ANALYSIS OF PILOT JAIL POST-PROFILE DATA

American Medical Association's
Program to Improve Medical Care and
Health Services in Jails

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I. INTRODUCTION

In June of 1975, the American Medical Association (AMA) received a grant from the Law Enforcement Assistance Administration (LEAA) to conduct a program to improve health care in the nation's jails. The AMA, in turn, sent out a Request for a Proposal to all interested state medical societies and subsequently selected six of these to serve as subgrantees. The successful applicants included medical societies in three mid-Western states (Indiana, Michigan, and Wisconsin), one Southern state (Georgia), one on the East Coast (Maryland) and one on the West Coast (Washington).

Each of these six state medical societies selected from three to seven jails to serve as pilot sites.[1] A pre-profile of these selected jails and their existing health care delivery systems was developed.[2] The information that was obtained initially served to identify health care deficiencies in each of the pilot jails. The state medical societies then utilized this information to develop model health care delivery systems to correct these deficiencies. Now, this same information serves as the baseline profile from which subsequent changes in the health care delivery systems are measured.

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[1] A total of thirty pilot jails were originally selected in the six states. Of these thirty jails, twenty-seven remain in the project at the time of this report.

[2] See, Anno, B. Jaye, Analysis of Jail Pre-Profile Data: American Medical Association's Program to Improve Medical Care and Health Services In Jails, June 1977. Hereinafter referred to as "Analysis of Jail Pre-Profile Data."

This report focuses on the collective characteristics of the pilot jails and the changes which have occurred during the first two years of the project's operations. A list of abbreviations and symbols used throughout the report may be found in Appendix A.

II. METHODOLOGY AND LIMITATIONS OF DATA COLLECTED

A. Types and Methods of Data Collected

Development of the Jail Pre-Profile (JP-P) forms began in December 1975. In January of 1976, additional input regarding the type and extent of data to be collected was solicited from the six state pilot projects and national program staffs as well as from LEAA representatives and other consultants. The forms were pre-tested at one of the county jails in Maryland on February 18, 1976. After further changes and refinements, the instruments were finalized.

The completed forms were distributed to the six states during the latter part of February and the first part of March, along with detailed instructions regarding their use. Specifically, the JP-P forms consisted of the following items:

1. An Instruction Sheet;
2. Questionnaire I - Characteristics of the Jail;
3. Questionnaire II - Characteristics of the Jail Inmate Population;
4. Questionnaire III - Health Care Services, Facilities, and Equipment;
5. Questionnaire IV - General Health Problems of the Inmate Population;
6. Questionnaire V - Current Medical Records System;
7. Questionnaire VI - Frequency of Health Services Delivered;
8. Questionnaire VII - Cost Data;

9. Worksheet A - Health Care Personnel Serving the Jail;
10. Worksheet B - Health Resources in the Community;
11. Worksheet C - Characteristics of the Inmate Population;[3]
12. Worksheet D - Cost Data -- Amount Expended by the Jail to Deliver Health Care in 1975;
13. Worksheet E - Estimated Costs for Health Care Services Delivered to Jail Inmates but not Paid for out of the Jail Budget.

In addition to providing an Instruction Sheet, the consultant made on-site visits to each of the six states to orient the medical society staffs to the use of the forms and to describe appropriate methodologies for collecting the necessary data. Site visits were conducted during February and March for a minimum of two days per state. The first day was spent going over the forms and the research strategies to ensure understanding and consistency of data collection techniques. The second (and third) day was spent visiting at least one jail per state to demonstrate the use of the forms.

During these initial visits, the consultant conducted the majority of the interviewing and data-gathering so that the state staffs would have further opportunity to become familiar with the forms and the research process. Following these site visits, the consultant prepared write-ups of each of the jails

[3] This worksheet was subsequently dropped and, hence, does not appear in the analysis which follows.

she had visited. A copy of the completed questionnaires along with notes for follow-up steps were submitted to each of the states during the last two weeks in March. Subsequently, the state project staffs collected their own data on remaining jails with the exception of Indiana, which received some assistance from the AMA central staff.

The state project staffs continued to collect data on an on-going basis throughout project years one and two. Changes in each jail's health care delivery system were reported as they occurred on monthly progress reports.

In addition, the consulting staff made semi-yearly visits to the pilot states at which time the progress made by each jail was reviewed with the Pilot Project Directors (PPDs). Furthermore, specific information was requested from the PPDs during July 1977 and again in January 1978 [4] for comparison with selected baseline data.

Not all of the informational data collected for the jail pre-profile will be used in this post-profile comparison. Much of the initial information served primarily to assist the state project staffs in the development and design of the model health

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[4] Most of the statistical data was collected in the fall of 1977. Since most jails do not maintain on-going statistical information, the PPDs were initially requested to supply data for the previous full year of 1976. Where it was deemed essential, additional statistical information was requested in January of 1978 for all of 1977. Because many jails do not compile their annual reports until well into the calendar year, however, the additional data requested for 1977 was not always available.

care delivery systems for their individual pilot jails, and thus was not always appropriate for comparative purposes. Furthermore, the baseline data were collected prior to the development and adoption of jail health care standards by the AMA. Because these standards serve as a major comparative vehicle in this post-profile report, topics covered in the pre-profile report that were not specifically addressed by the standards cannot be utilized here.

The specific data requested from the PPDs for this post-profile report consisted of the following for each pilot jail:

1. Changes in the physical characteristics of the jail;
2. Changes in policies regarding the housing or treatment of females, juveniles, drunks, addicts, mentally ill or other categories of special offenders;
3. Changes in the agencies inspecting the jail and/or changes in inspection policies and procedures;
4. Changes in policies and procedures for visiting hours;
5. Changes in the type, number and extent of health services offered and any changes in the policies and procedures governing these services;
6. Changes in the medical record system;
7. Changes in the number and type of health care personnel serving the jail;
8. Changes in any important demographic characteristics of the inmates held by the jail, such as sex, race, or age;
9. Specific statistical information, such as: the total number of inmates received; the average daily population; the total number of inmate deaths, their causes, and the length of incarceration prior to death; the type and duration of disease epidemics; and the number of individuals receiving various types of health services in 1976;

10. Specific cost data for both project years (1976 and 1977).

As with the pre-profile information, the consultants devoted considerable time and effort to cleaning and verifying the data obtained from the state project staffs. Numerous letters were sent and several follow-up telephone calls were made in an attempt to ensure that the data were as complete and as accurate as possible.

B. Limitations of Data Collected

There are a number of limitations to the data in this post-profile report which decrease its usefulness for comparative purposes. One which should be kept in mind is that data were often collected from the pilot jails at different points in time. This was true of the baseline data[5] as well as of the information collected for the post-profile. With respect to the latter, the most important data collection time difference occurred in the determination of which jails met which standards.[6]

The primary measure used to gauge the jail's compliance with the standards was the accreditation process itself. For those jails which applied for accreditation, sufficient information was available to accurately determine which standards were met as of the time they were reviewed for accreditation. The problem, however, was that there were two rounds of accreditation during the second project year -- the first in August of 1977 and the second in February of 1978. Since the consultant's resources did not permit a resurvey of the sixteen jails which went through the accreditation process in August,[7] the assumption was made that compliance with the standards had not changed in these jails

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[5] See Anno, Analysis of the JP-P, supra at note 2, pp. 5-6.

[6] It should be noted that any problems associated with time differences in data collection procedures are only applicable to qualitative data, since quantitative data were collected for comparable full year periods.

[7] See Table I on the next page for a summary of the current status of the original pilot sites.

TABLE I

ACCREDITATION STATUS OF
ORIGINAL PILOT JAILS AS OF
MARCH 1978

STATE	JAIL CODE	CURRENT STATUS
GEORGIA	1-1	Surveyed Feb. '78 - Not Accredited.
	1-2	Surveyed Aug. '77 - Fully Accredited.
	1-3	Not Surveyed - Not Accredited.
	1-4	Dropped from Project December 1977.
	1-5	Surveyed Feb. '78 - Provisionally accredited.
INDIANA	2-1	Not Surveyed - Not Accredited.
	2-2	Surveyed Aug. '77 - Fully Accredited.
	2-3	Dropped from Project December 1977.
	2-4	Surveyed Aug. '77 - Fully Accredited.
	2-5	Surveyed Feb. '78 - Fully Accredited.
	2-6	Not Surveyed - Not Accredited.
	2-7	Not Surveyed - Not Accredited.
MARYLAND	3-1	Surveyed Aug. '77 - Fully Accredited.
	3-2	Surveyed Feb. '78 - Provisionally Accredited.
	3-3	Surveyed Aug. '77 - Fully Accredited.
	3-4	Surveyed Aug. '77 - Fully Accredited.
	3-5	Surveyed Aug. '77 - Fully Accredited.
	3-6	Dropped from Project November 1977.
	3-7	Not Surveyed - Not Accredited.
MICHIGAN	4-1	Surveyed Aug. '77 - Fully Accredited.
	4-2	Surveyed Aug. '77 - Fully Accredited.
	4-3	Surveyed Aug. '77 - Fully Accredited.
	4-4	Surveyed Aug. '77 - Fully Accredited.
WASHINGTON	5-1	Not Surveyed - Not Accredited.
	5-2	Surveyed Aug. '77 - Provisionally Accredited. Resurvey early '78 to check Standard Compliance
	5-3	Surveyed Aug. '77 - Fully Accredited.
	5-4	Surveyed Aug. '77 - Fully Accredited.
WISCONSIN	6-1	Surveyed Feb.'78 - Fully Accredited.
	6-2	Surveyed Aug.'77 - Fully Accredited.
	6-3	Surveyed Aug. '77 - Provisionally Accredited.

by February of 1978 when an additional five pilot sites were surveyed. The consultants made an attempt to verify this assumption at the time of their February 1978 site visits to the six states and with the exception of one jail (5-2),[8] the PPDs indicated they did not think that compliance with the standards had changed significantly since August in the sixteen jails initially accredited. Thus, while it would have been preferable to measure the pilot sites' compliance with the AMA standards at the same point in time, the inability to do so is not regarded as a serious methodological problem.

A related difficulty concerns the six jails which remained in the project but did not apply for accreditation.[9] In these instances, exact measures of the jails' compliance with the standards were not available. Hence, at the time of the consultants' February site visits, the PPDs were asked to estimate which of the standards they thought these jails were then meeting. Thus, while it is recognized that the data obtained for these six jails with respect to the standards may not be as accurate as that obtained for the others, the PPDs' estimates of compliance were the next best available measure.

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[8] In this instance, the consultants relied on the PPDs' assessment of the jail's present compliance, rather than the situation that existed at the time the jail was accredited.

[9] See Table I.

A further limitation of the data occurred when three of the original pilot sites were dropped.[10] This meant that the aggregate data from the first and second years could not be used "as is." Instead, it was necessary to eliminate these three jails from the pre-profile data base before making any comparisons with second year results. While a complete accounting of all thirty jails' statuses would have been preferable, at least this latter step ensured that any comparisons between the first and second years were made on equivalent data sets.

The most important limitation, however, concerns the quality of the data itself. The extent of the reliability and completion of various items on the original baseline questionnaires varied not only between states but within states as well. This same deficiency was reflected in the Year Two data. In the consultants' opinion, this was more often the result of a lack of available data sources than a lack of diligence in collecting the data on the part of the state medical society staffs. Nevertheless, it does present problems in analyzing, interpreting, and comparing the data gathered.

The quality of the data was particularly problematical with respect to statistical and financial items. Very few of the

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[10] The reasons these jails were dropped will be dealt with in more detail in the "Year Two Final Evaluation Report." Suffice it to say that in all three instances the basic reason for dropping them as pilot sites can be attributed to a lack of cooperation with the project by members of the jail's medical team, or the corrections staff or both.

twenty-seven jails could provide actual statistics on anything other than the total number of inmates they received in their facilities during 1975. This ability to provide actual statistics did not appreciably improve as the project progressed. In some cases, the total number of inmates received still had to be estimated. Similarly, almost none of the jails had, or currently have, detailed health care budgets. Generally, the best they could provide was the total amount expended for health care during any given year and in some instances, a rough itemized breakdown of this total.

As might be expected, there was a general positive correlation between the type and extent of available statistics and the size of the facility. Where records were not kept, jail personnel were requested to make projections or "best estimates" of the desired information. In the analysis which follows, the statistics used are denoted as "A" for actual, "EP" for estimated projections, and "E" for estimates based on "best guesses" of jail personnel. This was done so that the source and the probable validity of the information presented could be known.

The reliability of the data was less suspect with regard to "factual" items concerning the current and baseline health care delivery systems. For example, items such as the type, extent, and frequency of health care services offered, the nature of the medical record systems, etc., were initially subject to additional verification when the baseline data were

collected. The present accreditation process also follows a similar stringent verification procedure. On-site surveys offer the opportunity to observe facilities and services; supporting documentation of the types and content of medical records and written policies and procedures is obtained; and interviews with inmate/patients, medical staff and correctional officers are conducted. Hence, most of the information concerning the health care delivery systems, both past and present, is considered to be reasonably sound.

Finally, the reader should be aware that, while the jails in this report are being compared across time, according to size, and by locale, their differences in other respects may outweigh their similarities in these areas. For example, one jail serves primarily as a short term lock-up where the average length of stay can be measured in hours, whereas jails in other areas may house long-term detainees and sentenced inmates because of overcrowding in state prisons. Therefore, even though these jails may be similar with respect to size and locale, their health care needs may be rather different.

In reviewing the pages which follow, then, the reader should keep these general limitations in mind. Additional sources of error and/or difficulties in interpreting specific information are discussed as each topic is presented.

III. RESULTS OF THE JAIL POST-PROFILE

A. Characteristics of the Jails

1. Size, locale, and type

The jails that were selected to serve as pilot sites represent a good mix of both size and locale at both the aggregate level and within each state. Table II on the next page summarizes the number, size, and locale of the pilot sites in the project at the end of Year Two.[11]

As indicated in Table II, nine of the remaining twenty-seven pilot sites were originally classified as small jails, eleven as medium-sized, and seven as large-sized facilities. However, due to population changes in some facilities during the first two project years, one small jail and one large jail would now be considered medium-sized facilities and one medium-sized jail would fall into the small-size category. For comparative purposes, though, these three jails are included in their original size classification columns.

