then to June 7, 1979. The third year proposal[8] established seven goals which were somewhat different from, but still consistent with, those developed for the previous two years. The seven goals were delineated as follows:

Goal 1: Accredit a total of fifty new jail medical systems within the original six pilot states by utilizing an accelerated approach of testing the Standards and providing consultation when necessary to supplement the various monographs and the prescriptive "How-to-do-it" package;[9]

Goal 2: Expand the accreditation program to ten new states and accredit fifty jails in these states.[10]

Goal 3: Develop standards for medical care and health services in short and long-term juvenile facilities, conduct a profile study of health care delivery systems in juvenile facilities in many if not most of the pilot states, and perform a one-time epidemiologic screening (youth/patient profile) on a sampling basis in the pilot states;

Goal 4: Develop mental health standards for jails and adult correctional institutions;

Goal 5: Develop standards for the care and treatment of chemically dependent inmates in jails and prisons;

Goal 6: Stimulate interest and knowledge among health care professionals, criminal justice officials and the public about the program and its products; and

Goal 7: Sponsor a second national conference devoted to workshops and seminars designed for extensive participant involvement in a "How-to-do-it" program.

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[8] American Medical Association, Third Year Proposal for the AMA Program to Improve Medical Care and Health Services in Jail, Chicago: January 1978 (unpublished).

[9] The original six pilot states were also expected to continue developing and refining models for health care delivery and to provide consultation to health care providers and officials in new states just entering the program.

[10] The ten new states also served as a test of the accelerated accreditation program and of the readiness of the program for expansion nationwide.

2. Organization and Staffing at the National Level

At the national level, the number of program personnel increased somewhat. The Jail Program Director, the Associate Director (who served as the "Health Care Systems Specialist") and the Clearinghouse Director,[11] were all carry-overs from the first two years of program operation. Other full-time staff positions carried forward were an administrative secretary and a clerk typist. Added to the staff for the third year were a former pediatrics nurse to work on the development and testing of the juvenile standards (Goal 3) and an additional clerk typist.

As in earlier years, the central staff was assisted by a paid half-time consultant, a voluntary National Advisory Committee (NAC),[12] and AMA leadership staff.[13] The consultant served 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 was 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 applied. In previous years, the NAC was composed of six health care professionals and four representatives of criminal justice groups. The third year, two more physicians were added. The

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

[12] 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 1, pp. 8-10.

[13] This term refers primarily to the Director of the Department of Applied Medical Systems, the Director of the Division of Medical Practice, and to the Group Vice President of External Affairs.

AMA leadership staff continued to stay informed on program activities and involved in policy decisions. Like the NAC members, their time was donated.

3. The State Projects

a. Background, tasks and objectives

At the state level, the program expanded during the third year to encompass a total of sixteen medical societies in fifteen states and the District of Columbia. The ten medical societies new to the program were geographically dispersed across the country in the following areas: Illinois, Massachusetts, Nevada, North Carolina, Ohio, Oregon, Pennsylvania, South Carolina, Texas, and Washington, DC. Eight of the new state medical societies entered the program at the beginning of the third funding year, while the District of Columbia and Oregon did not officially become involved until October.

The state projects shared the overall aim of the national program of improving health care in jails. However, their relationship with the national program went deeper than that since they were also, in effect, one of its major components. Consequently, the state projects were expected to perform a number of tasks to satisfy requirements of the national program.

These tasks differed somewhat between the original and new state projects. The major objectives and tasks[14/] of the original six pilot projects were as follows:

Objective 1: Process for accreditation a total of fifty jail medical systems (an average of eight per state);

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[14] See AMA, Third Year Proposal . . ., supra at note 8.

Objective 2: Tailor health care models to adequately serve pilot jails;

Objective 3: Organize and stimulate the medical society and community to upgrade jail health care;

Objective 4: Assist AMA central staff in re-testing and modifying jail medical standards;

Objective 5: Re-evaluate pilot jails to determine if their health care delivery systems met standards;

Objective 6: Train and orient jailers in receiving screening and health education;

Objective 7: Help to improve the accreditation process through continued application and critiquing;

Objective 8: Provide consultation on-site and via telephone to new pilot states and serve as a "show case" for various jails for the demonstration of replicable models for health care delivery; and

Objective 9: Assist the AMA central staff in the development and testing of standards for short-term juvenile detention and long-term juvenile treatment institutions.

The major objectives and tasks of the ten new project states were:

Objective 1: Assign one staff person and secretary, each part-time, to the accelerated accreditation program, and establish an office with all of the necessary tools to carry out the accreditation function;

Objective 2: Process for accreditation a total of fifty jail medical systems (an average of five per state);

Objective 3: When necessary, develop state and county medical society advisory committees to assist in effecting health care systems changes;

Objective 4: Provide technical assistance through use of monographs, the Practical Guide and on-site personal discussions, whenever a jail did not meet the Standards; and

Objective 5: Re-test jail health care systems.

In addition to the national performance requirements outlined in the AMA's third year proposal, all of the original pilot state projects except Indiana developed unique objectives of their own. Georgia planned two such activities: to transfer, and thus share with a teaching facility within the state, the receiving screening program developed in Year Two; and to assemble in conjunction with Michigan an orientation handbook for jails entering the accreditation program. Michigan, in addition to helping develop the orientation handbook, planned further efforts at getting the AMA standards adopted as part of the official state jail standards and also hoped to revive efforts at initiating a jail nurses' association within the state. Maryland planned three unique activities: continuation of the development of guidelines for jail medical facilities and equipment begun in Year Two; development of a medical record summary sheet which could accompany inmates transferred between correctional facilities; and development of a handbook to train new jail personnel in aspects of the program.

The Washington project also outlined three unique objectives for its third year: the development of a manual to facilitate the transfer of the state project director's job from one individual to another; the development of a guidebook for the Washington State Jail Commission presenting the types of assistance available to the state's jails through the Washington State Medical Society; and continued liaison with the Washington State Jail Commission concerning implementation of the AMA standards statewide. Finally, the Wisconsin project planned to sponsor a health intern to study particular health problems unique to the correctional environment.

The new state projects of Pennsylvania and Ohio also indicated some unique activities of their own. Pennsylvania projected efforts at trying to get the AMA standards adopted as part of the official state jail standards, while Ohio wanted to take a closer look at the legal issues involved in inmates' right to health care in Ohio's correctional facilities. Mid-way through the program year, Massachusetts expressed a desire to hold a state-wide conference on health care in corrections issues.

b. Organization and staffing at the state level

Staffing positions remained essentially unchanged from Year Two in the six original states, although some of the personnel filling particular positions were new.[15] All sixteen projects employed a State Project Director (SPD) who assumed responsibility for the overall operation of project activities in his/her particular state. In addition, four of the original and one of the new states also utilized the services of part-time Project Assistants (PAs).[16]

The medical societies in the ten new areas each filled the State Project Director's position, but did so in various ways. Seven of these state societies allocated the services of one of their staff to the project on a part-time basis. Two other state societies

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[15] Specifically, the new personnel were the project directors for Wisconsin and Michigan, although it should be noted that the previous Project Director in the latter state still maintained a very active advisory role.

[16] For a further discussion of the percent of time devoted to the project by the SPDs in the original six states and the utilization of the PAs in these states, see Anno, Final Evaluation Report . . . (Year Two), supra at note 1, pp. 10 and 11.

(Massachusetts and South Carolina) contracted with outside corporations for the services and personnel needed to implement the accreditation program. In Massachusetts, this corporation was the Commonwealth Institute of Medicine -- an offshoot of the Massachusetts Medical Society. In South Carolina, it was Carter-Goble-Roberts -- a correctional planning and consulting firm with prior experience in developing jail standards and jail programs. The Oregon medical society was unique in that it contracted with an outside individual -- a former state highway patrolman -- to serve as State Project Director and to initiate the AMA program within that state. In Ohio, the SPD's time was donated to the project and the grant funds were used to hire a law student as Project Assistant for fifteen hours per week.

In addition to staff positions, each of the original pilot states 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 various health professions as well as correctional officials and others.

Eight of the new project states also formed PACs. In one of the remaining states (North Carolina), an advisory body was considered and a chairman was selected, although no further efforts to form a PAC were made. The PACs in Ohio and the original one in the District of Columbia were essentially carry-overs of jail and prison health committees established prior to the involvement of these medical societies in the AMA program. These two state committees were also the only new PACs composed entirely of physicians. Half-way through the program year,

however, the DC society organized a new Advisory Committee with extensive representation from non-physician groups. The time and services of PAC members were donated in all of the states.[17/]

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

II. EVALUATION ACTIVITIES, METHODOLOGY AND TIME PERIOD

A. Tasks and Time Period

Evaluation of the AMA's Jail Program for Year Three consisted of both impact assessment and process evaluation components.

The impact assessment was designed to determine whether or not the AMA's accelerated approach to accrediting jails resulted in significant improvements in health care delivery systems in participating facilities. The primary measures of impact included:

1) a pre-post study of the health care delivery systems in all new third year sites;

2) an analysis of feedback from medical and correctional staff at participating jails regarding the sufficiency of technical assistance received from state medical society staff;

3) an intensive study of ten third year sites to isolate the factors contributing to the success or failure of the accreditation process and the accelerated approach in these areas;

4) an examination of the long-term effect of accreditation on improving health care by determining the re-accreditation status of jails accredited in Year Two; and

5) an analysis of the effect of initiating receiving screening on improving jail health care.

The bulk of the evaluation efforts were devoted to the impact assessment component, largely because it is more revealing than process evaluation in gauging the overall significance of program activities on a long-term basis. The impact measures numbered 1, 2 and 4 above will be reported on in a later section of this report. Results of impact measures 3 and 5 have already been analyzed and are available in a separate report.[18/]

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[18] See B. Jaye Anno and Allen H. Lang, Ten Jail Case Study and Analysis, Silver Spring, Maryland: B. Jaye Anno Associates (June 1979).

With respect to the process evaluation component, the evaluators were expected to assess at two points the progress and process of both the national and state staffs in meeting their third year goals. Sections of this account represent the second of the two required assessments. An interim report was filed in early December which covered the seven-month period from April 3 through October 31, 1978.[19] The focus of the process evaluation measures in this report is on the seven-month period of November 1, 1978 through May 31, 1979.

B. Methodology and Data Sources

The specific 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 evaluators for this report.

1. Process Evaluation

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 states and to AMA headquarters to observe meetings and program activities and to interview key staff; and administering questionnaires. Specifically, data sources consisted of the following:

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

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[19] See B. Jaye Anno and Allen H. Lang, Interim Evaluation Report of the American Medical Association's Program to Improve Health Care in Jails (Year Three), Silver Spring, Maryland: B. Jaye Anno Associates (December 8, 1978).

- Information regarding the operation and management of the central program and its activities was obtained from the AMA's third 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 SPDs; 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 October 1978 and again in April of 1979.

- Data specific to the state projects were obtained from their individual proposals and progress reports, in addition to the sources noted in the preceding paragraph. Evaluation staff also visited each of the medical societies for a full day during the month of October 1978 and again in February and March of 1979.20/ At the time of both the initial and follow-up visits, structured interviews of four or five hours' duration were conducted with each of the State Project Directors (and their Assistants where applicable) regarding their activities. The state staffs also provided feedback on the adequacy of the central staff's performance. In addition, brief interviews were held with the Executive Secretaries of the medical societies and with most of the physician chairmen of the state PACs.

- Data regarding the jail standards and the accreditation program were obtained by interviewing state and national staff regarding the sufficiency of existing documents and procedures and by observing at all national meetings held to discuss these topics. In addition to synthesizing the feedback from state staffs regarding the standards and accreditation procedures, the evaluators conducted their own review of the jail standards and of the forms, procedures and survey instruments utilized in accreditation.

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[20]Initial on-site visits were made to all but two of the sixteen state projects. In Texas and South Carolina, telephone interviews were conducted instead, since the progress in these two states at that time was deemed insufficient to justify a site visit for a full day. In one other state (Oregon), the SPD was unavailable at the time of the site visit, but was subsequently interviewed at the National Conference. Follow-up visits were made to all sixteen medical societies.

- Information regarding the development of the other three sets of standards was obtained by reviewing these drafts and by speaking with the central staff members who supervised their development.21/

- All statistics regarding the disbursement of clearinghouse materials were provided by central staff at the evaluators' 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. Feedback on the adequacy of the clearinghouse procedures and products was also obtained from interviews with state staff members, from reviewing the documents themselves, and from a survey which was mailed to correctional and medical staff at each of the third year jails.22/

- Feedback on the value of the second national conference on jail health -- which was held in Chicago on October 17-18, 1978 -- was obtained from questionnaires administered to participants and from on-site observation of the proceedings.23/

2. Impact Assessment

The three impact measures which will be discussed in detail in this report include:

a. a pre-post study of the health care delivery systems in all new third year sites;

b. feedback from medical and correctional staff at Year Three jails regarding (1) the sufficiency of technical assistance received from state medical society staff and (2) their assessment of the value of certain materials distributed through the national clearinghouse; and

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[21]It should be noted that in addition to the standards being drafted for juvenile facilities, for chemical dependency and for mental health, the AMA also developed health care standards for prisons. However, this latter activity was part of a subcontract with the Michigan Department of Corrections project and hence, was outside the scope of this evaluation.

[22]The methodology employed for this survey is discussed in more detail in the next section on impact assessment.

[23]The techniques used in the administration of questionnaires to conference participants were described in the Interim Evaluation Report, pages 68, 69 and 74. See note 19, supra.

c. the re-accreditation status of jails accredited in previous years.

The methodology employed for each of these measures is discussed separately below.

a. Pre-post study

In regard to the pre-post study of jails' health care delivery systems, the primary instrument used to measure change was the self-survey[24] each jail completed two times during the third year. As each jail entered the program, staff members were asked to complete a self-survey questionnaire designed to determine which standards (or parts of standards) the jail was presently complying with. In other words, these initial self-surveys served as the baseline measure of each jail's existing health care delivery system.

Insofar as possible, state medical society staff were asked to verify the responses given by their jails on the initial self-surveys to insure a more accurate portrayal of the existing delivery systems. Verification consisted of making telephone calls or site visits to each jail and discussing the AMA standards with the facility personnel completing the self-survey questionnaires to make sure that they understood what constituted compliance with each standard. Corrections were made on the initial self-surveys as necessary and the "verified" questionnaires were then sent to the AMA and to the evaluators.

Follow-up information regarding the jails' compliance with AMA standards was obtained in two ways. For those jails applying

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[24] See American Medical Association, "Survey Questionnaire for the Accreditation of Medical Care and Health Services in Jails," Chicago, Illinois: Spring, 1978.

for accreditation in Rounds IV and V, verification of the actual number of standards met was available from the reports of the states' on-site survey teams and the official decisions regarding accreditation made by the AMA's National Advisory Committee. Those jails which did not apply for accreditation in Rounds IV and V were asked to complete a second self-survey by April of 1979, which reflected the number of standards the jails complied with at the end of the year. Insofar as possible, the state medical society staffs were asked to again verify the responses from their jails which had not participated in an official on-site accreditation survey.

The purpose of obtaining the pre-post measures of compliance with AMA standards was to determine the extent of improvements which had occurred in the health care systems at each of the third year sites. Thus, each jail was given a score representing the number of standards it complied with before becoming involved in the AMA program and a score representing the number of standards it complied with by the end of the third year. In those instances where no follow-up data were provided to the evaluators, a "no change" situation was assumed. In other words, for these jails, the pre- and post-scores of compliance were identical.

In calculating the compliance scores, no attempt was made to weight the relative value of the standards. Instead, each standard simply counted as one point. If a standard had more than one element in it that needed to be complied with (as most of the standards did), then each element was given a fractional value -- which was usually derived by dividing the value of the total standard (i.e., "one") by the

number of elements it had within it.[25]

In a few of the cases of standards with multiple elements, a crude weighting of the elements within a standard seemed necessary. This was done whenever compliance with certain elements in a standard was contingent upon a prior element being complied with. For example, Standard #1010 required first aid kits to be on hand. If they were, it further required that the responsible physician approve the contents, number, location and procedures for inspection. Obviously, a jail could not comply with these latter elements unless it had first aid kits. It could have first aid kits, though, and not comply with the remaining elements. Thus, in these cases, the most important elements were weighted as .5 (i.e., half of the maximum value of "one" for the standard as a whole) and the remaining elements were assigned equal fractional values of the other .5 points.[26]

Since the maximum value a jail could receive for complying with any given standard was "one," it follows that the maximum pre or post score a jail could receive was "forty-two" (because there were forty-two AMA standards).

b. Feedback from jail staff

It was also of interest to determine whether the technical assistance which had been provided to staff at Year Three jails had been of benefit to them in helping them to improve their health care

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[25] For example, Standard #1004 required written policies and procedures for seventeen different areas. Thus, compliance with any one of the seventeen elements was given a value of .06 (i.e., 1 divided by 17 = .06)

[26] Weighting within a standard occurred for numbers #1010, #1011, #1012, #1019 and #1026. For all other standards, elements within a standard received equal fractional values.

systems. Consequently toward the end of the program year, state medical society personnel were asked by the evaluators to identify individuals at their jails from whom feedback could be solicited. Names were requested for at least one administrative staff member at each jail and at least one other individual who was primarily concerned with improving the health care system.[27] In other words, the evaluators wanted the names of the staff members at each jail who were the most active participants in working toward accreditation.

Once the medical society State Project Directors (SPDs) identified these individuals for the evaluators, each was sent a questionnaire designed to elicit his or her opinion about the technical assistance which had been received. The technical assistance (TA) was of two types: that provided directly by the SPDs in the form of on-site visits and telephone consultations and that provided by written materials which had been developed by the AMA and were distributed through its clearinghouse. The questionnaire contained items designed to elicit feedback from participating jail staff on the value of both types of TA.[28]

c. Re-accreditation status

The pre-post study discussed in "a." above was essentially a short-term measure of the impact of the AMA program on improving health care in jails. Whether there would be any lasting

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[27] In the larger facilities, these latter individuals tended to be health care staff employed by the jail. In the smaller facilities, they were usually correctional staff members who had been assigned to work toward improving the health care system or community providers who were interested in the jail's becoming accredited.

[28] See Appendix C for a copy of the questionnaire.

effect obviously could not be determined for the new third year sites. It was possible, though, to obtain some measure of the sustained effect of accreditation by examining the status of the health care systems in jails accredited during the second year. Hence, the evaluators kept track of the re-accreditation status of pilot jails.

