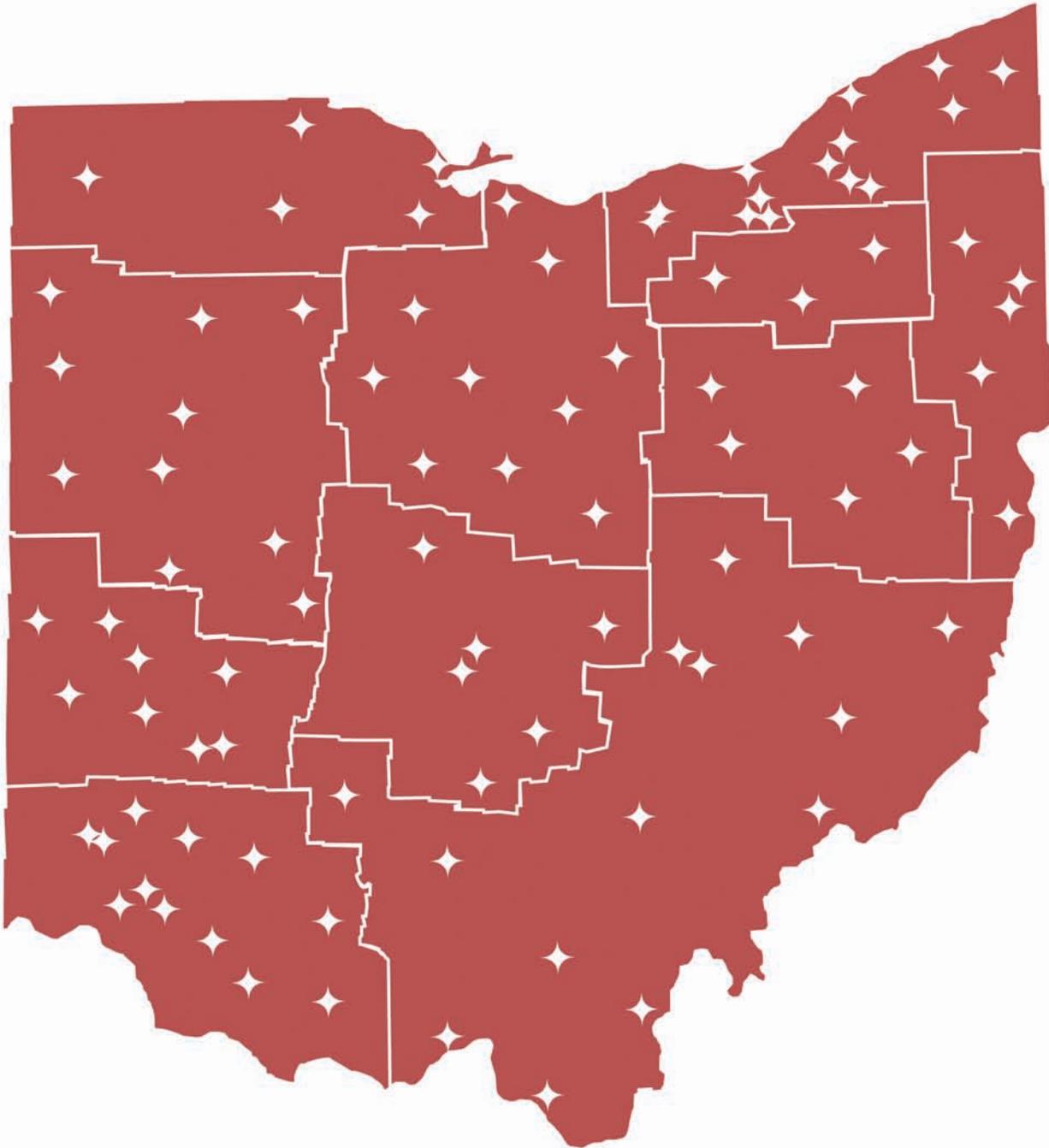


HIV Care in Ohio's Full Service Jails

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



OHIO
UNIVERSITY

Voinovich School of
Leadership and Public Affairs

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Ohio University

2009

Prepared By The Voinovich School of Leadership and Public Affairs

Acknowledgements

Many individuals contributed to this report, and the Voinovich School is most grateful for the support and assistance of each and every one of them.

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

Table of Contents

Introduction.....	1
Methodology.....	3
Participation in the Study.....	6
HIV Care in the Correctional Setting	10
Jails’ Perceptions of HIV Care	13
HIV Statistics	21
Identifying Inmates with HIV/AIDS (New and Diagnosed Cases).....	23
Availability of Trained Medical Care Personnel	30
HIV Medications.....	32
Non-Medical HIV Care	40
HIV Policies and Other Aspects of HIV Care	42
Release Care for Inmates with HIV/AIDS	45
Jails’ Linkages with their Communities	49
HIV Care in Managed Care and Non-Managed Care Jails.....	54
HIV Care in Small and Large Jails	65
HIV Care in Urban and Rural Jails.....	75
HIV Care in Regional, County, and Municipal Jails	85
Suggestions for Best Practices	88
Concluding Remarks.....	93
References.....	94

Table of Figures

Figure 1. <i>Identifying Inmates with HIV/AIDS: Perceived Strengths</i>	23
Figure 2. <i>Identifying Inmates with HIV/AIDS: Perceived Challenges</i>	24
Figure 3. <i>HIV Medications: Perceived Performance</i>	32
Figure 4. <i>HIV Medications: Missed Doses As Inmate Arrives at the Jail</i>	37
Figure 5. <i>HIV Medications: Missed Doses After Medications Have Been Obtained</i>	38
Figure 6. <i>HIV Medications: Missed Doses as an Inmate Leaves the Facility</i>	39
Figure 7. <i>Managed and Non-Managed Care Jails: Inmates Known to Have HIV/AIDS</i>	55
Figure 8. <i>Managed and Non-Managed Care Jails: HIV Testing Policies</i>	56
Figure 9. <i>Managed and Non-Managed Care Jails: Community Providers of HIV Care</i>	62
Figure 10. <i>Managed and Non-Managed Care Jails: HIV Care Provided by the Community</i>	63
Figure 11. <i>Large and Small Jails: Inmates Known to Have HIV/AIDS</i>	66
Figure 12. <i>Large and Small Jails: HIV Testing Policies</i>	67
Figure 13. <i>Large and Small Jails: Community Providers of HIV Care</i>)	72
Figure 14. <i>Large and Small Jails: HIV Care Provided by the Community</i>	73
Figure 15. <i>Urban and Rural Jails: Inmates Known to Have HIV/AIDS</i>	76
Figure 16. <i>Urban and Rural Jails: HIV Testing Policies</i>	77
Figure 17. <i>Urban and Rural Jails: Community Providers of HIV Care</i>	82
Figure 18. <i>Urban and Rural Jails: HIV Care Provided by the Community</i>	82

Table of Tables

Table 1. <i>Overall Participation in the Study</i>	7
Table 2. <i>Profile of Participating Jails</i>	8
Table 3. <i>Study Participants' Positions</i>	9
Table 4. <i>Perceived Strengths Related to Caring for Inmates with HIV/AIDS</i>	14
Table 5. <i>Perceived Strengths: Comparison of Jails With and Without Recent Experience</i>	15
Table 6. <i>Perceived Challenges Related to Caring for Inmates with HIV/AIDS</i>	16
Table 7. <i>Factors Contributing to Challenges Related to Caring for Inmates with HIV</i>	17
Table 8. <i>Overall Assessment of the Jails' Capacity to Care for Inmates with HIV/AIDS</i>	18
Table 9. <i>Number of Inmates Known to Have HIV/AIDS Housed in the Last 12 Months</i>	22
Table 10. <i>HIV Testing Policies Reported in Survey</i>	27
Table 11. <i>Conditions for HIV Testing Most Frequently Mentioned During Interviews</i>	28
Table 12. <i>HIV Medications: Factors Contributing to Missed Doses</i>	36
Table 13. <i>Elements of Release Care Provided by Jails</i>	45
Table 14. <i>Release Planning: Amount of Release Medications Provided to Inmates</i>	46
Table 15. <i>Release Planning: Ryan White Program Funds</i>	47
Table 16. <i>Community Organizations Providing HIV Care Services to Jails</i>	50
Table 17. <i>Specific HIV Care Services Provided by Community Organizations</i>	50
Table 18. <i>Managed and Non-Managed Care Jails: HIV-Related Medications</i>	57
Table 19. <i>Managed and Non-Managed Care Jails: Strengths</i>	58
Table 20. <i>Managed and Non-Managed Care Jails: Perceived Challenges</i>	59
Table 21. <i>Managed and Non-Managed Care Jails: Factors Contributing to Challenges</i>	60
Table 22. <i>Managed and Non-Managed Care Jails: Jail Capacity</i>	61

Table 23. <i>Large and Small Jails: HIV-Related Medications</i>	68
Table 24. <i>Large and Small Jails: Strengths</i>	69
Table 25. <i>Large and Small Jails: Perceived Challenges</i>	70
Table 26. <i>Large and Small Jails: Factors Contributing to Challenges</i>	71
Table 27. <i>Large and Small Jails: Jail Capacity</i>	71
Table 28. <i>Urban and Rural Jails: HIV-Related Medications</i>	78
Table 29. <i>Urban and Rural Jails: Strengths</i>	79
Table 30. <i>Urban and Rural Jails: Perceived Challenges</i>	80
Table 31. <i>Urban and Rural Jails: Factors Contributing to Challenges</i>	81
Table 32. <i>Urban and Rural Jails: Jail Capacity</i>	81