Sixteen of the pilot jails are located in rural areas (i.e., those serving a population of less than 110,000), while six are classified as suburban facilities and five as urban.

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[11] As previously indicated, thirty jails originally began the project. More jails have since been added and are being added on a continual basis. However, these newer jails are not included in this intensive study. It is restricted to the remaining twenty-seven of the thirty original pilot sites.

TABLE II

NUMBER, SIZE AND LOCALE
OF THE PILOT SITES BY STATE[1]

STATE	TOTAL NUMBER OF JAILS	NUMBER OF JAILS BY SIZE[2]			GEOGRAPHIC LOCALE[3]		
		SMALL	MEDIUM	LARGE	RURAL	SUBURBAN	URBAN
GEORGIA	4[4]	2	0[4]	2[5]	2[4]	1	1
INDIANA	6[4]	3	2[5]	1[4]	5	0[4]	1
MARYLAND	6[4]	0[4]	4	2	1[4]	4	1
MICHIGAN	4	1	2	1	2	1	1
WASHINGTON	4	2[5]	2	0	4	0	0
WISCONSIN	3	1	1	1	2	0	1
TOTAL	27	9	11	7	16	6	5

[1]This table may be compared with a similar table contained in the pre-profile report. (See Anno, B. Jaye, Analysis of Jail Pre-Profile Data: American Medical Association's Program to Improve Medical Care and Health Services in Jails, June 1977, p.10.)

[2]Size designations were based on the categories used by LEAA in its jail surveys. "Small" jails have average daily populations (ADPs) of 20 or fewer inmates; "Medium-sized" jails have ADPs between 21 and 249 inmates; and "large" jails have ADPs of 250 or more inmates.

[3]Geographic locale designations were based on the general population size of the area served by the jail. Boundaries were arbitrarily set as follows:

Rural = Population of less than 110,000;
Suburban = Population between 110,000 and 700,000;
Urban = Population of over 700,000.

The actual population ranges for these categories were:

Rural = 2,500 to 180,000;
Suburban = 250,000 to 690,000;
Urban = 828,000 to well over 1,000,000.

[4]One jail was dropped from the project in each of these states.

[5]Changes in the ADP for these three jails would place them into different size categories in 1977. The jail in Washington would classify as medium-sized, as would the jail in Georgia, while the jail in Indiana would now be considered small. See Appendix B for actual ADP changes.

Half of the states have at least one jail in each of the size categories and in no instance do all of the jails in any one state fall into just one size grouping. All of the geographic locales are also fairly well represented,although not distributed evenly across all of the states.

In the aggregate sense, the emphasis on small- and medium-sized facilities in rural areas is in keeping with the national picture. A 1972 survey determined that, of the 3,921 adult jails in the country which hold individuals for forty-eight hours or longer, 74% were small-sized jails, 23% were medium-sized and only 3% were large-sized facilities.[12]

Two of the large jails are municipal facilities while the remaining twenty-five are county-operated. In all but four instances, these twenty-seven jails are the only ones serving the population in their areas (see Appendix B for specifics).

2. Age[13]

The age range of the jails is over 150 years. The oldest jail was built in 1826, while the newest opened in 1977. Table III indicates the age of the pilot jails by size categories.

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[12]LEAA, "Survey of Inmates of Local Jails: Advance Report." Washington, D.C.: U. S. Department of Justice, National Criminal Justice Information and Statistics Service (1972), p. 13.

[13]See Appendix B for specifics.

TABLE III

AGE OF THE PILOT JAILS BY SIZE

AGE IN 1977	Small (R = 71 Years: 1897 - 1968)			Medium (R = 151 Years: 1826 - 1977)			Large (R - 117 Years: 1859 - 1976)			Total (R = 151 Years: 1826 - 1977)		
	#	%	Cum %	#	%	Cum %	#	%	Cum %	#	%	Cum %
Less than 10 Years	1	11	11	2	18	18	3	43	43	6	22	22
10 - 25 Yrs.	3(2)*	33	44	4(5)*	36	54	1	14	57	8	30	52
26 - 50 Yrs.	3	33	77	3(4)*	27	81	2(1)*	29	86	8	30	82
51 - 75 Yrs.	1	11	88	0	0	81	0	0	86	1	4	86
76 -100 Yrs.	1(2)*	11	99	1(0)*	9	90	0	0	86	2	7	93
More than 100 Years	0	0	99	1	9	99	1	14	100	2	7	93
TOTLAS	N=9(9)* MEAN = 35 Yrs.		99**	N-11(12)* MEAN = 39 Yrs.		99**	N=7(6)* MEAN = 33 Yrs.		100	Total N=27 MEAN = 36 Yrs.		100

*Three of these jails belong in different size categories but are retained in their original groupings for comparative purposes. The numbers in parentheses reflect what the true totals would be if current size disignations were used (see Appendix B for details).

**Errors due to rounding.

As can be seen from this table, the jails, by and large, were not new facilities but neither were they ancient, for the most part. While about half of the jails were built less than twenty-five years ago, only five were more than fifty years old. If one reads across the table and then down, there appears to be an inverse relationship between age and size (i.e, large jails were generally newer, followed by medium-sized jails, while the smallest jails also tended to be the oldest). The adjusted jail sizes for 1976 (the numbers in parentheses) make this inverse relationship between size and age even more apparent among the pilot sites.

The average age of the jails in each size category is also given in Table III. However, the reader should be aware that these mean figures are somewhat distorted for the medium- and large-sized jails in view of the extreme scores falling in the "more than 100 years" category.

3. Inmate Population Size and Overcrowding[13/]

The average number of inmates received by the various sized jails, their average daily populations, their average rated capacities, and the number of overcrowded facilities are given in Table IV for both 1975 and 1976.

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[13]See Appendix B for specifics.

TABLE IV

POPULATION SIZE CHARACTERISTICS BY JAIL SIZE[1]

JAIL SIZE	Average Number of Inmates Received		Average Daily Population		Average Rated Capacity		Number of Overcrowded Jails	
	1975	1976	1975	1976	1975	1976	1975	1976
Small (N=9)	780.3	718.2	10.2	11.0	26.4	26.4	0	0
Medium[2] (N=10)	2,507.1	2,473.4	84.3	99.5	94.4	94.4	3	3
Large (N=7)	23,264.9	21,547.9	581.9	601.8	540.1	561.6	4	4

[1]Per usual, jails in this table are retained in their 1975 size categories.

[2]Figures were unavailable for one medium-sized jail for 1976, therefore it has not been included in this comparison.

The total number of inmates received in 1975 in the small jails ranged from a low of 221 (A) to a high of 1,650 (E), while the average daily population (ADP) ranged from four to eighteen inmates. In 1976, these figures varied from 230 (A) to 1,304 (E) for total inmates received, and from 2.9 to 26.9 for the average daily population. In the medium-sized jails the ranges for the total number of inmates received were 1,306 (A) to 5,818 (A) in 1975 and 1,395 (A) to 5,104 (A) in 1976. The average daily populations in these facilities varied from 25 to 190 in 1975 and 18 to 246 in 1976. The large facilities, although fewer in number, received more inmates by far than both the small and medium-sized jails combined. In 1975, the total number of inmates they received ranged from 12,782 (EP) to 68,711 (A) and in 1976 these figures varied from 10,017 (A) to 54,308 (A). Their average daily populations ranged from 290 to 1,545 in 1975 and from 167 to 1,812 in 1976.

It should be noted that the average number of inmates received has gone down from 1975 to 1976 in all three size categories, but the average daily populations have gone up. As might be expected, where ADPs have increased, there has been a corresponding increase in the jail's length of stay (LOS) figures (see Appendix B for details). These trends may be due to changes in both jail and court policies[14] as well as the

[14]For example, one jail in Georgia indicated that the increase in their ADP was due to a court backlog resulting from a shortage of judges, whereas jails elsewhere indicated their increased ADPs and LOSs were a reflection of overcrowding at state prison facilities.

fact that more of the 1976 figures are based on actual -- hence, presumably more accuarte -- data rather than on "estimated predictions" or "best guesses," which predominated in 1975.

Overcrowding was a problem in the same seven jails in 1975 and 1976. As indicated by Table IV, overcrowding was positively associated with size. Almost a third of the medium-sized jails and more than half of the large jails had overcrowded conditions. This situation was most prevalent in Maryland, where four of its six jails were overcrowded. Two jails in Michigan and one in Georgia were also overcrowded (see Appendix B for details).

It should also be noted, however, that this situation has improved since 1976. Two new facilities opened in Maryland in late 1977 and early 1978. This has eliminated much of the overcrowded conditions existing in those two county jails. In addition, a judicial order in November 1977 greatly reduced the number of inmates in one other Maryland jail by forcing the transfer of over 700 state prisoners to other facilities. This, plus the initiation of a work release program and the utilization of a half-way house, has removed the overcrowded condition which existed there. Also, a large jail in Georgia which was previously overcrowded has seen a drastic reduction in its average daily population. Hence, conditions have improved there as well.

However, it should be realized that the definition of overcrowding used in this report was made by comparing each jail's total rated capacity with its total ADP figure. Where the latter

figure exceeded the former, a designation of overcrowding was made. Thus, the definition of overcrowding is a conservative one, since it is possible for a jail to exceed its capacity in various sections (e.g., adult male, adult female, juvenile male, juvenile female, administrative segregation, etc.) and still not exceed its total rated capacity.

4. Correctional Officer Characteristics; and
5. Correctional Officer Shift Coverage

Information on correctional officers was originally collected to aid the states in their health care planning for the pilot sites. Since this information is of limited value in measuring changes in health care delivery systems, a systematic follow-up of this original data was not undertaken. In general, the information that exists indicates that few changes have occurred in these areas. Where changes have occurred, they have been in the direction of a decrease in the part-time utilization of health care personnel as correctional officers; and an increase in the number of correctional officers trained to handle various emergency medical conditions.[15]

6. Inmate Housing Patterns

Inmate housing patterns have not changed appreciably since 1975 except in those instances previously mentioned where new jail facilities have opened and/or where overcrowded conditions

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[15]For further information on the baseline "Correctional Officer Characteristics" and "Shift Coverage," see Anno, B. Jaye, Analysis of Jail Pre-Profile Data, supra at note 2, pp. 15-19.

have been alleviated. Again, information on inmate housing patterns was collected primarily to aid the states in their health care planning. However, some notable changes will be mentioned.

In one jail in Maryland (Jail 3-5), female inmates are now being housed in a former male detention facility. This change, made possible by the opening of a new jail, has meant better access to medical care for female inmates. In Wisconsin, sentenced female inmates at Jail 6-3 have also been transferred to a formerly all-male facility. Their old facility is being renovated, but is is uncertain at this time which inmates will be housed in the remodeled site.

The housing of juveniles has also changed in two of the pilot jails. In one county in Indiana (Jail 2-5), juveniles are no longer being incarcerated. Instead, they are being diverted to a juvenile shelter. At Jail 6-1, in Wisconsin, juveniles are still being incarcerated, but for a much shorter period of time. This was made possible by sharing a juvenile detention home with another county -- a change brought about by a heightened awareness of juvenile problems on the part of the local social service agency.

7. Inspection of the Jails and Associated Jail Legislation

No appreciable changes have occurred with respect to the inspection of jails except in Wisconsin. Here, the number of state jail inspectors was reduced from five to two and this resulted in a proportional decrease in the number of yearly jail inspections.

In all six pilot states, there appears to be pressure from various sources for the improvement of jail conditions. In four of the states this pressure has resulted in legislative action. Georgia and Washington have already enacted laws directed toward the mandatory improvement of jail conditions and both Indiana and Maryland currently have bills pending. In all four instances, specific attention is given to the medical care of inmates.

Of the four, Washington's legislation is potentially the most far reaching. The law sets out provisions for the establishment of a commission to develop physical and custodial standards. It also provides for the closure of inadequate facilities, contingent upon a public hearing and the ability of the commission to provide funds for the construction of new jails.

8. Visiting Hours

There were no reported changes in visiting hours except at one Indiana jail (2-2), where the time allotted for visiting was considerably shortened. Again, as with the baseline data, the adequacy of visiting hour policies was not examined, since there still appears to be no clear cut standard in terms of the number and type of visitors or the frequency and duration of visits that an inmate should be allowed on a regular basis.[16/]

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[16]See, for example, pp. 66-68 of the National Advisory Commission on Criminal Justice Standards and Goals, Corrections. Washington, D.C.: U. S. Government Printing Office (1973).

B. Characteristics of the Inmate Population

At the time the baseline information was collected, only two of the largest facilities kept records reflecting the demographic characteristics of their inmate populations. The demographic data which was estimated was meant to be used primarily for health care planning purposes. Because of this fact and the fact that sizeable demographic changes usually do not occur in a time period as short as two years, no in-depth follow-up data was sought.

It is worth noting, however, that more jails are recognizing the value of accurate statistics for planning purposes. This is reflected in the data included in Appendix B by the increase in the number of actual figures reported for 1976 and 1977 as opposed to the estimates given in 1975.

C. Availability of Health Care Services, Facilities and Equipment

As the Jail Pre-Profile[17] indicated, the dearth of available health care facilities and services reported in a 1972 AMA survey of 1,159 of the nation's jails[18] was mirrored in the original pilot sites involved in the AMA program. At the time the baseline data was collected, there were no jail health care standards available against which the adequacy of a jail's health care system could be measured. The development of such standards was itself a major component of the AMA's program for the first two years. While these standards are used as the primary measure of change in this particular section, the standards themselves are still undergoing evaluation and refinement.[19] Nevertheless, it is assumed that they can and do serve as a fairly objective measure of the adequacy of the health care systems within the pilot jails.