As a result of problems which surfaced when four of the original pilot sites sought re-accreditation in June of 1978, a special study was conducted to determine the reasons why the health care systems at these four jails had seemingly declined. Since three of the four jails were in Maryland, the evaluators visited each of these facilities in August of 1978 and interviewed key medical-correctional staff. The Maryland SPD, the physician chairman of the PAC and the executive secretary of the medical society were also interviewed. Since the other jail which experienced problems in remaining fully accredited was in the state of Washington, a telephone interview was conducted with the SPD there as well.

As a result of these efforts, a special report was issued regarding problems associated with the standards and the accreditation process.[29] In this report, the re-accreditation status of additional pilot jails will be examined to see if anything can be concluded regarding the lasting effect of accreditation on improving a jail's health care system.

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[29] Allen H. Lang, "Special Report on the Problems Encountered at the Probationary Jails," Silver Spring, Maryland: B. Jaye Anno Associates, November 30, 1978 (unpublished).

III. EXAMINATION OF THE THIRD YEAR PROGRAM RESULTS

In this chapter, the extent of the AMA's success in achieving its third year goals is examined. Strengths and weaknesses of the national program and the state projects are identified and, where applicable, recommendations for next year's program are made.[30]

There are four major subdivisions in this part of the report which discuss activities directed toward attaining the AMA's third year goals.[31] Section A is devoted to an examination of the state projects and their success in achieving the objectives outlined for them in the AMA's proposal.[32] Section B reviews the current status of the AMA's "Jail Health Care Standards" and the accreditation program. In addition, this section looks at the progress made in developing three additional sets of standards covering: medical care and health services in juvenile facilities (National Program Goal Three); the care and treatment of mentally ill and deficient inmates (National Program Goal Four); and the care and treatment of chemically dependent inmates (National Program Goal Five). The activities of the clearinghouse are discussed in Section C;[33] while Section D is concerned with the success of the

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[30] While this year marks the end of the three year pilot program, the AMA will be continuing its efforts to improve health care in jails. A new LEAA grant has already been received by the AMA to develop an expanded technology transfer program.

[31] See p. 4 of this report for a listing of these seven goals.

[32] The individual state projects' responsibility toward achieving National Program Goals One, Two and Six were included within these objectives. See pp. 6-7 of this report for a listing of the specific objectives laid out for both the six old state projects and the ten new ones.

[33] The clearinghouse was a major vehicle for accomplishing National Program Goal Six, although successful achievement of this goal depended upon both national and state level efforts.

"Second National Conference on Medical Care and Health Services in Correctional Institutions" (National Program Goal Seven).

A. The State Projects

In this section, the success of the sixteen state projects in meeting their Year Three objectives is examined. Sub-section "1." represents the process evaluation component. Here activities at the state level are discussed, covering both national program requirements and any unique objectives of the individual projects. The impact of the state projects on improving health care in jails is assessed in sub-section "2.". Overall ratings of the states are presented in sub-section "3." along with recommendations for future efforts, while sub-section "4." is devoted to a discussion of the national role vis-a-vis the state projects.

1. Activities at the State Level

a. National Program Requirements

It should be noted at the outset that the national program requirements for the six old states versus the ten new states differed. The maximum funding available to the latter group was only about half the amount given to the former group.[34/] Hence, the activities expected to be performed by the new states were not identical to those expected from the old. Still, most of the differences in the national program requirements between the two types of state projects were differences in the level of activity expected rather than the kind.

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[34]Old states were given $20,000 apiece. The ten new states were given only $5,000 each to cover basic administrative costs, but could draw as much as $5,500 additional on a cost-reimbursable basis for expenses incurred in connection with on-site visits to their jails.

For example, since it was anticipated that the staff time devoted to the project in the new states would be less than in the old ones, the new projects were asked to work with five jails while the old states were to recruit eight. Similarly, because of the cost-reimbursement restrictions, new states were limited to two on-site visits per jail -- one to provide technical assistance and one for the official accreditation survey. The same limitations for reimbursement purposes did not apply to the old projects.

The discussion below reviews the various activities which the state projects were expected to perform. Those applicable to both old and new states are identified in parentheses after each heading. Those applicable to the old states only are similarly noted.[35]

(1) Selecting Sites (OSO-1/NSO-2)

The first step in the accelerated accreditation process for both the old and new states was to identify those jails interested in participating in the third year AMA program. The process by which sites were initially contacted and then selected for particpation varied a great deal between the sixteen individual projects. Except for the Oregon Project,[36] the procedures and criteria used in all of the states were thoroughly discussed in the Interim Evaluation Report and will only be brought up-to-date at this time.[37]

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[35] In order to avoid needless repetition, the state objectives listed on pages 6 and 7 of this report are identified by abbreviations. "OSO" followed by a number refers to the number of the "Old State Objective" being discussed, e.g., "OSO3" = Old State Objective Three. Similarly, "NSO" followed by a number refers to the number of the "New State Objective" being discussed. These notations are given in parentheses following the headings for parts 1.a.1) through 1.a.7).

Essentially, the state projects followed one of two procedures for initially contacting sites for participation in the program: either they attempted to inform all of the jails in their respective states concerning participation, or they only contacted and elicited responses from those jails which met certain criteria that they themselves had established, over and beyond the three general criteria set by the AMA.[38] As the subscripts on Table I on the following page indicate, nine state projects attempted to contact all of the jails in their respective states, and six other projects contacted only those jails which met their own pre-established criteria. The District of Columbia stands out as a special case, since it has only one jail within its borders.

As Table I further shows, all of the state projects except Georgia, Indiana, and Maryland were able to get the designated number of jails to participate in the Year Three Program (i.e., eight jails in each of the old states and five jails from each of the new states, with the exception of the District of Columbia). The state projects in Georgia and Indiana fell short of meeting their quota,

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[36] Because Oregon entered the AMA program in October 1978, it faced a time-constraint problem from the beginning. In order to facilitate the processing of jails for accreditation, initial contacts were made by phone and only with those jails situated in the western part of the state. These jails served the most populous counties in the state and also presented far less of a transportation problem because of their location.

[37] See Interim Evaluation Report...(Year Three), supra at note 19, pages 16-22 and 38-42.

[38] These three general criteria for participation were (1) the desire of the person legally responsible for the jail; (2) the interest of the

TABLE I

SUMMARY TABLE OF THE SIXTEEN STATES' ACTIVITIES WITH REGARD TO SELECTING SITES FOR PARTICIPATING IN THE YEAR THREE AMA PROGRAM

	Number of jails contacted for participation in Year Three	Number of applications made to the AMA	Number of applications accepted by the AMA
OLD STATES:			
Georgia	9[a]	6	6
Indiana	8[a]	6	6
Maryland	15[b]	2	2
Michigan	10[a]	8	8
Washington	28[b]	8	8
Wisconsin	60[b]	10	10 (9)*
Subtotal	130	40	40
NEW STATES:			
District of Columbia	1[c]	1	1
Illinois	17[a]	8	5
Massachusetts	14[b]	10	7
Nevada	24[b]	6	5
North Carolina	97[b]	9	5
Ohio	144[b]	9	5
Oregon	7[a]	6	6
Pennsylvania	67[b]	9	9 (8)*
South Carolina	34[a]	8	6
Texas	254[b]	11	5 (4)*
Subtotal	659	77	54
TOTAL ALL STATES	789	117	94

* One jail subsequently withdrew its application in each of these states.
[a] Jails in these states were contacted on a selective basis.
[b] Attempts were made to contact all the jails in these states.
[c] There is only one jail in the District of Columbia.

simply because they did not solicit the interest or participation of enough jails. In Maryland, all of the jails in the state not already in the AMA program by Year Three (i.e., fifteen) were contacted repeatedly about participation during the course of the year. Unfortunately, only two of these jails made application to the program.[39]

It should also be noted that while some state projects failed to get the participation of the designated number of jails, five states requested that more than the required number of sites be allowed into the AMA program. Four of these states -- Massachusetts, Oregon, Pennsylvania, and South Carolina -- were new, while only one (Wisconsin) was part of the original AMA pilot program. The additional jails in these states created more work for the respective SPDs. In some states, this added work was more easily absorbed, while in others, it meant that each jail received less attention than it might have otherwise.

In all, 117 jails made application to enter the AMA program in the third year, and of these, ninety-four were accepted. In seven states (Illinois, Massachusetts, Nevada, North Carolina, Ohio, South Carolina, and Texas), more jails made application than were allowed to participate in the program. A brief analysis was done using cross-

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local medical society, and (3) that the jails chosen represent a mixture of different sizes and degrees of sophistication in regard to their health care delivery systems.

[39]It should be noted, however, that the SPD in Maryland has letters of intent signed by sheriffs from eight of the remaining thirteen jails in the state indicating they will participate in the AMA's program in 1979 and 1980. Thus, the SPD's efforts during the third year program with regard to these jails were not wasted.

tabulation and the chi square statistic to see if the jails accepted into the program in these states differed significantly from those jails not allowed to officially participate. This analysis used fourteen items taken from the "Jail Application Form."[40/]

It appeared from the results of this analysis that in the seven states where more jail applications were received than were accepted, a selection bias did not exist which favored those jails father along in the development of their health care delivery systems. Nor were any biases demonstrated in favor of certain types of jails (e.g., large, urban, etc.). The results from this analysis indicated that significant differences existed on only one of the fourteen items. This one item was concerned with medically supervised sick call. In 50% of the jails not accepted into the AMA program, this service was already being provided to inmates, whereas only 21% of the jails accepted into the program provided a similar service. This difference was significant beyond the .05 level.

(2) Providing technical assistance to jails (OSO-2/NSO-4)

One of the primary tasks of all sixteen project directors was to provide technical assistance (TA) to each of the jails

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[40] See American Medical Association, "Application for Accreditation of Medical Care and Health Services in Jails," Chicago, Illinois: Spring 1978. The fourteen items were: (1) jail size; (2) age; (3) locale; (4) average daily inmate population; (5) whether any persons were providing inmate medical care; (6) whether the jail had a physician; whether the jail provided (7) medically supervised sick call, (8) on-going medical care, (9) dental care, or (10) mental health care; whether the jail provided detoxification from (11) alcohol or (12) drugs; (13) whether the jail had any law suits against it at present or (14) in the past where the adequacy of health care was an issue.

accepted into the AMA program from their own state. With the help of this TA, the jails were to upgrade their health care delivery systems sufficiently to be accredited by the AMA. The TA provided by the state project directors (SPDs) usually took the following pattern: First, the AMA standards would be reviewed with appropriate staff at each jail, in order to familiarize them with the intent of the standards and to define what constituted compliance. Next, by using the standards and the self-survey as guides, the SPD and the jail staff would identify the deficiencies in the jail's health care delivery system and devise an appropriate plan for correcting these weaknesses. The SPD would then further assist the jail by providing appropriate written materials, phone consultations, and very often, help in locating needed medical personnel, community resources, and examining room equipment. In several instances, SPDs helped organize jailer training programs and made appearances before funding sources on behalf of the jails in their projects.

The manner in which TA was to be provided was supposed to be an integral part of the AMA's accelerated accreditation approach. SPDs were instructed by the AMA central staff to try and limit the number of site visits to each jail to two -- one to deliver preparatory TA and one to do an accreditation survey. Additional TA, which individual jails might require, was to be delivered through the mail and by phone.

Very early, most SPDs realized that one TA site visit would simply not be enough preparation for most jails to gear up

for an official on-site accreditation survey. In those instances where particular jails ultimately showed substantial improvement in their health care delivery systems, generally the SPDs had ignored the "one visit" guideline and arranged several personal contacts with jail staff. In several states (i.e., Michigan, Georgia, Wisconsin and Massachusetts), the SPDs held group orientation sessions or conferences, which allowed them to deliver TA efficiently to a number of jails at the same time. Such an approach -- besides being an efficient use of the SPD's time and travel resources -- also tended to promote inter-jail rivalry and peer-group pressure, as well as eliciting a degree of commitment from jail staff for the time required to attend such a meeting.[41] It is recommended that similar group sessions be organized in all states in the future.

Most SPDs felt that the written TA materials from the AMA were good, but were insufficient in and of themselves. Therefore, project staff in a number of states supplemented the written materials available through the AMA with examples and manuals of their own. One such manual, which dealt with all forty-two of the AMA standards, was compiled by the Michigan and Georgia projects. It was reproduced and disseminated to all the states by the AMA. Other states -- most notably Illinois, Maryland, Washington, Nevada, and Massachusetts -- put special packets of TA materials together for the use of the jails in their projects. These packets included examples of compliance with standards more specific to the jails in their respective states.

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[41] For a further discussion of the benefits of group orientation sessions see Interim Evaluation Report...(Year Three), supra at note 19, pp. 21 and 22.

One disturbing factor which seemed to be present in some of the state projects with regard to delivering TA was the lack of aggressiveness on the part of the SPDs in getting jail staff thoroughly involved and committed to improving their health care delivery systems. Too often, the evaluators saw instances where the SPDs made no on-site visits to a jail or only one visit late in the program year. Usually, the SPDs in these instances let the jails know that assistance was available if they requested it, but did very little else to encourage the jails to seek assistance. In many cases, the SPDs did not even get the jails to fill out and return their initial self-survey forms, let alone their final ones. With very few exceptions, jails where the SPD had only marginal involvement showed little or no improvement. Therefore, it is recommended that on-site TA visits be required of SPDs in any future program.

(3) Participating in the accreditation process (OSO-4, 5 & 7/NSO-2 & 5)

As part of their third year activities, each state project was to assist the AMA central staff in the retesting and modifying of the AMA's Standards for Medical Care and Health Services in Jails. Through continued application and critiquing of the standards, the survey instruments, and TA materials, they were to help improve the entire accreditation process as well. While these tasks were written as specific objectives for the six old state projects, the new states also participated in varying degrees. Through feedback at the time of the evaluation team's on-site visits to the states and the SPDs' meeting in October, as

well as written correspondence between the states and the AMA, the central program staff was kept abreast of problems with the standards and the accreditation process.[42/]

The project director in Maryland, and to a lesser extent, the SPD in Washington, offered special assistance to the evaluators in examining the accreditation process after several jails in their states failed to be re-accredited in June of 1978. Their comments, along with the evaluator's discussion and recommendations, were presented in a special report.[43/]

The actual on-site surveying of jails for accreditation proved to be the most important method by which the standards and the accreditation process were examined and tested. The on-site accreditation survey was also the culmination of the entire accreditation process, and thus, represented one of the most important aspects of the third year program. Table II on the following page presents the number of jails that entered the AMA program in Year Three by state; the time and number of Year Three jails that underwent an on-site accreditation survey; and finally, the number of these jails that were accredited for either one or two years.

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[42]For more information on the feedback received by the evaluation team concerning the standards and the accreditation process, see Section III.B of this report.

[43]See "Special Report on the Problems Encountered at the Probationary Jails," supra at note 29.

TABLE II

YEAR THREE JAILS AND THEIR ACCREDITATION STATUS BY STATE

	Number of Year III Jails A	Number going through Oct. '78 round of accreditation B	Number going through Feb. '79 round of accreditation C	Number going through June '79 round of accreditation D	Total number going through accreditation surveys E	Total number accredited for one year F	Total number accredited for two years G
OLD STATES:							
Georgia	6	1	0	1	2	1	1
Indiana	6	0	1	1	2	0	2
Maryland	2	0	0	1	1	1	0
Michigan	8	1	0	2	3	2	1
Washington	8	0	0	1	1	0	0
Wisconsin	10 (9)*	0	1	3	4	0	4
Subtotal	40	2	2	9	13	4	8
NEW STATES:							
District of Columbia	1	0	0	1	1	0	0
Illinois	5	0	0	2	2	1	0
Massachusetts	7	1	0	4	5	2	3
Nevada	5	0	0	1	1	0	1
N. Carolina	5	0	0	1	1	0	1
Ohio	5	0	2	2	4	0	4
Oregon	6	N/A	0	4	4	2	2
Pennsylvania	9 (8)*	2	2	0	4	3	0
S. Carolina	6	0	0	3	3	0	2
Texas	5 (4)*	0	0	1	1	0	1
Subtotal	54	3	4	19	26	8	14
TOTAL ALL STATES	94	5	6	28	39	12	22

* One jail subsequently withdrew its application in each of these states.

As column E on Table II indicates, a total of thirty-nine of the ninety-four Year Three jails (or a little over 41%) participated in on-site accreditation surveys. Of these, thirty-four, or 87%, received accreditation for either one or two years (see columns F and G on Table II). Thus, a little more than a third of the total number of Year Three jails obtained accreditation.

It should be noted that the number of Year Three jails accredited from each of the states differed. This number ranged from zero in the District of Columbia and Washington State to five in Massachusetts. However, it should also be realized that accreditation is only one indication of a jail's progress and should not, in and of itself, be taken as the primary measure of the extent of success of the national program, a state project, or an individual jail's efforts.

More justifiable measures of the progress made by the jails and the state projects will be dealt with in the impact section of this report. At that time, not only will a jail's accreditation status be considered, but also, the amount of improvement that was necessary in order to attain accreditation. Where a jail began in regard to compliance with the standards compared to the level it finally attained is a more valid measure of progress than simply determining its final accreditation status. Nonetheless, accreditation is an important aspect of the AMA program and should not be overlooked when judging a jail's or a state's performance.

(4) Providing assistance to other states (OSO-8)

As part of their Year Three activities, the SPDs from the original six pilot states were supposed to provide technical assistance to the new project directors. In this way, it was hoped that the knowledge and expertise gained by the old SPDs through hard experience could be readily passed along. Unfortunately, this valuable resource was not efficiently utilized during the course of the third year program.

The failure to properly and fully use the old SPDs as consultants to the new states was primarily the fault of the central staff. The old state projects did not supply as much technical assistance as they could have during the course of the Program Year, because very little was initially requested from them by the central staff, and they were not informed of what was needed. By the same token, the new project directors were unaware of what types of TA were available and, more importantly, what kinds of assistance might be helpful to them in getting their jails accredited. Only toward the end of Year Three did the central staff sufficiently coordinate the needs of the new states with the experience of the old project directors.

Early in the third year, the project directors in Maryland and Washington did provide technical assistance to other states through direct personal contacts, phone consultations, and written materials. For example, the District of Columbia's project director and his assistant were invited along on the reaccreditation site survey of the Baltimore City Jail. This jail is similar in size to the DC facility and served as a good introduction and orientation for the new project director and his assistant.