Table of Appendices

Appendix A: Interview Guide.....	96
Appendix B: Intake Screening Forms Provided by Interviewed Jails	103
Appendix C: HIV Policies & Protocols Provided by Interviewed Jails	130
Appendix D: HIV Formularies Provided by Interviewed Jails.....	190
Appendix E: Community Providers of HIV Care Named in Interviews	210
Appendix F: Cover Letter Sent with Survey	212
Appendix G: Survey	213
Appendix H: Survey Results: <i>Overall Results</i>	217
Appendix I: Survey Results: <i>Large Jails and Small Jails</i>	237
Appendix J: Survey Results: <i>Managed Care Jails and Non-Managed Care Jails</i>	244
Appendix K: Survey Results: <i>Urban Jails and Rural Jails</i>	252
Appendix L: Survey Results: <i>Experience and No Experience with HIV/AIDS</i>	260
Appendix M: Guide to Consortia Report Preparation	264

Introduction

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

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

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

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

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

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

Methodology

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

Instrumentation

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

Interview Information

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

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

Survey Data

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

Data Analysis

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

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

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

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

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

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

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

Participation in the Study

Recruitment of Jails

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

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

Overall Participation

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

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

By the conclusion of the study, a total of 55 jails completed either a face-to-face or telephone interviews¹ and a total 56 jails completed and returned the survey questionnaire. Table 1 provides detailed information on the participation in the project.

Table 1. Overall Participation in the Study

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

Profile of Participating Jails

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

¹ Eleven of the interviews were conducted by telephone.

² This criterion was provided by ODH.

³ Ohio Jail Administrator’s Handbook, 2nd Edition.

Table 2. Profile of Participating Jails

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

Profile of Respondents

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

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

Table 3. Study Participants' Positions

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

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

HIV Care in the Correctional Setting

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

Minimum Standards

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

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

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

The Correctional Setting

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

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

“Due to a range of issues and characteristics of prisons and jails, it is often difficult for HIV-infected inmates to access HIV counseling, testing, early HIV intervention, and ongoing clinical management that meet the community standards of care.”

-Linda Frank,
Journal of the Association of Nurses in AIDS Care, (1999)

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

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

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

“The structure provided within these sites allows individuals to focus on health-seeking behaviors rather than devoting much of their time to acquiring basic needs”

-Sandra Springer & Frederick Altice,
Current HIV/AIDS Reports, (2005)

Jails' Perceptions of HIV Care

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

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

Survey Data

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- According to the respondents from the surveyed jails, the most common cause of HIV care challenges was, on average, a lack of finances. While the survey respondents reported this factor occurred, on average, *sometimes*, the interview data suggest that this was very often the case.
- According to the respondents from the surveyed jails, the issue that least often contributed to the challenging nature of HIV care is a jail's relationship with the local community and elected officials. The respondents from the surveyed jails perceived that this happens, on average, *never* or *rarely*. This issue also was not frequently raised during the interviews.

“The cost is overwhelming...it’s very burdensome.”
 -A medical staff member from one of Ohio’s FSJs

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

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

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

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

Interview Data

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

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

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

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

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

“We would love it if inmates were more forthright.”

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

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

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

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

HIV Statistics

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

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

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

“Some people believe that HIV/AIDS are widespread in jails, which is not true. We have more cases of Hepatitis C than HIV/AIDS.”

-An Ohio FSJ Health Care Administrator

⁶ All but one of the interviewed jails reported that, at some point in their history, they have housed an inmate known to have HIV/AIDS.

⁷ The average is expressed as a range because survey data were collected in the form of ranges.

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

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

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

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

“There are so many people out there that you know haven’t been tested...I think we probably have a lot higher number than we’re aware of.”

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

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

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

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

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

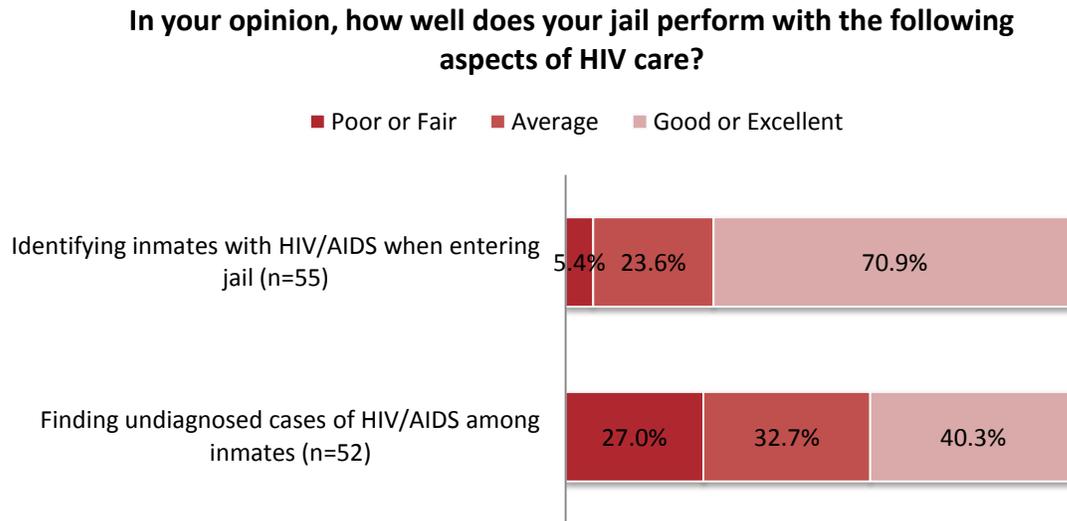
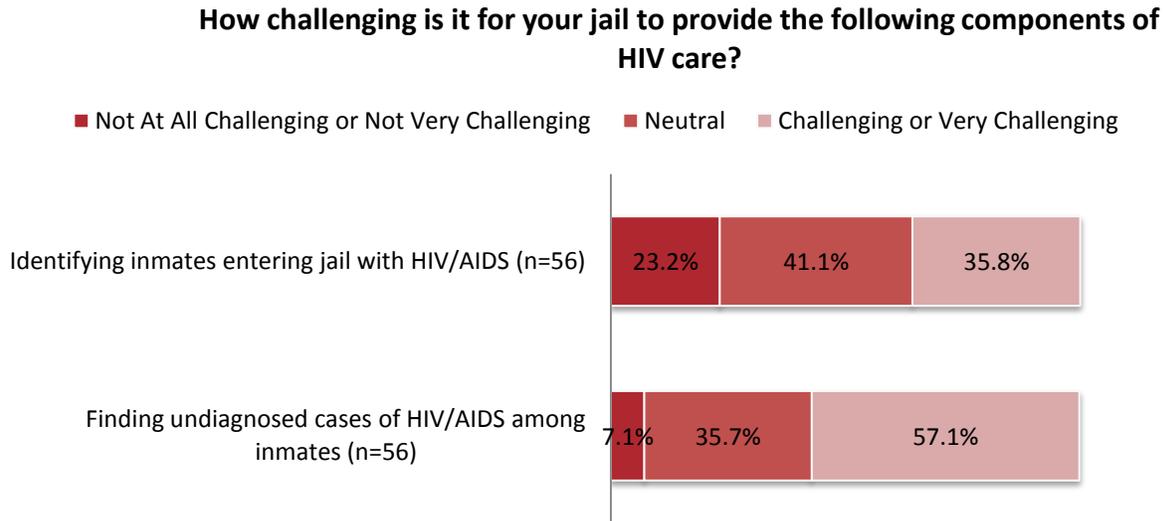


Figure 2. Identifying Inmates with HIV/AIDS: Perceived Challenges



Identifying Diagnosed Cases

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

Intake screening. It appears that many inmates who know they have HIV/AIDS disclose

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

their HIV serostatus as they are booked into jail. In most jails, this means that they revealed their HIV serostatus to a corrections officer who conducts the initial intake screening (only seven of the informants from the interviewed jails reported that members of the medical staff conduct the intake screening performed when an inmate arrives at the jail).⁹ Fourteen of the informants from the interviewed jails volunteered that their intake questionnaire asks specifically about HIV/AIDS. Many other interview informants reported asking questions about sexually transmitted diseases and chronic health

conditions that provide opportunities for inmates to report their HIV serostatus. Regardless of whether inmates identify themselves as having HIV/AIDS, if they report that they are on any medications this usually triggers a quick meeting with the medical staff so that medications

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

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

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

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

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

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

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

Identifying New Cases

Much of the medical and scholarly literature on HIV in the correctional setting views incarceration as a public health opportunity (Frank, 1997; see also Spaulding, et al., 2002, 2007; Springer & Altice, 2005). Because the prevalence rates for HIV/AIDS are said to be significantly higher in correctional institutions than in the general population, incarceration affords health care providers access to a larger than normal population of individuals affected by the illness. Incarceration reportedly can also provide the structured setting needed to treat HIV/AIDS in a consistent way, thereby improving the health of a population that will be returning to the community. Treatment services that reduce an inmate's HIV viral load may render him or her less infectious after being released from jail.