The baseline information gathered for the original Jail Pre-Profile indicated which specific health care facilities were present within each jail, and which routine and special health care services were available to jail inmates. This information was not intended as a measure of the quality of health

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[17] See Anno, B. Jaye, Analysis of Jail Pre-Profile Data, supra at note 2.

[18] American Medical Association. Medical Care in U. S. Jails-A 1972 AMA Survey. Chicago, Illinois: Division of Medical Practice (February 1973).

[19] The developmental process of the AMA's "Jail Health Care Standards" and their subsequent refinement will be discussed in more detail in the Year Two final evaluation report. While there have been additional drafts of the standards since the Spring of 1977, the standards utilized as measures of change in this report are the ones contained in the AMA's document entitled Survey Questionnaire for the Accreditation of Medical Care and Health Services in Jails. This is the draft used by the AMA in its accreditation processes to date to determine a jails compliance with its standards.

care present in the individual jails. As the pre-profile report states:

> It should be noted that even in jails where the number of services provided is high, the conclusion that their health care delivery systems are satisfactory is unwarranted. Availability of health care services is not synonymous with adequacy. The latter status can only be determined after considering other factors such as the number of inmates to be served compared with the number of health care personnel, the frequency with which the services are offered, the procedures and policies for obtaining the services, etc.[20]

By contrast, the standards developed by the AMA do attempt to measure the adequacy of a jail's health care delivery system. Adequacy, in this instance, also necessarily implies the availability of certain health care facilities and services to the jail's inmates.

It should further be noted that the primary consideration in collecting the original baseline data was for its use in health care planning and only secondarily for its use as a comparative tool. Therefore, the Pre-Profile Report again cautions the reader that, "...the findings are presented independent of other considerations such as the size of the jails, the availability of community resources, cost/benefit ratios, etc."[21]

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[20] Anno, B. Jaye, Analysis of Jail Pre-Profile Data; supra at note 2, p. 37.

[21] Ibid, p. 34.

By comparison, the AMA standards were constructed in such a manner that they are almost universally applicable to all of the nation's jails regardless of size or locale. For example, the standards do not require that a jail have in-house bed care, which would be totally impractical for a small facility. Rather, the standards insist that adequate chronic and convalescent care be provided regardless of the size of the facility. Thus, the adequacy of the care, not where it is provided (e.g., in-house versus in the community) is one important distinction between the standards and the original baseline data.

In view of these differences between the first and second year data sets, it was sometimes necessary to relabel the topics covered in this section of the report in a manner different from those in the corresponding section of the pre-profile report. Thus, it will immediately be noted by the reader making comparisons with the first year report that the number of categories measuring the availability of selected health care services has been reduced from thirteen to eleven. This change is also reflected in the reduced number of categories present in Table V in this report (see next page) compared with Table IX in the Jail Pre-Profile Report. The eleven categories discussed here appear in a format which corresponds more closely to the health care standards as established by the AMA. The three categories dropped from this analysis -- special services for females, emergency equipment and allied health services (including eye

TABLE V

Time Comparison of Availability of
Selected Health Care Services by Jail

State/ Jail Code	Size (as of 1975) (S)mall (M)edium (L)arge	Locale (R)ural (S)uburban (U)rban	The Jail has a Clinic Which Is Adequately Equipped and Supplied (Standard 1023)**		The Jail Has Established Guidelines for Providing Chronic & Convalescent Care (Standards 1028-1029)**		The Jail Has Regular and Adequate Sick Call (Standard 1020)**	
			Time of Baseline Survey	Time of Accreditation Survey	Time of Baseline Survey	Time of Accreditation Survey	Time of Baseline Survey	Time of Accreditation Survey
1-1	L	U		NA				
1-2	L	S	A	AA		AA	A	AA
1-3*	S	R		AA		AA		AA
1-5	S	R		AA		AA		AA
2-1*	S	R						
2-2	S	R		AA	A	PC		AA
2-4	L	U	A	AA	A	AA	A	AA
2-5	M	R		AA		AA		AA
2-6*	M	R			A	PC		
2-7*	S	R		AA	A	AA		AA
3-1	M	S	A	AA	A	AA	A	AA
3-2	L	U	A	A	A	AA	A	AA
3-3	M	S	A	AA	A	AA	A	AA
3-4	M	S	A	AA	A	AA	A	AA
3-5	L	S	A	AA	A	AA	A	AA
3-7*	M	R					A	
4-1	S	R		AA		AA		AA
4-2	L	U	A	AA	A	AA	A	AA
4-3	M	R		AA		AA	A	AA
4-4	M	S	A	AA	A	AA	A	AA
5-1*	M	R	CINA***	-	-	-	-	-
5-2	S	R		AA	A	AA		AA
5-3	M	R		AA		AA		AA
5-4	S	R		AA	A	AA		AA
6-1	S	R		AA	A	AA		AA
6-2	M	R		NA		AA		AA
6-3	L	U	A	AA	A	AA	A	AA
TOTALS			10	21	15	21	12	22

KEY: A = Available (adequacy not measured).
AA = Available and Adequate (i.e., in compliance with the AMA standards).
NA = Not applicable.
PC = Partial compliance with the standards. These designations are not computed in the totals, however.

*In these six jails, information regarding compliance with the AMA standards was based on the assessment of PPDs rather than a formal accreditation survey.

**The numbering of these standards corresponds to those in the Survey Questionnaire for the Accreditation of Medical Care and Health Services in Jails, American Medical Association, Spring 1977.

***Current Information was Not Available.

TABLE V

Time Comparison of Availability of Selected Health Care Services by Jail (con't.)

State/ Jail Code	The Jail Has A Specific Program for Alcohol Detoxification (Standards 1047-1048)**		The Jail Has a Specific Program for Drug Detoxification (Standards 1048-1048)**		The Jail Has a Policy for Providing Special Diets to Inmates Who Require Them (Standard 1083)**		The Jail Provides Routine Dental Maintenance (Standards 1036-1037)**		Total Number of Services Available	
	Time of Baseline Survey	Time of Accreditation Survey	Time of Baseline Survey	Time of Accreditation Survey	Time of Baseline Survey	Time of Accreditation Survey	Time of Baseline Survey	Time of Accreditation Survey	Time of Baseline Survey	Time of Accreditation Survey
1-1									0	0
1-2	A	AA	A	AA	A	AA			5	6
1-3*	A				A	AA			2	4
1-5	A	PC	A	PC	NA	AA			2	4
2-1*	A	AA		AA	A	AA			2	3
2-2		AA		AA	A	AA		AA	2	6
2-4	A	AA	A	AA		AA		AA	5	7
2-5	A	AA	A	AA	A	AA			3	6
2-6*		AA		AA	A	AA			2	3
2-7*					A	AA		AA	2	5
3-1		AA	A	AA		PC			4	5
3-2	A	AA	A	AA	A	AA	A	A	7	7
3-3		AA	A	AA	A	AA			5	6
3-4	A	AA	A	AA	A	AA	A	A	7	7
3-5	A	AA	A	AA	A	AA		AA	6	7
3-7*									1	0
4-1	A	AA	A	AA		AA		AA	2	7
4-2		AA		AA	A	AA			4	6
4-3		AA		AA	A	AA		AA	2	7
4-4		AA	A	AA	A	AA			5	6
5-1*	CINA***	-	-	-	-	-	-	-	-	-
5-2	A	AA		AA		AA			2	6
5-3	A	AA		AA		AA			1	6
5-4	A	AA		AA		AA			2	6
6-1	A	AA		AA		AA		AA	2	7
6-2		AA		AA	A	AA		AA	1	6
6-3	A	AA	A	AA	A	AA			6	6
TOTALS	15	21	12	21	16	23	2	10	82	139

KEY: A = Available (adequacy not measured).
AA = Available and Adequate (i.e., in compliance with the AMA standards).
NA = Not Applicable.
PC = Partial Compliance with the standards. These designations are not computed in the totals, however.

*In these six jails, information regarding compliance with the AMA standards was based on the assessment of PPDs rather than a formal accreditation survey.

**The numbering of these standards corresponds to those in the Survey Questionnaire for the Accreditation of Medical Care and Health Services in Jails, American Medical Association, Spring 1977.

***Current Information was Not Available.

tests, glasses, hearing tests, etc.) -- were not specifically a part of the AMA's standards and, therefore, information concerning their availability in the pilot jails was not collected for this report. However, the fact that these services were not followed up in the second year does not necessarily imply that they are not currently being offered in a given jail.

Table V summarizes the availability of selected health care services in each of the pilot jails both at the time the baseline data was collected and at the time of the second year accreditation surveys.[22] Here, again, the reader should be reminded that the pre-profile data implied only availability and not adequacy of health care services, whereas the accreditation survey data implies both availability and adequacy. This means that the measure of change between the original health care delivery system and what is currently in place is a very conservative one, since it is based only on availability of services and not adequacy.[23] In addition, please note that these categories represent only selected health care facilities and services and not the total picture of any one jail's health care delivery system.

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[22] Those jails that did not participate in an accreditation survey are marked by an asterisk. As noted previously, the information concerning these six jails was obtained from the PPD's in their respective states and should be considered as the PPDs' "best estimates" of a jail's compliance with the standards.

[23] For example, the baseline data for jails 3-2 and 3-4 indicated only that routine dental care was then being offered. While the same level of dental care is still present, we now know that it is inadequate since it does not comply with the AMA standards.

On an aggregate basis, Table V shows that the total number of health care services in the pilot sites increased from 82 at the time of the pre-profile to 139 at the time of the accreditation surveys. This represents an overall increase of 70% in the availability of services. Further, it is worth noting that increases occurred within each of the service categories listed and in all but five of the twenty-six jails represented.[24/] More importantly, however, 136 of the 139 available services in the pilot jails in Year Two were judged to be in compliance with the AMA's requirements for adequacy, as defined by the specific standards referenced in Table V. Since there was no pre-measure of adequacy, however, the percent change in adequacy from Year One could not be calculated.

Tables VI, VII and VIII which follow examine the changes in availability of the selected services noted in Table V with respect to variables of state, jail size and locale.

Table VI represents a comparison of the mean number of selected health care services available within each state at the time of the baseline survey and again at the time of the accreditation survey. Examining the change in availability of selected services between states, it can be seen that increases occurred in all six states, albeit in different degrees. In general, those states which began with the fewest average

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[24]The five jails where no increase in availability of services occurred included one in Georgia, three in Maryland and one in Wisconsin. Note also that although there were twenty-seven pilot sites remaining at the end of the second year, current data were not available for Jail 5-1. Hence, in the tables which follow, usually only twenty-six jails are reported on.

TABLE VI

Time Comparison of Availability of
Selected Health Care Services by State

State	# of Jails	Average Number of Services per Jail		Net Average Change in # of Services	Percent Positive Change
		Time of Baseline Survey	Time of Accreditation Survey		
Georgia	4	2.25	3.50	+1.25	56%
Indiana	6	2.67	5.00	+2.33	87%
Maryland	6	5.00	5.33	+0.33	7%
Michigan	4	3.25	6.50	+3.25	100%
Washington	3*	1.67	6.00	+4.33	259%
Wisconsin	3	3.00	6.33	+3.33	111%
Total	26	3.15	5.35	+2.20	70%

*Data was not available for one jail in this state.

number of health care services also showed the greatest percent improvement. Therefore, the relatively low increase in availability of services in Maryland should not be construed as a negative finding. Table VI clearly shows that Maryland had the highest average number of services available per jail initially, and hence did not need to increase availability to the same extent as the other states.

On an absolute basis, Table VI indicates that Michigan's jails have the highest average number of these selected services available at the present time, whereas Georgia's have the fewest. A glance back at Table V reveals that Georgia's average was pulled down by Jail 1-1, where no improvements occurred. If this jail was eliminated from the computation of the mean number of services available, Georgia would still have the lowest number, but the figure would be closer to that of the other states.

Table VII, which compares changes in availability of selected health care services by jail size, clearly indicates that the pre-program availability was directly related to the size of the facilities. The smallest jails offered the fewest services (Mean = 2.0), the largest jails the most (Mean = 4.7), and the medium-sized jails fell somewhere in the middle (Mean = 3.1). Note that this relationship completely disappeared by the time of the accreditation surveys, however. The average number of services available is now just over five per jail, regardless of the size category.

TABLE VII

Time Comparison of Availability of
Selected Health Care Services by Jail Size

Jail Size	# of Jails	Average Number of Services per Jail		Net Average Change in # of Services	Percent Positive Change
		Time of Baseline Survey	Time of Accreditation Survey		
Small	9	2.00	5.33	3.33	166%
Medium*	10	3.10	5.20	2.10	68%
Large	7	4.71	5.57	0.86	18%

*Data was not available for one jail in this category.

While there were increases over time in the average number of services in all three size categories, the most dramatic improvements occurred in the small-sized facilities. Here, the average number of available services increased 166% over the baseline figures. These results are especially significant in view of the large proportion of small-size jails nationwide.

Table VIII compares the change in availability of selected health care services by jail locale. At the time the baseline data was collected, the rural jails offered the fewest average number of services (Mean = 1.9), followed by the urban jails (Mean = 4.4), and then the suburban facilities (Mean = 5.3). Again, by the time of the accreditation surveys, jails in all three locales showed improvements in the average number of services offered, with the rural jails showing the greatest percentage increase. The suburban jails still offered the highest average number of services per jail (Mean = 6.2), again followed by the urban facilities (Mean = 5.2), and then the rural ones (Mean - 5.1).

TABLE VIII

Time Comparison of Availability of
Selected Health Care Services by Locale

Jail Locale	# of Jails	Average Number of Services per Jail		Net Average Change in # of Services	Percent Positive Change
		Time of Baseline Survey	Time of Accreditation Survey		
Rural*	15	1.87	5.07	3.20	171%
Suburban	6	5.33	6.17	0.84	16%
Urban	5	4.40	5.20	0,80	18%

*Data was not available for one jail in this category.

The results of Tables VII and VIII are especially encouraging. They seem to illustrate the fact that the availability and adequacy of health care services within the nation's jails need not be dependent upon jail size or locale. Presumably, most jails, regardless of their size or locale, have the ability to deliver adequate health care services to their inmates, if given sufficient encouragement and guidance.