Similarly, Oregon's project director was invited to Washington for an orientation by that state's SPD. Phone consultations between Maryland and Washington's SPDs and their counterparts in Nevada, Massachusetts and Pennsylvania also took place in the early part of the program year. In addition, Washington's SPD sent out a guidebook for small jails to all of the new state projects and Maryland's "Guidebook for Jail Medical Facilities and Equipment" was distributed through the auspices of the Clearinghouse.

About halfway through the program year, the central staff became more involved in coordinating the needs of the new state projects with the available experience of the old SPDs. This coordination increased as the remainder of the year progressed. Their efforts began with the distribution of Georgia and Michigan's excellent jail orientation manual to the other fourteen states. This manual proved to be of particular assistance in several of the new states. The central staff also helped arrange technical assistance visits between several of the old SPDs and their counterparts in the new states. These TA visits were meant to help orient the new SPDs to the on-site accreditation survey process. There were three such visits: in February, the Wisconsin SPD met with her counterpart in Illinois; in March, the Maryland SPD met with her counterpart in North Carolina; and in April, the Georgia SPD met with her counterpart in Texas.

In spite of the somewhat limited coordination efforts of the central staff, many of the SPDs kept in close communication with one another on their own and were thus able to offer and receive

mutual assistance. Unfortunately, not all of the SPDs had this same close communication with their counterparts in the other states, and this fact undoubtedly hindered their efforts at locating resources available through other projects.

(5) Undertaking training efforts for jail staff (OSO-6)

Nine state projects gave various amounts of attention to the training of jail staff in different aspects of inmate health care. The Indiana, Texas, Washington and Wisconsin projects all participated in formal jailer training courses in receiving screening and health education. These courses were not a part of the AMA Jail Program per se, but rather a separate program sponsored by the National Institute of Corrections (NIC). While they were only offered on a one-time trial basis, they reportedly had a positive and stimulating effect on the jail personnel who took part in them. They also tended to heighten the awareness of the correctional community to the medical needs of inmates. In Wisconsin, the course was offered on a correspondence basis, which may prove to be a practical way to train jailers in more isolated locations in the future.

Besides the one-time NIC course, both Wisconsin and Washington pushed for more jailer training in their states. In Washington, the State Correctional Officer's Training Academy agreed to sponsor basic elements of the NIC training package at least three times in different areas of the state, beginning in September 1979. In addition, the basic correctional officer course now being offered by the state will include a four-hour segment of health care training. In

Wisconsin, the project director is currently exploring the possibility of a state jailer training course with the people who developed the NIC package. To date, however, no substantive commitments have emerged.

In other states, jailer training also got a good deal of attention. In Maryland, the Physician Advisory Committee (PAC) established a task force on jailer training. It was successful in getting the Maryland Correctional Officer Training Academy to revamp its jailer training curriculum to incorporate classes in receiving screening, recognition of symptoms, sick call, first aid, CPR, and the administration of medications. These changes will become effective in September 1979.

In Nevada, portions of the NIC course were offered at the Las Vegas City Jail and correctional personnel from around the state were invited to attend. This special course was made possible through the efforts of Nevada's SPD, the central staff, and a special allocation from LEAA.

The Massachusetts project director organized a conference on Health Care in County Correctional Facilities. It was very well attended and proved to be a good vehicle for the dissemination of jail health care information. Similar conferences or state-wide workshops would be valuable in other states as well. In addition to this conference, one jail nurse provided technical assistance and training to personnel at two other jails.

The Georgia project continued to disseminate the receiving screening package it developed in Year Two. Portions of this package are available on video-tape and have been mailed to different

places throughout the county and even to one jail in Canada.

In Illinois and Oregon, efforts were initiated to improve the health care training jail staff currently receive in these two states. In Illinois, the PAC is involved in reviewing those portions of the state's correctional officer training course that deal with inmate health care. It is hoped this review will result in improved jailer training throughout the state. In Oregon, the SPD is currently looking into jailer training through the auspices of the State Police Board and Training School. However, in both of these states, substantive results have not yet been achieved.

(6) Reviewing and testing new sets of standards (OSO-9)

During the course of the program year, various staff and other persons connected with the sixteen state projects were called upon to review and critique drafts of the three new sets of standards being developed by special physician task forces appointed by the AMA. These sets of standards covered: (1) the medical care and health services in short and long-term juvenile facilities; (2) the care and treatment of chemically dependent inmates in jails and prisons; and (3) the care and treatment of the mentally ill and handicapped in jails and adult correctional institutions.

In addition, three state projects -- Massachusetts, Michigan, and Wisconsin -- were asked to assist in the testing of the juvenile standards at a number of juvenile facilities within their states. This task, which required approximately one week of the SPD's time in each state, was accomplished adequately by all three projects.

(7) Stimulating interest in the AMA program (OSO-3/NSO-3)

The success of the program at the state and local levels was dependent upon the interest and cooperation of various diverse elements within the correctional, health care and governmental communities. The outreach, publicity, and liaison efforts generated by each of the state projects were invaluable in coordinating and stimulating these diverse communities to work toward the goal of improved inmate health care. As project activities within most states became more widely known, increasing numbers of interested parties began initiating contacts with the project directors for help in improving correctional health care systems.

In general, the state directors kept the medical communities in their respective areas informed through state medical society newsletters and journals. It was especially gratifying to note the increased and continued efforts in several states to involve local medical societies with individual jails. The following discussion briefly highlights some of the publicity, outreach, and liaison activities conducted by the sixteen projects since the beginning of Year Three. The six old states will be discussed first in alphabetical order, followed by the ten new projects.

The Georgia project continued the adequate levels of outreach activities begun in Year Two. The SPD maintained her close liaison with the Georgia Jail Managers' Association and was invited to make a presentation about the project at the National Jail Managers' Association meeting in Orlando, Florida. She also strengthened contacts

with several county medical societies and the Georgia Sheriff's Association. Interest in the Georgia project also resulted from the dissemination of the receiving screening package throughout the state and the country. During the course of the year, the SPD also began working with the Georgia Health Systems Agency on a related, but separate, health care project in the state's jails.

During Year Three, Indiana expanded its efforts to keep county medical societies informed about the project and the participating jails. The SPD made several presentations at local medical society meetings. He also continued his close liaison with the State Sheriff's Association and the Indiana Lawyer's Commission. In addition, there was local news media coverage surrounding the accreditation of several Indiana jails and statewide media coverage of the NIC jailer training course. Further, the SPD met with representatives of the Kentucky Medical Association about the Jail Health Care Program.

Maryland continued its excellent outreach efforts through frequent advisory committee meetings and the contacts with the directors of various state agencies. The different participating jails took turns hosting the PAC sessions, giving the project added exposure at the county level and within each jail. The Maryland SPD also made presentations before the State Sheriff's Association and the Correctional Health Care Program in Ann Arbor, Michigan. The Maryland project also lobbied and helped to get new state jail standards passed through the legislature. These standards largely incorporate the AMA standards. In addition, the SPD maintained her liaisons with local

medical societies, the Maryland State Jail Inspector's Office and the Community Corrections Administration.

Michigan continued to maintain its very close liaison with the State Department of Corrections, and, as in Maryland, the AMA standards are in the process of being adopted (almost verbatim) as the official health care standards for all of Michigan's jail facilities. County medical societies with participating jails were also kept abreast of project activities.

Through the efforts of Washington's SPD, that program gained a high degree of exposure both in and outside the state. The SPD made presentations to the AMA's Rural Health Care Conference in Denver and to correctional and health care personnel in Oregon. Within the state, the project director moderated a panel on jail health standards at the Washington State Health Officers annual meeting and made presentations before the state Board of Pharmacy. The SPD also developed a close working relationship with the jail health care committees organized by several local medical societies. In addition, the SPD initiated contacts with the state Nurse's Association in an effort to locate nurses for participating jails and to promote the adoption of the AMA standards as state law. In conjunction with these outreach activities, jailer training in health care was promoted and the National Health Service Corps began functioning at the King County Jail.

In Wisconsin, the publicity generated by the project resulted in more than a few persons contacting the SPD about information

and involvement in the program. Many of the state's sheriffs gained a high level of exposure to the program during a statewide conference on jailer liability. The assistant project director became the project director in January, and she reinitiated contacts with two state agencies: the Bureau of Institutional Health and the Department of Mental Health Services for Prisons. In addition, the project maintained its liaison and worked closely with the state jail inspectors.

As previously indicated, the ten new state projects were funded at a lower level than the original six projects and as such, were not expected to devote the same degree of effort to outreach, publicity and liaison activities. Nevertheless, all of the new states performed adequately in this regard and in several cases, quite exceptionally.

The District of Columbia did a good job of involving a large number of individuals in its efforts to help the D.C. jail improve its health care delivery system. It did this primarily through the active involvement of different groups in its PAC. The situation within the District of Columbia was unique. Not only was the D.C. jail the only one the project had to work with, but it was also a jail deeply involved in local political controversy and inmate law suits. Therefore, the D.C. project had to maintain a posture of absolute neutrality in order to remain creditable with the various factions within the city.

The Illinois project developed a good working relationship with several groups and state agencies. The SPD consulted

with the Illinois Bar Association concerning jail physician liability and with the University of Illinois School of Pharmacy concerning the development of standard pharmaceutical protocols in state correctional institutions. The project also involved several local medical societies in the accreditation effort, and the state's PAC reviewed and responded to current efforts at creating state-wide jail standards. In addition, the PAC reviewed the Department of Correction's curriculum on jailer health care training and legislation for jail medical care reimbursement. Publicity surrounding the project was also fairly good.

The Massachusetts project did a fine job of nurturing the interest in jail health care that already existed in the state. The SPD got the year rolling by announcing the program at a state-wide press conference attended by representatives from all of the jails involved. Early in 1979, the SPD organized a conference/workshop entitled "Health Care in Correctional Facilities--Who's Responsible?" This conference was attended by more than eighty representatives from correctional, medical, and governmental communities, and had the effect of focusing attention on the problems of inmate health care and the accreditation efforts of the individual jails. In addition to these conferences, the SPD developed very close working relationships with the State Department of Youth Services, the Department of Corrections, the State Commission of Mental Health, and the Massachusetts Association of Sheriffs.

In Nevada, the interest in jail health care and the AMA program was almost non-existent when the project year began.

Through outreach and publicity efforts and a jailer training course, the Nevada project became better known as the year progressed. Presentations were made before medical groups, Rotaries, and representatives of county commissions. A jailer training course in receiving screening was held in Las Vegas to which correctional personnel from around the state were invited.

The outreach and liaison efforts of the North Carolina project were limited during the year. A press release was issued announcing the jails selected for participation in the program. During the course of the year, physicians interested in jail health care issues were identified in anticipation of the project forming a Physician Advisory Committee in the coming year.

The Ohio project did a good job of publicizing the program within the state and stimulating interest within the correctional community. The SPD held a news conference and issued press releases surrounding the accreditation of the first two Ohio jails. He also maintained liaison with the Ohio Legislature's Correctional Inspection Committee. He augmented the project's work at individual jails by involving county medical societies in the accreditation effort. At the state-wide level, the SPD developed a working relationship with the Ohio Sheriffs' Association.

In Oregon, the SPD was able to build on an already existing interest in the accreditation of jail health care delivery systems. The project director promoted the program throughout the state through contacts he developed prior to his involvement with

the Oregon State Medical Society. The SPD made presentations about the project before the Sheriffs' Correctional Association, two groups of correctional people in Eugene and Portland, one county medical society, and a group of correctional administrators and county commissioners. The medical community throughout the state was also kept informed of program progress through notices in the state medical society's journal and newsletter.

Pennsylvania's project director was very active in promoting the program through state-wide groups and agencies. In efforts to get public health nurses into the state's jails, the SPD met with the State Director of Institutional Nursing and made a presentation before a group of public nurses at the Pennsylvania Department of Health. In addition, the project director maintained a liaison with the Department of Corrections and began efforts to get the AMA standards adopted state-wide. A private organization, the Pennsylvania Prison Society, was also contacted and now has an unofficial representative on the state's PAC. Publicity through the news media was also good within the medical community and the state in general.

The project director in South Carolina did a good job of promoting the program within the state, especially considering the outside contract role under which the project operated. The SPD made a presentation before the Community Correctional Administrators' annual meeting and kept the South Carolina Medical Association membership abreast of developments through a report to its house of delegates and two articles in the state medical journal. The PAC also

contacted county medical societies about their participation in the project at the local level.

Interest and support for the Texas project was reported to be strong within the medical community, both at the state and county medical society levels. The new SPD publicized the jail project within the state medical community through notices in the medical society's journal and newsletter. The Texas project received extensive press and television coverage surrounding the first jail accreditation survey to be held in the state. Contacts were also made with the State Sheriffs' Association.

b. Unique Objectives

Several of the state projects established unique goals for themselves which they hoped to accomplish in Year Three. This section will briefly review those goals that were successfully completed by the end of the third year.

The Georgia and Michigan projects, in conjunction with one another, developed a handbook of standards for the use of the jails within their respective states. This handbook was passed along to the other state projects about midway through the program year. In addition to this handbook, the project in Michigan saw one of its goals from previous years nearly accomplished. This goal was to get the AMA standards adopted as the official jail standards throughout the state.

Indiana's project completed an exercise handbook which could be used by inmates confined in jail. This handbook takes into

consideration that recreational facilities are very often not present in many jails and develops appropriate procedures to insure proper exercise in these facilities. This handbook is the completion of a goal Indiana began working on in Year Two.

In Maryland, four unique goals were undertaken, and three successfully accomplished. First, Maryland's "Guidebook for Jail Medical Facilities and Equipment" was revised and edited. Second, a medical summary sheet to accompany inmates transferred between Maryland correctional facilities was developed and tested. Third, new jail medical standards were passed by the state legislature. And fourth, some work was done by a committee of Med/Chi on reviewing drug usage and disposal in the state's jails.

In Washington, jail health care standards very similar to the AMA standards were nearly through the final review process before adoption by the state legislature. Passage of this legislation has been a goal of the Washington project since the first year of the program.

Massachusetts held a state-wide conference on correctional health care that was well attended. This conference created a heightened awareness of inmate health care needs throughout the state.

The Nevada project developed a resource book which covered the forty-two AMA standards. This book was designed to fit the special needs of the jails in the Nevada project. Similarly, Ohio developed examples of jail operating procedures which were specific to the jails in that state.

2. Impact of the State Projects

The three measures discussed here consist of: (a) a measure of average pre/post gains in number of standards complied with; (b) feedback from jail staff regarding the technical assistance provided by SPDs and (c) a review of the re-accreditation status of Year One and Year Two jails. The findings with respect to each will be discussed separately in the subsections which follow. The reader is referred back to the chapter on methodology for more information regarding the purpose of each of these measures and how they were developed and applied.

a. Extent of improvement

As noted previously (see page 33), whether or not the third year jails attained accreditation is not the best measure of the extent of improvements which occurred in their health care delivery systems. Simply totaling up the number of jails accredited during the year does not take into account the level of their health care systems initially. In other words, it would not be possible to determine from this measure whether jails which eventually attained accreditation had made significant improvements during the year or already had good, working health care systems.

If the primary goal of the AMA program was simply to reward jails which had good delivery systems by giving them a certificate, then the number of jails accredited would be an appropriate measure of the extent of the AMA's successful attainment of that goal. However, over the course of the three years this program has been

operating, the AMA has consistently expressed its major purpose as being one of improving health care in jails. Thus, the evaluators believed that the original phrasing of Year Three National Program Goals 1 and 2 as well as Old State Objective - 1 and New State Objective - 2, in terms of accreditation, was inappropriate--in light of the overall purpose expressed as one of improvement. Subsequent discussions between AMA central staff and the evaluators confirmed this, and it was agreed that the extent of improvements made by jails should be the primary evaluative measure of the program's impact.

In order to determine how much progress had been made, each of the Year Three jails was given a score which represented the number of standards complied with initially and a score representing the number of standards complied with by the end of the program year.[44/] These two scores were then compared to determine the extent of gains in standards compliance.

Table III (see next page) gives the average gain in the number of standards complied with for the jails within each state and the evaluators' rankings of the states in terms of the extent of improvements made. Columns B and C represent the average number of standards complied with by the jails in each state on a pre and post basis respectively. Column D shows the average gain in the number of standards complied with by state.

Interestingly, Column E ranks reveal that with the

44/ See pages 16-18 for more information on how these scores were derived.

TABLE III

AVERAGE PRE/POST STANDARDS COMPLIANCE SCORES AND RANKINGS OF IMPROVEMENT BY STATE

	Number of of Year III Jails	Pre Baseline Mean All Standards	Post Baseline Mean All Standards	Mean Difference Post-Pre	Baseline Rank: Low to High	Average Improvement Per Jail Rank: High to low	Average Improvement Per Jail Quota Rank: a/ High to low	Number of Jails Showing Any Improvement	
	A	B	C	D	E	F	G	Number	/Percent H
OLD STATES:									
Georgia	6	22.2	25.8	3.6	4	11	13	3	50.0
Indiana	6	11.2	19.9	8.7	1	1	5	2	33.3
Maryland	2	36.2	39.9	3.7	16	10	15	1	50.0
Michigan	8	24.0	27.6	3.6	5	12	10	3	37.5
Washington	8	24.4	30.4	6.0	6	6	6	6	75.0
Wisconsin	(10)9*	20.0	28.2	8.2	2	4	2	9	100.0
NEW STATES:									
Distict of Columbia	1	29.8	30.7	.9	11	16	16	1	100.0
Illinois	5	26.8	34.9	8.1	8	3	4	4	80.0
Massachusetts	7	33.2	39.7	6.5	13	5	1	7	100.0
Nevada	5	20.8	29.4	8.6	3	2	3	5	100.0
N. Carolina	5	27.7	29.3	1.6	9	15	14	3	60.0
Ohio	5	31.1	35.6	4.5	12	7	9	4	80.0
Pennsylvania	(9)8*	28.6	31.8	3.2	10	13	7	8	100.0
S. Carolina	6	25.8	29.8	4.0	7	8	8	3	50.0
Texas	(5)4*	34.4	38.2	3.8	15	9	12	3	75.0
Oregon	6	34.2	37.1	2.9	14	14	11	3	50.0
TOTALS	(91)94							64	70.0

* = One jail subsequently withdrew its application in each of these states. The figures in this table are based on the results from the remaining sites.

a/ = The quota of Year Three jails for each old state was eight, for each new state five, except for the District of Columbia, which has only one jail within its borders.

exception of Maryland (with a high average initial compliance score) and Nevada (with a low average initial compliance score), the old states were working with jails more in need of improvements than the new states were. This is to be expected, however, since typically, SPDs tend to solicit the better (and therefore, easier) jails their first year.