“Correctional settings are important sites for screening, detection, and treatment of HIV and can serve as a conduit to care after release into the community. They represent structural sites of contact where many individuals with or at high risk for HIV interface on a daily basis.”

-Sandra Springer & Frederick Altice, *Current HIV/AIDS Reports*, (2005)

Incarceration is also reported to provide the opportunity to identify and educate persons with HIV/AIDS or at risk for HIV/AIDS, which is predicted to reduce the spread of the disease when inmates with HIV/AIDS return to the community. Voinovich School staff solicited the jails' view of this issue by asking interview respondents the following question, “We've talked about existing conditions, what about conditions inmates might not know about? Do you view it as your role to uncover these conditions, in particular HIV/AIDS?” Slightly more than half of the interview informants answered no, often reluctantly. Specifically, 53.7 percent of respondents said no, and 46.3 percent of respondents said yes.¹⁰ Many informants remarked on the difficulty of the question or called the question “tricky.” Typical answers to this question included, “I sure

“Medical expenses wiped out our budget last year. We cannot afford to do more than maintain already established care.”

--An Ohio FSJ Health Care Administrator

wish we could,” and “we can only do so much.” Some respondents said that they do work to uncover some undiagnosed health conditions, but not HIV/AIDS because that condition is far too costly to treat.

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

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

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

HIV Testing

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

Table 10. *HIV Testing Policies Reported in Survey*

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

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

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

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

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

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

“I’m not sure if any investment in testing would be worth it. If an inmate is only in for a couple of days they would have to get follow up care on the outside.”

-An Ohio FSJ Health Care Administrator

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

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

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

“Typically HIV cases don't have early symptoms and that is part of the reason we don't test everyone that walks through the door. If we find a new case and start meds, their chance of med compliance after they leave the jail is very low because they don't feel sick.”

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

Despite the prevalence of these concerns, there were still many informants that indicated they would welcome testing services if a local health department, free clinic, AIDS Task Force, or other organization would offer them for free. Several jails that already receive testing services from community organizations

and informants from such facilities expressed great satisfaction with the arrangement. There appears to be mixed feelings on the part of jail staff about whether the potential ramifications of increased HIV testing should be viewed as prohibitive.

Availability of Trained Medical Care Personnel

Jail Medical Personnel

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

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

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

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

¹¹ This medical staff is shared between two jails.

¹² These managed- and non-managed care figures include both jails that participated in interviews and jails that completed surveys. The rest of this section is based on interview data only.

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

Access to Specialists

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

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

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

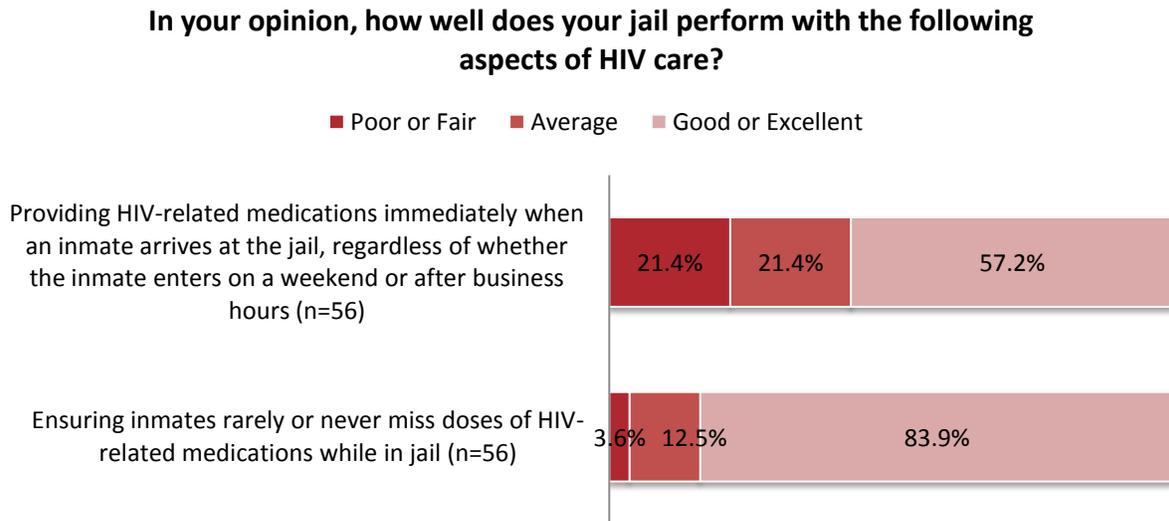
HIV Medications

Medications While in Jail

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

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

Figure 3. HIV Medications: Perceived Performance



Obtaining Medications

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

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

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

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

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

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

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

Medication Administration

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

Medications at Release or Transfer

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

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

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

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

Medication Interruptions

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

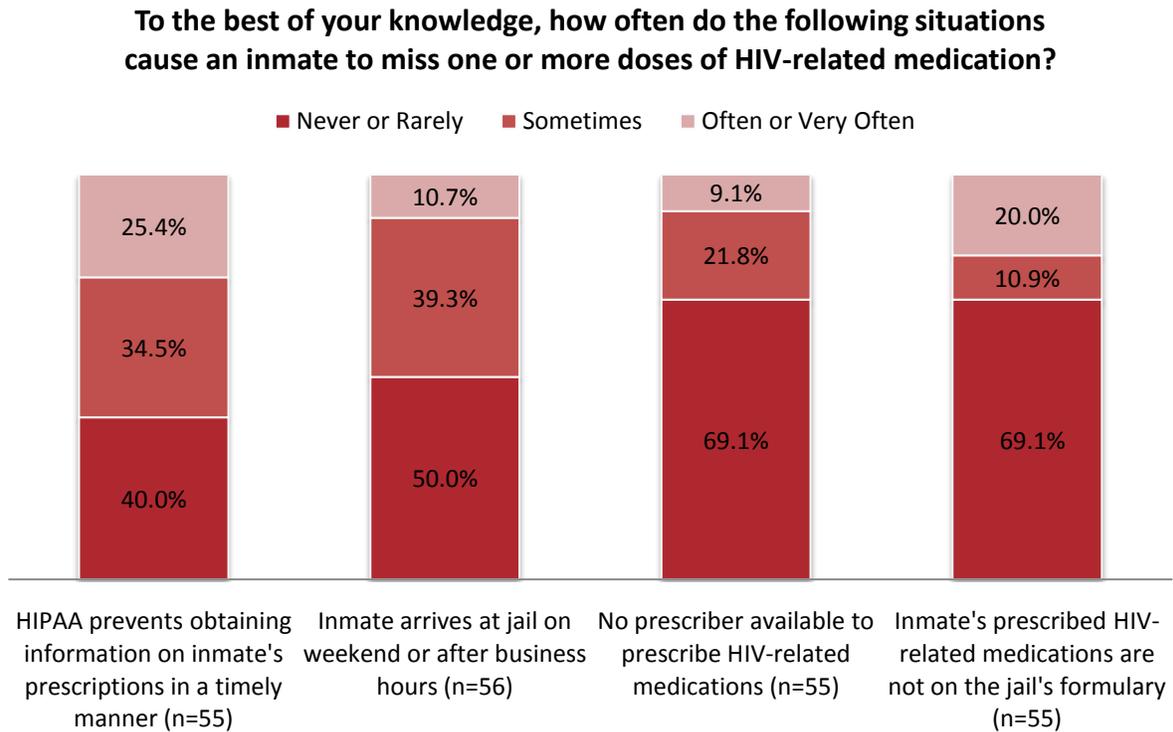
Table 12. HIV Medications: Factors Contributing to Missed Doses

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

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

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

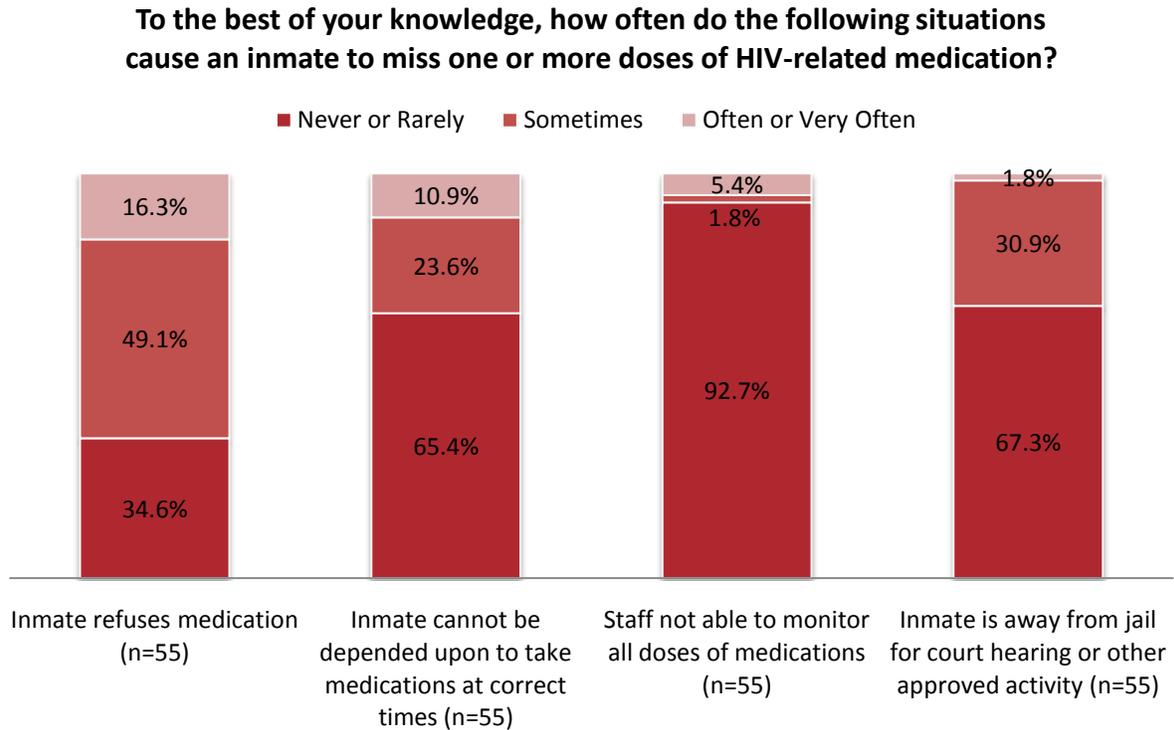
Figure 4. HIV Medications: Potential Causes of Missed Doses As Inmate Arrives at the Jail