Tables VI, VII and VIII also seem to support what several PPDs have discovered, namely, that it is often more difficult to improve and change an existing health care delivery system than it is to build one from scratch. The resistance to change on the part of jail staff, the reluctance to commit the necessary resources as well as other political considerations may stand in the way of improvements. For this reason, the reader should note that changes in the number of services made available to inmates is not always indicative of the actual degree of progress. The addition of just one service in a jail frought with political problems may represent a greater breakthrough in improving health care than the addition of several services in other jails without these obstacles.

In the sub-sections which follow, changes in the availability of specific types of health care services and facilities in the pilot jails are summarized. The types of services described include those presented in Table V as well as others. As noted previously, the categorization of services in this report is

based on those included in the AMA standards. Hence, the titles of the sub-sections below do not always directly correspond with those on pages 38 - 45 of the Pre-Profile Report.[25] In order to minimize confusion for those making comparisons between the two reports, however, similar topic areas are presented in the same order. In addition, the titles below include reference numbers for the standards discussed.

1. Guidelines for chronic and convalescent care (Standards 1028 -1029)

As Table V indicates, when the baseline data were collected, fifteen of the twenty-six pilot jails reporting made provisions or had guidelines for delivering chronic and convalescent care to their inmates. Six of these jails provided bed-care by means of in-house facilities while the rest of the jails relied on community hospitals.

By the end of February 1978, the number of jails able to provide bed-care in-house had not changed. However, all but five of the pilot jails now had written guidelines approved by their responsible physicians, which established procedures for providing chronic and convalescent care whether in-house or in the community. In addition, two jails (numbers 2-2 and 2-4) had written guidelines which partially fulfilled this requirement as set forth in the AMA standards.

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[25] See Anno, Analysis of Jail Pre-Profile Data, supra at note 2. Further, as noted on page 28 of this report, three topic areas have been totally eliminated. In addition, one new topic area, receiving screening, has been added.

2. In-house clinics (Standard 1023)

When the baseline data were collected, only ten of the twenty-seven pilot jails had medical clinics in-house and three of these were considered to be inadequate. Furthermore, at that time having an in-house clinic was clearly related to jail size. As Table V indicates, all but one of the large jails had an in-house clinic, but only four out of the ten medium-sized jails, and none of the small jails, had such facilities. By the time of the accreditation surveys, however, the situation had improved to the extent that twenty of the pilot jails could now meet the standard with regard to an in-house clinic.[26] Of those jails meeting this accreditation standard, five are large jails, seven medium-sized, and eight small.

3. Administration of drugs (Standards 1049-1058)

At the time the baseline data were collected, all but one of the pilot jails (1-1 in Georgia) administered medications in-house and stored and distributed any drugs prescribed by a physician, including controlled substances. However, in some instances, the jails reported having problems with the security and administration of drugs which related directly to the number of suicide attempts in these facilities.

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[26] It should also be noted that this standard is not applicable (NA) in two of the pilot jails (Jails 1-1 and 6-2) because all of their medical services are provided outside of the jail itself.

The standards which were subsequently developed by the AMA placed a strong emphasis on the secure storing and proper handling and dispensing of medications and supplies. By the time the end-of-the-second-year data was compiled, twenty-one of the twenty-six pilot sites were said to have established written policies governing the administration of medications which were approved by their responsible physicians. Further, the persons administering the medications in twenty-one of the pilot jails -- ableit, not necessarily the same ones that had the written policies -- had received appropriate training in this regard from the jail's responsible physician and the jail administrator. In addition, in twenty of the sites, the administration of medications was now being recorded on a form approved by the responsible physician, and in twenty-three of the twenty-six jails, the medications form was included as part of the inmate's medical file. Finally, in all but two of the pilot jails, all controlled substances, syringes, needles, and surgical instruments were stored under maximum security conditions.

However, it should also be mentioned that at the time of the accreditation surveys, only half of the pilot jails were able to comply with all of the state and federal laws and regulations concerning the dispensing of medications. Apparently, more work is still needed in this area.

4. Physical exams (Standards 1010 - 1014)

As the Jail Pre-Profile indicated,[27] ten of the twenty-six pilot jails routinely administered some sort of physical exam to at least some inmates, either upon admission to the jail or at a later time. In some cases, these "physical exams" were cursory affairs, consisting only of screening for one or two communicable diseases. In others, full physicals were performed, but only on inmates meeting specific criteria (e.g., those staying longer than thirty days).

At the time of the pre-profile, it was difficult to make comparisons between the pilot sites because their policies with respect to who should receive physical exams, when they should be conducted and what they should consist of, varied widely. It was only when the AMA standards were developed that a consistent measure with which to compare the jails was created.

The AMA standards require that a health appraisal be completed for every inmate within fourteen days of admission to the jail. Further, the standards clearly specify that the health appraisal data collection must include at least the following:

- o A review of the receiving screening done upon admission;[28]
- o Additional data to complete the medical history;
- o Laboratory work to detect communicable diseases including venereal disease and tuberculosis;

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[27] See Anno, Analysis of Jail Pre-Profile Data, supra at note 2, pp. 40 - 41.

[28] See pages 48-51 of this report for a detailed discussion of receiving screening.

- o Height, weight, pulse, blood pressure and temperature;
- o Other tests and examinations as appropriate; and
- o A standardized physical examination to include appropriate comments on mental and dental conditions.

At the time of their accreditation surveys, fifteen of the pilot jails were able to fully comply with this standard, while four other jails were in partial compliance. In addition, twenty-two of the jails had written procedures for the collection of this health appraisal data which were approved by their responsible physicians.

5. Sick call (Standards 1016 - 1020)

When the baseline data were collected, only twelve of the twenty-six jails provided what might be called a regular sick call. As seen in Table V, by the time of the accreditation surveys, twenty-two jails provided this service on a regular basis.[29/] In addition, inmates' medical complaints are now collected daily in twenty of the sites and in twenty-three jails, sick call is conducted by qualified medical personnel. Furthermore, twenty jails now fully comply with the health care standard which requires that inmates be informed in writing of the procedures to be followed for gaining access to medical services. Also, the screening of inmate requests for medical services is now controlled by medically trained personnel in

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[29]The AMA standards require that sick call be provided a minimum of once a week in jails with an average daily population (ADP) of twenty or fewer inmates, three times per week in jails with an ADP between 20 and 200 inmates, and five times per week in jails with an ADP greater than 200 inmates.

twenty-one of the pilot sites. Previously, in all but three of these jails, such access was controlled by correctional officers.

6. Alcohol and drug detoxification (Standards 1047-1048)

When the baseline data were collected, fifteen of the pilot jails had a formalized program for alcohol detoxification and only twelve sites had a similar program for drug detoxification (see Table V). This situation was markedly changed by the time of the accreditation surveys. Twenty-one jails were able to fully comply with the single standard (#1047) that deals with all acute detoxification, whether from alcohol, opiates, barbiturates, or similar drugs. This standard requires that a medically supervised, formal detoxification program be available, whether at the jail or in the community. Of the jails fulfilling this requirement, two provided all acute detoxification in community health facilities, twelve provided all detoxification services at the jail itself, and seven provided services both at the jail and in the community.

Since a high percentage of all arrests and incarcerations are for alcohol and drug abuse, many jails also make provisions for rehabilitation and counseling services in addition to detoxification. Initially, fifteen of the pilot sites were able to offer some form of alcohol counseling, albeit only on a limited basis at some jails (e.g., only to special categories of inmates such as those on work release). At the present time, the number of jails offering alcohol rehabilitation services remains the same. However, two jails reported greatly

improved programs with better referral systems and more intensive counseling (jails 5-3 and 6-2). The number of jails offering drug rehabilitation and counseling services also has not changed from what was reported in the Jail Pre-Profile, with the exception of one jail (#2-5) which now diverts all of its drug addicts to the local hospital within hours of their booking. Previously, this had not been done. The relatively insignificant increase in the number of pilot sites offering drug and alcohol rehabilitation and counseling services is undoubtedly due to the fact that only detoxification services are required by the current AMA standards.

7. Special diets (Standard 1083)

At the time of their accreditation surveys, twenty-three of the twenty-six pilot jails could provide special diets to inmates needing them. Previously, as Table V indicates, only sixteen of the jails provided this service.

8. Mental health care and services (Standards 1040-1041)

One of the greatest problems confronting jail administrators today concerns the handling of mentally ill and/or deficient inmates in a custodial environment. Thus, it is not surprising that twenty-three of the twenty-six pilot jails maintain a policy of seeking admission to appropriate health facilities in lieu of incarceration for individuals with mental problems. In spite of such a stated policy, however, individuals with mental

illnesses and/or deficiencies are still being incarcerated.

The care and treatment of these special inmates continue to present problems for the jail staff. Many communities simply do not have the resources necessary to accommodate referrals from local jails except on an emergency basis. Even in those communities where sufficient resources exist, the jail is often the first agency to come in contact with the mentally ill or deficient person, and thus, the first place where some action must be taken. For this reason, twenty-two of the twenty-six pilot jails now have written guidelines, which have been approved by their responsible physicians, that outline the procedures for implementation of the screening, referral, and care of mentally ill or dificient inmates. In addition, twenty jails routinely screen all inmates for mental health problems.

At the time the baseline data were collected, sixteen of the twenty-six jails offered some form of routine mental health care to their inmates. Nine jails did so in-house, five routinely utilized community facilities, and two provided care both in-house and in the community -- although, in one of these latter two jails, care was given only if the inmate could pay for it.

Since that time, several of the jails have been able to substantially improve their on-going mental health care services. One jail has begun providing routine mental health care in-house (#3-5), while another now has a full-time licensed mental health counselor (#5-4). Except for the hours it takes to make a

referral to community facilities, one Indiana jail (2-5) no longer houses the mentally ill at all, and one site in Maryland (3-7) transfers all problem mental health cases to a local mental hospital. In addition, a Washington jail (5-3) has improved its mental health referral system as well as added special observation cells in order to decrease the risk of injury or death to inmates with mental problems. Jails 1-2 and 3-7 have also added special observation cells.

9. Dental services (Standards 1033-1039)

One of the most neglected areas of health care in correctional institutions continues to be the provision of dental services. The baseline data revealed that, for the most part, the only dental care provided by the pilot sites consisted of emergency extractions. None of them performed routine dental screening and only two of the twenty-six sites reporting offered any type of regular maintenance services (see Table V). This failure to provide sufficient dental services resulted in a significant proportion of inmates' dental care needs going unmet.[30/]

By the time of the accreditation surveys, less than one-third of the pilot jails were able to meet the AMA's standards requiring the examination and initiation of routine dental care within

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[30]In 1976, an examination of 641 inmates in the pilot jails revealed that at least 40% were in need of some type of dental care that was not being provided. See, B. Jaye Anno, Analysis of Inmate/Patient Profile Data, Blackstone Associates, Washington, D.C., June 1977, pp. 72-77.

three months of an inmate's admission to the jail. However, some form of routine dental services are now offered in eleven of the jails and should soon be available in two others when new dental facilities are completed.

All of the pilot jails provide some form of emergency dental care, albeit, in most cases, emergency extractions are still the only service offered. In twenty-two of the jails, emergency dental care is available on a twenty-four hour basis and is governed by written guidelines that comply with the appropriate AMA standard.

Thus, while both routine and emergency dental care have improved somewhat overall, much still remains to be done to bring the dental services offered in the pilot jails into compliance with the AMA's standards.

10. Policies and procedures

In its standards, the AMA placed a major emphasis on the development and implementation of policies and procedures designed to strengthen and improve a jail's health care delivery system. Of the seventeen topic areas listed in the AMA's Survey Questionnaire,[31] virtually all of them include a requirement that the policies and procedures governing these services be written. In the absence of such requirements, the responsibility and delivery of health care to inmates is too often

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[31] Supra, at note 19.

dependent upon the idiosyncrasies and discretion of individual jail personnel.

When the baseline data were collected, only nine jails had any written policies and procedures for the delivery of health care, and in all but three jails, inmates' access to health care services was controlled by correctional rather than medical personnel (i.e., initial requests were made through correctional officers). Of the twenty-six jails reported on here, twenty-two now have extensive written policies and procedures governing the administration of their health care delivery systems.

In addition, all but three jails have a physician or qualified medical authority who assumes responsibility for the jail's medical services. In nineteen jails, this responsibility is outlined in a contractual arrangement. Further, medically trained personnel now screen and respond to inmate requests for medical services in twenty-one facilities. Such changes have helped to formalize and institutionalize the health care delivery systems in the jails where they have been implemented.

11. Receiving Screening[32] (Standards 1006 - 1009)

The medical screening of all inmates prior to their admission to jail should be a required element of any facility's health care delivery system. Once an individual is booked into a jail, his or her health and well-being become that facility's moral

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[32]Receiving screening was not covered in the Jail Pre-Profile Report.

and legal responsibility. The prompt recognition of medical problems is essential if crises are to be averted.[33]

As the Jail Pre-Profile indicated,[34] over half of the responding pilot sites reported admitting individuals with injuries, over three-fourths reported admitting individuals with medical complaints, and all but one reported admitting individuals still intoxicated from alcohol or drugs. In addition, the large jails typically reported that dealing with drug and alcohol intoxication and withdrawal was their biggest problem, while the medium and small-sized jails had the most difficulty in handling inmates with mental problems.

Health care needs which go undetected or untreated at the time of an inmates' admission to jail can result in serious and costly medical and legal complications. In spite of this potential for significant problems, the baseline data indicated that only four of the pilot jails performed anything resembling a thorough screening on admission, and even then, it was only performed on those inmates who were going to be incarcerated longer than one day. In eleven other pilot sites, questions on the booking form routinely inquired about the inmate's state of health, but in no instance could this be considered a thorough probe for potential health problems.

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[33] For example, a large percentage of all deaths that occur in jails, especially from suicides, happen within the first twenty-four hours of an inmate's admission.

[34] See, Anno, Analysis of Jail Pre-Profile Data, supra at note 2, pp. 49-53.