Column D shows that some gains were made by at least some jails in all sixteen projects. The most improvements were made by the jails in Indiana (which averaged the equivalent of almost nine more standards complied with on a post basis) and the least by the jail in Washington, D.C. (which implemented the equivalent of only one additional standard). The rankings of the states with respect to the average improvements made per jail are reflected in Column F, where "1" = most improvement and "16" = least.

Obviously, the Column F rankings were made on the basis of the actual number of jails each state has enrolled in the program, but it was also of interest to determine what their rankings would be if the number of jails they were supposed to have enrolled was taken into account. Old states were expected to work with eight jails and new states with five. Since some states did not enroll their quota of jails and others worked with more than the required number, these differences in workload needed to be reflected in the overall rankings of improvement by state. Thus, for each state, the average pre/post difference in standards compliance (Column D) was multiplied by the actual number of jails enrolled. This total was then divided by the

expected quota for each state.

As Column G indicates, states which had fewer than the required number of jails dropped in the overall rankings, whereas rankings for those states which had more than the expected number of jails improved. The "average improvement per jail quota" rankings are considered by the evaluators to be a fairer measure of the comparative state progress than those given in Column F.

The last column ("H") simply indicates the number of third year jails within each state which made any improvements in their health care systems over the course of the year. On an average basis, at least two-thirds of the Year Three sites showed some positive changes.

A comparison of Columns A and B on Table IV (see next page) shows that in all of the states, the largest gains were in the number of "Important" standards complied with. To a large extent, however, this may be a function of the disproportionate number of "Important" versus "Essential" standards.[45/] Similarly, a comparison of Columns C, D and E indicates that the largest pre/post gains by type of standards were in the Procedural area, followed by increases in the number of Service standards complied with, and then, Environmental. This is consistent with the fact that there were twenty-one Procedural standards, thirteen Service standards, and only eight Environmental standards.

45/ Of the forty-two AMA standards used in Year Three, thirty-two were rated "Important" and only ten were deemed "Essential."

TABLE IV

AVERAGE DIFFERENCE IN PRE/POST COMPLIANCE SCORES BY VALUE AND TYPE OF STANDARDS BY STATE

NOTE: Columns A + B = F and C + D + E = F	Number of Year III Jails	Mean Difference Important Post - Pre a/ A	Mean Difference Essential Post - Pre b/ B	Mean Difference Service Post - Pre c/ C	Mean Difference Procedural Post - Pre d/ D	Mean Difference Environ-mental Post-Pre e/ E	Mean Difference All Stds. Post-Pre F
OLD STATES:							
Georgia	6	2.8	.7	1.3	2.2	0.0	3.6
Indiana	6	6.0	2.6	2.4	5.9	.4	8.7
Maryland	2	3.1	.7	1.4	1.3	1.0	3.7
Michigan	8	2.6	1.0	1.4	2.1	.2	3.6
Washington	8	4.5	1.5	2.6	3.2	.2	6.0
Wisconsin	(10)9*	5.0	3.2	2.6	5.4	.2	8.2
NEW STATES:							
District of Columbia	1	.6	.3	.1	.8	0.0	.9
Illinois	5	5.8	2.3	3.1	4.8	.1	8.1
Massachusetts	7	4.0	2.5	1.3	4.8	.4	6.5
Nevada	5	5.4	3.2	2.9	5.8	0.0	8.6
N. Carolina	5	1.1	.5	.3	1.3	0.0	1.6
Ohio	5	2.9	1.6	.6	3.9	0.0	4.5
Pennsylvania	(9)8*	2.4	1.1	1.0	2.5	0.0	3.2
S. Carolina	6	3.1	.9	1.9	2.0	.1	4.0
Texas	(5)4*	2.7	1.2	1.3	2.5	0.0	3.8
Oregon	6	1.6	1.4	.6	2.4	0.0	2.9
TOTALS	(91)94						

a/ = The important standards are numbers 1003, 1009, 1010, 1013 through 1017, 1910 through 1042.
b/ = The essential standards are numbers 1001, 1002, 1004 through 1008, 1011, 1012 and 1018.
c/ = The standards designated as service standards are numbers 1011, 1012, 1015 through 1018, 1021 through 1023, 1025 through 1027, and 1042.
d/ = The standards designated as procedural standards are numbers 1001 through 1010, 1013, 1014, 1019, 1020, 1024, 1028 through 1033.
e/ = The standards designated as environmental standards are numbers 1034 through 1041.

What is important about Table IV is that it clearly shows that improvements were made in the number of "Essential" and Service standards complied with in each state.[46/] In other words, not all of the pre/post gains resulted from jails writing up new procedures. New health care services were begun as well.

b. Feedback from jail staff regarding technical assistance received from SPDs

(1) Response rates

As shown in Table V (see next page), the response rate for the questionnaire sent to medical and correctional staff at third year jails was quite good--especially for a mail-out survey. There were 124 usable questionnaires returned to the evaluators out of the original 190. This represents an overall response rate of 65%. On an aggregate basis, the number of medical staff responding was exactly the same as the number of correctional staff responding, although there were some imbalances in these numbers within states. Over four-fifths of the Year Three jails were represented by at least one respondent.

When comparing response rates within states, most of them were still quite good with a few exceptions. The extent to which the opinions of respondents in Georgia, Indiana, Illinois and North Carolina are representative is questionable. In these four states, only about half or fewer of the questionnaires were returned,

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46/ It should be recognized that the term "Essential" is a value label whereas "Service" is a label of type of standard. Thus, these categories are not mutually exclusive, and in fact, most of the "Essential" standards are Service standards.

TABLE V

STAFF SURVEY QUESTIONNAIRE RESPONSE RATES
THIRD YEAR JAILS

States (# of Year III Jails)	Number of Surveys Mailed Out	# of Usable Surveys Returned				Number of Jails Represented	% of All Year III Jails Represented
		by Medical Staff	by Correctional Staff	TOTAL #	TOTAL %		
OLD STATES:							
Georgia (N=6)	16	4	2	6	38	3	50
Indiana (N=6)*	11	2	1	3	27	3	50
Maryland (N=2)	4	1	2	3	75	2	100
Michigan (N=8)	19	3	7	10	53	7	87.5
Washington (N=8)	23	11	7	18	78	8	100
Wisconsin (N=9)	19	4	7	11	58	8	88.9
Subtotal (N=39)	92	25	26	51	55	31	79.5
NEW STATES:							
District of Columbia (N=1)	4	2	2	4	100	1	100
Illinois (N=5)	9	3	2	5	56	3	60
Massachusetts (N=7)	14	7	5	12	86	7	100
Nevada (N=5)	8	3	4	7	88	5	100
N. Carolina (N=5)	11	2	4	6	55	3	60
Ohio (N=5)	11	7	2	9	82	4	80
Oregon (N=6)*	7	1	5	6	86	5	83
Pennsylvania (N=8)	20	8	7	15	75	8	100
S. Carolina (N=6)*	4	1	3	4	100	4	67
Texas (N=4)	10	3	2	5	50	4	100
Subtotal (N=52)	98	37	36	73	74	44	84.6
TOTAL ALL STATES (N=91)	190	62	62	124	65	75	82.4

*In these states, staff were not surveyed in at least one facility because SPDs did not submit names of potential respondents to the evaluators.

and only about half of the jails in these states were represented. Thus, the opinions of respondents in these states may not accurately reflect the opinions of those not sampled.

(2) Findings

As might be expected in view of the differences in their level of funding, more of the respondents in the old states reported that the SPDs had met with them more often than was true of respondents in the new states. The average number of SPD visits reported by the former group was 3.5 and for the latter group, this figure was 2.8.[47/] While there appeared to be some association between the average number of on-site TA visits made to jails within a state and that state's ranking in terms of overall improvements, this could not be firmly established since some of the jails included in the latter measure were not represented in the former.

On an aggregate basis, four-fifths of the 124 respondents stated that the assistance they received from the SPDs was "invaluable" or "very valuable." The remaining fifth said it was at least of "some value."[48/] While no one in any of the states said that the SPD had been "of no real value," respondents in the old states seemed to think somewhat more highly of the TA received from the SPD than did those in new states (see Table VI below). This is not surprising, since the SPDs in the old states were more experienced

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47/ See Chart 1, Appendix D, for breakdowns by state of the number of SPD visits reported.

48/ See Chart 2, Appendix D, for aggregate totals as well as breakdowns by state.

in providing on-site TA and more familiar with the AMA standards and accreditation procedures. In fact, there would have been cause for concern if the results had been reversed and the new SPDs were believed to provide more effective technical assistance than experienced ones.

TABLE VI

VALUE RATINGS BY JAIL STAFF OF ASSISTANCE

RECEIVED FROM STATE PROJECT DIRECTORS BY TYPE OF STATE

Type of State	Percent Responding: "Invaluable"	"Very Valuable"	"Of Some Value"	"Of No Real Value"	Totals #	Totals %
Old (N=6)	33.3	59.0	7.7	0	39	100
New (N=10)	20.0	52.3	27.7	0	65	100
Total (N=16)	25.0	54.8	20.2	0	104	100

The survey questionnaire also contained a number of items regarding the value of specific types of assistance received from the SPDs. Aggregate responses are presented in Table VII on the next page. Breakdowns by state may be found in Charts 3-12 in Appendix D.

Table VII indicates that jail staff survey respondents believed that the SPDs were the most helpful in clarifying what compliance with each of the AMA standards entails (see item "e"). Over

TABLE VII

VALUE RATINGS BY JAIL STAFF REGARDING THE
TYPES OF ASSISTANCE RECEIVED FROM STATE PROJECT DIRECTORS

Types of Assistance: How helpful was the State Project Director in assisting you to:	Number and Percent Responding: "very helpful" #	%	"somewhat helpful" #	%	"of little help" #	%	"help not needed in this area" #	%	TOTALS #	%
a. Develop standard operating procedures?	57	54.8	27	26.0	5	4.8	15	14.4	104	100
b. Develop a receiving screening program (procedures & forms).	46	46.0	26	26.0	6	6.0	22	22.0	100	100
c. Develop an adequate medical record system?	33	33.3	25	25.3	14	14.1	27	27.3	99	100
d. Develop a procedure for the administration and recording of medications?	25	25.3	25	25.3	14	14.1	35	35.4	99	100
e. Clarify what compliance with each standard entails?	71	69.6	24	23.5	3	2.9	4	3.9	102	100
f. Establish a contractual arrangement between the jail and the responsible medical authority (e.g., doctor, hospital, etc.)?	22	21.4	24	23.3	10	9.7	47	45.6	103	100
g. Locate medical personnel resources for the jail (e.g. doctor, nurse, physician assistant, etc.)?	11	10.8	11	10.8	18	17.6	62	60.8	102	100
h. Locate other needed medical resources (e.g., medical supplies, laboratory facilities, etc.)?	7	7.0	11	11.0	18	18.0	64	64.0	100	100
i. Locate needed medical equipment (e.g., dental or examining room equipment)?	6	5.9	7	6.9	19	18.8	69	68.3	101	100
j. Tie into existing community medical resources (e.g. mental health, drug, communicable disease screening, etc.)?	10	9.7	15	14.6	19	18.4	59	57.3	103	100

two-thirds said that the SPDs were very helpful in this area and almost none indicated that no help was needed. This was a consistent pattern across all sixteen projects.

The second most useful service provided by SPDs was in assisting jail staff to develop standard operating procedures. Over half of the respondents rated this type of assistance given as "very helpful." Similarly, almost half of the respondents (46%) rated the assistance provided by the SPDs regarding establishing receiving screening programs as "very helpful."

While a number of respondents indicated they did not need assistance with items g - j, about a fifth said they could have used more help in these areas, but did not receive it. It is recommended that SPDs devote more effort to helping the jails locate and tie into medical resources in the future.

c. Lasting effect of accreditation

The best available measure of whether or not the AMA program has any lasting impact on improving a jail's health care system is the current status of jails accredited by the AMA in previous years. Therefore, the evaluators kept track of the thirty original pilot sites as well as the eighteen added in Year Two, to see what progress had been made. Table VIII on the next page summarizes the current status of Year One and Year Two jails in the six original states.

Of the forty-eight first and second year sites (Columns A and B, respectively), twelve were dropped from the program at some

TABLE VIII

STATUS OF YEAR ONE AND YEAR TWO JAILS BY STATE

State	Number of Year One Jails A	Number of Year Two Jails B	Number of Year One Jails Currently Accredited C	Number of Year Two Jails Currently Accredited D	Total Number of Year One & Year Two Jails Currently Accredited E	Number of Year One & Two Jails Whose Accreditation Has Lapsed F	Number of Year One & Two Jails Dropped From the Program G	Number of Year One & Two Jails Continuing But Not Accredited H
Georgia	5	2	1	0	1	2	2	2
Indiana	7	3	4	3	7	0	3	0
Maryland	7	2	5*	1	6	0	2	1
Michigan	4	3	4	2	6	0	0	1
Washington	4	4	2**	0	2	1***	5	0
Wisconsin	3	4	2	1	3	2	0	2
TOTAL	30	18	18(15)	7	25	5	12	6

* The accreditation status of two Year One jails will lapse in June 1979. Reaccreditation is unlikely in the foreseeable future.

** The accreditation status of one Year One jail will lapse in June 1979. Reaccreditation is unlikely in the foreseeable future.

*** The accreditation of this jail was revoked.

point (Column G). Of the remaining thirty-six jails, thirty had received accreditation at some point (Columns E and F) and the remaining six continued in the program during the third year, but never applied for accreditation (Column H). Thus, about two-thirds of the forty-eight original jails attained accreditation of their health care systems during the second or third year of program operation.[49/] What is of interest here, though, is how many of the thirty jails once accredited were able to sustain a sufficient level of health care to become re-accredited when due. Four of the original sites were accredited for the first time in Year III. Thus, the discussion which follows relates only to the twenty-six sites which should have applied for re-accreditation.

On an aggregate basis, Column F shows that five of the sites previously accredited allowed this status to lapse. These five jails were located in three different states. Technically, the jail in Washington had its accreditation revoked by the AMA.[50/] The two jails in each of the other two states (Georgia and Wisconsin) simply did not reapply for accreditation when their first awards expired.

The reason given for not reapplying by the medium-sized jail in Wisconsin and by the two large facilities (one in each state) was a recognition on the part of jail staff that their facilities could not meet some aspects of the "essential" standards--primarily the requirement that full health appraisals be given to all inmates within fourteen days. While this standard has always been considered "essential,"

[49/] More information regarding when these jails within each pilot state received accreditation, the number of years they were accredited for, and their current accreditation status may be found in Appendix E.

[50/] See pages 26-28 of the Interim Evaluation Report, note 19 supra, for the reasons for revocation and additional discussion regarding the problems encountered by jails seeking accreditation.

it was not mandatory at the time that two of these jails were initially accredited. As for the other Georgia jail, the sheriff there simply indicated he was no longer interested in participating in the AMA program, but did not say why.

In addition to the five jails noted above, there were three more facilities--two in Maryland and one in Washington--where accreditation was due to expire at the end of June 1979. None of these three jails reapplied for accreditation in April and it is doubtful whether at least one of them ever will. All three of these sites were placed on "probationary accreditation status" at one point, which had a deleterious effect on their interest in continued participation--at least for the two Maryland jails.[51/] The sheriff at the Washington jail was interested in continuing, but he lost his bid for re-election last November. This undoubtedly contributed to the halting of progress at this site.

Thus, even if these three jails where accreditation is expected to lapse at the end of June are added to the five whose accreditation has already lapsed, this would mean that just under a third of the twenty-six sites once accredited and due for reaccreditation had problems maintaining this status. However, the actual number of jails maintaining their accreditation status as of June 7, 1979 was twenty-one (i.e., four-fifths of the twenty-six due for reaccreditation). Therefore, it seems fair to conclude that the AMA program has had a lasting effect on improving health care for most of the jails

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51/ See "Special Report on the Problems Encountered at Probationary Jails," supra at note 29 and pages 35-36 and 53-54 of the Interim Evaluation Report for more information regarding jails given "probationary" status. It should be noted that the use of this term was subsequently eliminated.

originally accredited.

On a state basis, Table VIII reveals that Indiana, Michigan and then Maryland were the most successful in getting and keeping their original sites accredited, whereas Wisconsin, Washington and lastly, Georgia were the least successful. It should be noted, however, that this table does not take into account the extent of "creaming" which may have occurred at different states in the selection of original sites. In other words, the states with more jails accredited may also be the ones that worked with jails with better health care systems to begin with. While the number of jails accredited within each state should not be totally discounted, this is another illustration of why the evaluators believe that "extent of improvement" is a better measure of program impact.

3. Overall Ratings of the State Projects

In the previous sections, the progress of each state in fulfilling the national program requirements was simply described. No attempt was made to compare or rate the states across all of their efforts, nor to make recommendations specific to individual projects. This is what this section seeks to do.

This process is complicated, however, by the fact that the various activities are not all of equal significance in determining whether the projects will be successful. Further, not all of the states were expected to fulfill each objective equally. For example, the jailer training courses sponsored by the National Institute of Corrections were conducted in only four of the states. While the NIC

training efforts are clearly outside the auspices of this AMA program, some of the states were nevertheless expected to assist in implementing these courses in their areas (see Old State Objective 6 in the AMA's third year proposal). The same was true regarding the testing of the juvenile standards, where only three states were asked to participate.

In addition, it must be remembered that each state exists in its own unique environment. This requires that each Project Director tailor the AMA program to the situation with which he or she is confronted. Certain outreach and publicity efforts in one state, for example, may not be feasible or workable in another. Resources and types of problems also vary greatly between states and play an important part in a project's success or lack thereof. Thus, the states' activities to date toward accomplishing each national requirement objective have met with mixed degrees of success through varying levels of efforts.