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

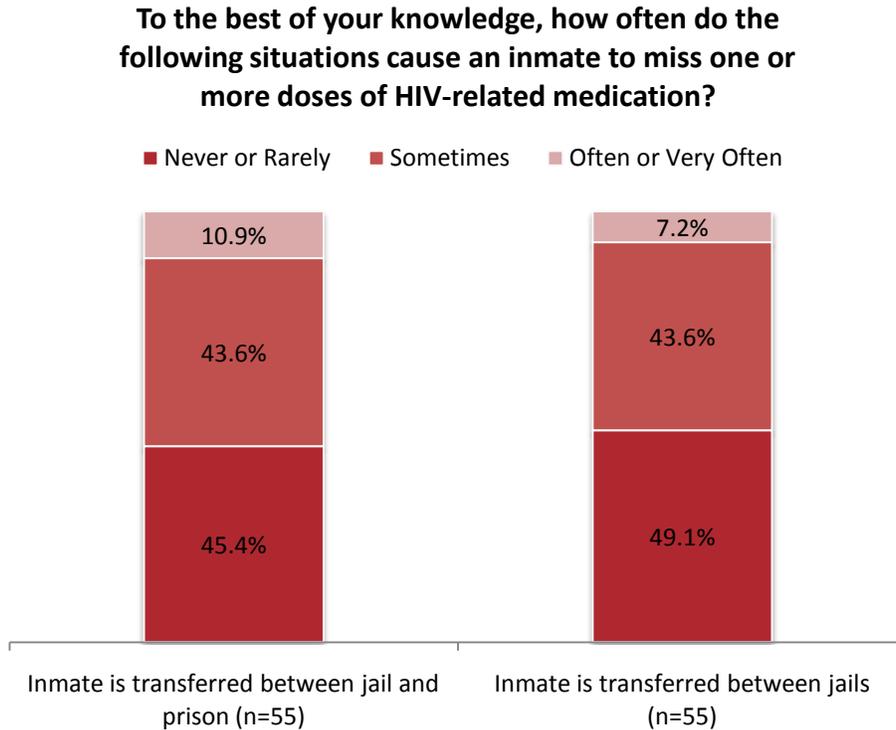
Both survey and interview data make clear that jails do *not* perceive staff inability to monitor doses of medication to be a factor behind any missed doses. A total of 92.7 percent of survey respondents reported that this is *rarely* or *never* the cause of a missed dose. Less than ten percent of interview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

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



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

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



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

Non-Medical HIV Care

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

“Inmates on complicated antiretroviral regimens must also be provided with access to information and instruction about their medications. They must be provided with counseling, reminders, and other tools to assure timely, consistent medication adherence.”

--Linda Frank, *Journal of the Association of Nurses in AIDS Care*, (1999)

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

Mental Health Care

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

HIV Education

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

Case Management

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

Other Non-Medical Care

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

HIV Policies and Other Aspects of HIV Care

Housing Policies for Inmates with HIV/AIDS

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

Transfer of Inmates with HIV/AIDS

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

Disclosure of an Inmate's HIV Serostatus

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

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

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

“We utilize universal precautions and don't know the status of 95 percent of the population here. Officers don't usually like that and would like to know [inmates' HIV] status. But we tell them that someone you *do* know is HIV-positive is no more contagious than someone you *don't* know is HIV-positive. Always treat them the same and put your gloves on.”

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

Regardless of a jail's official policy, many interview informants stressed that it is extremely difficult to preserve the confidentiality of inmates' health information in the jail setting. To disclose their HIV serostatus when they are being admitted to the jail frequently requires telling the member of the non-medical staff who is conducting the intake screening. Moreover, these screenings are often conducted in settings that make it difficult to avoid being overheard by others. Many informants reported that at least one corrections officer is present during any interaction between medical staff and inmates. This means that even when inmates disclose their HIV serostatus to a member of the medical staff in the jail's

“The Corrections Officers are well-taught. They know how to handle inmates with HIV and don't mistreat, stigmatize them, or overreact to their HIV status.”

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

medical area, at least one member of the non-medical staff is always privy to the information. The fact that corrections officers administer medications in many jails also creates an opportunity for non-medical staff to learn about an inmate's HIV serostatus. The frequency with which inmates living with HIV/AIDS have to take medications can also indicate an inmate's HIV serostatus to corrections officers as well as other inmates.

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

HIV Awareness and Training of Non-Medical Staff

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

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

Release Care for Inmates with HIV/AIDS

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

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

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

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

* The survey instrument did not solicit this information.

Release Medications

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

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

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

Ryan White Program Funds

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

Table 15. Release Planning: Ryan White Program Funds

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

Follow-Up Care

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

Almost one-third of informants from the interviewed jails stated explicitly that they

“It’s all about self-care...it’s [the inmate’s] responsibility to follow up.”

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

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

Impediments to Release Planning

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

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

“I think it’s very difficult for inmates to keep appointments with their outside providers.”

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

Jails' Linkages with their Communities

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

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

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

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

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

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

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

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

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

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

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

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

* The survey did not ask about this component.

**The interview did not ask about this component.

Medical HIV Care

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

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

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

Non-Medical HIV Care

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

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

Release Care

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

Impediments to Community Linkages

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

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

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

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

Incentives for Community Linkages

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

“We’d love to have access to anything we can get.”

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

HIV Care in Managed Care and Non-Managed Care Jails

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

HIV Statistics

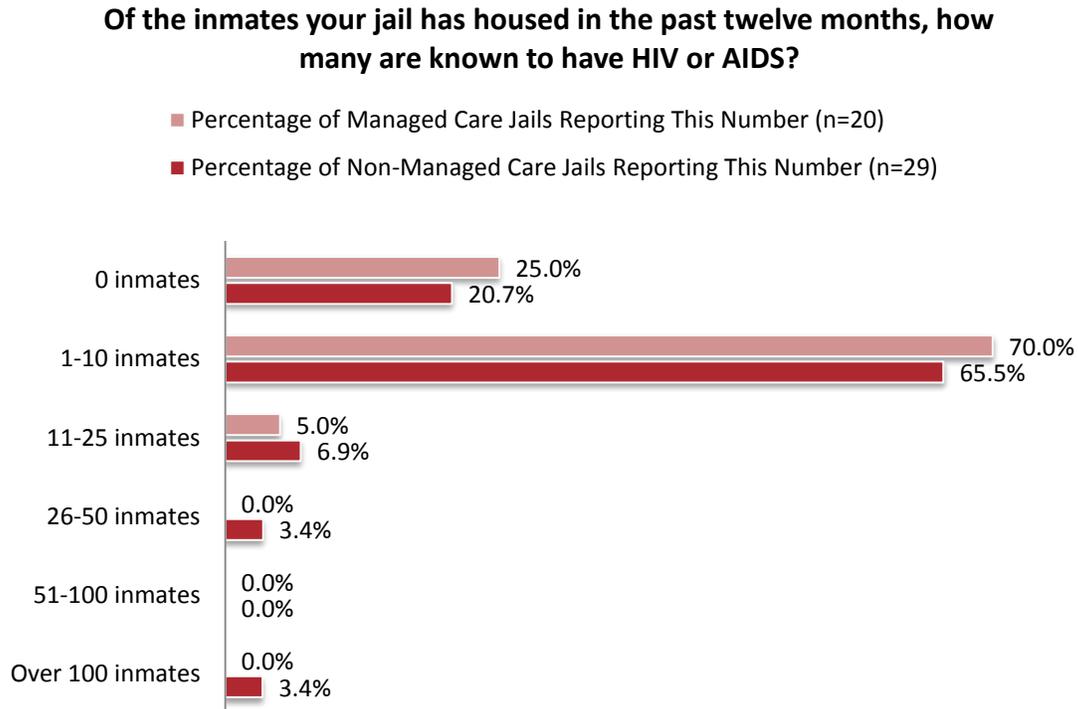
Managed care jails, on average, housed a slightly higher number of inmates than non-managed care jails in the last year. The average number of inmates housed by managed care jails in the last year was 8,052 while the average for non-managed care jails was 7,357. Despite the higher number of inmates,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