One essential element of the AMA standards is that a jail perform a thorough medical receiving screening of all inmates upon admission. This receiving screening must be:

> "...a system of structured observation/initial health assessment designed to prevent newly arrived inmates who pose a health or safety threat to themselves or others from being admitted to the jail's general population and to rapidly get them to medical care. The receiving screening can be performed by allied health personnel or by a trained booking officer at the time of booking. The initial assessment of health needs and the general condition of the inmate at this crucial point may prevent further complications such as communicable disease epidemics, rapid states of health regression, suicides and assaults. The welfare of the inmate, other inmates, the correctional staff and the community can be protected."[35]

At the time of the accreditation surveys, nineteen of the twenty-six pilot jails were in full compliance with the four standards governing receiving screening and three additional jails were in near full compliance. To be in full compliance, it was essential that receiving screening be performed by trained personnel[36] on all inmates immediately upon their admission to the jail and prior to their being placed in the general population. In addition, the jail had to use an acceptable screening form and

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[35] AMA Survey Questionnaire, supra at note 19, p. 9.

[36] Trained allied health care personnel or trained correctional officers can perform receiving screening.

have written receiving screening guidelines [37] - both approved by the jail's responsibile physician - and a copy of the receiving screening information had to be forwarded to the inmate's medical record.

The total effect of receiving screening on improving the health care of inmates and averting major medical crises is not known at this time.[38] However, at least the potential for crisis avoidance is now present. Receiving screening has proven to be workable in a number of the pilot jails and has formed the basis around which adequate health care delivery systems were built.

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[37] Minimally, the receiving screening form has to inquire into: current illnesses and health problems including medications taken and any special health requirements; screening of other health problems designated by the responsible physician; behavioral observation, including state of consciousness and mental status; notation of body deformities, trauma markings, bruises, lesions, ease of movement, jaundice, etc.; condition of skin and body orifices, including infestations; and disposition/referral of inmates to qualified medical personnel on an emergency basis.

[38] An extensive qualitative and quantitative assessment of receiving screening is to be a major part of the third year evaluation effort.

D. General Health Problems of the Inmate Population

1. Deaths

Table IX presents a comparison of the number of deaths and their causes which occurred in the pilot jails in 1975 and 1976. It is immediately apparent that the overall number of jail deaths declined by more than one-half in 1976. No deaths were reported in either year in any of the small jails, nor in any jails not reporting a death the previous year. The medium-sized facilities reported no deaths in 1976 compared with four in 1975. In the large jails, a further decline can be seen. Here, the deaths dropped from thirteen in 1975 to eight in 1976.

One should not necessarily attribute the decline in deaths in 1976 to the improvement of the jails' overall health care systems. It must be remembered that improvements in health care at most of the pilot jails did not occur until late 1976 and 1977. However, one should also not totally discount the effects of a heightened awareness of jail health care problems and the beginnings of efforts to improve health care as contributing factors in the decline of jail deaths.

It is unfortunate that at the time of this writing, complete data on the number and cause of jail deaths in 1977 is not available for comparison with the previous two years. It would be interesting to note whether the decline in jail deaths continued.

TABLE IX

Comparison of the Number and Cause of Deaths in 1975 and 1976 by Jail and Size

Jail Size	Causes										Total	
	Jail Violence		Medical Reasons		Natural Causes		Suicides		Information Not Available			
	1975	1976	1975	1976	1975	1976	1975	1976	1975	1976	1975	1976
Small											0	0
Medium												
3-1			1								1	0
3-3							1				1	0
4-4			1				1				2	0
Large												
1-1						1			4		4	1
1-2			1								1	0
2-4							1				1	0
3-2							2	2			2	2
4-2						1	2	2			2	3
6-3							3	2			3	2
TOTAL	0	0	3	0	0	2	10	6	4	0	17	8

2. Assaults

The original baseline information collected on assaults was very unreliable. To begin with, few jails keep accurate statistics in this area, and in addition, many assaults go undetected by jail staff. Therefore, no attempt was made to compare baseline data with information from subsequent years.

3. Disease epidemics

None of the pilot jails reported any outbreaks of serious diseases (such as hepatitis) that could be said to have reached epidemic proportions from 1974 to 1977. Those jails which experienced less serious types of disease outbreaks (such as lice, scabies, or the flu) during this same time period described them as something far less than what could be called epidemics.

4. Inmate condition on admission; and

5. Usual inmate condition and/or complaints

Baseline information collected for these two categories was used primarily for health care planning and was not specifically intended for comparative purposes. Although it might have proved interesting to examine any changes in the number of inmates being admitted with medical problems and in the types of inmate medical complaints between the two time periods, the poor quality of the original data precluded any valid comparisons.

A more accurate assessment of inmates' medical problems can be found in the comparison of the results between the first and second year Inmate/Patient profiles.[39]

[39]This report should be available in early May 1978.

E. Existing Medical Record Systems

As the Jail Pre-Profile indicated,[40] over one-fourth of the pilot sites did not keep management records at the time the baseline data were collected. Frequently, even where records were kept, they were inadequate and incomplete. This was especially true in the small jails.

Realizing the importance of management records for the efficient planning and operation of a health care delivery system, the AMA included a standard requiring the responsible physician to submit an annual statistical report to the official in charge of the jail. This report is supposed to outline the frequency with which various health care services are delivered.

In addition, the responsible physician is required to review the jail's health care delivery system and health environment on a quarterly basis and to submit a written report to the responsible jail administrator. This quarterly report must include a review of the medical care system processes, a description of any substandard health environment factors, a list of any changes in the health care system, and any recommendations for improvements.

At the time of the accreditation surveys, twenty-two of the twenty-six jails had made provisions for submitting annual management reports, and twenty of these same jails also had

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[40] See, Anno, B. Jaye, Analysis of Jail Pre-Profile, supra at note 2, pp. 54-55.

provisions for a quarterly reporting system.[41]

When the baseline data were collected, deficiencies in the maintenance of inmate treatment records were far greater than deficiencies in their management information systems. Of the twelve pilot jails which kept treatment records, only five had what could be considered unified record systems,[42] only ten jails kept confinement and medical records separately, and all but six of the sites allowed correctional officers regular access to inmates' treatment records.

Again, by the time the pilot jails underwent their accreditation surveys, their treatment record systems had changed. Eighteen jails could now fully comply with the standard requiring a unified treatment record system and two more jails were in near full compliance. Twenty-two of the pilot sites also complied with the standard mandating that confinement and medical records be kept separate.

This latter requirement helps ensure the confidentiality of the physician-patient relationship. Because of the nature of the jail environment and the frequent transfer and turnover of jail populations, this is often difficult to do. The efficient

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[41] Since most of the health care delivery systems in the pilot jails were only fully operational a short time prior to the accreditation surveys, an evaluation of the adqequacy of each jail's reporting system was not available.

[42] A unified medical record system may be defined as one where each inmate has a single folder containing pertinent information from all types of health care providers rather than one where each health care provider maintains individual files on the same inmate.

operation of the jail and its health care delivery system may conflict with the rights of inmates. Nevertheless, the health care standards developed by the AMA place firm emphasis on maintaining the inmates' rights to privacy and confidentiality in the area of health care and treatment.

The standards insist that the physician-patient privilege applies to the medical record and require that access to this record be controlled by the responsible physician. Nineteen of the pilot sites ascribe to the policy of applying the physician-patient privilege to inmates' medical records, and twenty-one jails now restrict access to such records.

F. Frequency of Health Services Delivered

As indicated in the previous section, the pilot jails are only beginning to keep adequate management records. The Practical Guide that the AMA plans to include as an accompanying document to its health care standards describes ways to keep management records and provides some examples. Hopefully, this will facilitate better record-keeping in the future and make possible accurate comparisons over time of the quality and quantity of health care services delivered to jail inmates. At present, however, such an assessment is not possible.

G. Cost Data Comparisons

The cost of inmate health care is of immense concern to jail administrators and local government officials. When changes in a jail's health care delivery system are proposed, inquiries about expenditures always arise. Usually administrators ask, "How much is it going to cost?" -- although "How much is it going to save?" is an equally valid question. Ideally, it should be possible to answer questions about the cost of implementing various changes in a jail's health care delivery system before they take place. Unfortunately, the lack of reliable data makes it difficult even to obtain good estimates of what it cost to initiate past improvements.

The absence of adequate management records was reflected in the quality of health care cost data available for comparative purposes. The reliability and completeness of such data varied greatly between the pilot jails. Two facilities (3-7 and 5-1) were unable to supply any of the requested cost information, and three jails (2-4,3-1 and 3-5) could only provide partial data, whereas one jail (5-4) did a rather thorough per capita health cost analysis. Nevertheless, based on the information supplied by twenty-two pilot jails for 1976 and 1977, reasonable costs comparisons could be made in some areas for these two years.

The instruments used to collect the 1976 and 1977 cost information were the same as those used to collect the baseline

fiscal data for 1975 which were presented in the Jail Pre-Profile.[43] However, it was decided not to incorporate the 1975 data into the present analysis for several reasons. First, while cost data for all three years were available in only fourteen of the twenty-seven pilot jails remaining in the program, they were available in twenty-two jails for both 1976 and 1977. Second, although the state projects began in January 1976, most changes in the pilot jails' health care delivery systems did not occur until 1977. For that reason, 1976 may be a more appropriate baseline year than 1975. Third, in most cases, the 1976 and 1977 cost data were collected at the same point in time by the same individuals in each state, whereas the 1975 data were collected at different points in time and, often, by different individuals.

Although the states all utilized the same data collection instruments, some variations in the types of data collected still occurred.

It should be recognized that an ideal cost analysis would include all of the expenses involved in delivering health care to a jail's population, regardless of whether these costs were explicit or implicit, or whether they were actually charged to the jail itself or included in other health care agency budgets. Unfortunately, in order to achieve comparability of data between

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[43] See, Anno, Analysis of Jail Pre-Profile Data, supra at note 2, pp. 58-61.

the pilot jails, a less-than-ideal analysis had to be undertaken. The cost figures in this report were derived only from those actual or estimated expenditures that fell into the following categories: (a) health staff salaries;[44] b) contract or fee-for-service expenditures; and c) the cost of drugs and other services.[45]

It is recognized that these three categories are not necessarily mutually exclusive and that they do not cover all of the costs involved in providing health care to a jail's inmates. However, they do represent the areas where similar cost figures could be derived. For the most part, they are explicit costs that were paid for as part of the jail's budget, although in some instances, other funding sources were involved. Implicit costs, such as transportation for medical reasons, security at hospitals or clinics, etc., could not be included in the totals, since these data were not provided for all of the jails.

This inability to include implicit figures in the cost totals gives a less than complete picture and makes it impossible to reach any conclusions regarding the cost/benefit ratio of the jails' present systems for delivering care versus those

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[44]Because of the numerous inconsistencies between the pilot jails, fringe benefits were not included as part of health staff salaries.

[45]For a breakdown of these three categories of cost by jail see Appendix C.

that were in place before the AMA program got underway. Further, it is not even possible to make accurate cost comparisons between two jails with different delivery systems.

For example, if one jail provides some services in-house and another does not, the explicit per capita cost of health care in the former will undoubtedly exceed that of the latter. However, if implicit costs such as those involved in transporting the inmate outside the jail were added (e.g., C.O. time and vehicle costs), the cost of providing health care in the second site might well be substantially higher. Thus, the decision as to which services should be provided in-house and which in the community to arrive at the best cost/benefit ratio, is one which must be determined for each jail on an individual basis. Other factors such as existing community resources and available funding sources must also be taken into account.

In addition to the cost/benefit problem, it must be remembered that health care expenditures vary by locale and by differences in the average length of stay of inmates. Facilities which house inmates for longer periods of time will usually incur higher health care costs than those which do not, since a jail's responsibility to provide various health care services increases the longer an inmate is incarcerated.[46]

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[46]For a cursory analysis of per capita health care costs as they related to average length of stay in 1976, see Appendix C.

TABLE X

Per Capita Health Care Cost

Jail/ State Code	Size (S)mall (M)edium (L)arge	Health Care Cost per Inmate received in 1976 in Dollars	Health Care Cost per Inmate received in 1977 in Dollars	Net Change from 1976 to 1977 in Dollars	Percent of Change from 1976 to 1977
1-1	L	1.85	1.79	- .06	- 3%
1-2	L	4.61	5.40	+ .79	+ 17%
1-3	S	2.15	5.57	+ 3.42	+159%
1-5	S	.72	1.14	+ .42	+ 58%
2-1	S	INA*	-	-	-
2-2	S	2.15	4.29	+ 2.14	+ 99%
2-4	L	14.84	15.59	+ .75	+ 5%
2-5	M	6.83	5.41	- 1.42	- 21%
2-6	M	INA*	-	-	-
2-7	S	2.54	6.75	+ 4.21	+166%
3-1	M	40.09	41.61	+ 1.52	+ 4%
3-2	L	61.83	74.30	12.47	+ 20%
3-3	M	32.90	40.43	+ 7.53	+ 23%
3-4	M	50.11	74.41	+24.30	+ 48%
3-5	L	INA*	-	-	-
3-7	M	INA*	-	-	-
4-1	S	1.12	1.01	- .11	- 10%
4-2	L	6.56	7.10	.54	+ 8%
4-3	M	8.62	14.58	5.96	+ 69%
4-4	M	12.91	19.82	+ 6.91	+ 53%
5-1	M	INA*	-	-	-
5-2	S	3.88	4.52	+ .64	+ 16%
5-3	M	2.19	5.82	+ 3.63	+166%
5-4	S	4.67	3.40	- 1.27	- 27%
6-1	S	1.82	2.64	+ .82	+ 45%
6-2	M	2.93	7.49	+ 4.56	+156%
6-3	L	11.16	12.41	+ 1.25	+ 11%
Total N=22		$\bar{X}$ = $12.57	$\bar{X}$ = $16.16	$\bar{X}$ = $3.59	$\bar{X}$ = +29%

*INA = Information Not Available

Furthermore, the lack of available information on the number of inmates receiving various types of treatment (see section F) meant that the cost per inmate/patient for the various types of health care services could not be calculated. This points up a particularly serious deficiency of the cost data, since it is possible that the total amount expended for health care during 1976 or 1977 in any given jail was a result of only a few individuals being hospitalized, and not of a number of different individuals receiving various types of treatment.