In comparing the states, a distinction will be made between those which have participated for three years and those that were added this year. The primary indicator of success for both groups was the extent of improvements made by the jails in their respective areas (see Table III, especially Column G). In addition, the number of jails accredited was considered, but it was not weighted as heavily. For the old states, their success in assisting the Year One and Year Two sites to maintain their accreditation status was included also. All other activities--e.g. training efforts, publicity and outreach, and special activities--were considered only as secondary indicators. Strengths and weaknesses of the old state projects will be examined first.

a. Ratings of old state projects

Without a doubt, Wisconsin was able to accomplish more than the other old state projects this year. It enrolled more than its quota of jails and all nine showed improvements in the number of standards complied with on a pre/post basis. There was an average gain of 8.2 standards per site. Five of Wisconsin's jails were accredited and two of its four pilot sites were re-accredited. Publicity in this state was good, and outreach efforts were effective. The only negative aspect of this project was the lack of involvement on the part of its PAC. This group has been virtually inactive over the full three years. It is recommended that this advisory body be disbanded and a new one appointed.

Indiana's strongest accomplishment was the ability of its SPD to get jails accredited and re-accredited. Three sites received accreditation for the first time and all six of the jails previously accredited were able to maintain this status. The emphasis in the Indiana project has been almost solely on accreditation, though, and the evaluators see this as a weakness. Less than the required number of jails were recruited for the third year, and of the six enrolled, two were not worked with by the SPD. Publicity and outreach efforts were adequate, but not outstanding. Again, there was no use of the PAC and little involvement of other physician groups. This project continues to be a one-man effort and more diversification is needed. In addition, the SPD should devote more resources to jails in need of improvements in their health care systems, even though they

may not be ready for or interested in accreditation per se.

The Michigan and Washington projects fell out somewhere in the middle in terms of rankings. Both were able to enroll the required number of sites, albeit Michigan experienced some delay in this process. Washington did better on the improvement measure (six of its jails showed some pre/post improvements with an average gain of six standards per site), whereas Michigan did better on the accreditation/re-accreditation measure (four new jails were accredited and all five sites that were due were re-accredited).

In addition to the above measures, Washington's strongest accomplishment was the ability of its SPD to involve county medical societies as well as state and local health care and correctional organizations in the jail project. This state had the best outreach program of all of the old ones and was able to demonstrate some tangible results. For example, the AMA health care standards were incorporated into the state standards and mandated for all jails, and the jailer training package was adopted by the state as well. The weakest aspect of the Washington project concerned its efforts regarding re-accreditation of jails. The SPD needs to spend more time on-site providing TA to both old and new jails so that their interest and improvements do not fade.

Michigan provided good TA to its jails. Its orientation manual developed in conjunction with Georgia's SPD is deserving of special praise and its efforts to have the AMA standards adopted by the state are expected to be successful. However, Michigan did not

make good use of opportunities for publicity and its outreach efforts to other than the medical community were weak. More attention needs to be devoted to both of these aspects in the future.

Georgia and Maryland both had difficulties in soliciting the participation of a sufficient number of sites this year, but for different reasons. In Maryland's case, the SPDs efforts to enroll jails were hampered by at least two factors. First, there are only twenty-four jurisdictions in the state and jails in nine of these areas were already participating. Second, political difficulties with the jails on the Eastern Shore coupled with the political problems created when three jails were placed on "probationary accreditation status," contributed to the lack of interest of other potential sites. Only two new jails could be added in Year Three.[52/] One of them was ultimately accredited, as was one Year Two site.

Georgia's problems in recruiting jails were very different. There are over one hundred and fifty counties in this state, so finding a sufficient number of jails should not have been difficult. Georgia did not actively recruit jails, though. Instead, the SPD relied on those that had expressed interest previously or ones recommended informally by the sheriffs' association. Georgia should change its recruitment procedures in the future. Only nine jails were even contacted about participating and six of these agreed. Of these six, the SPD did not

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52/ It should be noted that this difficulty has largely been resolved. One of the wardens participating in the AMA program previously was appointed to a cabinet post within the state. Part of his duties include overseeing Maryland's correctional system, and he has mandated that jail standards be implemented. The Legislature concurred and the Maryland SPD already has letters of commitment from eight new jails for next year.

work with two much at all. Of the remaining four, three showed some improvements and two of the three were ultimately accredited.

As for the re-accreditation efforts, Maryland performed somewhat better. All five sites were re-accredited when due, although two received only one year awards and it is doubtful whether they will reapply when these certificates expire. Only one of Georgia's three sites was able to maintain its accreditation status.

Maryland provided good TA to those jails in its programs and worked with five others informally. The Georgia SPD needs to become more aggressive in providing TA and should visit each of the jails regularly.

Publicity and outreach efforts in both states were good. Maryland still has the most active advisory committee of the old states, but Georgia is beginning to use its PAC more. Both states also had special interests which they pursued with good results. Georgia's excellent orientation manual, which was developed in conjunction with the Michigan project, has already been noted. In addition, the receiving screening training package was disseminated to jails in several areas. Maryland completed its guidelines for designing and equipping jail medical facilities, revised the state's jailer training curriculum to incorporate health care topics, and developed a standard form to facilitate the transfer of inmates' medical records to other institutions within the state.

b. Ratings of the new state projects

Massachusetts had the best overall accomplishments of

the new state projects. Two more than the required number of jails were recruited and all seven showed improvements, with an average gain of 6.5 standards per site. Five of the seven were ultimately accredited this year. In addition, Massachusetts had one of the best publicity and outreach programs. The SPD made effective use of the state-wide accreditation effort, and was able to generate enthusiasm among correctional officials for the health care project. The PAC was active and a state-wide conference held in February helped to generate additional interest and support for the project. The on-site TA provided to sites was also good. The biggest problem this state will face in the future is in recruiting a sufficient number of new jails, since the total number of existing facilities is small.

Nevada experienced some difficulties in recruiting jails initially, but was subsequently able to enroll the required five sites. All five showed improvements, with an average gain of 8.6 standards per site. One of these jails was accredited during the third year. One of the strengths of the Nevada project was the ability of the SPD to generate enthusiasm for improving jail health care in a state showing the least initial interest by both correctional officials and physician groups. Like Massachusetts, Nevada also faces the potential problem of recruiting new jails, due to the small number of these facilities in the state. It is hoped that the high level of outreach efforts shown this year can be effectively maintained.

Illinois had a good, solid project. The necessary number of jails were recruited and four of them showed improvements on a pre/

post basis. The average gain in standards compliance for these four sites was 8.1, and one jail improved sufficiently to receive accreditation. The development and use of an advisory group and the SPDs organizational abilities were other strengths. The TA provided to jails was sufficient, although more on-site visits would have proved beneficial.

Pennsylvania recruited more jails than any other new state, and all eight showed some improvement. The average number of standards gained per site was only 3.2 though, and this helped to pull Pennsylvania down in the rankings. Three of these jails were accredited. One of the best aspects of this project was the high degree of enthusiasm demonstrated by its advisory group and the strong commitment expressed by the state medical society itself. One of the factors affecting the extent of progress made at individual jails was the limitation on the time available to the SPD to provide TA. In the future, more TA, especially in the form of on-site visits, would be required before greater progress at individual jails could result.

Ohio recruited its five jails early in the program year, but then let this momentum lag. Ultimately, one of the sites showed no improvement, but the other four received accreditation for either one or two years. The average gain in pre/post compliance for these four jails was 4.5 standards per site. The Ohio project was able to generate good interest from new groups and to sustain the involvement of the medical community. This state society had been working on its own to improve health care in corrections prior to participating in the AMA program, so its commitment to the AMA effort was strong. Publicity

and outreach efforts were also good. With more staff time being devoted to the project, no special problems are anticipated for next year.

South Carolina and North Carolina both experienced special problems this year. The major defect of the South Carolina project was that it was sub-contracted out to a consulting firm. The SPD actually performed well by recruiting six jails, three of which showed improvements. Two of these three were accredited. The problem is that $5,000 does not buy much of a consultant's time, however, and more could have been accomplished if the medical society had used its own in-house staff. More importantly, this model demonstrates a lack of commitment on the part of the state society. Few physicians were involved in the consultant's efforts to upgrade health care at individual sites. Further, the use of this model means that the South Carolina medical association still has no in-house expertise regarding how to improve jail health care. If South Carolina is to continue in the AMA program, a strong commitment on the part of the medical society would be required. The use of outside consultant groups does not meet the need for active physician involvement.

North Carolina's major difficulty was that the role and tasks required of the state projects were not fully understood by the SPD. Once its five jails were recruited, the SPD was not sure what was supposed to happen next. Part of this confusion stemmed from the initial orientation meeting for the new SPDs. They were told that they were restricted to one on-site TA visit per jail and that this

should occur after the jails had submitted their initial site-survey questionnaires. The North Carolina SPD took these restrictions literally, and did not visit sites he did not hear from. Toward the end of the year, he had a better understanding of what the SPDs were expected to do, and began providing TA to all jails. Three of them showed improvements by the end of the year and one of these three was accredited.

This is an example of a state where on-site TA by AMA central staff was needed, but not provided. North Carolina could have also used assistance regarding the purpose and use of a project advisory committee. A PAC chairman was appointed, but no further action taken. In the future, this state should adopt a more aggressive stance in working with its jails, and a PAC should be formed to increase the amount of physician involvement.

The three remaining new projects will be discussed as a separate grouping, since personnel problems and/or the length of their involvement in the AMA program make them unique. While Texas entered the program at the same time as the other states, and recruited its five jails, little else was accomplished during the first few months due to other commitments of the SPD. In January, a new SPD was hired and the project started over again. Considering the short amount of time he had, the new SPDs accomplishments were good. One of the initial jails was dropped, but three of the remaining four showed improvements over their short pre/post time-span of active participation. One of these three was ultimately accredited.

The new SPD is hard-working and enthusiastic and provided

good TA to his jails. While commitment on the part of the state medical society is high, the prior personnel and timing problems noted above contributed to a lack of sufficient physician involvement. A PAC should be formed in Texas to support the efforts of the SPD.

Oregon did not join the AMA program officially until October, which was several months after most of the other new states. After joining, activities got underway quickly and more than the required number of jails were enrolled. Four of the six were eventually accredited, which was all the more remarkable given the time the SPD had to work with. It should be noted, though, that the Oregon jails had a high level of initial compliance.

The organizational model used in this state was unique. The medical society sub-contracted the jail project activities to an individual, but continued to provide support services. Good physician involvement was also demonstrated and a number of jails outside the project expressed interest in participating. Thus, future prospects for this state appear to be excellent.

The project in the District of Columbia was unique in several ways. Like Oregon, it did not officially enter the program until October. Unlike any of the other projects, however, D.C. has only one jail within its borders. The medical society offered TA to the D.C. jail as requested, but its approach has consistently been one of maintaining its neutrality. Its advisory group--composed of representatives from several different medical and correctional organizations--participated in the on-site survey of the D.C. jail. The accreditation

team was unanimous in the opinion that the D.C. jail was not meeting the intent of the standards and accreditation should thus be denied. While the District of Columbia is ineligible for participation in next year's program (since it only has one jail), it is hoped that the medical society will continue its efforts to oversee improvements in the health care system of the D.C. jail.

4. The National Role

The national role vis-a-vis the state projects essentially consisted of setting guidelines and providing support and technical assistance (TA) as required. In addition to the constant contact which was maintained with all of the state projects by telephone and written correspondence, central staff members made on-site visits to a few of the states as well.

At the time of the evaluation team's initial and final site visits, project staff were asked to comment on the performance of the central program staff. For the most part, the states were well-satisfied with the direction and assistance they received. Suggestions made by SPDs after the initial visits[53/] were subsequently considered by the AMA central staff, and it was decided that in the coming year, the orientation for the SPDs would be shortened, and hopefully better organized; yearly tasks and timetable outlines would be provided; and a summary of the sequencing of events regarding accreditation would be developed.

Feedback from SPDs at the time of the final evaluation site

53/ See pages 48-49 of the Interim Evaluation Report, supra at note 19.

visits elicited few complaints regarding the TA provided to them by central staff. A couple of the SPDs continued to feel that the AMA set unrealistic deadlines, some still wanted more contact with other SPDs, and several commented that they had experienced problems receiving materials, which AMA staff had mailed.[54/] The only negative feedback of any real consequence, however, concerned the lack of sufficient on-site TA visits by central staff.

The AMA's third year proposal called for central staff to make on-site visits to the new states, especially, and for them to coordinate TA activities which could be provided by the old SPDs to the new states. The problem with the central staff's performance in the latter area was noted previously (see pages 34 - 36). Many of the new states also felt that there were problems with the central staff's performance of the first task as well. In truth, most of the new states were not visited by AMA staff until late in the program year and a few were not visited at all. Many of the new states, especially, felt that a visit by AMA staff early in the program year would have been very beneficial.

In all fairness, many SPDs indicated that on-site assistance had been offered, but they were reluctant to tell AMA staff that it was needed. Hence, in the future, it is recommended that central staff take a more aggressive stance regarding on-site TA. Monitoring visits should be regularly scheduled to all participant states, and

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54/ This suggests that a review of the mailing lists and procedures used may be needed.

not just to states requesting assistance.

Similarly, on-site visits should also be scheduled to states whenever there is a turnover in SPDs to orient the new staff member to the AMA program. This year, there was a change in the SPD in Texas and the new director was not visited. On-site TA from AMA staff would have facilitated his becoming acquainted with his new role. The Executive Secretary of the Texas Medical Society also pointed out that AMA staff should have come out to orient the new SPD. As he put it, "We should have asked, but they should have offered."

On the positive side, specific areas were singled out as deserving special praise. Among these was the manner in which telephone requests and questions from the SPDs were handled by the central staff. For the most part, the central staff were said to have responded to requests promptly and very adequately, and to have exhibited a flexibility suitable to meet each situation. Several SPDs particularly noted that materials necessary for the on-site accreditation surveys arrived well in advance of the actual survey dates, thus allowing sufficient time for adequate preparation on the part of the survey teams and the jails.

In addition to project staff, the Executive Directors of some of the sixteen medical societies were interviewed and asked to comment on the national program's role. None of them 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 societies' continued interest and support.

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 next section on the standards and the accreditation process and the one on the activities of the clearinghouse.

B. The Standards and the Accreditation Process

This chapter describes the AMA's third year activities with respect to the standards developed for jail health care systems and the resultant accreditation system which was launched in August of 1977. In addition, the AMA's progress in developing and testing standards for juvenile facilities is detailed.[55/] Further, the status of the standards drafted on the handling of chemical dependency and mental illness in jails and prisons is noted.[56/] As indicated previously, the AMA's progress in devising standards for prison health care systems is not covered in this report, since that activity is part of a different LEAA-funded grant.

1. The Jail Health Care Standards and the Accreditation System

By the end of the second program year, the AMA's standards for medical care and health services in jails had been repeatedly revised and two rounds of accreditation had been completed. Twenty-two jails were accredited by March of 1978 and twenty of these were original pilot sites.

The third round of accreditation was initiated in January of 1978 (Year Two) and completed in June of 1978 (Year Three). Following a meeting of the National Advisory Committee (NAC) in February, the AMA standards were subsequently revised. The most significant change was that the original eighty-three standards were pared to forty-two. While a few of the initial standards were eliminated, most of the remainder were simply clarified and/or reformatted. However, since

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55/ See Goal 3, p. 4 of this report.

56/ See Goals 4 and 5, p. 4 of this report.

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this revision did not occur until Spring 1978, it was the old set of standards that governed Round III of the accreditation process.

At its June meeting, the NAC reviewed sixteen jails and took the following actions:

- The provisional accreditation status which had been granted to one jail in Washington in August of 1977, was rescinded due to non-compliance with the standards.[57]
- One of the original Indiana sites was not accredited since it did not meet a sufficient number of standards.[58]
- One of the original pilot sites in Georgia was provisionally accredited for one year.
- Four of the new second year sites were fully accredited for one year.
- Five of the original pilot sites which had been previously accredited were fully re-accredited--this time for a two year period.
- Four of the original pilot sites which had attained full accreditation in Year Two were deemed not to have maintained this level of compliance. Hence, they were awarded "probationary" accreditation status for a period of one year.

This last action of the National Advisory Committee engendered a lot of controversy. It created particular problems for the Maryland project (which have been noted elsewhere),[59] since three of the four "probationary" jails were in this state. A special study conducted by the evaluators attempted to determine what had happened at these four jails which could account for their seeming inability to maintain full

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[57] This jail was subsequently dropped from Washington's project, although it reentered at a later date.

[58] This jail was subsequently dropped from Indiana's project.

[59] See page 67 of this report.

accreditation status.

Each standard missed by these jails in Round III, which had been previously met, was individually examined. The report concluded that a number of factors contributed to the different outcomes between accreditation rounds including: more stringent application of the standards in Round III, problems with the survey instruments and a lack of shared understanding (on the part of the jails especially) regarding how compliance would be measured.60/

As a result of this special study, a number of recommendations were made to AMA staff regarding necessary changes in the accreditation procedures. First, it was suggested that in the letters sent to jails notifying them of the results of their accreditation surveys, standards not complied with should be differentiated from standards where compliance was weak, but credit for meeting the standard was still given. Second, it was recommended that where non-compliance was found, these letters should state specifically which part(s) of the standards were not met. This not only enables the jails to understand why they were not given credit for particular standards, but also suggests what they need to do to correct existing deficiencies. AMA staff readily agreed to these suggestions and subsequently changed their procedures for notifying jails of their accreditation status.

The evaluators also recommended that the use of the term "probationary" be eliminated. It was felt that this term was both

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60/ See "Special Report on the Problems Encountered at Probationary Jails," supra at note 29.

punitive and offensive to jails, especially in view of the connotation of "probation" in criminal justice settings. Finally, it was recommended that the standards, the survey instruments and certain of the site survey procedures again be reviewed by the AMA staff and the NAC in an effort to eliminate some of the measurement problems which existed.

These latter two recommendations were considered by the Advisory Committee at its meeting in October 1978. The NAC requested AMA staff and the evaluation team to assemble all available data regarding the jails' problems in understanding and/or in meeting specific standards. In addition, it requested AMA staff to explore the feasibility of applying a "weighting scheme" to the standards to help eliminate some of the objections to certain standards and some of the problems of measurement. All of this information was to be considered by the NAC at a three-day meeting to be held in March 1979, prior to the finalization of the standards and the accreditation procedures.