¹⁵ $N = 20$

¹⁶ $N = 30$

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

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



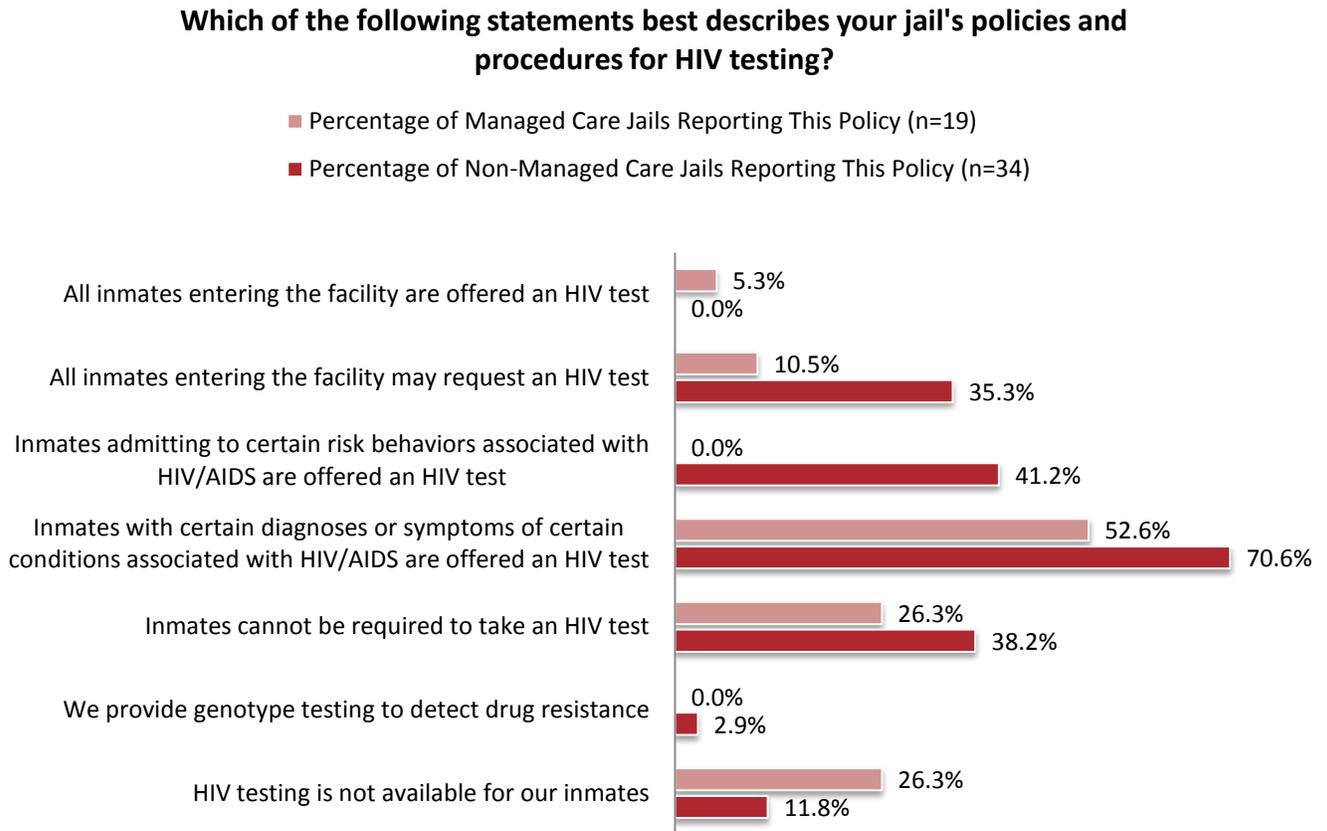
HIV Testing

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

“The [managed care] company has a set contract price and lab work is rolled into that. [HIV testing] is going to up the lab costs.”

-An Ohio FSJ Medical Director

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



Medications

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

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

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

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

Note. Higher rankings indicate higher perceived frequencies.

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

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

Jails’ Perceptions of HIV Care

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Note. Higher rankings indicate stronger expressed agreement.

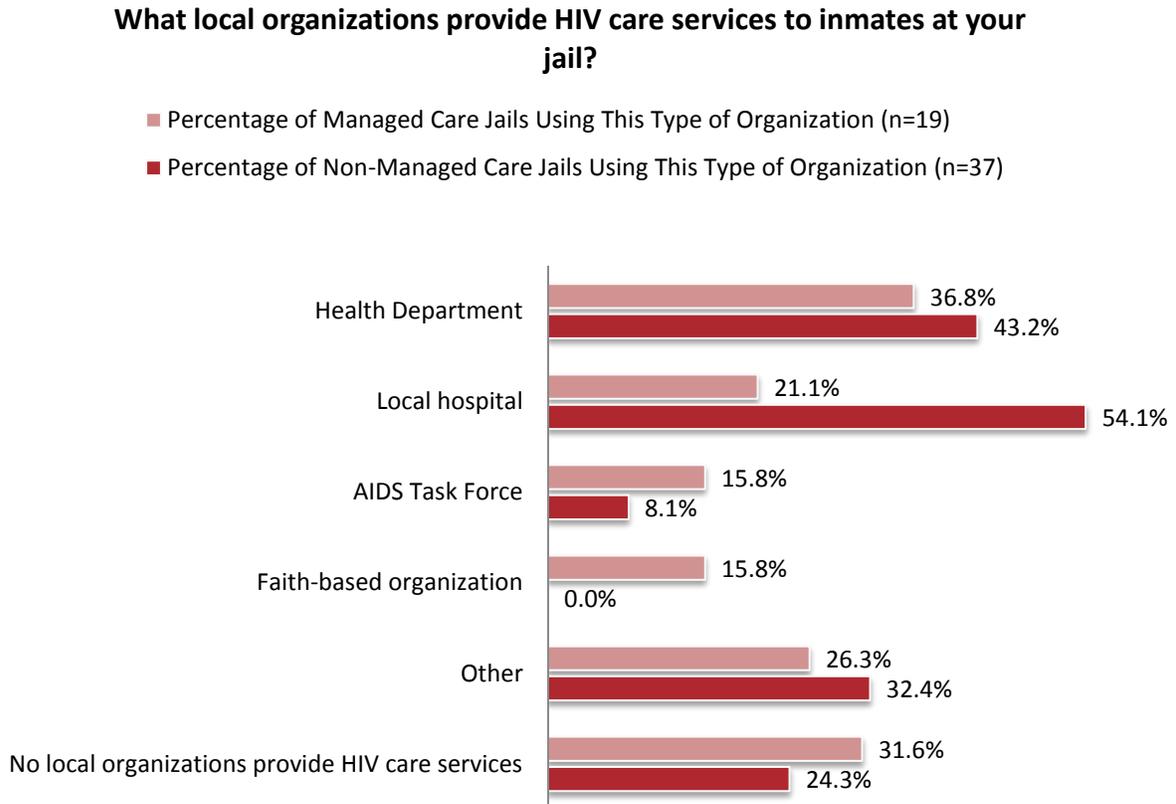
Please indicate how strongly you agree or disagree with the following statements.	Managed Care Ranking	Non-Managed Care Ranking
We would like local organizations to be more involved in providing care for inmates with HIV	1	2
Inmates at this jail have adequate access to HIV specialists	2	1
This jail is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

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

Community Linkage

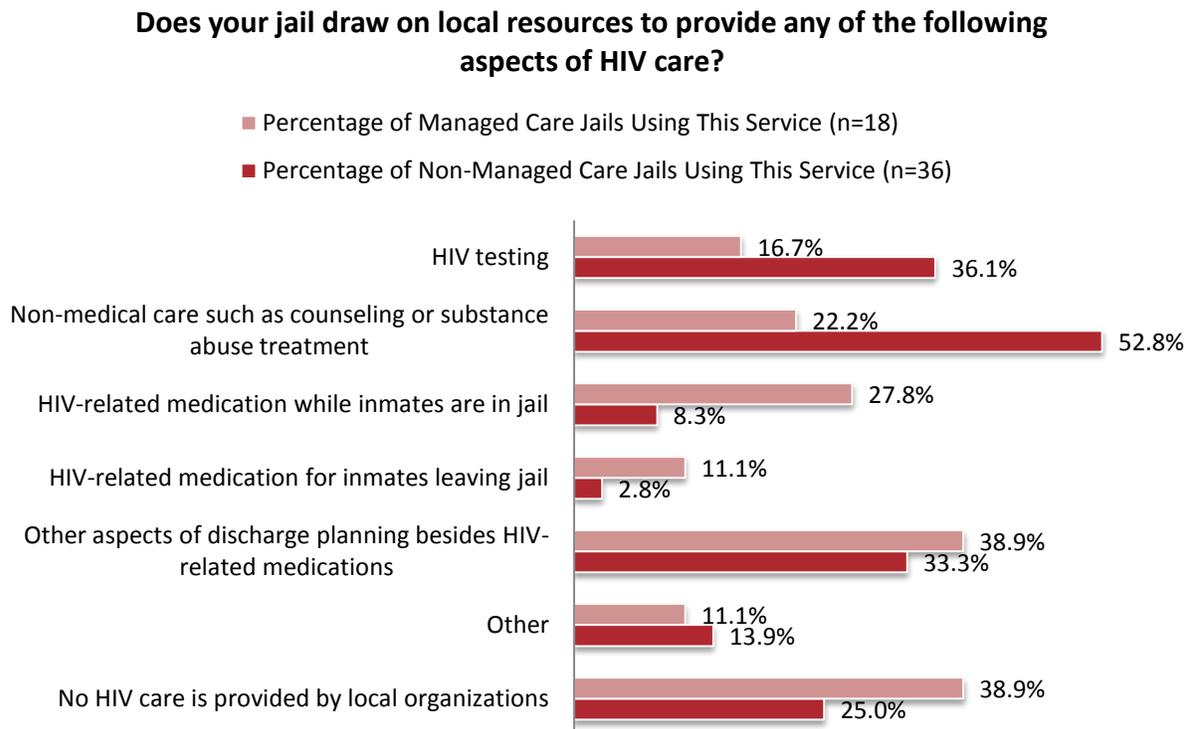
The types of local organizations that managed and non-managed care jails use for HIV care for their inmates are very similar. As for the services they use, it seems that non-managed care jails are more likely to draw on community organizations for non-medical HIV care and for HIV testing. The following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