Thus, in order to calculate some form of per capita cost it was necessary to use the total number of inmates received by each jail in a given year. This figure, while saying nothing about the number of inmates receiving various types of health care treatment, did have the advantage of being fairly precise and, more importantly, was available for most of the pilot jails. Other figures which might have been used for arriving at per capita cost, such as the average daily population, had to be estimated in many jails and, therefore, were not as reliable or as comparable across all of the sites. With these caveats in mind, we turn now to a discussion of the cost comparisons that could be made.

Table X presents the explicit health care cost per inmate received in the twenty-two pilot jails reporting this information for 1976 and 1977. In 1976, the average amount expended per inmate for health care in all of these pilot jails was $12.27.

This figure increased to $16.16 in 1977 for a net rise of 28% or $3.59 per inmate. Four jails showed net decreases in per capita health care cost, while eighteen jails showed increases. The range in the amount spent per inmate received went all the way from .72 cents in jail 1-5 in 1976 to $74.41 in jail 3-4 in 1977.[47]

Looking at Table XI, it appears that small jails spend far less per capita on health care than do most medium and large size jails. However, this is probably a reflection of the fact that small jails generally provide far fewer health care services in-house. This means that more of their health care costs are undoubtedly implicit ones, which were not included in these per capita figures.

As previously indicated in section C, when the baseline data were collected, the number of health care services available to a jail's inmates was directly related to the jail's size -- i.e., the larger the jail the more services that were available. As Table XI shows, however, the average per capita change in health care expenditures was inversely related to jail size -- i.e., the smaller the jail the greater the percent increase in health care expenditures from 1976 to 1977. During this time

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[47] It should be remembered that changes in per capita health care costs are affected by both changes in the number of inmates received and changes in the total amount expended for health care. For example, if the total number of inmates decreased in 1977 for a particular jail while the amount spent on health care remained the same, the per capita health care costs would rise. For a breakdown of the actual amounts spent by each jail on the three categories of health care expeditures being discussed, refer to Appendix C.

period the small jails increased their per capita expenditures for health care by 54 percent, the medium jails by 34 percent, and the large jails by 16 percent. It should be noted, though, that these percentage increases in per capita health care expenditures closely parallel similar increases in the number of health care services offered by the different size jails during this same time period and, thus, may be partially related to these latter changes.[48] (See table VII, p. 35)

TABLE XI

Average Per Capita Expenditure for Health Care by Jail Size for 1976 and 1977

Size	#	1976 Average $	1977 Average $	Net Dollar Change $	Percent Dollar Change
Small	8	$ 2.38	$ 3.67	$ 1.29	54%
Medium	8	19.57	26.20	6.63	34%
Large	6	16.81	19.43	2.62	16%

[48] The addition of health care providers to jail staff is one reason for the rapid increase in per capita costs. For a summary of those jails which added health care staff, see Section H - "Health Care Personnel Serving the Pilot Jails."

However, when health care costs are viewed as a percent of total jail costs (see Table XII), they do not appear to be rising faster than overall expenditures regardless of jail size. Even though percentage increases in health care costs apparently rose at a faster rate in the smaller jails, overall expenditures were also rising faster in these facilities. Therefore, as shown in Table XII , the overall percents of the total jail budgets devoted to health care remained almost constant from 1976 to 1977 regardless of jail size. In the small jails, it rose slightly from three to four percent, while in the medium and large-sized jails, it remained constant at nine and seven percent respectively. Of the twenty-two jails for which data were available, four jails showed overall decreases in the percent of their budgets devoted to health care, nine jails showed no change and nine jails showed percentage increases.

The results of this cost analysis, while somewhat encouraging on the surface, must be accepted as only the most preliminary and inconclusive of findings. Changes in health care costs are more a function of each jail's individual environmental characteristics, of which size is only one variable, than they are of any considerations which have been presented here. This analysis focused on only three cost categories which were primarily explicit ones, and even these were often estimates. A much more thorough cost analysis is needed which would include better per capita figures based upon the number of health care services delivered, the computation of implicit costs, and a larger

TABLE XII

Percent of Total Jail Budget Devoted to Health Care:
A Comparison of 1976-77 Data

A. Small-sized Jails

State/ Jail Code	Total Amount Expended for Jail Overall in 1976	Amount Expended for Health Care for 1976 (from Appendix C)	Percent of Total Budget Devoted to Health Care for 1976 (from Appendix C)	Total Amount Expended for Jail Overall in 1977	Amount Expended for Health Care for 1977 (from Appendix C)	Percent of Total Budget Devoted to Health Care for 1977 (from Appendix C)	Change in % of Budget Devoted to Health Care from 1976 - 1977
1-3	$ 31,057	$ 2,243	7%	$ 39,862	$ 6,171	15%	+ 8%
1-5	136,828	941	1%	153,330	854	1%	0%
2-1	82,000	4,000	5%	92,000	7,000	8%	+ 1%
2-2	72,725	2,100	3%	72,725	2,400	3%	0%
2-7	55,000	1,016	2%	55,000	2,248	4%	+ 2%
4-1	55,181	257	1/2%	67,449	267	1/2%	0%
5-2	136,291	3,610	3%	136,381	4,904	4%	+ 1%
5-4	16,100	2,190	14%	21,000	1,654	8%	- 6%
6-1	65,875	716	1%	69,854	982	1%	0%
TOTALS	$ 651,057	$ 17,073	3%	$ 707,601	$ 26,480	4%	+ 1%

TABLE XII

Percent of Total Jail Budget Devoted to Health Care:
A Comparison of 1976-77 Data

B. Medium-sized Jails

State/ Jail Code	Total Amount Expended for Jail Overall in 1976	Amount Expended for Health Care for 1976 (from Appendix C)	Percent of Total Budget Devoted to Health Care for 1976 (from Appendix C)	Total Amount Expended for Jail Overall in 1977	Amount Expended for Health Care for 1977 (from Appendix C)	Percent of Total Budget Devoted to Health Care for 1977 (from Appendix C)	Change in % of Budget Devoted to Health Care from 1976 - 1977
2-5	$ 86,456	$ 18,592	22%	$ 136,256	$ 18,513	14%	- 8%
2-6	69,957	7,338	10%	74,600	2,882	4%	- 6%
3-1	IIA*	-	-	-	-	-	-
3-3	1,100,000	102,000	9%	1,300,000	114,500	9%	0%
3-4	1,509,960	174,188	12%	2,094,310	238,410	11%	- 1%
3-7	IIA*	-	-	-	-	-	-
4-3	121,885	17,294	14%	126,482	30,273	24%	+10%
4-4	1,184,476	65,912	6%	1,371,635	84,135	6%	0%
5-1	IIA*	-	-	-	-	-	-
5-3	119,854	3,500	3%	161,227	8,849	5%	+ 2%
6-2	195,952	5,508	3%	187,913	14,102	8%	+ 5%
TOTALS	$4,388,540	$ 394,332	9%	$5,452,423	$511,664	9%	0%

*Insufficient Information Available

CONTINUED

1 OF 2

TABLE XII

Percent of Total Jail Budget Devoted to Health Care:
A Comparison of 1976-77 Data

C. Large-Size Jails

State/ Jail Code	Total Amount Expended for Jail Overall in 1976	Amount Expended for Health Care for 1976 (from Appendix C)	Percent of Total Budget Devoted to Health Care for 1976 (from Appendix C)	Total Amount Expended for Jail Overall in 1977	Amount Expended for Health Care for 1977 (from Appendix C)	Percent of Total Budget Devoted to Health Care for 1977 (from Appendix C)	Change in % of Budget Devoted to Health Care from 1976 - 1977
1-1	$ 939,184	$ 100,617	11%	$ 983,203	$ 110,679	11%	0%
1-2	1,428,277	92,228	6%	1,502,232	106,997	7%	+ 1%
2-4	IIA*	-	-	-	-	-	-
3-2	10,208,000	867,247	8%	11,058,000	1,093,093	10%	+ 2%
3-5	IIA*	-	-	-	-	-	-
4-2	2,332,000	142,080	6%	2,914,000	164,224	6%	0%
6-3	4,831,414	157,585	3%	5,796,909	174,272	3%	0%
TOTALS	$19,738,875	$1,359,757	7%	$22,254,344	$1,649,265	7%	0%

*Insufficient Information Available

sample size covering longer periods of time, before any generalized conclusions can be drawn regarding whether improving health care delivery systems increases or decreases a jail's overall expenditure in this area.

To a large extent, the answer to this question will always remain an individualized one, since the determination of whether planned improvements will increase or decrease a jail's health care expenditures is dependent upon the type of delivery system currently being offered. While it is true that providing certain services in-house may reduce or eliminate implicit costs of transportation and security to outside facilities, explicit costs are bound to rise with the addition of new services. On the other hand, these additional expenditures may be more than offset by the "savings" that occur in reducing potential legal fees resulting from class action suits charging the jail with failure to provide adequate medical care.

H. Health Care Personnel Serving the Pilot Jails

Since the inception of the AMA's program to improve health care in jails, the Pilot Project Directors (PPDs) have reported a steady increase in the overall extent of medically trained personnel serving the pilot sites. Although Table XIV (see next page) indicates that some jails have not increased the number or extent of the medical personnel serving their inmates,[49] where changes have occurred, they have all been in a positive direction. There have been increases either in: 1) the total number of health care personnel serving the jail; (2) the number of hours existing health care personnel serve the jail; and/or 3) increases in the extent of health care training that correctional officers receive.[50]

In addition to the changes noted in Table XIV, it should be remembered that in nineteen pilot sites, a contractual agreement now exists between the responsible physician and the jail. Such contractual agreements, as specified in the AMA standards, outline the responsibilities and authority of the jail physician. This standard specifically states that the jail physician's authority with respect to the practice of medicine cannot be

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[49]For a complete discussion of the health care personnel serving the pilot jails at the time of the baseline data collection, see Anno, Analysis of Jail Pre-Profile Data, supra at note 2, pp. 62 - 71.

[50]The value of health care training for correctional officers was demonstrated by an incident at one of the pilot jails (5-3). An inmate suffering a severe allergic reaction to aspirin had his life saved due to the prompt recognition of the problem and immediate reaction of the EMT-trained Medical Liaison Officer.

TABLE XIV

Changes in the Health Care Personnel
Serving the Pilot Jails

Jail Code	Size of Jail*	Changes in Health Care Personnel Since the Inception of the AMA Health Program	Jails with Contractual Arrangements with the Jail Physician Marked with an "X"
1-1	L	NC	
1-2	L	NC	
1-3	S	NC	X
1-5	S	Two EMTs come by daily	
2-1	S	NC	
2-2	S	EMTs in county now available to jail	X
2-4	L	NC	
2-5	M	New jail physician comes to jail	X
2-6	M	NC	
2-7	S	NC	X
3-1	M	1 EMT trained person available in jail; all COs to get CPR training	X
3-2	L	Jail added 1 dental hygenist; 1 X-ray tech.; and 1 lab tech.; dental students also serve jail	X
3-3	M	Jail added 1 PA	X
3-4	M	Jail added 1 RN and 1 medical tech.	X
3-5	L	NC	X
3-7	M	NC	
4-1	S	NC	X
4-2	L	RNs' hours increased from 16 to 40 hrs. week; dentist available 1½ days per week	X
4-3	M	1 RN added for 6 hours per week	X
4-4	M	NC	X
5-2	S	Health Department supplies 1 RN and 1 PA one time per week. Physician also comes once a week	X
5-3	M	1 RN added for 12 hours per week	X
5-4	S	1 RN part-time, EMT personnel within 5 minutes of jail at all times	X
6-1	S	1 RN one time per week	X
6-2	M	1 Physician once every other week; 1 RN three times per week; 1 mental health worker full-time	X
6-3	L	1 RN to be added to staff; 1 dentist to be added for two days per week	X

KEY: CO = Correction Officer
CPR = Cardio-pulmonary Resusitation
EMT = Emergency Medical Technician
L = Large
M = Medium
NC = No Change in the Health Care Personnel
PA = Physician Assistant
RN = Registered Nurse
S = Small

restricted by the jail administration except in those areas pertaining to the maintenance of security for the protection of all parties concerned.

Furthermore, the standard states that it is the jail physician's responsibility to assure that the custodial staff has an understanding of basic health care issues and to assure that, regardless of the size of the jail, there is a person on duty at all times who is able to recognize medical emergencies, carry out physicians' orders and arrange for prompt disposition of medical matters. The jail physician also has the responsibility of approving the written guidelines that cover all aspects of the jail's health care delivery system.[51]

The existence of this contractual arrangement in and of itself should help to increase the efficiency and responsiveness of health care personnel to the medical needs of jail inmates.

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[51] For a listing of the fifteen specific areas where written guidelines must be approved by the responsible physician, see American Medical Association, Survey Questionnaire, supra at note 19, p.26.

IV. SUMMARY OF PILOT JAIL PRE/POST HEALTH CARE DELIVERY SYSTEM COMPARISONS[52]

Specific findings of pre/post comparisons of health care availability in the various pilot sites have been sufficiently detailed in the text and the tables, and need not be reiterated in full. Likewise, important differences in the results between the six states and among the three size categories have been noted. Nevertheless, a brief summary of a few of the highlights of the aggregate findings seems warranted.

Of the thirty original pilot sites, sixteen were fully accredited and four provisionally accredited by the end of February 1978 (although one of this latter group subsequently lost its provisional status). Of the remaining ten jails, six did not apply for accreditation, one applied and was turned down, and the other three were dropped from the project in the Fall of 1977. It should be noted, though, that with one or two exceptions, improvements occurred even in those jails falling short of accreditation status. Consider the following statistics:

- Of the twenty-six remaining sites for which data could be gathered, overall availability of some of the most important health care services (see Table V) increased from a total of 82 to 139, which represents a 70% increase in availability of these selected services.