At its October session, the Advisory Committee did agree to eliminate the use of the term "probation." It also eliminated the use of the terms "full" and "provisional," and adopted the terms "one year" and "two year" accreditation instead. It was agreed that the criteria for awarding two year accreditation status to a given jail would be evidence that all ten Essential Standards[61/] and 85% of the remaining

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61/ At its June 1978 session, the NAC considered feedback from the Year Two evaluation report and determined that ten of the now forty-two standards were so important that it would not want to accredit a facility unless these standards were complied with. Hence, these ten standards were determined to be "Essential" and are so designated in the latest version of the AMA's Standards for the Accreditation of Medical Care and Health Services in Jails, Chicago: August 1978.

applicable standards were met at the time of an on-site survey. The criteria for awarding one year accreditation consisted of again meeting all ten Essential Standards, but only 70% of the remaining applicable ones. It was further decided that the one year status could be renewed twice, after a jail once received such an award.

Following these decisions, site survey reports from eight jails applying for accreditation were considered. The NAC subsequently awarded two year accreditation to two jails, one year accreditation to five jails and deferred a two year award to one jail until December 1978, pending additional evidence of comliance with one of the Essential standards. At the end of four rounds of accreditation then (from August 1977 through October 1978), the AMA had awarded forty-four certificates of accreditation, although one was deferred for two months.

The National Advisory Committee met again in March of 1979 to consider ten more applications for Round V. Of these, one jail was denied accreditation, one was awarded a one year certificate, five were awarded two year certificates, and the remaining three jails were awarded two year certificates contingent upon a re-visit to ensure that newly implemented standards were still being complied with.

A sub-committee of the NAC met for one final time on June 6 of 1979 to review additional jails seeking accreditation at the end of the third year. Thirty-eight jails applied for accreditation in Round VI and the NAC sub-committee made the following decisions:

a. Four jails were denied accreditation for insufficient compliance with the standards;

b. Four jails were awarded unconditional one year certificates;

c. Seven other jails were awarded one year certificates contingent upon a revisit showing continued compliance with certain newly implemented standards;

d. Ten jails were awarded unconditional two year certificates; and

e. The remaining thirteen jails were awarded two year certificates contingent upon re-visits to ensure compliance.

By the end of the third program year, then, the AMA had awarded a total of eighty-seven accreditation certificates (see Table IX on the next page). Only one of these was subsequently rescinded and only four jails had allowed their accreditation status to lapse. Of the remaining eighty-two certificates, several went to twenty-one jails seeking reaccreditation.

Thus, as of June 1979, there were fifty-nine different facilities which were currently accredited by the AMA. This represents just over 40% of the 142 jails which have ever been involved in the AMA program over the course of its three years of operation. It should also be remembered that a sizeable proportion of those jails not receiving accreditation still made substantial improvements in their health care systems.

2. Final Status of the Various Sets of Standards

In addition to finalizing the jail health care standards, the AMA's third year proposal called for the development of three additional sets of standards for: a. short and long-term juvenile facilities; b. handling chemically dependent inmates; and c. mental health programs in jails and prisons. Consequently, the AMA appointed special task forces to develop standards in each of these areas.

TABLE IX

SUMMARY OF ACCREDITATION DECISIONS OF THE AMA'S NATIONAL ADVISORY COMMITTEE (NAC)

Accreditation Round (Date)	NAC DECISIONS				
	# of Jails Accredited			# of Jails Denied Accreditation	# of Jails Where Accreditation Was Rescinded
	Provisional/ Probationary/ One Year	Full/ Two Years	Total		
Round I (August 1977)	2	14	16	0	0
Round II (February 1978)	3	3	6	1	0
Round III (June 1978)	5	9	14	1	1
Round IV (October 1978)	5	3	8	0	0
Round V (March 1979)	1	8	9	1	0
Round VI (June 1979)	11*	23**	34	4	0
Totals (Aug. '77-June '79)	27	60	87	7	1

* Seven of these sites must be revisited within sixty days to ensure continued compliance.

** Thirteen of these sites must be revisited within sixty days to ensure continued compliance.

Each task force met several times to initially draft their standards and to revise subsequent drafts. The juvenile standards were field-tested in short and long-term facilities in three states, whereas the other two sets of standards were submitted to various medical and correctional representatives for their review and critique. Feedback from these different sources was considered prior to the submission of the finalized sets of standards to the AMA's advisory committee.

In addition to making decisions regarding awarding accreditation to jails, the primary purpose of the NAC's March 1979 meeting was to review all of the different sets of standards developed to date. The evaluator summarized the feedback received from the SPDs regarding remaining problems with the jail health care standards, and a representative from each of the different task forces was present to submit their finalized standards. The NAC spent three days going over all of the standards. Ultimately, it was decided to incorporate the most important aspects of the chemical dependency and mental health standards into the existing sets for a. jails, b. juvenile facilities, and c. prisons. Substantive as well as editing changes were made in the jail standards and this new draft was re-submitted to NAC members for their final review. In addition, the finalized jail standards were submitted to the AMA House of Delegates for approval at their annual meeting to be held in July.

All three sets of standards--for jails, juvenile facilities and prisons--are now in the process of being printed for general distribution. The standards for jails now number sixty-nine in length. It is this set which will govern the technical assistance activities

for next year's program. Since the jail standards have changed, the "Standards Notebook", the self-survey questionnaires and the on-site accreditation instruments are also being revised. Again, feedback from the SPDs was considered prior to revisions. Thus, National Program Goals 4 and 5 and parts of Goals 1 and 3 appear to have been satisfactorily accomplished (see page 4 of this report).

C. Clearinghouse Activities

The clearinghouse had two major functions. The first was to provide TA to anyone interested in improving health care in jails by developing and distributing relevant materials. The second was 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

Six new monographs were published this year consisting of:

a. One on the management of common medical problems in jails;

b. One summarizing results of juvenile epidemiological studies;62/

c. One describing health care systems in juvenile facilities;62/

d. One on guidelines for handling chemically dependent inmates;

e. One on health care delivery models for jails; and

f. One on providing dental care to inmates, which was developed in cooperation with the American Dental Association.

Besides publishing new monographs, a large part of the clearinghouse activities this third year included the extensive promotion and distribution of materials developed in previous years. During the fourteen month period from April 1978 through May of 1979, the clearinghouse disseminated 1,212 fact sheets and approximately

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62/ These two monographs fulfill National Program Goal 3, in conjunction with the development of the standards for juvenile facilities (see page 4 of this report).

54,000 copies of various monographs and the different sets of standards.[63/] In addition, several thousand copies of a bimonthly newsletter entitled The Correctional Stethoscope were mailed out. Circulation of this newsletter now reaches over 3,400 correctional and health care personnel.

Further, the program's award-winning film, "Out of Sight--Out of Mind," was shown to a number of diverse groups by both the AMA and the state projects. Each state has its own copy of the film to show or lend. The program's public relations director developed a sample commentary, which can be used in conjunction with the film, as well as a ninety-second clip suitable for television usage. A model speech outlining the AMA's program was also sent to the states. However, statistics regarding the frequency of state usage of the film, the film clip and the model speech are not presently available. The AMA has requested that the states supply this information in the future, so that the utility of these efforts can be gauged. Finally, the long-awaited annotated bibliography listing references on various jail health care topics was completed.

On a quantitative basis, then, the AMA's clearinghouse was extremely active during the third year. The quality of the materials distributed was more of interest to the evaluators, though. Consequently, a number of questions were included on the survey instrument mailed

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63/ These totals were obtained from AMA staff records for April 1978 through April 1979. Figures for May 1979 were estimated on the basis of the average distribution figures for previous months.

to medical and correctional staff at Year Three jails.[64/] Respondents were asked to indicate how familiar they were with various AMA publications including selected monographs, the jail standards, the Practical Guide and the Correctional Stethoscope. If these materials had been read, the respondents were asked to rate the value of the various publications in assisting them to upgrade their health care systems. The findings with respect to these items are discussed below.

Table X (next page) shows the reaction of jail staff to eight selected monographs. With the exception of letters d, e, and f, over half of the respondents had read each of the different publications. "The Use of Volunteers in Jails" was the least well-received. For all the others, at least three-fourths of the respondents who read the publications rated them as either "good" or "excellent."

Feedback on the jail standards is shown in Table XI (see page 91). As indicated, 98% of the respondents were acquainted with the standards and all but 5% felt they were written clearly. The respondents were somewhat less satisfied with the discussions accompanying the standards, but even here, all but 6% said the discussions were at least adequate for most of the standards, if not all. Hopefully, the latest revision and editing of the jail standards will help to clarify any remaining confusion.

64/ See pp. 18-19 & 54-56 for a discussion of the methodology employed and the response rate for the survey.

TABLE X

FEEDBACK FROM YEAR THREE JAIL STAFF ON EXTENT OF FAMILIARITY WITH AND VALUE OF SELECTED AMA CLEARINGHOUSE PUBLICATIONS

Publication*	RESPONSES																TOTAL	
	A Familiar?				B If so, read?				C Value--if read?									
	Yes		No		Yes		No		Excellent		Good		Fair		Poor			
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
a. "The Use of Allied Health Personnel in Jails" (121)	77	64	44	36	69	92	6	8	8	12	45	65	16	23	0	0	69	100
b. "Models for Health Care Delivery in Jails" (121)	66	54	55	46	56	92	5	8	8	14	36	64	11	20	1	2	56	100
c. "The Use of Volunteers in Jails" (119)	62	52	57	48	51	90	6	10	4	8	28	55	14	28	5	10	51	101**
d. "The Recognition of Inmates with Mental Illness: Their Special Problems and Needs for Care" (118)	55	47	63	53	44	86	7	14	15	34	25	57	4	9	0	0	44	100
e. "Orienting Health Providers to the Jail Culture" (119)	42	35	77	65	36	90	4	10	11	31	19	53	5	14	1	3	36	101**
f. "Orienting Jailers to Health and Medical Care Delivery Systems" (118)	44	37	74	63	37	88	5	12	7	19	22	60	8	22	0	0	37	101**
g. "Constitutional Issues in the Prisoner's Right to Health Care" (119)	68	57	51	43	58	91	6	9	21	37	29	51	7	12	0	0	57	100
h. "Health Care in Jails: Inmate's Medical Records and Jail Inmate's Right to Refuse Medical Treatment" (119)	63	53	56	47	59	98	1	2	21	37	32	56	4	7	0	0	57	100

*NOTE: The total number of survey respondents from the 16 projects was 124. The numbers in parentheses indicate how many of the total respondents answered these items.

**Errors due to rounding

TABLE XI

FEEDBACK FROM YEAR THREE JAIL STAFF REGARDING

THE AMA JAIL STANDARDS

Extent of Acquaintance With Standards

	#	%
Very acquainted	78	64.5
Somewhat acquainted	39	32.2
Vaguely acquainted	2	1.7
Not at all acquainted	2	1.7
Total	121	100

Extent of Clarity of Standards

	#	%
Very clear	46	38.0
Clear	69	57.0
Unclear	4	3.3
Very unclear	2	1.7
Total	121	100

Extent of Adequacy of Discussions

	#	%
Adequate for all standards	21	18.1
Adequate for most standards	88	75.9
Inadequate for most standards	7	6.0
Inadequate for all standards	0	0
Total	116	100

The Practical Guide was designed to be used in conjunction with the standards. It provides examples of policies and procedures, sample contracts with medical authorities, health care statistics forms, medical treatment records, and forms for recording medications administered among other items. Over half of the respondents (54.3%) stated that they referred to the Practical Guide "very often" for assistance in meeting the AMA standards, and an additional 33% said they used it "occasionally." Table XII (see next page) gives the value ratings by jail staff regarding how helpful they found the examples in assisting them to develop certain forms and written procedures. These data suggest that some improvements

TABLE XII

VALUE RATINGS BY JAIL STAFF REGARDING THE EXAMPLES PROVIDED IN THE PRACTICAL GUIDE

How helpful was the Practical Guide in assisting you to do the following:	Number and Percent Responding: "Very Helpful" #	%	"Helpful" #	%	"Of Little Assistance" #	%	TOTAL #	%
a. Develop standard operating procedures, job descriptions, and standing orders?	46	44.2	50	48.1	8	7.7	104	100
b. Develop a receiving screening program (procedures and forms)?	51	49.0	43	41.3	10	9.6	104	100
c. Develop an adequate medical record system?	31	30.1	48	46.6	24	23.3	103	100
d. Develop a procedure for the administration and recording of medications?	26	25.0	43	41.3	35	33.7	104	100
e. Understand what compliance with the standards involves?	49	46.7	50	47.6	6	5.7	105	100

may be needed in the medical record examples and in those addressing the administration and recording of medications. The other items were said to be "helpful" or "very helpful" to 90% or more of the respondents.

Finally, jail staff were asked to indicate the value of the bimonthly newsletter to them. Surprisingly, only 29% of the 121 respondents were even aware of this publication, and of these, only twenty-five individuals read it regularly (see Table XIII below). This lack of awareness is undoubtedly related to the fact that the AMA does not automatically add participant jails to its mailing list. It is recommended that this practice be instituted in the future.

TABLE XIII

FEEDBACK FROM YEAR THREE JAIL STAFF REGARDING

THE CORRECTIONAL STETHOSCOPE

Aware?				Read Regularly?				Value--If Read?									
Yes		No		Yes		No		Always Worthwhile		Usually Worthwhile		Occasionally Worthwhile		Seldom Worthwhile		Total	
#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
35	28.9	86	71.1	25	73.5	9	26.5	9	31.0	8	27.6	11	37.9	1	3.5	29	100

Table XIII also shows that about two-fifths of the respondents did not usually find the Correctional Stethoscope worthwhile. A few of the comments indicated that brief reviews of recent publications in the correctional health area as well as reviews of recent case law would be of more benefit. It is recommended that the newsletter incorporate

these suggestions in future issues.

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 "outside" media coverage has occurred also. Articles focusing on various aspects of the jail program's activities have appeared in major papers, and radio and television coverage have been generated as well. Press conferences held at the AMA's annual convention in June, 1978 and again at the national conference on jail health in October of 1978 resulted in extensive publicity.

During the third year, AMA central staff also made speeches or appearances before a number of professional organizations, including: the Colorado Sheriffs' Association, the Wisconsin Sheriffs' Association, the Virginia Sheriffs' Association, the National Sheriffs' Association, the Illinois Academy of Criminology, and the American Public Health Association (APHA), among others. In addition, presentations were made at the AMA Auxilliary's annual meeting, the AMA's Rural Health Conference and the conference on the jail crisis sponsored by the National Association of Counties. Literature was distributed at a number of the sessions noted above and, in some instances, booths were staffed as well.

Finally, representatives of the AMA Jail Program have been active participants in meetings of the National Jail Coalition and

continue to work with other national efforts such as the Commission on Accreditation for Corrections.

D. The National Conference

The final goal the AMA wished to accomplish in Year Three was to hold a second national conference on the topic of "Medical Care and Health Services in Correctional Institutions." The first conference was held in Milwaukee in August 1977 in conjunction with the American Correctional Association's annual meeting. This time, the AMA decided to hold the conference on its own. There was some initial concern on the part of AMA leadership staff regarding whether interest in the topic would be sufficient to sustain a conference devoted solely to jail/prison health care issues. These fears proved to be groundless.

Response to the second national conference was overwhelming. A count of the number of people registered totaled 370 individuals.[65/] The two-day conference was held in Chicago on October 27 and 28, 1978. In response to last year's evaluation, this conference consisted primarily of smaller group workshops and seminars rather than speeches to the general audience.

Feedback questionnaires were distributed to participants on both days. Analyses of the results from these data sets were discussed in detail in the Interim Evaluation Report,[66/] and will not be repeated here. In general, most participants felt that the conference was well-

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65/ It is difficult to compare this figure accurately with last year's, since the latter was based on estimates which may have been inflated. However, a reasonable estimate would be that there were a third again as many participants this year compared with last year.

66/ See pages 68-76 and Appendix D of the Interim Evaluation Report, supra at note 19, for specifics.

planned and well-organized and that it was a valuable educational experience. Of the people rating Saturday's program, 86% said it was at least "good" in providing relevant information about health care in corrections and 74% said it was at least "good" in providing practical suggestions and solutions as well. Responses to Friday's program were similar, albeit somewhat less favorable (i.e., the figures were 84% and 60% respectively).

Planning for the third national conference is now underway. It is scheduled to be held on November 9 and 10 at the Radisson Hotel in Chicago. Feedback from last year's participants was considered by AMA staff in designing the next conference.

IV. SUMMARY AND CONCLUSIONS

On balance, the process evaluation and impact assessment measures indicated that the American Medical Association had successfully achieved its Year Three goals.[67/] A total of ninety-four jails were enrolled in the program this year, and only three were dropped for lack of interest. Of the remaining ninety-one jails, thirty-four were subsequently accredited. An additional thirty-one facilities made improvements in their health care systems. This means that the health care systems in almost three-fourths of the third year sites were positively affected by their jail's participation in the AMA's program.

Four of the original sites were also accredited during the third year. Further, an examination of the re-accreditation status of Year One and Year Two facilities indicated that the majority were able to sustain the improvements made previously. Twenty-one sites were re-accredited, one had its accreditation rescinded, and only four had allowed their accreditation status to lapse. This means that accreditation had a lasting effect in over 80% of the jails which had been accredited in previous years. Even if the three jails whose accreditation is expected to lapse at the end of June are added to the "failures," this still means that over two-thirds of the twenty-six sites successfully maintained their accreditation status over time. Thus, as of June 7, 1979, a total of fifty-nine jails were currently accredited (thirty-four plus four plus twenty-one).

While there were differences in the amount of progress made by the jails in different states, all sixteen projects had at least one

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67/ See page 4 of this report for an exact listing of the seven national program goals.

jail showing some improvements, and all except the District of Columbia had at least one jail which was awarded accreditation. Survey responses from medical and correctional staff at third year sites revealed that a substantial majority had high praise for the technical assistance received from the State Project Directors (SPDs). Only a very few indicated that the SPDs had been "of little assistance" to them on any of the various items inquiring about specific types of assistance.

In addition, the jail standards as well as the accreditation instruments and procedures were revised and a new set of standards for short and long-term juvenile facilities was developed. Standards drafted for handling chemically dependent inmates and those in need of mental health care were incorporated into the three sets for jails, juvenile facilities and prisons.

Six new monographs were written this year and the clearinghouse disseminated over 55,000 publications. Feedback from the jail staff survey indicated that, for the most part, the clearinghouse materials were of value to them. Extensive publicity--including speeches, newspaper articles and radio and television coverage--served to generate substantial interest in the problem of providing good health care in jails and motivated innumerable groups to become involved in working toward solutions.