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



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

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



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

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

Conclusions

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

HIV Care in Small and Large Jails

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

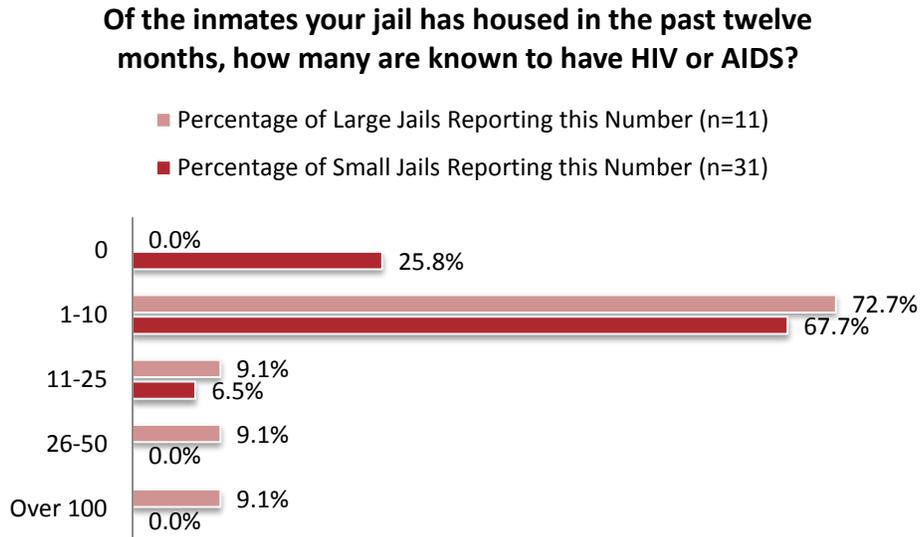
HIV Statistics

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

¹⁸ Averages are given in the form of ranges because survey data was gathered in the form of ranges.

¹⁹ For large jails, $n = 11$; for small jails, $n = 31$. Data from 23 jails had to be omitted because it could not be disaggregated, it was based on a duplicative tracking system, or it was inconsistent between the survey and interview.

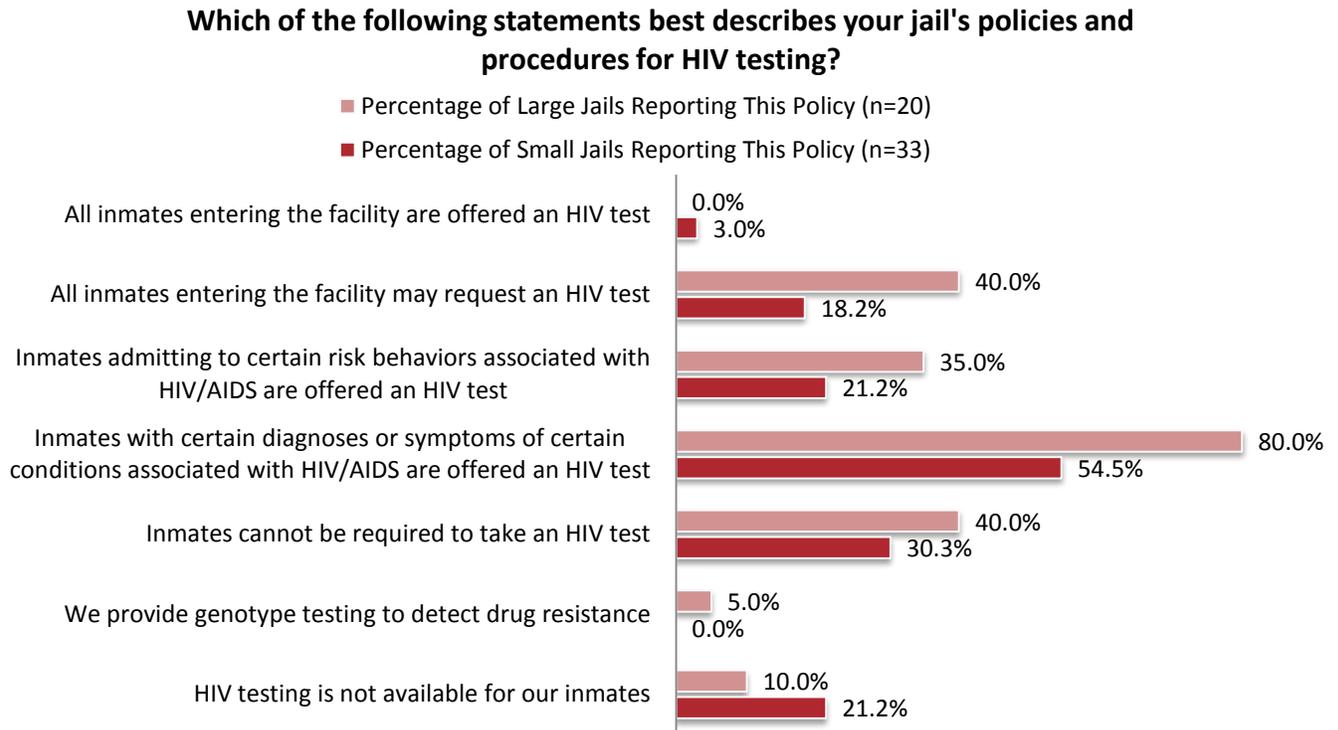
Figure 11. Comparison of Large and Small Jails: Number of Inmates Known to Have HIV/AIDS Housed in the Last Year



HIV Testing

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

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



Medications

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

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

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

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

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

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

Jails' Perceptions of HIV Care

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

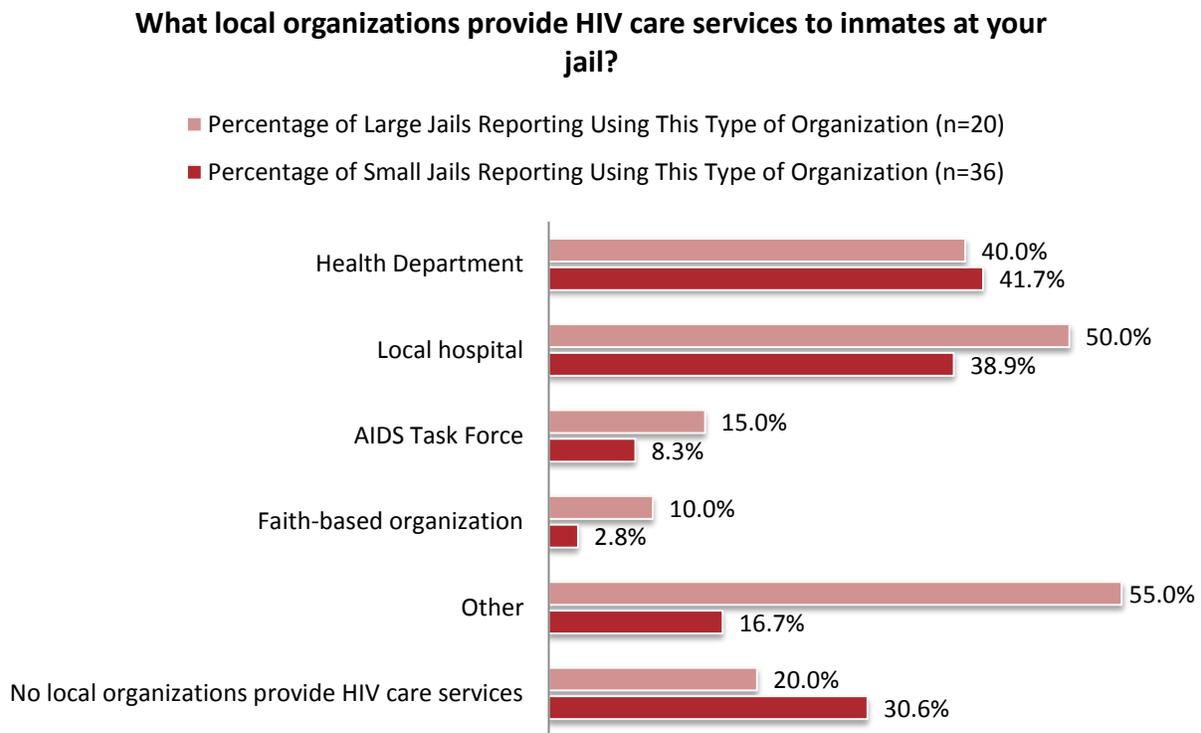
- Providing access to HIV specialists received the highest average level of agreement from large jails and the second highest level of agreement from small jails. This is somewhat surprising given the other survey data that suggests small jails perceive it to be more difficult to gain access to HIV specialists.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