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[52]This summary focuses only on significant improvements in the health care delivery systems which occurred in the pilot sites during the first two years of the AMA's program. It does not include a synopsis of other parts of this report, such as the section on jail characteristics, inmate characteristics, or cost.

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

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

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

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

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

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

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

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

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

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

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

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

APPENDIX A

ABBREVIATION KEY

ABBREVIATION KEY

National Organizations/Agencies

ABA - American Bar Association
ACA - American Correctional Association
ADA - American Dental Association
AMA - American Medical Association
BNDD - Bureau of Narcotics and Dangerous Drugs
JCAH - Joint Commission on Accreditation of Hospitals
LEAA - Law Enforcement Assistance Administration
NACCJSG - National Advisory Committee on Criminal Justice Standards and Goals
NSA - National Sheriffs' Association
PSRO - Professional Standards Review Organizations

Personnel

Corrections:
CO - Correctional Officer

Health Care:
DO - Doctor of Osteopathy
ECT - Emergency Care Technician
EMT - Emergency Medical Technician
LPN - Licensed Practical Nurse
MD - Doctor of Medicine
RN - Registered Nurse
PA - Physician's Assistant

Research and Evaluation

ADI - Average Daily Intake
ADP - Average Daily Population
ATP - Average Total Population
I/PP - Inmate/Patient Profile
JP-P - Jail Pre-Profile
LOS - Length of Stay
N - Number
R - Range
TA - Technical Assistance

Symbols Used in Charts

$\bar{x}$ = Mean
\# = Number
% = Percent
Cum % = Cumulative percentage
$>$ = Greater than
$\geq$ = Greater than or equal to
$<$ = Less than
$\leq$ = Less than or equal to

APPENDIX B

Characteristics of the Pilot Jails
by Size for 1975, 1976, and 1977

Characteristics of the Pilot Jails

1A. Small[1] *

State	Type of Jail	Code	Area Served[2]	Other Jails[3]	Date Built	Major Renovations
GEORGIA	County	1-3	Rural	No	1937	1974
	County	1-5	Rural	No	1968	None
INDIANA	County	2-1	Rural	No	1897	1962
	County	2-2	Rural	No	1960	None
	County	2-7	Rural	No	1917	None
MICHIGAN	County	4-1	Rural	No	1964	None
WASHINGTON	County	5-2	Rural	Yes, City Jails	1957	None
	County	5-4	Rural	No	1928	1976
WISCONSIN	County	6-1	Rural	No	1950	1975- New Wing Added

*See Footnotes following the last table.

Statistics of the Pilot Jails*

1B. Small

Code	Total Received[4]			ADP[5]			Rated Capacity[6]			Average LOS[7]			ADI[8]		
	1975	1976	1977	1975	1976	1977	1975	1976	1977	1975	1976	1977	1975	1976	1977
1-3	1104(A)	1044(E)	1107(E)	17.0	16.0	19.0	36	36	NR	5.6	4.0	3.0	3.0	2.9	3.0
1-5	1650(E)	1304(E)	746(A)	15.0	16.0	11.0	32	32	NR	1.0?	14.0	NR	4.5	3.6	2.0
2-1	387(A)	NR	NR	4.0a	7.0	NR	14	14	NR	3.8	NR	NR	1.1	NR	NR
2-2	1200(A)	975(A)	560(A)	13.5	8.0	NR	27	27	NR	4.1	2.0	NR	3.3	2.7	1.5
2-7	300(E)	400(E)	333(A)	4.5	4.0	NR	17	17	NR	5.5	14.0	NR	0.8	1.1	.9
4-1	221(A)	230(A)	263(A)	4.4a	2.9a	NR	20	20	NR	7.3	4.6	NR	0.6	0.6	.7
5-2	1168(EP)	930(A)	1086(A)	18.0	26.9a**	NR	42	42	NR	5.6	27.3	NR	3.2	2.5	3.0
5-4	631(A)	469(A)	487(A)	7.0	7.6a	NR	25	25	NR	4.0	5.9	NR	1.7	1.3	1.3
6-1	362(A)	394(A)	371(A)	8.0	10.6	7.0	24	24	NR	9.9	9.8***	10	1.0	1.1	1.0

*See Footnotes and Key following the last table.
**By definition, this is now a different sized jail.
***Denotes an overcrowded condition.
****Length of stay for this jail is a weighted average of male, female, and juvenile inmates.

NR = not reported

Characteristics of the Pilot Jails

2A. Medium[1]*

State	Type of Jail	Code	Area Served[2]	Other Jails[3]	Date Built	Major Renovations
INDIANA	County	2-5	Rural	No	1936	None
	County	2-6	Rural	No	1890	1974
MARYLAND	County	3-1	Suburban	No	1967	None
	County	3-3	Suburban	No	1957	New facility planned
	County	3-4	Suburban	No	1961	New Jail Opened '77
	County	3-7	Rural	No	1826	1858 & 1904
MICHIGAN	County	4-3	Rural	No	1963	None
	County	4-4	Suburban	No	1934	New Jail To Open 1978
WASHINGTON	County	5-1	Rural	Yes-City Jail	1970	1976
	County	5-3	Rural	Yes-City Jail	1949	None
WISCONSIN	County	6-2	Rural	No	1952	1974

*See Footnotes following the last table.

Statistics of the Pilot Jails*

2B. Medium

Code	Total Received[4]			ADP[5]			Total Rated Capacity[6]			Average LOS[7]			ADI[8]		
	1975	1976	1977	1975	1976	1977	1975	1976	1977	1975	1976	1977	1975	1976	1977
2-5	2534(A)	2724(A)	3423(A)	22.5	24.0	NR	36	36	NR	3.3	8.0	NR	6.9	7.5	9.4
2-6	1306(A)	1395(A)	NR	25.0	18.0**	NR	54	54	NR	7.0	14.0	NR	3.6	3.8	NR
3-1	1762(EP)	1744(A)	1848(EP)	120.0	144.0	NR	218	218	NR	24.9	30.1	NR	4.8	4.8	5.1
3-3	2680(EP)	3100(A)	2832(EP)	190.0	212.0	NR	120***	120***	NR	21.1	25.0	NR	7.3	8.5	7.3
3-4	3218(EP)	3476(A)	3204(EP)	165.0	246.0	NR	125***	125***	250	18.7	25.8	NR	8.8	9.5	8.8
3-7	1808(EP)	1706(A)	2148(EP)	70.0	75.0	NR	110	110	NR	14.1	16.0	NR	5.0	4.7	5.9
4-3	2405(A)	2007(A)	2076(A)	37.3a	35.9a	NR	45	45	NR	5.7	6.5	NR	6.6	5.5	5.7
4-4	5818(A)	5104(A)	4245(A)	130.0	157.0	NR	124***	124***	NR	8.2	11.2	NR	15.9	14.0	11.6
5-1	1490(EP)	NR	NR	39.0	NR	NR	26***	26	NR	9.6	NR	NR	4.1	NR	NR
5-3	1670(A)	1600(E)	1520(A)	36.0	36.0	31	53	53	NR	7.9	NR	NR	4.6	4.4	4.2
6-2	1870(A)	1878(A)	1884(A)	47.5	47.5	44.6	59	59	NR	9.3	12.5	10	5.1	5.1	5.2

*See Footnotes and Key following the last table.
**By definition, this is now a different sized jail.
***Denotes an overcrowded condition.

NR = not reported

Characteristics of the Pilot Jails

3A. Large[1]*

State	Type of Jail	Code	Area Served[2]	Other Jails[3]	Date Built	Major Renovations
GEORGIA	City	1-1	Urban	Yes-County Jail	1934	Funds for New Facility now Available
	County	1-2	Suburban	No	1973	None
INDIANA	County	2-4	Urban	No	1965	New Wings Opened at Later Dates
MARYLAND	City	3-2	Urban	No	1859	1958, 1964, and 1971
	County	3-5	Suburban	No	1928	1956, New Facility opened 1976
WISCONSIN	County	6-3	Urban	No	1929	25 Bed Honor Dorm 1976

*See Footnotes following last table.

Statistics of the Pilot Jails*

1C. Large

Code	Total Received[4] 1975	1976	1977	ADP[5] 1975	1976	1977	Total Rated Capacity[6] 1975	1976	1977	Average LOS[7] 1975	1976	1977	ADI[8] 1975	1976	1977
1-1	68,711 (A)	54,308 (A);	61,914 (A)	330.0	167.0**	165	160***	160***	NR	1.8	.9	.9	188.2	148.8	169.3
1-2	18,851 (A)	20,015 (A)	19,807 (A)	400.0	410.0	445	443	443	NR	7.7	7.5	8.2	51.6	54.8	54.3
2-4	15,483 (A)	16,696 (A)	16,123 (A)	650.0	620.0	NR	778	778	NR	15.3	15.3	NR	42.4	45.7	44.2
3-2	13,894 (EP)	14,026 (A)	14,712 (EP)	1545.0a	1812.0a	NR	1500***	1500***	NR	40.6	47.1	NR	38.1	38.4	40.3
3-5	12,782 (EP)	10,017 (A)	11,412 (EP)	290.0a	369.0a	NR	77***	227***	NR	8.3	13.4	NR	35.0	27.4	31.3
4-2	19,696 (E)	21,648 (A)	23,135 (A)	526.6a	528.4a	NR	484***	484***	NR	9.8	8.9	NR	54.0	59.3	63.4
6-3	13,437 (A)	14,125 (A)	14,044 (A)	332.0a	306.3a	288.8a	339	339	NR	8.7	**** 14.9	**** 14.4	36.8	38.7	38.5

*See Footnotes and Key following the last table.
**By definition, this is now a different sized jail.
***Denotes an overcrowded condition.
****Length of stay for this jail is a weighted average of male, female, and juvenile inmates.

NR = not reported

Footnotes and Key for "Jail Characteristics" Tables, Appendix B

1. Size designation is based on categories used by LEAA in its jail surveys.
"Small" indicates an ADP of 20 inmates or less.
"Medium" indicates an ADP of 21 - 249 inmates.
"Large" indicates an ADP of 250 inmates or more.

2. "Area Served" refers to the general population size of the jail's jurisdiction. Categories for the thirty pilot jails were arbitrarily defined as follows:

Rural - Population size range = 1 - 110,000;
Suburban - Population size range = 110,000 - 700,000;
Urban - Population size range = over 700,000.

3. "Other Jails" refers to additional adult facilities in the same jurisdiction that hold individuals for longer than 48 hours. Thus, it includes city jails that serve as detention facilities and/or correctional facilities for city ordinance violators but it specifically excludes police lockups.

4. "Total Received" refers to the jails annual intake of prisoners. Since different sources were used to obtain these figures, the following symbols were used to denote source:

"A" means Actual Annual Intake - a figure obtained from available statistics;
"E" means Estimated Annual Intake - a figure obtained from "best guesses" of jail personnel;
"EP" means Estimated Projections of Annual Intake - This figure is based on partial year statistics for the total number of inmates received or on the average monthly number of inmates received.

5. "ADP" is the abbreviation used for Average Daily Population. The subscript "a" indicates that this is a true average based on total annual intake. In other instances, the figure represents "best guesses" of jail personnel.

6. "Rated Capacity" refers to the number of persons the jail was originally designed to hold. In comparing the rated capacity of the jail with its ADP, a double asterisk (***) indicates an overcrowded condition.

7. "Average LOS" refers to the average length of stay for all inmates received during 1975 regardless of category (e.g., unsentenced and sentenced). It is computed as follows:

$$\frac{\text{ADP} \times 365 \text{ days}}{\text{Total Inmates Received}} = \text{Average Length of Stay (LOS)}$$

Obviously, this figure is most suspect when the Total Inmates Received figure was derived from an estimate (e.g., as in jails 1-4 and 1-5).

8. "ADI" is the average daily intake. It is computed by dividing the "Total Inmates Received" figure by 365 days.

APPENDIX C

Cost Data:

1. Per Capita Health Care Expenditures as a Function of Average Length of Stay
   a. Small Jails
   b. Medium Jails
   c. Large jails

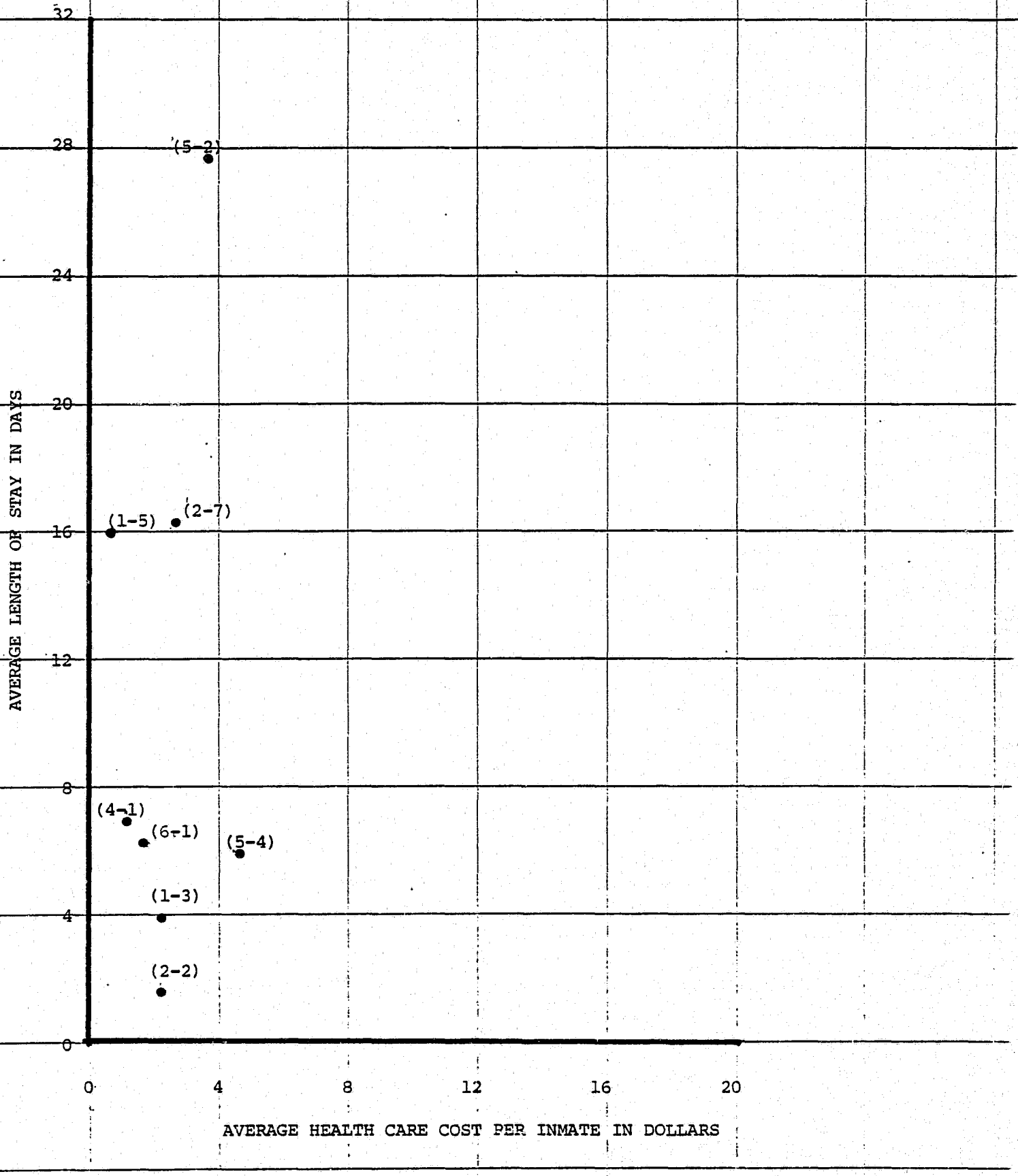
2. Three Cost Categories for 1975, 1976 and 1977, by Jail