Attendance at the second national conference was high and participants rated the program positively, both in terms of the educational value of the information provided and in terms of the practical suggestions and solutions offered. Plans for next year's conference are

well underway.

In reviewing the impact of the AMA program on improving health care in jails, the various measures applied to the program over its three years of L.E.A.A. funding revealed a strong effect. To be sure, the AMA's success has not been 100%, but success stories of any magnitude are a rarity in the criminal justice field.

Previous evaluation reports have indicated that the AMA program had a substantial impact on increasing the availability and adequacy of health care services in jails;[68/] on increasing the ability of participant jails to detect and treat inmates' medical problems, thereby improving the health status of inmates;[69/] and on improving the attitudes of both inmates and booking officers regarding the effectiveness of the health care systems in their jails. Further, implementing the AMA standards in some jails led to decreases in their transportation requirements for medical reasons and to a more cost-effective method of delivering health care.[70/]

When so many reform movements fail, why was the AMA program able to demonstrate substantial results? In part, the answer seems to lie in the fact that it was organized medicine undertaking the reform.

68/ See Analysis of Pilot Jail Post-Profile Data, supra at note 7, and the Ten Jail Case Study and Analysis, supra at note 18.

69/ See Analysis of Inmate/Patient Profile Data--Year Two, supra at note 7, and the Ten Jail Case Study and Analysis, supra at note 18.

70/ See Ten Jail Case Study and Analysis, supra at note 18.

An analysis of the factors contributing to whether or not jails starting from approximately the same point in terms of the status of their health care systems, are able to achieve accreditation in the same amount of time, revealed some interesting findings.[71] The key determinant of success appeared to be the extent of cooperation and support received from the medical community. Where physician involvement was high and good support was received from health care agencies, jails were able to become accredited. Where this involvement was lacking, little progress was made.

When the Executive Secretaries of the state medical societies were interviewed by the evaluators, there was general agreement that a program to improve health care in jails was long overdue. There was also unanimous agreement that organized medicine had an important role to play in bringing about change, and AMA leadership staff were praised highly for moving organized medicine in this direction. There was also a belief though, that only organized medicine could achieve significant results on a national scale. Even if the correctional community were 100% behind a national program to improve health care in jails, their efforts could not succeed without the influence and cooperation of the medical community. From the findings in our own research, the evaluators concur.

71/ Ibid..

APPENDIX A

ABBREVIATION KEY

Abbreviation Key

AA = Alcoholics Anonymous

AMA = American Medical Association

CPR = Cardiopulmonary Resuscitation

DOC = Department of Corrections

LEAA = Law Enforcement Assistance Administration

NAC = National Advisory Committee

NIC = National Institute of Corrections

PA = Project Assistant

PAC = Project Advisory Committee

RA = Research Assistant

RN = Registered Nurse

SPA = State Planning Agency

SPD = State Project Director

TA = Technical Assistance

Symbols Used in Charts

$\overline{X}$ = Mean

N = Number

= Number

% = Percent

APPENDIX B

CHARACTERISTICS OF THE PROJECT ADVISORY COMMITTEES

CHART 1

CHARACTERISTICS OF THE PROJECT ADVISORY COMMITTEE: COMMITTEE MAKEUP

State	Total Number	Health Representatives	Correctional Representatives	Legal Representatives	Other
District of Columbia	11	6 physicians	1 Dept. of Human Resources 1 representative from Council on Criminal Justice	None	1 ward supervisor 1 state planning agency 1 DC Chamber of Commerce
	Subtotal 6		2		3
Georgia***	15	13 physicians (including a psychiatrist, a pediatrician and a medical educator) 1 dentist	1 DOC Health Services Director	One legal representative to be added from Attorney's Office	None
	Subtotal 14		1		
Illinois	12	4 physicians 1 dentist 1 RN representative, Illinois Dept. of Public Health 1 representative Illinois Pharmaceutical Assoc. 1 representative Illinois Nurses Assoc. 1 representative Assoc. of Ambulatory Services	1 sheriff 1 representative Illinois DOC	1 representative Illinois Bar Association	None
	Subtotal 9		2	1	

CHART 1

COMMITTEE MAKEUP (continued)

State	Total Number	Health Representatives	Correctional Representatives	Legal Representatives	Other
Indiana	24	5 physicians (including a forensic psychiatrist) 1 pharmacist 1 dentist 2 medical educators 1 DOC medical administrator	1 jail inspector 1 Sheriffs' Assoc. executive 1 administrator of an ex-offender program	1 criminal court judge 1 public defender 1 state legislator 4 attorneys (representatives of the Bar Assoc. and the ILC)	1 Chamber of Commerce executive 1 Assoc. of Counties executive 1 AA representative 1 SPA representative
	Subtotal 10		3	7	4
Maryland	16	7 physicians (one forensic psychiatrist) 2 representatives of the state health department	1 jail inspector 1 Sheriffs' Assoc. representative 1 Jail Administrators' Assoc. representative 1 correctional trainer	1 attorney from the bar association	1 Association of Counties executive 1 SPA representative
	Subtotal 9		4	1	2
Massachusetts	12	7 physicians (one ex-officio-Pres. of Mass. Medical Society) TO BE ADDED: 1 representative Dept. of Public Health 1 representative from the Attorney General's office	1 Sheriffs' Assoc. representative 1 Director Health Services DOC 1 representative Youth Service Bureau	1 attorney	1 member of the Crime and Justice Commission
	Subtotal 7		3	1	1

CHART 1

COMMITTEE MAKEUP (continued)

State	Total Number	Health Representatives	Correctional Representatives	Legal Representatives	Other
Michigan	8	6 physicians 1 RN 1 dentist	3 representatives of the DOC Office of Jail Services--Advisor status** 1 Sheriffs' Assoc. executive--Advisor status**	None	None
	Subtotal	8			
Nevada	8	8 physicians	None	None	None
North Carolina		Committee Being Considered			
Ohio	10	10 physicians (two jail physicians and one prison physician)	None	None	None
Oregon**	8	8 physicians (one physician for state penitentiary) 1 director of nurses from county jail	1 consultant from DOC 1 sheriff 1 jail administrator	None	1 consultant from State Assoc. of Counties

CHART 1

COMMITTEE MAKEUP (continued)

State	Total Number	Health Representatives	Correctional Representatives	Legal Representatives	Other
Pennsylvania	9	4 physicians (one from Governor's Task Force on Prison Health Services) 1 RN representative from the PA Dept. of Health	1 representative from the PA Bureau of Corrections 1 representative from the PA Prison Wardens' Assoc. 1 representative from the PA Prison Society****	1 lawyer 1 PA Medical Society legal counselor**** 1 staff member of PA House of Representatives Judicial Comm.****	1 representative from the PA State Assoc. of County Commissioners
	Subtotal	5	3	3	1
South Carolina	11	5 physicians	1 representative from the Office of Criminal Justice Programs 1 representative from the DOC 1 representative from the Community Corrections Administrators' Assoc. 1 representative from the SC Sheriffs' Assoc. 1 other jail representative	None	1 representative from SC Municipal Assoc.
	Subtotal	5	5		1

CHART 1

COMMITTEE MAKEUP (continued)

State	Total Number	Health Representatives	Correctional Representatives	Legal Representatives	Other
Texas		Committee in the Process of Being Formed			
Washington***	9	9 physicians (one is medical director for DOC)	None	None	None
Wisconsin	15	6 physicians 1 dentist 1 hospital administrator 1 Division of Health representative 1 medical educator 1 Hospital Assoc. representative	1 Sheriffs' Assoc. executive	1 Bar Assoc. executive	1 League of Women Voters representative 1 Council of Churches representative
	Subtotal	11	1	1	2

** The 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.

**** Pennsylvania has three interested observers who are also unofficial committee members.

CHART 2

CHARACTERISTICS OF THE PROJECT ADVISORY COMMITTEE: OTHER CHARACTERISTICS

State	Date Formed	# of Meetings 4/78 - 5/79	Paid or Voluntary	Major Role	Committee Task Forces
District of Columbia	**** Jan.'79	1 Feb. 1 Apr.	voluntary	Policy-making, project review and planning, provide technical assistance to the DC Jail, staff on-site accreditation survey team.	None
Georgia**	Nov. '75	1 Apr. 1 Oct. 1 Feb. 1 May	voluntary	Policy-making, project review and planning. Accreditation site surveys and review.	None to date, although members have been utilized on an individual basis to review and critique the standards, accreditation process, etc.
Illinois	Aug.'78	1 Sep. 1 Dec. 1 Feb. 1 May	voluntary	Policy-making, project review and planning, provide technical assistance to project jails, promote state-wide standards and jailer training.	There has been some use of individual members on an ad hoc basis.
Indiana	Mar.'76	None	voluntary	Policy-making, project review and planning. No use of committee this year.	There has been some use of individual members on an ad hoc basis, particularly the PAC physician chairman.

CHART 2

OTHER CHARACTERISTICS (continued)

State	Date Formed	# of Meetings 4/78 - 5/79	Paid or Voluntary	Major Role	Committee Task Forces
Maryland	Apr.'76	1 May 1 Jun. 1 Sep. 1 Nov. 1 Jan. 1 Feb. 1 Apr.	voluntary	Policy-making, project review and planning, quality assessment, assist in locating jail physicians, plus specific activities of task forces. Committee actively supporting adoption of state jail medical standards.	Yes - task forces established on (1) standing orders and medical records; (2) physical facilities; and (3) jailer training.
Massachusetts	Jul.'78	1 Aug. 1 Sep. 1 Dec. 1 Apr.	voluntary	Policy-making, project review and planning. Moderate use of full committee to date.	None to date. Individual members used on an ad hoc basis to assist in accreditation site survey.
Michigan	Jan.'76	1 Nov.	voluntary	Policy-making, project review and planning. Limited use of full committee this year.	Yes - Physician Task Force has focused on reviewing standards and revising its manual of policies and procedures for jail health care.
Nevada	*	1 Jan.	voluntary	Policy-making, project review and planning. Limited use of full committee to date.	Yes - a regional committee for the southern part of the state was formed. Works fairly independently of larger PAC. Committee is composed of three physicians, one of whom is a member of larger PAC.

CHART 2

OTHER CHARACTERISTICS (continued)

State	Date Formed	# of Meetings 4/78 - 5/79	Paid or Voluntary	Major Role	Committee Task Forces
North Carolina		Committee Not Formed			
Ohio	*	1 Jun. 1 Sep.	voluntary	Policy-making, project review and planning. Actively work with project jails providing technical assistance in preparation for accreditation. Moderate use of full committee to date.	None
Oregon	Dec.'78	1 Dec.	voluntary	Policy-making, project review and planning. Actively work with project jails providing technical assistance in preparation for accreditation. Limited use of full committee to date.	There has been some use of individual members on an ad hoc basis.
Pennsylvania	Sep. '78	1 Sep. 1 Jan.	voluntary	Policy-making, project review and planning. Raise the awareness of Medical Society members to the needs of jails. Act as liaison with county medical societies. Moderate use to date.	None

CHART 2

OTHER CHARACTERISTICS (continued)

State	Date Formed	# of Meetings 4/78 - 5/79	Paid or Voluntary	Major Role	Committee Task Force
South Carolina	Sep.'78	1 Sep. 1 Dec. 1 Jan.	voluntary	Policy-making, project review and planning, raise awareness of Medical Society members to the needs of jails. Act as liaison with county medical societies.	One physician acted as observer during accreditation survey.
Texas		Committee Not Formed			
Washington	1972***	1 May 1 Sep. 1 Dec. 1 Feb. 1 Mar.	voluntary	Policy-making, project review and planning, review jailer training materials.	One formed to study questions of quality assessment.
Wisconsin	Jan.'76	None	voluntary	Policy-making, project review and planning. Not used since January 1977.	None

* These committee were in existence prior to state medical societies' entry into AMA program.

** This committee also serves the DOC health program.

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

**** Originally used existing medical society committees. Special jail committee with non-physician members formed with first meeting held in February 1979.

APPENDIX C

EXAMPLE OF THE JAIL STAFF SURVEY QUESTIONNAIRE

B. Jaye Anno

Evaluation — Research — Consulting

11200 LOCKWOOD DRIVE • SILVER SPRING, MARYLAND 20901 • 301—593-8199

The American Medical Association (AMA) is continually striving to improve its capability to assist those jails trying to upgrade their health care delivery systems. As part of this improvement effort, the AMA has asked B. Jaye Anno Associates to survey key people in all participating jails. We would like for you, as one of those key people, to take several minutes and respond to a series of questions about the types of assistance you have received from the AMA and the medical society in your state. Any additional comments you may care to make would also be appreciated. We have enclosed a stamped, self-addressed envelope for your use.

Thank you.

Allen H. Lang

Allen H. Lang

1. As you may already know, the AMA has established a correctional health care clearinghouse in order to stimulate interest in the problems of health care in jails and to provide assistance to those interested in upgrading existing medical systems. We have selected several items from the clearinghouse publication list which we would like for you to evaluate. For each item, please tell us: (A) if you are familiar with the publication, (B) whether you read it, and (C) if read, how valuable you found it.

Publication	A Familiar		B Read		C Value--if Read			
	Yes	No	Yes	No	Exc.	Good	Fair	Poor
a. "The Use of Allied Health Personnel in Jails"	___	___	___	___	___	___	___	___
b. "Models for Health Care Delivery in Jails"	___	___	___	___	___	___	___	___
c. "The Use of Volunteers in Jails"	___	___	___	___	___	___	___	___
d. "The Recognition of Inmates with Mental Illness: Their Special Problems and Needs for Care"	___	___	___	___	___	___	___	___
e. "Orienting Health Providers to the Jail Culture"	___	___	___	___	___	___	___	___
f. "Orienting Jailers to Health and Medical Care Delivery Systems"	___	___	___	___	___	___	___	___
g. "Constitutional Issues in the Prisoner's Right to Health Care"	___	___	___	___	___	___	___	___
h. "Health Care in Jails: Inmate's Medical Records and Jail Inmate's Right to Refuse Medical Treatment"	___	___	___	___	___	___	___	___

2. The AMA's standards are an important tool in measuring a jail's health care delivery system. How acquainted are you with these standards?

_____very acquainted _____somewhat acquainted _____vaguely acquainted

_____not at all acquainted

b. In general, how clear is the meaning or intent of the standards?

_____very clear _____clear _____unclear _____very unclear

c. In general, how adequate are the discussions which accompany the standards?

_____adequate for all standards _____adequate for most standards

_____inadequate for most standards _____inadequate for all standards

3. The AMA developed a Practical Guide which was designed to assist jails in meeting the AMA standards.

a. How often have you used this Practical Guide?

_____very often _____occasionally ____seldom _____never

How helpful was the Practical Guide in the following areas:

	very helpful	helpful	of little assistance
b. Developing medical standard operating procedures, job descriptions, and standing orders	_____	_____	_____
c. Developing a receiving screening program (procedure and forms)	_____	_____	_____
d. Developing an adequate medical record system	_____	_____	_____
e. Developing a procedure for the administration and recording of medications	_____	_____	_____
f. In general, helping to clarify what compliance with the standards involves	_____	_____	_____

4. The clearinghouse has a bimonthly newsletter called the Correctional Stethescope.

a. Are you aware of this newsletter? _____Yes _____No

b. (If yes) Do you regularly read it? _____Yes _____No

c. (If yes) How worthwhile do you find it is to read?

_____always worthwhile _____worthwhile most of the time

_____occasionally worthwhile _____seldom worthwhile

GO TO NEXT PAGE

5. The medical society in your state has assigned someone as pilot project director whose ole is to assist jails in their efforts toward upgrading their health care delivery systems and to help them become AMA-accredited.

a. How many times have you met with the pilot project director for your state?