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

Community Linkage

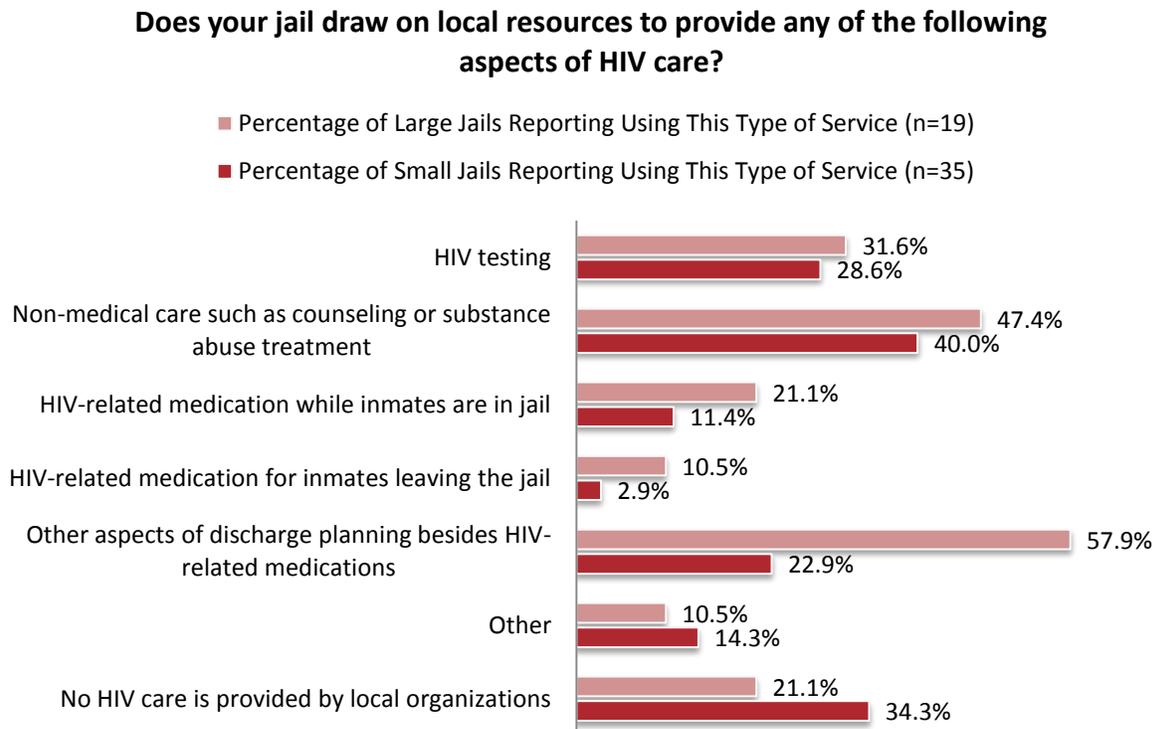
Survey and interview data do not provide a clear indication of differences between large and small jails when it comes to community provision of HIV care services. The following figures present the survey data related to community linkage.

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



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

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



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

Conclusions

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

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

HIV Care in Urban and Rural Jails

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

HIV Statistics

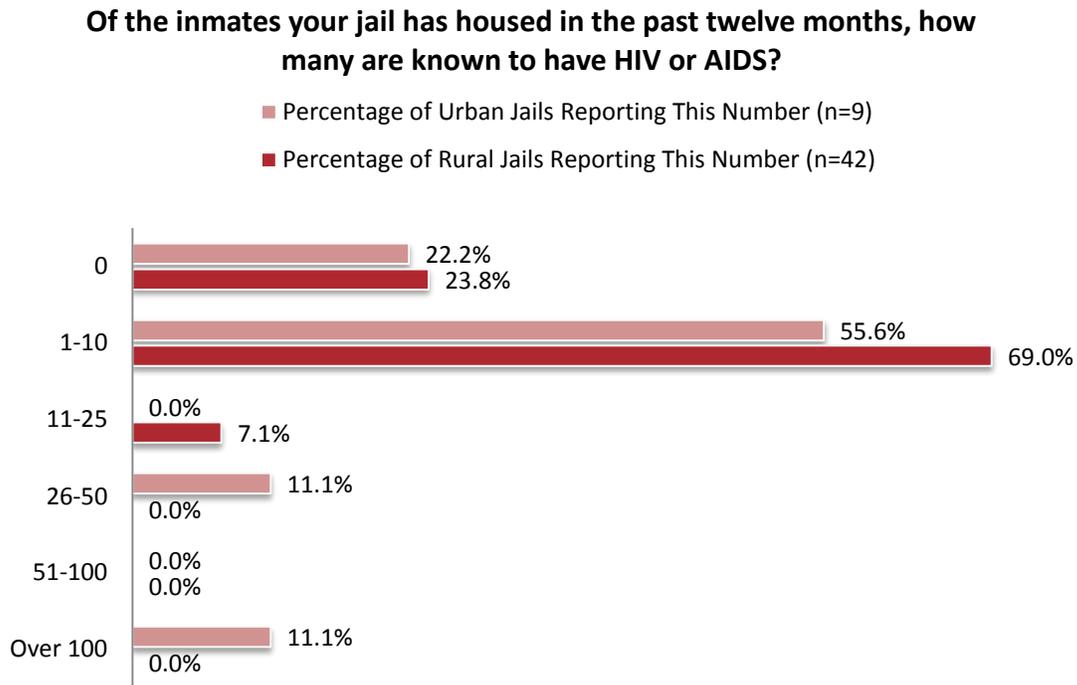
Not surprisingly, jails in urban areas housed more inmates than jails in rural areas. The average number of inmates housed by an urban jail in the last year was 15,292, while the average number housed by a rural jail was 5,575. As would be expected given the difference in the number of inmates, urban jails reported housing more inmates known to be living with HIV/AIDS in the last year than rural jails. The average number of inmates known to be living with HIV/AIDS housed by urban jails in the last year is estimated to range between 23-25²⁰, while the average for rural jails is estimated to range between 3-5.^{21, 22} Figure 15 provides more specific data for the two categories of jails. The numbers and percentages represent combined data from the interview and survey.

²⁰ $N = 9$; data from four jails were omitted because the jails have potentially duplicative tracking systems and data from two jails were omitted because the jails provided contradictory data in their survey and interview responses.

²¹ $N = 42$; one jail did not answer the question, data from three jails were omitted because of potentially duplicative tracking systems, and data from four jails were omitted because survey and interview responses for those jails conflicted.

²² The averages are presented in the form of ranges because survey data was gathered in the form of ranges.

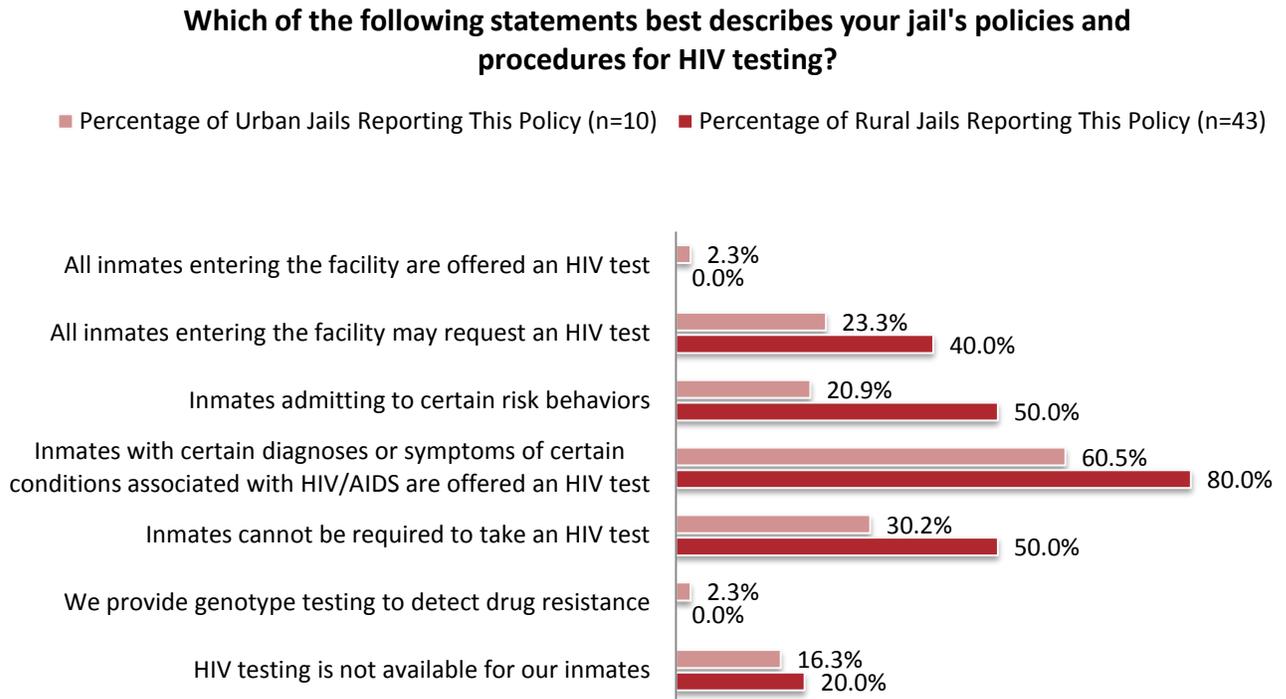
Figure 15. Comparison of Urban and Rural Jails: Number of Inmates Known to Have HIV/AIDS Housed in the Last Year