1. A Brief Discussion of Per Capita Health Care Expenditures as a Function of Average Length of Stay

Graphs A, B, and C plot the relationship between the per capita health care costs and Average Length of Stay for the various pilot jails for which this data was available in 1976. Average Length of Stay information was not available for a number of jails for 1977, so it was impossible to make comparisons between these two years.

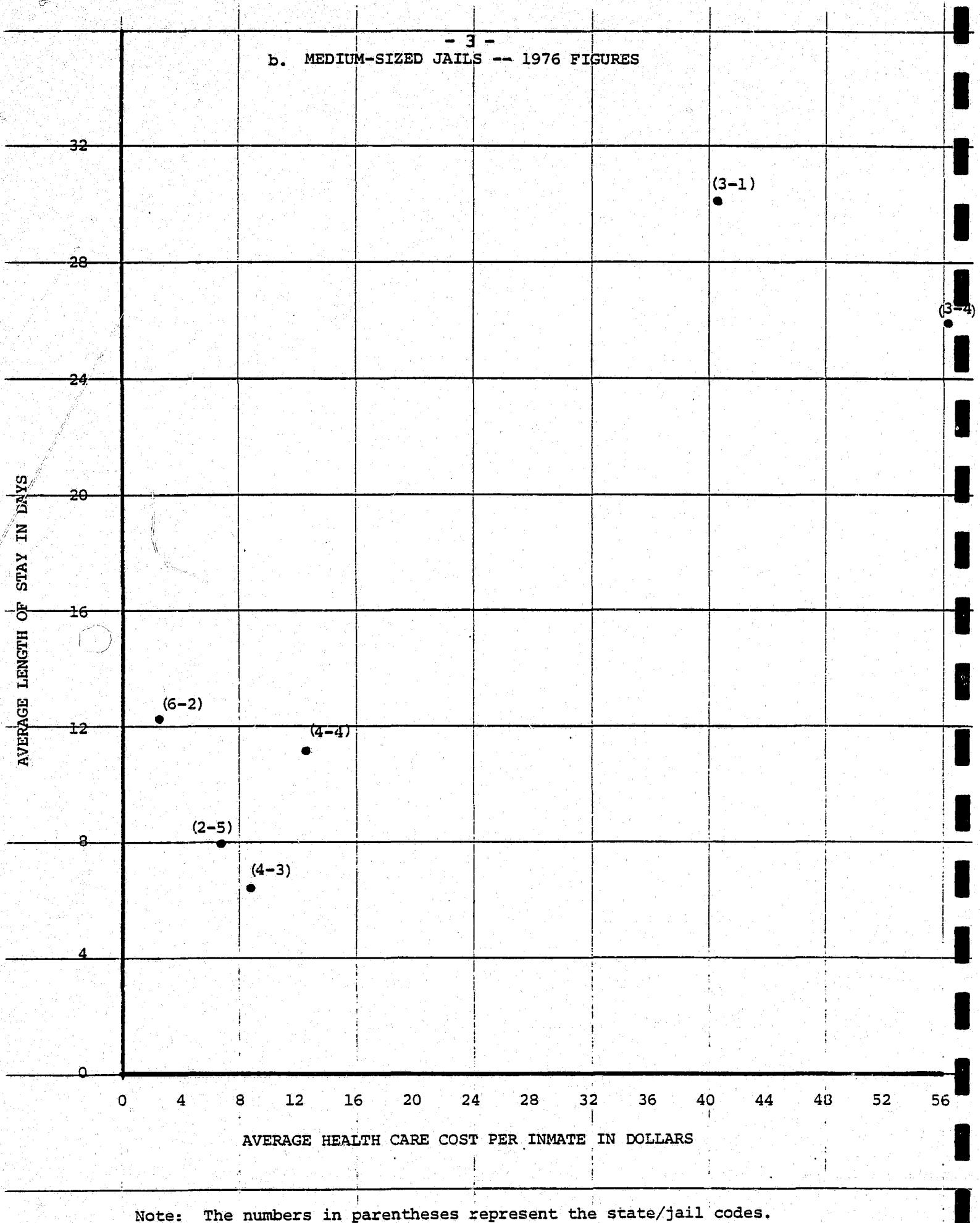
The information presented in these graphs seems to indicate that in the small jails and in some medium-sized jails, per capita health care costs in 1976 -- at least those explicit health care costs included in the per capita cost figures -- are relatively inelastic with respect to Average Length of Stay. That is to say, Average Length of Stay in these jails did not have a very great effect on their per capita expenditures for health care. In the other medium-sized jails and the large jails, however, Average Length of Stay seems to be directly related to per capita health care expenditures. The greater the Average Length of Stay, the greater the per capita cost. Since the small and some medium-sized jails offered fewer health care services in 1976 than did most large facilities, per capita health expenditures may not have been as closely linked to Average Length of Stay. Further, more health care costs are implicit ones at these smaller jails and, therefore, were not reflected in the calculations used here. It would have been interesting to see if per capita health care costs became more responsive to Average Length of Stay figures as the smaller jails increased the number of health care services provided to their inmates in 1977. However, please remember that before any definite conclusions about such cost relationships can be made, more accurate cost information is needed.

a. SMALL JAILS -- 1976 FIGURES



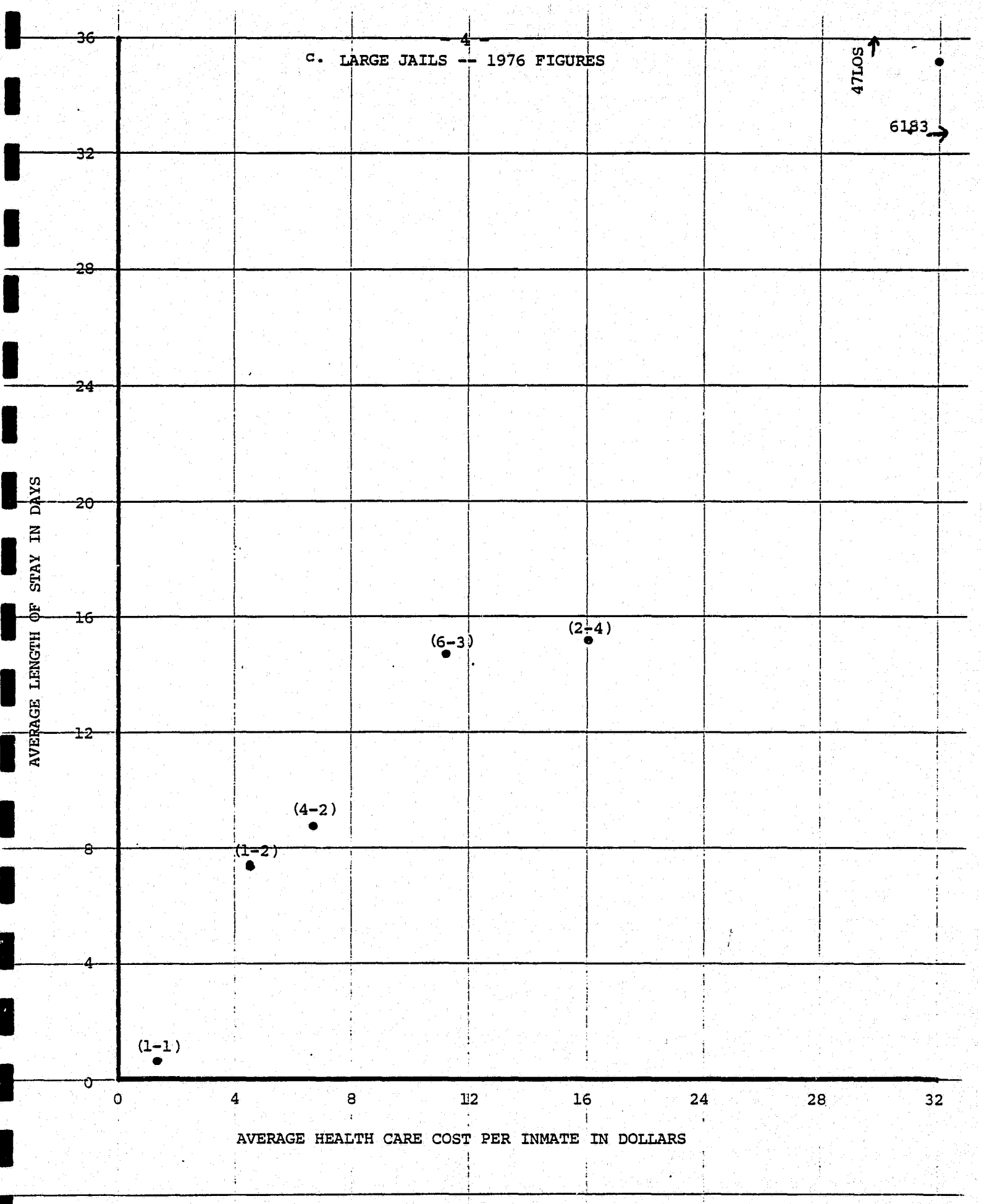
Note: The numbers in parentheses represent the state/jail codes.

b. MEDIUM-SIZED JAILS -- 1976 FIGURES



Note: The numbers in parentheses represent the state/jail codes.

c. LARGE JAILS -- 1976 FIGURES



Note: The numbers in parentheses represent the state/jail codes.

2. Three Categories of Cost Data for 1975, 1976 and 1977 By Jail

State/ Jail Code	Size	1975 a) Health Staff Salaries $	1975 b) Contract/Fee-for-Service c) Drugs/Other Services $	1975 Total $	1976 a) Health Staff Salaries $	1976 b) Contract/Fee-for-Service c) Drugs/Other Services $	1976 Total $	1977 a) Health Staff Salaries $	1977 b) Contract/Fee-for-Service c) Drugs/Other Services $	1977 Total $
1-1	L	NA	NR	-	NA	100,617	100,617	NA	110,679	110,679
1-2	L	67,533	28,910	96,443	67,277	24,951	92,228	76,497	30,500	106,997
1-3	S	NA	4,295	4,295	NA	2,243	2,243	NA	6,171	6,171
1-5	S	NA	814	814	NA	941	941	NA	854	854
2-1	S	NA	NR	-	NA	4,000	4,000	NA	7,000	7,000
2-2	S	NA	1,560	1,560	NA	2,100	2,100	NA	2,400	2,400
2-4	L	56,000	84,624	140,624	75,000	172,802	247,802	75,000	176,302	251,302
2-5	M	NA	NR	-	NA	18,592	18,592	NA	18,513	18,513
2-6	M	NA	NR	-	NA	7,338	7,338	NA	2,882	2,882
2-7	S	NA	NR	-	NA	1,016	1,016	NA	2,248	2,248
3-1	M	NR	NR	-	46,780	23,134	69,914	51,458	25,447	76,905
3-2	L	338,363	413,500	751,863	390,261	476,986	867,247	491,892	601,201	1,093,093
3-3	M	NR	NR	-	37,000	65,000	102,000	37,000	77,500	114,500
3-4	M	-	-	173,680	72,629	101,559	174,188	113,110	125,300	238,410
3-5	L	48,036	64,476	112,512	51,000	70,000	121,000	NR	NR	-
4-1	S	NA	203	203	NA	257	257	NA	267	267
4-2	L	66,800	68,250	135,050	59,000	83,080	142,080	63,000	101,224	164,224
4-3	M	NA	5,499	5,499	1,647	15,647	17,294	6,624	23,649	30,273
4-4	M	NR	NR	62,856	12,734	53,178	65,912	15,692	68,443	84,135
5-2	S	NA	2,928	2,928	1,300	2,310	3,610	2,600	2,304	4,904
5-3	M	NA	5,213	5,213	2,678	822	3,500	1,954	6,895	8,849
5-4	S	NA	1,222	1,222	500	1,690	2,190	900	754	1,654
6-1	S	NA	4,314	4,314	NA	716	716	NA	982	982
6-2	M	NA	3,375	3,375	NA	5,508	5,508	6,160	7,942	14,102
6-3	L	43,668	73,937	117,605	47,437	110,148	157,585	52,658	121,614	174,272

KEY: NA = Not Applicable
NR = Not Reported

END