_____once _____twice _____three times _____four times
_____five times _____six times _____seven or more times

b. In general, how would you rate the assistance you received from your state's pilot project director? _____invaluable _____very valuable _____of some value _____of no real value

How helpful was the Pilot Project Director in the following areas?	very helpful	somehwat helpful	of little assistance	help not needed in this area
c. Developing medical standard operating procedures	_____	_____	_____	_____
d. Developing a receiving screening program (procedures and forms)	_____	_____	_____	_____
e. Developing an adequate medical record system	_____	_____	_____	_____
f. Developing a procedure for the administration and recording of medications	_____	_____	_____	_____
g. Clarifying what compliance with <u>each</u> standard entails	_____	_____	_____	_____
h. Helping to establish a contractual arrangement between the jail and the responsible medical authority (doctor, hospital, etc.)	_____	_____	_____	_____
i. Locating medical personnel resources for the jail (doctor, nurse, physician assistant, etc.)	_____	_____	_____	_____
j. Locating other needed medical resources (medical supplies, laboratory facilities, etc.)	_____	_____	_____	_____
k. Locating needed medical equipment (dental or examining room equipment)	_____	_____	_____	_____
l. Assisting the jail in tying into existing community medical resources (mental health, drug, communicable disease screening, etc.)	_____	_____	_____	_____

THANK YOU

APPENDIX D

BREAKDOWNS BY STATE OF RESPONSES TO JAIL STAFF SURVEY REGARDING TECHNICAL ASSISTANCE RECEIVED FROM STATE PROJECT DIRECTORS

Chart 1: Number of Times Jail Staff Reported Meeting With State Project Director

Chart 2: Value Ratings by Jail Staff of Assistance Received From State Project Director

Chart 3: Jail Staff Ratings Regarding How Helpful the State Project Director Was in Assisting Them to Develop Standard Operating Procedures

Chart 4: Jail Staff Ratings Regarding How Helpful the State Project Director Was in Assisting Them to Develop a Receiving Screening Program

Chart 5: Jail Staff Ratings Regarding How Helpful the State Project Director Was in Assisting Them to Develop an Adequate Medical Record System

Chart 6: Jail Staff Ratings Regarding How Helpful the State Project Director Was in Assisting Them to Develop Procedures for the Administration and Recording of Medications

Chart 7: Jail Staff Ratings Regarding How Helpful the State Project Director Was in Clarifying the Meaning of Compliance With Each Standard

Chart 8: Jail Staff Ratings Regarding How Helpful the State Project Director Was in Assisting Them to Establish a Contractual Arrangement With a Responsible Authority

Chart 9: Jail Staff Ratings Regarding How Helpful the State Project Director Was in Assisting Them to Locate Medical Personnel

Chart 10: Jail Staff Ratings Regarding How Helpful the State Project Director Was in Assisting Them to Locate Needed Medical Resources

Chart 11: Jail Staff Ratings Regarding How Helpful the State Project Director Was Regarding Assisting Them to Locate Medical Equipment

Chart 12: Jail Staff Ratings Regarding How Helpful the State Project Director Was in Assisting Them to Tie Into Existing Medical Resources in the Community

CHART 1

NUMBER OF TIMES JAIL STAFF REPORTED
MEETING WITH STATE PROJECT DIRECTOR

States	None	Once	Two or Three Times	Four or Five Times	Six or More Times	Total Number of Respon-dents	Number of Missing Cases
OLD:							
Georgia	1	0	0	1	3	5	1
Indiana	1	0	0	2	0	3	0
Maryland	0	0	0	2	0	2	1
Michigan	1	2	6	1	0	10	0
Washington	1	2	3	3	7	16	2
Wisconsin	1	1	4	3	1	10	1
Subtotal	5	5	13	12	11	46	5
NEW: District of Columbia	1	0	1	0	1	3	1
Illinois	1	1	2	0	0	4	1
Massachusetts	0	1	5	2	3	11	1
Nevada	0	2	3	1	1	7	0
N. Carolina	1	4	1	0	0	6	0
Ohio	0	1	2	3	3	9	0
Oregon	0	0	3	2	0	5	1
Pennsylvania	0	6	9	0	0	15	0
S. Carolina	0	0	3	0	1	4	0
Texas	0	3	2	0	0	5	0
Subtotal	3	18	31	8	9	69	4
TOTAL ALL STATES	8	23	44	20	20	115	9

CHART 2

VALUE RATINGS BY JAIL STAFF OF ASSISTANCE
RECEIVED FROM STATE PROJECT DIRECTOR

States	Number Responding: "Invaluable"	"Very Valuable"	"Of Some Value"	"Of No Real Value"	Total Number of Respondents	Number of Missing Cases
OLD: Georgia	2	2	0	0	4	2
Indiana	0	2	0	0	2	1
Maryland	1	1	0	0	2	1
Michigan	2	4	1	0	7	3
Washington	7	6	2	0	15	3
Wisconsin	1	8	0	0	9	2
Subtotal	13	23	3	0	39	12
NEW: District of Columbia	0	2	0	0	2	2
Illinois	1	2	0	0	3	2
Massachusetts	2	8	2	0	12	0
Nevada	3	3	0	0	6	1
N. Carolina	0	3	2	0	5	1
Ohio	4	5	0	0	9	0
Oregon	0	1	4	0	5	1
Pennsylvania	0	8	7	0	15	0
S. Carolina	3	1	0	0	4	0
Texas	0	1	3	0	4	1
Subtotal	13	34	18	0	65	8
TOTAL ALL STATES	26	57	21	0	104	20

CHART 3

JAIL STAFF RATINGS REGARDING HOW HELPFUL THE STATE PROJECT DIRECTOR WAS IN ASSISTING THEM TO DEVELOP STANDARD OPERATING PROCEDURES

States	Number Responding: "Very Helpful"	"Some-what Helpful"	"Of Little Help"	"Help Not Needed"	Total Number of Respon-dents	Number of Missing Cases
OLD: Georgia	4	0	0	0	4	2
Indiana	2	0	0	0	2	1
Maryland	1	0	0	1	2	1
Michigan	6	1	1	1	9	1
Washington	11	2	1	0	14	4
Wisconsin	5	2	1	0	8	3
Subtotal	29	5	3	2	39	12
NEW: District of Columbia	2	0	0	0	2	2
Illinois	2	2	0	0	4	1
Massachusetts	5	3	0	3	11	1
Nevada	6	1	0	0	7	0
N. Carolina	1	3	0	1	5	1
Ohio	6	1	0	2	9	0
Oregon	0	1	0	4	5	1
Pennsylvania	4	9	1	1	15	0
S. Carolina	2	1	0	1	4	0
Texas	0	1	1	1	3	2
Subtotal	28	22	2	13	65	8
TOTAL ALL STATES	57	27	5	15	104	20

CHART 4

JAIL STAFF RATINGS REGARDING HOW HELPFUL THE STATE PROJECT DIRECTOR WAS IN ASSISTING THEM TO DEVELOP A RECEIVING SCREENING PROGRAM

States	Number Responding: "Very Helpful"	"Somewhat Helpful"	"Of Little Help"	"Help Not Needed"	Total Number of Respondents	Number of Missing Cases
OLD: Georgia	3	1	0	0	4	2
Indiana	2	0	0	0	2	1
Maryland	1	0	0	1	2	1
Michigan	4	3	1	1	9	1
Washington	6	5	0	1	12	6
Wisconsin	4	2	1	0	7	4
Subtotal	20	11	2	3	36	15
NEW: District of Columbia	0	2	0	0	2	2
Illinois	3	0	0	1	4	1
Massachusetts	4	3	0	4	11	1
Nevada	6	1	0	0	7	0
N. Carolina	1	1	0	3	5	1
Ohio	4	1	0	4	9	0
Oregon	0	1	0	4	5	1
Pennsylvania	6	5	2	1	14	1
S. Carolina	2	0	1	1	4	0
Texas	0	1	1	1	3	2
Subtotal	26	15	4	19	64	9
TOTAL ALL STATES	46	26	6	22	100	24

CHART 5

JAIL STAFF RATINGS REGARDING HOW HELPFUL THE STATE PROJECT DIRECTOR WAS IN ASSISTING THEM TO DEVELOP AN ADEQUATE MEDICAL RECORD SYSTEM

States	Number Responding: "Very Helpful"	"Some-what Helpful"	"Of Little Help"	"Help Not Needed"	Total Number of Respon-dents	Number of Missing Cases
OLD: Georgia	1	3	0	0	4	2
Indiana	2	0	0	0	2	1
Maryland	1	0	0	1	2	1
Michigan	1	4	3	1	9	1
Washington	5	3	1	3	12	6
Wisconsin	4	2	1	0	7	4
Subtotal	14	12	5	5	36	15
NEW: District of Columbia	0	0	2	0	2	2
Illinois	0	0	1	2	3	2
Massachusetts	5	2	0	4	11	1
Nevada	4	1	1	1	7	0
N. Carolina	1	1	0	3	5	1
Ohio	5	1	1	2	9	0
Oregon	0	1	0	4	5	1
Pennsylvania	3	6	2	3	14	1
S. Carolina	1	1	1	1	4	0
Texas	0	0	1	2	3	2
Subtotal	19	13	9	22	63	10
TOTAL ALL STATES	33	25	14	27	99	25

CHART 6

JAIL STAFF RATINGS REGARDING HOW HELPFUL THE STATE PROJECT DIRECTOR WAS IN ASSISTING THEM TO DEVELOP PROCEDURES FOR THE ADMINISTRATION AND RECORDING OF MEDICATIONS

States	Number Responding: "Very Helpful"	"Somewhat Helpful"	"Of Little Help"	"Help Not Needed"	Total Number of Respondents	Number of Missing Cases
OLD: Georgia	1	2	0	1	4	2
Indiana	1	1	0	0	2	1
Maryland	1	0	0	1	2	1
Michigan	1	3	2	3	9	1
Washington	2	7	1	2	12	6
Wisconsin	3	4	0	0	7	4
Subtotal	9	17	3	7	36	15
NEW: District of Columbia	0	0	2	0	2	2
Illinois	0	0	0	4	4	1
Massachusetts	4	2	0	5	11	1
Nevada	4	1	2	0	7	0
N. Carolina	1	1	0	3	5	1
Ohio	2	0	1	6	9	0
Oregon	0	0	1	4	5	1
Pennsylvania	4	4	2	3	13	2
S. Carolina	1	0	2	1	4	0
Texas	0	0	1	2	3	2
Subtotal	16	8	11	28	63	10
TOTAL ALL STATES	25	25	14	35	99	25

CHART 7

JAIL STAFF RATINGS REGARDING HOW HELPFUL THE STATE PROJECT DIRECTOR WAS IN CLARIFYING THE MEANING OF COMPLIANCE WITH EACH STANDARD

States	Number Responding: "Very Helpful"	"Somewhat Helpful"	"Of Little Help"	"Help Not Needed"	Total Number of Respondents	Number of Missing Cases
OLD: Georgia	2	2	0	0	4	2
Indiana	2	0	0	0	2	1
Maryland	1	0	0	1	2	1
Michigan	4	4	1	0	9	1
Washington	11	2	0	0	13	5
Wisconsin	5	3	0	0	8	3
Subtotal	25	11	1	1	38	13
NEW: District of Columbia	2	0	0	0	2	2
Illinois	4	0	0	0	4	1
Massachusetts	9	2	0	0	11	1
Nevada	5	2	0	0	7	0
N. Carolina	3	1	1	0	5	1
Ohio	9	0	0	0	9	0
Oregon	1	1	0	3	5	1
Pennsylvania	8	6	0	0	14	1
S. Carolina	4	0	0	0	4	0
Texas	1	1	1	0	3	2
Subtotal	46	13	2	3	64	9
TOTAL ALL STATES	71	24	3	4	102	22

CHART 8

JAIL STAFF RATINGS REGARDING HOW HELPFUL THE STATE PROJECT DIRECTOR WAS IN ASSISTING THEM TO ESTABLISH A CONTRACTUAL ARRANGEMENT WITH A RESPONSIBLE AUTHORITY

States	Number Responding: "Very Helpful"	"Somewhat Helpful"	"Of Little Help"	"Help Not Needed"	Total Number of Respondents	Number of Missing Cases
OLD: Georgia	2	1	0	1	4	2
Indiana	0	2	0	0	2	1
Maryland	0	0	0	2	2	1
Michigan	0	3	2	4	9	1
Washington	5	2	1	5	13	5
Wisconsin	4	4	0	0	8	3
Subtotal	11	12	3	12	38	13
NEW: District of Columbia	0	0	0	2	2	2
Illinois	1	0	0	3	4	1
Massachusetts	2	2	0	7	11	1
Nevada	3	1	2	1	7	0
N. Carolina	1	1	0	3	5	1
Ohio	0	4	0	5	9	0
Oregon	0	1	0	4	5	1
Pennsylvania	3	3	3	6	15	0
S. Carolina	1	0	1	2	4	0
Texas	0	0	1	2	3	2
Subtotal	11	12	7	35	65	8
TOTAL ALL STATES	22	24	10	47	103	21

CHART 9

JAIL STAFF RATINGS REGARDING HOW HELPFUL THE STATE PROJECT DIRECTOR WAS IN ASSISTING THEM TO LOCATE MEDICAL PERSONNEL

States	Number Responding: "Very Helpful"	"Somewhat Helpful"	"Of Little Help"	"Help Not Needed"	Total Number of Respondents	Number of Missing Cases
OLD: Georgia	1	0	2	1	4	2
Indiana	0	1	1	0	2	1
Maryland	0	0	0	2	2	1
Michigan	0	1	2	6	9	1
Washington	1	1	2	8	12	6
Wisconsin	3	2	2	1	8	3
Subtotal	5	5	9	18	37	14
NEW: District of Columbia	0	0	0	2	2	2
Illinois	0	0	0	4	4	1
Massachusetts	2	1	1	7	11	1
Nevada	3	1	1	2	7	0
N. Carolina	0	2	0	3	5	1
Ohio	0	1	0	8	9	0
Oregon	0	0	1	4	5	1
Pennsylvania	1	0	4	10	15	0
S. Carolina	0	1	0	3	4	0
Texas	0	0	2	1	3	2
Subtotal	6	6	9	44	65	8
TOTAL ALL STATES	11	11	18	62	102	22

CHART 10

JAIL STAFF RATINGS REGARDING HOW HELPFUL THE STATE PROJECT DIRECTOR WAS IN ASSISTING THEM TO LOCATE NEEDED MEDICAL RESOURCES

States	Number Responding: "Very Helpful"	"Somewhat Helpful"	"Of Little Help"	"Help Not Needed"	Total Number of Respondents	Number of Missing Cases
OLD: Georgia	1	0	2	1	4	2
Indiana	0	1	1	0	2	1
Maryland	0	0	0	2	2	1
Michigan	0	1	2	6	9	1
Washington	0	1	3	8	12	6
Wisconsin	1	2	1	3	7	4
Subtotal	2	5	9	20	36	15
NEW: District of Columbia	0	0	0	2	2	2
Illinois	0	0	0	4	4	1
Massachusetts	2	1	1	7	11	1
Nevada	2	1	2	2	7	0
N. Carolina	0	2	1	1	4	2
Ohio	0	1	0	8	9	0
Oregon	0	0	2	3	5	1
Pennsylvania	1	0	2	12	15	0
S. Carolina	0	1	0	3	4	0
Texas	0	0	1	2	3	2
Subtotal	5	6	9	44	64	9
TOTAL ALL STATES	7	11	18	64	100	24

CHART 11

JAIL STAFF RATINGS REGARDING HOW HELPFUL THE STATE PROJECT DIRECTOR WAS REGARDING ASSISTING THEM TO LOCATE MEDICAL EQUIPMENT

States	Number Responding: "Very Helpful"	"Somewhat Helpful"	"Of Little Help"	"Help Not Needed"	Total Number of Respondents	Number of Missing Cases
OLD: Georgia	1	1	2	0	4	2
Indiana	0	1	1	0	2	1
Maryland	0	0	0	2	2	1
Michigan	0	1	2	6	9	1
Washington	0	0	3	9	12	6
Wisconsin	2	0	2	3	7	4
Subtotal	3	3	10	20	36	15
NEW: District of Columbia	0	0	0	2	2	2
Illinois	0	0	0	4	4	1
Massachusetts	2	0	2	7	11	1
Nevada	0	0	3	4	7	0
N. Carolina	0	2	0	3	5	1
Ohio	0	1	0	8	9	0
Oregon	0	0	1	4	5	1
Pennsylvania	1	0	2	12	15	0
S. Carolina	0	1	0	3	4	0
Texas	0	0	1	2	3	2
Subtotal	3	4	9	49	65	8
TOTAL ALL STATES	6	7	19	69	101	23

CHART 12

JAIL STAFF RATINGS REGARDING HOW HELPFUL THE STATE PROJECT DIRECTOR WAS IN ASSISTING THEM TO TIE INTO EXISTING MEDICAL RESOURCES IN THE COMMUNITY

States	Number Responding: "Very Helpful"	"Somewhat Helpful"	"Of Little Help"	"Help Not Needed"	Total Number of Respondents	Number of Missing Cases
OLD: Georgia	1	2	1	0	4	2
Indiana	0	1	1	0	2	1
Maryland	0	0	0	2	2	1
Michigan	0	2	1	6	9	1
Washington	1	4	2	6	13	5
Wisconsin	2	1	3	2	8	3
Subtotal	4	10	8	16	38	13
NEW: District of Columbia	0	0	0	2	2	2
Illinois	0	0	0	4	4	1
Massachusetts	2	0	2	7	11	1
Nevada	3	1	1	2	7	0
N. Carolina	0	2	0	3	5	1
Ohio	0	1	1	7	9	0
Oregon	0	0	2	3	5	1
Pennsylvania	1	0	4	10	15	0
S. Carolina	0	1	0	3	4	0
Texas	0	0	1	2	3	2
Subtotal	6	5	11	43	65	8
TOTAL ALL STATES	10	15	19	59	103	21

APPENDIX E

THE ACCREDITATION STATUS OF YEAR ONE AND YEAR TWO JAILS AS OF JUNE 7, 1979

THE ACCREDITATION STATUS OF YEAR ONE AND YEAR TWO JAILS AS OF JUNE 7, 1979

State	Jail Code	Initial Accreditation Status - Date Awarded	Current Accreditation Status - Date Awarded
Georgia	1-2	Fully accredited - Aug. 1977	Accreditation lapsed
	1-3	Fully accredited for one year June 1978	Reaccredited for two years February 1979
	1-5	Provisionally accredited February 1978	Accreditation lapsed
Indiana	2-2	Fully accredited - Aug. 1977	Reaccredited for two years June 1978
	2-3	Dropped from program	Reentered program - accredited for one year June 1979*
	2-4	Fully accredited - Aug. 1977	Reaccredited for two years October 1978
	2-5	Fully accredited - Feb. 1978	Reaccredited for one year June 1979
	2-21	Fully accredited for one year June 1978	Reaccredited for two years June 1979
	2-22	Fully accredited for one year June 1978	Reaccredited for two years June 1979
	2-23	Fully accredited for one year June 1978	Reaccredited for two years June 1979
Maryland	3-1	Fully accredited - Aug. 1977	Reaccredited for one year June 1978; reaccredited for two years June 1979*
	3-2	Provisionally accredited February 1978	Reaccredited for two years October 1978
	3-3	Fully accredited - Aug. 1977	Reaccredited for one year June 1978; accreditation will lapse
	3-4	Fully accredited - Aug. 1977	Reaccredited for two years June 1978
	3-5	Fully accredited - Aug. 1977	Reaccredited for one year June 1978; accreditation will lapse
	3-22	Accredited for two years June 1979*	N/A

(continued)

State	Jail Code	Initial Accreditation Status - Date Awarded	Current Accreditation Status - Date Awarded
Michigan	4-1	Fully accredited - Aug. 1977	Reaccredited (after a lapse) for one year June 1979
	4-2	Fully accredited - Aug. 1977	Reaccredited for one year October 1978
	4-3	Fully accredited - Aug. 1977	Reaccredited for two years June 1978
	4-4	Fully accredited - Aug. 1977	Reaccredited (after a lapse) for two years June 1979*
	4-21	Provisionally accredited February 1978	Reaccredited for two years June 1978
	4-22	Accredited for two years February 1979	N/A
Washington			
	5-2	Provisionally accredited August 1977	Accreditation revoked June 1978
	5-3	Fully accredited - Aug. 1977	Reaccredited for one year June 1978; accreditation will lapse
	5-4	Fully accredited - Aug. 1977	Reaccredited for two years June 1978
Wisconsin			
	6-1	Fully accredited - Feb. 1978	Reaccredited for two years February 1979
	6-2	Fully accredited - Aug. 1977	Reaccredited for two years June 1978
	6-3	Provisionally accredited August 1977	Accreditation lapsed
	6-21	Fully accredited - Feb. 1978	Accreditation lapsed
	6-24	Accredited for two years February 1979*	N/A

* Accreditation award will be delayed at these jails until compliance with one or more standards is verified.

END