HIV Testing

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

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



Medications

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

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

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

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

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

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

Jails’ Perceptions of HIV Care

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

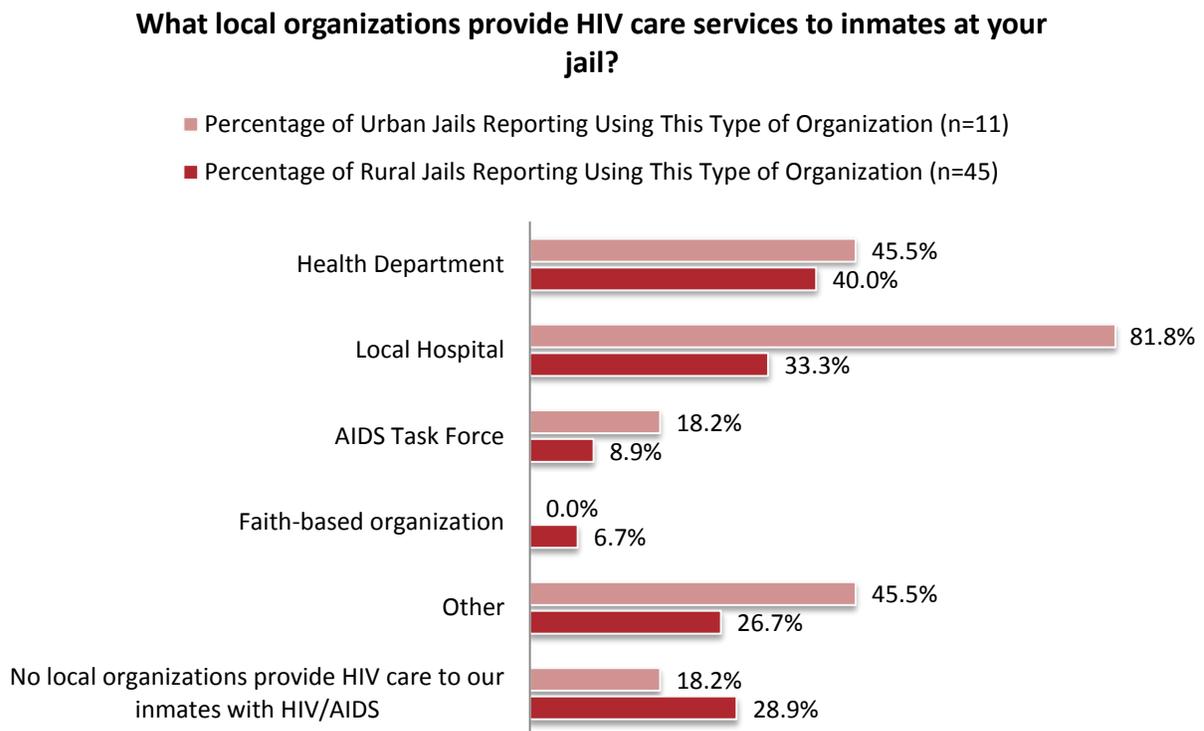
- Despite giving similar rankings to the statement “Inmates at this jail have adequate access to HIV specialists,” urban jails, on average, appear to be more in agreement with this statement. Urban jails gave access to specialists an average score of 4.5 (where 4 = *agree* and 5 = *strongly agree*) while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

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

Community Linkage

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

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



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

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

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

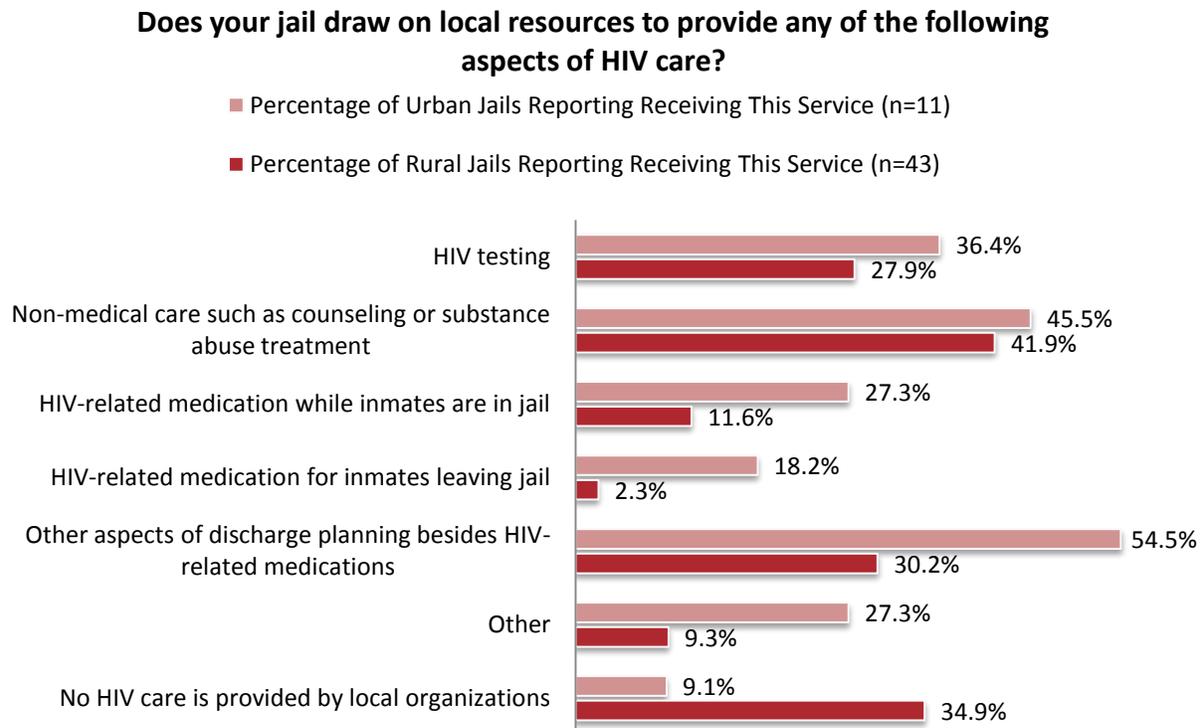


Figure 18 also shows that urban jails are more likely to use the resources available in the community compared to their rural counterparts. Urban jails are especially more likely to use community resources as a source of inmate medication, while inmates are in jail and when they are leaving. Using a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

Conclusions

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

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

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

HIV Care in Regional, County, and Municipal Jails

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

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

HIV Statistics

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

²³ $N = 3$; data from one jail were not included because of a potentially duplicative tracking system.

²⁴ $N = 4$; data from one jail were not included because number provided in the interview and survey were inconsistent.

HIV Testing

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

Medications

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

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

Community Linkage

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

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

Observations

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

Suggestions for Best Practices

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

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

Funding

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

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

Community Linkage

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

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

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

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

“It doesn’t make sense to put a lot of time and money into researching and having provisions on things that I never see...I know that HIV is a big concern, but we just don’t see it and so for me to spend a lot of time, money, and resources to try to have a big program set up just doesn’t make sense.”

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

HIV Awareness/Education

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

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

A Policies and Procedures “Toolkit”

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

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

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

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

- (2) It would seem critically important for jails to ensure that inmates living with HIV are connected with a local AIDS service organization (ASO) when released back into the community. ASOs can help with issues such as housing, medications and adherence, legal assistance, and mental health care. During the release period, it seems important for jail staff to have current information about community resources available to inmates being released.
- (3) More confidential/private intake environments may be needed to facilitate a fuller disclosure of an inmate's health issues (e.g., HIV-serostatus disclosure). Regardless of a jail's official policy, many interview respondents stressed that it is extremely difficult to preserve the confidentiality of inmates' health information in the jail setting. To disclose their HIV status when they are being admitted to the jail frequently requires inmates telling a member of the non-medical staff who is conducting the intake screening. Moreover, these screenings are often conducted in settings that make it difficult to avoid being overheard by others. Many respondents reported that at least one corrections officer is present during any interaction between medical staff and inmates. This means that even when inmates disclose their HIV serostatus to a member of the medical staff in the jail's medical area, at least one member of the non-medical staff is always privy to the information.
- (4) All jails should permit HIV-infected inmates to bring their HIV-related medications into jail with them.
- (5) Policies are needed so that non-adherence does not occur when a person moves from a jail to prison.

Some suggestions for resources include:

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

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

Concluding Remarks

Limitation of the Study

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

Directions for Future

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

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